EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA
PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patients

1st Form
Diagnosis of the disease

CENTER	
Name	______________________________
Address	______________________________
Country	______________________________
Phone number	______________________________
Fax number	______________________________
Referant doctor	______________________________
Email	______________________________
Comments	

IDENTIFICATION		
ID Patient	Surname (Family name) Name (First name)	|__|__
__	
Date of birth	mm/yyyy	|__|__| / |__|__|__|__|
Sex		[1] ❑ Male [2] ❑ Female
Country		______________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

DEMOGRAPHIC DATA AT DIAGNOSIS		
Marital status	[1] ❑ Married [2] ❑ Never been married [3] ❑ Divorced [4] ❑ Widowed	
Highest graduation basic	[1] ❑ Secondary school [2] ❑ Intermediate school [3] ❑ High graduation school, A level [4] ❑ University	
Employment status	[1] ❑ Unemployed [2] ❑ Full time employed [3] ❑ Part time employed [4] ❑ Not applicable	
Weight	kg	|__|__|__|
Height	cm	|__|__|__|
Currently smoker (if yes, specify number of daily cigarettes smoked and for how long)	[0] ❑ No [1] ❑ Yes	
	[1] ❑ < 20 [2] ❑ > 20	
	Number of years	|__|__|
Past smoker (if yes, specify number of years and date of stop smoking)	[0] ❑ No [1] ❑ Yes	
	Number of years	|__|__|
	Date of stop smoking (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Oral contraception (if yes, then, please specify name, dose and for how long)	[0] ❑ No [1] ❑ Yes [2] ❑ Not applicable	
	Name (use trade name if possible)	____________________
	Dose	____________________
	Number of years	|__|__|
Pregnancy at diagnosis	[0] ❑ No [1] ❑ Yes	
	If yes then please specify number of weeks	|__|__|
Comments		

DISEASE CHARACTERISTICS AT DIAGNOSIS		
Date of diagnostic	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
WHO Performance	0 ❑ 0 – Fully active 1 ❑ 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature 2 ❑ 2 – Ambulatory and capable of all selfcare but unable to carry out work activities 3 ❑ 3 – Capable of only limited selfcare, confined to bed or chair more than 50 % of waking hours 4 ❑ 4 – Completely disabled, cannot carry on any selfcare 5 ❑ 5 – Dead	
Disease related symptom	0 ❑ No 1 ❑ Yes	
Extramedullary manifestations (apart from liver and spleen)	0 ❑ No 1 ❑ Yes	
	If yes, please specify	____________________
Spleen size	cm below costal margin palpated	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Liver size	cm below medium clavicular line	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Sokal score (Before any treatment)	1 ❑ Low 2 ❑ Intermediate 3 ❑ High	
Hasford score (Before any treatment)	1 ❑ Low 2 ❑ Intermediate 3 ❑ High	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

HEMATOLOGY AT DIAGNOSIS

PERIPHERAL BLOOD AT DIAGNOSIS		
Peripheral blood analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of peripheral blood analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Hemoglobin	g/dl	|__|__| , |__|
Hematocrit	%	|__|__| , |__|
Erythrocyte	10^{12}/l	|__| , |__|__|
Reticulocyte	%	|__|__| , |__|
Platelets	10^{9}/l	|__|__|__|__|
Leukocyte	10^{9}/l	|__|__|__| , |__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Myelaemia	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Blasts	%	|__|__|
Erythroblasts	%	|__|__|
Others		____________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

BONE MARROW AT DIAGNOSIS		
Bone marrow analysis	0 ❑ No 1 ❑ Yes 2 ❑ Not applicable	
If not applicable or not done, please specify the reason		____________________
If yes, please specify below:		
Date of bone marrow analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Cellularity	1 ❑ Low 2 ❑ Normal 3 ❑ High	
Megakaryocyte	1 ❑ Low 2 ❑ Normal 3 ❑ High	
Blasts	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Erythroblasts	%	|__|__|
Plasmocyts	%	|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

OSTEOMEDULLARY BIOPSY AT DIAGNOSIS		
Osteomedullary biopsy	0 ❑ No 1 ❑ Yes	
If yes, please specify		
Date	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Fibrosis	0 ❑ No 1 ❑ Yes	
Adipocytes	1 ❑ Normal 2 ❑ Decreased	
Granulopoesis	1 ❑ Increased 2 ❑ Normal	
Erythropoesis	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Megakaryocyte	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Result	________________________________	
Comments		

