EWOG MDS 2006

cbl Follow-up 0-5 years

Examination interval: Every 3 months

Patient Name |____|

Patient identification number |____|

Sex ☐ male Date of Birth (dd/mm/yy) |___________|

☐ female

Medical history and physical examination

Height: _______cm

Weight : _______cm

< 1 year: Head circumference: _______cm

	No	Yes	
Dysmorphic features	☐	☐	if yes, please specify : ______________________________ ______________________________
Xanthoma	☐	☐	if yes, give exact number: |________|
“Cafe au lait” spots	☐	☐	if yes: ☐ < 10 spots give exact number |__________| ☐ ≥ 10
Received anaesthesia previously	☐	☐	
If yes: Complications during anaesthesia:	☐	☐	if yes, please enclose medical report.
Seizures	☐	☐	if yes, please enclose medical report.
Hepatitis [illegible]	☐	☐	if yes, please enclose medical report.
Known Bleeding disorder	☐	☐	if yes, please specify: ______________________________
Bleeding complications:	☐	☐	if yes, please enclose medical report.
If male: Maldecensus testis	☐	☐	

Spleen size below costal margin by palpation |______| cm

Liver size below costal margin by palpation |______| cm

Blood pressure:

Right arm: _________ Left arm:

Right leg: _________ Left leg:

Other signs or symptoms ☐ ☐ if yes, specify: ________________________________

Motor development:

Age		No	Yes
3 months	Raises head when lying on stomach	☐	☐
6 months	Sits with assistance	☐	☐
	Head control	☐	☐
9 months:	Sits without support	☐	☐
12 months:	Pulls to stand	☐	☐
15 month:	Walks with assistance	☐	☐
18 months	Walks alone	☐	☐
2 years:	Walks up and downstairs holding on to support	☐	☐
3 years:	Jumps with both feet	☐	☐
	Runs with change of speed and direction	☐	☐
4 years	Can pedal tricycle	☐	☐
	Stands on one foot up to 5 sec	☐	☐
5 years:	Hops and stands on one foot up to 10 sec.	☐	☐
	Walks up and downstairs without support	☐	☐

Speech development

Age		No	Yes
1 year:	Speaks 1-2 words	☐	☐
2 years:	2-word phrases	☐	☐
3 years:	Uses 2-3 word phrases to talk about and ask for things	☐	☐
4 years:	Uses sentences with four or more words	☐	☐
5 years:	Speaks eloquently and uses most words correctly	☐	☐

Therapy

I. Observation period (no therapy)

From (dd/mm/yy) |____________| until (dd/mm/yy) |____________|

II. Drug treatment:

Begin	**ongoing** no	yes	**end**	**drug**	**dosage**
|____________|	☐	☐	|____________|	|____________________|	|____________|
|____________|	☐	☐	|____________|	|____________________|	|____________|
|____________|	☐	☐	|____________|	|____________________|	|____________|
|____________|	☐	☐	|____________|	|____________________|	|____________|

Remission achieved ☐ ☐ date (dd/mm/yy) |____________|

	No	Yes	
II. Splenectomy	☐	☐	date (dd/mm/yy) |____________|
III. Stem cell transplantation:			
	☐	☐	date (dd/mm/yy) |____________| (please fill in SCT form)

Haematological data

Date (dd/mm/yy) |____________|

receives red cell transfusions regularly ☐ no ☐ yes

receives platelet transfusions regularly ☐ no ☐ yes

Peripheral blood

Hb _______ unit ______

MCV _______ unit ______

Platelets _______ unit ______

WBC _______ unit ______

Reti count _______

Bone marrow aspirate: ☐ not done

cell content ☐ decreased ☐ normal ☐ increased

megakaryocytes ☐ decreased ☐ normal ☐ increased

☐ none

auer rods ☐ no ☐ yes

Hb-Electrophoresis

HbA_1 I______I (%) ☐ not done HbA_2 I______I (%) ☐ not done

HbF I______I (%) ☐ not done

Differential count (%)	**Peripheral blood**	**Bone marrow**
Blast		
Promyelocyte		
Myelocyte		
Metamyelocyte		
Band		
Segmented		
Eosinophil		
Basophil		
Lymphocyte		
Monocyte		
Erythroblast		
	100	**100**

Name of reviewing center:

Annual Exams

		No	Yes	
Opthalmologic exam:	Opticus atrophy	☐	☐	if yes, please specify side: |_________________|
Audiometry:	Hearing loss	☐	☐	if yes, please specify side: |_____________________| degree: |_____________________|

<1y: cranial ultrasound: Pathological ÁÁÁ ☐ Á ☐ if yes, please specify in detail or enclose report:
____

Abdominal ultrasound incl. Doppler ultrasound:

	No	Yes	
Pathological if yes, please specify:	☐	☐	
Splenomegaly	☐	☐	if yes: size below costal margin ____cm
Hepatomegaly	☐	☐	if yes: size below costal margin _____cm
Liver abnormality	☐	☐	if yes please specify: ___________________________
Signs of vasculopathy	☐	☐	if yes please specify: ___________________________
Other	☐	☐	if yes, please specify in detail or enclose report: ______

____

		No	Yes	
ECG:	Pathological	☐	☐	if yes please specify: ________________________

____

Echocardiography:

	No	Yes	
Pathological	☐	☐	
Hypertrophy	☐	☐	if yes please specify: ________________________
Valvular pathologies	☐	☐	if yes please specify: ________________________
Other:	☐	☐	if yes, please specify in detail or enclose report: ______

____

Additional laboratory data:

GOT/ASAT _______ unit ______ g-GT _______ unit _____ CHE _______ unit _____
GPT/ALAT _______ unit ______ AP _______ unit ______ Bilirubin dir _____ unit _______

Date I____________I Signature ___________________________________