CYTOGENETIC FEATURES AT DIAGNOSIS		
Cytogenetic features	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of Cytogenetic features	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Ph chromosome status	1 ❑ Positive 2 ❑ Negative 3 ❑ Unknown	
Number of evaluated metaphases		|__|__|__|
Number of Ph positive metaphases		|__|__|__|
Karyotype	____________________	
Other clonal chromosomal abnormalities in Ph positive cells (if yes, specify % and type)	0 ❑ No 1 ❑ Yes	
	%	|__|__|__|
	Type	____________________
Other clonal chromosomal abnormalities in Ph negative cells (if yes, specify % and type)	0 ❑ No 1 ❑ Yes	
	%	|__|__|__|
	Type	____________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

F.I.S.H AT DIAGNOSIS		
FISH analysis	0 ❑ No 1 ❑ Yes	
If no,		
Technique failure	0 ❑ No 1 ❑ Yes	
If yes		
Date of F.I.S.H	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Number of evaluated nuclei		|__|__|__|
Number of BCR/ABL + nuclei		|__|__|__|
Number of BCR/ABL + mitosis		|__|__|__|
Deletion of genetic material on chromosome 9q+ (FISH)	0 ❑ No 1 ❑ Yes	
Result	____________________	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

MOLECULAR BIOLOGY AT DIAGNOSIS		
Molecular biology analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Source of material	1 ❑ Peripheral blood 2 ❑ Bone marrow	
Volume	ml	|__|__|__|
BCR-ABL transcript	1 ❑ Positive 2 ❑ Negative 3 ❑ Unknown	
Ratio BCR-ABL/ABL	%	|__|__|__| , |__|__|__|
Other control gene	Please specify	____________________
Ratio BCR-ABL/other gene	%	|__|__|__| , |__|__|__|
Nested PCR	1 ❑ Positive 2 ❑ Negative 3 ❑ Not done	
Level BCR-ABL transcript		____________________
Transcript	1 ❑ b2a2 2 ❑ b3a2 3 ❑ b2a3 4 ❑ b3a3 5 ❑ e1a2 6 ❑ b2a2 and b3a2 7 ❑ e6a2 8 ❑ e19a2 9 ❑ Others	
	If others, please specify	____________________
HLA status	1 ❑ A 2 ❑ B 3 ❑ C 4 ❑ DR 5 ❑ DQ	
Comments		

**EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA
PATIENTS IN FAILURE AFTER IMATINIB THERAPY**

By European Leukemia Net
CML WP4

ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patients

2nd Form
Disease status at the beginning of Imatinib therapy

DEMOGRAPHIC DATA		
Center		______________________
ID Patient		|__|__
__	
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

DISEASE CHARACTERISTICS AT THE BEGINNING OF IMATINIB THERAPY		
Date of examination	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
WHO Performance	0 ❑ 0 – Fully active 1 ❑ 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature 2 ❑ 2 – Ambulatory and capable of all selfcare but unable to carry out work activities 3 ❑ 3 – Capable of only limited selfcare, confined to bed or chair more than 50 % of waking hours 4 ❑ 4 – Completely disabled, cannot carry on any selfcare 5 ❑ 5 – Dead	
Disease related symptom	0 ❑ No 1 ❑ Yes	
Extramedullary manifestations (apart from liver and spleen)	0 ❑ No 1 ❑ Yes	
	If yes, please specify	______________________
Spleen size	cm below costal margin palpated	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Liver size	cm below medium clavicular line	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

HEMATOLOGY

PERIPHERAL BLOOD AT THE BEGINNING OF IMATINIB THERAPY		
Peripheral blood analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of peripheral blood analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Hemoglobin	g/dl	|__|__| , |__|
Hematocrit	%	|__|__| , |__|
Erythrocyte	10^{12}/l	|__| , |__|__|
Reticulocyte	%	|__|__| , |__|
Platelets	10^{9}/l	|__|__|__|__|
Leukocyte	10^{9}/l	|__|__|__| , |__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Myelaemia	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Blasts	%	|__|__|
Erythroblasts	%	|__|__|
Others		____________________
Comments		

BONE MARROW AT THE BEGINNING OF IMATINIB THERAPY		
Bone marrow analysis	0 ❑ No 1 ❑ Yes 2 ❑ Not done	
If not applicable or not done, please specify the reason		______________________
If yes, please specify below:		
Date of bone marrow analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Cellularity	1 ❑ Low 2 ❑ Normal 3 ❑ High	
Megakaryocyte	1 ❑ Low 2 ❑ Normal 3 ❑ High	
Blasts	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Erythroblasts	%	|__|__|
Plasmocyts	%	|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

OSTEOMEDULLARY BIOPSY AT THE BEGINNING OF IMATINIB THERAPY		
Osteomedullary biopsy	0 ❑ No 1 ❑ Yes	
If yes, please specify		
Date	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Fibrosis	0 ❑ No 1 ❑ Yes	
Adipocytes	1 ❑ Normal 2 ❑ Decreased	
Granulopoesis	1 ❑ Increased 2 ❑ Normal	
Erythropoesis	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Megakaryocyte	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Result	________________________________	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

<table>
<tr><th colspan="3">CYTOGENETIC FEATURES
AT THE BEGINNING OF IMATINIB THERAPY</th></tr>
<tr><td>Cytogenetic features</td><td colspan="2">0 ❑ No
1 ❑ Yes</td></tr>
<tr><td>If no, please specify the reason</td><td></td><td>______________________</td></tr>
<tr><td colspan="3">If yes, please specify below:</td></tr>
<tr><td>Date of Cytogenetic features</td><td>dd mm yyyy</td><td>|__|__| |__|__| |__|__|__|__|</td></tr>
<tr><td>Ph chromosome status</td><td colspan="2">1 ❑ Positive
2 ❑ Negative
3 ❑ Unknown</td></tr>
<tr><td>Number of evaluated metaphases</td><td></td><td>|__|__|__|</td></tr>
<tr><td>Number of Ph positive metaphases</td><td></td><td>|__|__|__|</td></tr>
<tr><td>Karyotype</td><td colspan="2">____</td></tr>
<tr><td rowspan="3">Other clonal chromosomal abnormalities in Ph positive cells
(if yes, specify % and type)</td><td colspan="2">0 ❑ No
1 ❑ Yes</td></tr>
<tr><td>%</td><td>|__|__|__|</td></tr>
<tr><td>Type</td><td>______________________</td></tr>
<tr><td rowspan="3">Other clonal chromosomal abnormalities in Ph negative cells
(if yes, specify % and type)</td><td colspan="2">0 ❑ No
1 ❑ Yes</td></tr>
<tr><td>%</td><td>|__|__|__|</td></tr>
<tr><td>Type</td><td>______________________</td></tr>
<tr><td colspan="3">Comments

</td></tr>
</table>

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

F.I.S.H AT THE BEGINNING OF IMATINIB THERAPY		
FISH analysis	0 ❑ No 1 ❑ Yes	
If no		
Technique failure	0 ❑ No 1 ❑ Yes	
If yes		
Date of F.I.S.H	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Number of evaluated nucleus		|__|__|__|
Number of BCR/ABL + nucleus		|__|__|__|
Number of BCR/ABL + mitosis		|__|__|__|
Deletion of genetic material on chromosome 9q+ (FISH)	0 ❑ No 1 ❑ Yes	
Result	______________________	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

MOLECULAR BIOLOGY AT THE BEGINNING OF IMATINIB THERAPY		
Molecular biology analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Source of material	1 ❑ Peripheral blood 2 ❑ Bone marrow	
Volume	ml	|__|__|__|
BCR-ABL transcript	1 ❑ Positive 2 ❑ Negative 3 ❑ Unknown	
Ratio BCR-ABL/ABL	%	|__|__|__| , |__|__|__|
Other control gene	Please specify	____________________
Ratio BCR-ABL/other gene	%	|__|__|__| , |__|__|__|
Nested PCR	1 ❑ Positive 2 ❑ Negative 3 ❑ Not done	
Level BCR-ABL transcript		____________________
Transcript	1 ❑ b2a2 2 ❑ b3a2 3 ❑ b2a3 4 ❑ b3a3 5 ❑ e1a2 6 ❑ b2a2 and b3a2 7 ❑ e6a2 8 ❑ e19a2 9 ❑ Others	
	If others, please specify	____________________
HLA status	1 ❑ A 2 ❑ B 3 ❑ C 4 ❑ DR 5 ❑ DQ	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Imatinib Failure Patients

3rd Form
Profile of failure patient

DEMOGRAPHIC DATA		
Center		________________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

SUBCATEGORIES OF FAILURE	
Subcategories of failure	1 ❑ Hematological relapse 2 ❑ Cytogenetic relapse or progression 3 ❑ Progression at any time 4 ❑ Treatment discontinuation for toxicity 7 ❑ No complete hematological response after 3 months 8 ❑ Not any significant Cytogenetic response after 6 months 9 ❑ No major Cytogenetic response after 12 months

Hematological relapse	0 ❑ No 1 ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Cytogenetic relapse or progression	0 ❑ No 1 ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Progression at any time (accelerated or blast crisis)	[0] ❑ No [1] ❑ Yes	
	If yes then please specify	
	Accelerated phase	
	[0] ❑ No [1] ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Blast crisis	
	[0] ❑ No [1] ❑ Yes	
	If yes then please specify	
	Date of blast crisis (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Lymphoid	
	[0] ❑ No [1] ❑ Yes	
	Myeloid	
	[0] ❑ No [1] ❑ Yes	
	Other	________________________
Treatment discontinuation for toxicity	[0] ❑ No [1] ❑ Yes	
	If yes then please specify	
	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	[1] ❑ Hematological toxicity [2] ❑ Non hematological toxicity [3] ❑ Other	
	If other then please specify	________________________
No complete hematological response after 3 months	[0] ❑ No [1] ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Not any significant Cytogenetic response after 6 months of therapy	[0] ❑ No [1] ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
No major Cytogenetic response after 12 months of therapy	[0] ❑ No [1] ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
No complete Cytogenetic response	[0] ❑ No [1] ❑ Yes	
	If yes then please specify the date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Death		
	[0] ❑ No [1] ❑ Yes	
	If yes then please specify	
	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	[1] ❑ CML related [2] ❑ Other	
	If other then please specify	______________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA
PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patients

4th Form
Disease status at time of failure

DEMOGRAPHIC DATA		
Center		________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	[1] ❑ Male [2] ❑ Female	

DISEASE CHARACTERISTICS AT TIME OF FAILURE		
Date of examination	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
WHO Performance	[0] ❑ 0 – Fully active [1] ❑ 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature [2] ❑ 2 – Ambulatory and capable of all selfcare but unable to carry out work activities [3] ❑ 3 – Capable of only limited selfcare, confined to bed or chair more than 50 % of waking hours [4] ❑ 4 – Completely disabled, cannot carry on any selfcare [5] ❑ 5 – Dead	
Disease related symptom	[0] ❑ No [1] ❑ Yes	
Extramedullary manifestations (apart from liver and spleen)	[0] ❑ No [1] ❑ Yes	
	If yes, please specify	________________
Spleen size	cm below costal margin palpated	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Liver size	cm below medium clavicular line	|__|__|
	Longest diameter in ultrasound, cm	|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

HEMATOLOGY AT TIME OF FAILURE

PERIPHERAL BLOOD AT TIME OF FAILURE		
Peripheral blood analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		______________
If yes, please specify below:		
Date of peripheral blood analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Hemoglobin	g/dl	|__|__| , |__|
Hematocrit	%	|__|__| , |__|
Erythrocyte	10^{12}/l	|__| , |__|__|
Reticulocyte	%	|__|__| , |__|
Platelets	10^9/l	|__|__|__|__|
Leukocyte	10^9/l	|__|__|__| , |__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Myelaemia	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Blasts	%	|__|__|
Erythroblasts	%	|__|__|
Others		______________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

BONE MARROW AT TIME OF FAILURE		
Bone marrow analysis	[0] ❑ No [1] ❑ Yes [2] ❑ Not done	
If not applicable or not done, please specify the reason		______________________
If yes, please specify below:		
Date of bone marrow analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Cellularity	[1] ❑ Low [2] ❑ Normal [3] ❑ High	
Megakaryocyte	[1] ❑ Low [2] ❑ Normal [3] ❑ High	
Blasts	%	|__|__|
Myeloblasts	%	|__|__|
Promyelocytes	%	|__|__|
Myelocytes	%	|__|__|
Metamyelocytes	%	|__|__|
Neutrophils	%	|__|__|
Eosinophils	%	|__|__|
Basophils	%	|__|__|
Monocytes	%	|__|__|
Lymphocytes	%	|__|__|
Erythroblasts	%	|__|__|
Plasmocyts	%	|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

OSTEOMEDULLARY BIOPSY AT TIME OF FAILURE		
Osteomedullary biopsy	0 ❑ No 1 ❑ Yes	
If yes, please specify		
Date	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Fibrosis	0 ❑ No 1 ❑ Yes	
Adipocytes	1 ❑ Normal 2 ❑ Decreased	
Granulopoesis	1 ❑ Increased 2 ❑ Normal	
Erythropoesis	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Megakaryocyte	1 ❑ Increased 2 ❑ Normal 3 ❑ Decreased	
Result	______________________________	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

CYTOGENETIC FEATURES AT TIME OF FAILURE		
Cytogenetic features	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		____________________
If yes, please specify below:		
Date of Cytogenetic features	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Ph chromosome status	1 ❑ Positive 2 ❑ Negative 3 ❑ Unknown	
Number of evaluated metaphases		|__|__|__|
Number of Ph positive metaphases		|__|__|__|
Karyotype	____________________	
Other clonal chromosomal abnormalities in Ph positive cells (if yes, specify % and type)	0 ❑ No 1 ❑ Yes	
	%	|__|__|__|
	Type	____________________
Other clonal chromosomal abnormalities in Ph negative cells (if yes, specify % and type)	0 ❑ No 1 ❑ Yes	
	%	|__|__|__|
	Type	____________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

F.I.S.H AT TIME OF FAILURE		
FISH analysis	0 ❑ No 1 ❑ Yes	
If no,		
Technique failure	0 ❑ No 1 ❑ Yes	
If yes		
Date of F.I.S.H	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Number of evaluated nucleus		|__|__|__|
Number of BCR/ABL + nucleus		|__|__|__|
Number of BCR/ABL + mitosis		|__|__|__|
Deletion of genetic material on chromosome 9q+ (FISH)	0 ❑ No 1 ❑ Yes	
Result	____________________	
Comments		

MOLECULAR BIOLOGY AT TIME OF FAILURE		
Molecular biology analysis	0 ❑ No 1 ❑ Yes	
If no, please specify the reason		______________________
If yes, please specify below :		
Date of analysis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Source of material	1 ❑ Peripheral blood 2 ❑ Bone marrow	
Volume	ml	|__|__|__|
BCR-ABL transcript	1 ❑ Positive 2 ❑ Negative 3 ❑ Not done	
Ratio BCR-ABL/ABL	%	|__|__|__| , |__|__|__|
Other control gene	Please specify	______________________
Ratio BCR-ABL/other gene	%	|__|__|__| , |__|__|__|
Nested PCR	1 ❑ Positive 2 ❑ Negative 3 ❑ Not done	
Level BCR-ABL transcript		______________________
Transcript	1 ❑ b2a2 2 ❑ b3a2 3 ❑ b2a3 4 ❑ b3a3 5 ❑ e1a2 6 ❑ b2a2 and b3a2 7 ❑ e6a2 8 ❑ e19a2 9 ❑ Others	
	If others, please specify	______________________
HLA status	1 ❑ A 2 ❑ B 3 ❑ C 4 ❑ DR 5 ❑ DQ	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA
PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patient

5th Form (a)
Imatinib therapy

DEMOGRAPHIC DATA		
Center		____________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

IMATINIB THERAPY		
Start of Imatinib	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Administrated dose at the beginning of treatment	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other	
	If other then please specify	____________________
Clinical trial	0 ❑ No 1 ❑ Yes	
	If yes, please specify	____________________

Modification(s) of dose	0 ❑ No 1 ❑ Yes	
Reason for modification(s)	1 ❑ Adverse event 2 ❑ Inefficacy 3 ❑ Dose error 4 ❑ Protocol 5 ❑ Other	
	If other, please specify	____________________
New administrated dose(s)	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other or successive doses	
	If other, please specify	____________________

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Period of modification		
First occurrence	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Last occurrence	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Combination with other treatment	[0] ❑ No [1] ❑ Yes	
If yes, please specify		
Cytarabine	[0] ❑ No [1] ❑ Yes	
	If yes, please specify	
	Dose	______________________
	Period	
	From	|__|__| |__|__| |__|__|__|__|
	To	|__|__| |__|__| |__|__|__|__|
Interferon	[0] ❑ No [1] ❑ Yes	
	If yes, please specify	
	Dose	______________________
	Period	
	From	|__|__| |__|__| |__|__|__|__|
	To	|__|__| |__|__| |__|__|__|__|
Other	[0] ❑ No [1] ❑ Yes	
	If yes, please specify	______________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

CONCOMITANT TREATMENT		
Concomitant treatment	0 ❑ No 1 ❑ Yes	

Name of molecule which can explain resistance or intolerance	1 ❑ Corticoids 2 ❑ Other	
	If other then please specify	____________________________
Period or date of concomitant treatment	From (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	To (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

Name of molecule which can explain resistance or intolerance	1 ❑ Corticoids 2 ❑ Other	
	If other then please specify	____________________________
Period or date of concomitant treatment	From (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	To (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

RESPONSE WITH IMATINIB

HEMATOLOGICAL RESPONSE		
Chronic phase	0 ❑ No 1 ❑ Yes	
Subsequent phase	0 ❑ No 1 ❑ Yes	
Complete hematological response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

CYTOGENETIC RESPONSE		
Any significant response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Major Cytogenetic response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Complete Cytogenetic response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

MOLECULAR RESPONSE		
Best response	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Specify	______________________

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Imatinib Failure Patient

5th Form (b)
Imatinib therapy at failure

DEMOGRAPHIC DATA		
Center		____________________
ID Patient		|__|__
__	
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

IMATINIB THERAPY AT FAILURE		
Discontinuation	0 ❑ No 1 ❑ Yes	
	If yes, please specify	
	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Dose	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other
No discontinuation	0 ❑ No 1 ❑ Yes	
	If yes, please specify	
	Current dose at failure	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other
	Schedule dose after failure	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Imatinib Failure Patient

5th Form (c)
Treatment before Imatinib therapy

DEMOGRAPHIC DATA		
Center		______________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	[1] ❑ Male [2] ❑ Female	

TREATMENT BEFORE IMATINIB THERAPY		
Treatment before Imatinib therapy	[0] ❑ No [1] ❑ Yes	
If yes, please specify below:		
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Drug :		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

RESPONSE WITH PRE-TREATMENT

HEMATOLOGICAL RESPONSE		
Chronic phase	0 ❑ No 1 ❑ Yes	
Subsequent phase	0 ❑ No 1 ❑ Yes	
Complete hematological response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

CYTOGENETIC RESPONSE		
Any significant response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Major Cytogenetic response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Complete Cytogenetic response	0 ❑ No 1 ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

MOLECULAR RESPONSE		
Best response	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Specify	______________________

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patient

6th Form
Adverse events

DEMOGRAPHIC DATA		
Center		______________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

ADVERSE EVENTS	
Adverse effects	0 ❑ No 1 ❑ Yes

Effects / symptom		______________________
During the treatment	0 ❑ No 1 ❑ Yes	
Date	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Intensity (grade)	1 ❑ 1 2 ❑ 2 3 ❑ 3 4 ❑ 4 11 ❑ Low 12 ❑ Moderate 13 ❑ High	
In relation with the therapy	0 ❑ No 1 ❑ Yes 2 ❑ Not applicable	
Follow-up	1 ❑ Recovery 2 ❑ No complete recovery 3 ❑ Sequelae 4 ❑ Death 5 ❑ Other	
Gravity	0 ❑ No 1 ❑ Yes	
Frequency		______________________

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Action	[1] ❑ Any [2] ❑ Medical treatment [3] ❑ Hospitalization [4] ❑ Other	
	If other then please specify	____________________

Effects / symptom		____________________
During the treatment	[0] ❑ No [1] ❑ Yes	
Date	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Intensity (grade)	[1] ❑ 1 [2] ❑ 2 [3] ❑ 3 [4] ❑ 4 [11] ❑ Low [12] ❑ Moderate [13] ❑ High	
In relation with the therapy	[0] ❑ No [1] ❑ Yes [2] ❑ Not applicable	
Follow-up	[1] ❑ Recovery [2] ❑ No complete recovery [3] ❑ Sequelae [4] ❑ Death [5] ❑ Other	
Gravity	[0] ❑ No [1] ❑ Yes	
Frequency		____________________
Action	[1] ❑ Any [2] ❑ Medical treatment [3] ❑ Hospitalization [4] ❑ Other	
	If other then please specify	____________________

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA
PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

Imatinib Failure Patients

7th Form
Therapeutic decision after failure

DEMOGRAPHIC DATA		
Center		______________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

TREATMENT AFTER FAILURE		
Imatinib ongoing	0 ❑ No 1 ❑ Yes	
If No, please specify		
Date of Discontinuation	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Dose	1 ❑ 400mg/day 2 ❑ 600mg/day 3 ❑ 800mg/day 4 ❑ Other	

New treatment	0 ❑ No 1 ❑ Yes	
If yes then please specify		
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Drug:		______________________
Dose:		______________________

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Drug:		______________________
Dose:		______________________
Period of administration		
From	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
To	dd mm yyyy	|__|__| |__|__| |__|__|__|__|

Experimental drug [1]	0 ❑ No 1 ❑ Yes
Comments	

[1] If you don't wish to specify the name of drug then, check experimental drug

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

TRANSPLANTATION		
Transplantation	0 ❑ No 1 ❑ Yes	
Status at transplantation	1 ❑ First chronic phase 2 ❑ Second or subsequent chronic phase 3 ❑ Accelerated phase 4 ❑ Blast phase	
Allogeneic SCT	0 ❑ No 1 ❑ Yes	
Age of donor	Years (yy)	|__|__|
Sex of donor	1 ❑ Male 2 ❑ Female	
Donor	1 ❑ Related 2 ❑ Unrelated	
Autologous SCT	0 ❑ No 1 ❑ Yes	
Date of transplantation	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

ID Patient |__|__| - |__|__| - |__|__|__|

RESPONSE WITH NEW THERAPY

HEMATOLOGICAL RESPONSE		
Chronic phase	[0] ❑ No [1] ❑ Yes	
Subsequent phase	[0] ❑ No [1] ❑ Yes	
Complete hematological response	[0] ❑ No [1] ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

CYTOGENETIC RESPONSE		
Any significant response	[0] ❑ No [1] ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Major Cytogenetic response	[0] ❑ No [1] ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
Complete Cytogenetic response	[0] ❑ No [1] ❑ Yes	
	If yes, please specify the date of first occurrence (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|

MOLECULAR RESPONSE		
Best response	Date (dd mm yyyy)	|__|__| |__|__| |__|__|__|__|
	Specify	________________________

GRAFT VERSUS HOST DISEASE	
Graft versus host disease	[0] ❑ No [1] ❑ Yes

Comments

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

EUROPEAN REGISTRY OF CHRONIC MYELOGENOUS LEUKEMIA PATIENTS IN FAILURE AFTER IMATINIB THERAPY

By European Leukemia Net
CML WP4

8th Form, Page 1
ID Patient |__|__| - |__|__| - |__|__|__|

Imatinib Failure Patients

8th Form
Survival status after discontinuation of Imatinib therapy

DEMOGRAPHIC DATA		
Center		______________________
ID Patient		|__|__| |__|
Date of birth	mm / yyyy	|__|__| |__|__|__|__|
Sex	1 ❑ Male 2 ❑ Female	

SURVIVAL STATUS		
Progression at any time (accelerated or blast crisis)	0 ❑ No 1 ❑ Yes	
If yes then please specify		
Accelerated phase	0 ❑ No 1 ❑ Yes	
Date of Accelerated phase	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Blast crisis	0 ❑ No 1 ❑ Yes	
If yes then please specify		
Date of blast crisis	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Lymphoid	0 ❑ No 1 ❑ Yes	
Myeloid	0 ❑ No 1 ❑ Yes	
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr

SURVIVAL STATUS		
Death	0 ❑ No 1 ❑ Yes	
If Yes, please specify		
Date of death	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Cause of death	1 ❑ CML related 2 ❑ Other	
	If other then please specify	________________
Comments		

FOLLOW-UP		
Date of last follow-up	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Disease status at follow-up		________________
Date of last follow-up	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Disease status at follow-up		________________
Date of last follow-up	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Disease status at follow-up		________________
Date of last follow-up	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Disease status at follow-up		________________
Date of last follow-up	dd mm yyyy	|__|__| |__|__| |__|__|__|__|
Disease status at follow-up		________________
Comments		

Department of Oncology Hematology and Cell Therapy
University Hospital
Rue de la Milétrie – B.P. 577 – 86021 POITIERS cedex FRANCE
Phone: +33.5.49.44.42.01 Fax: +33.5.49.44.38.63
Onco.hema@chu-poitiers.fr