

Title: S(P)EAR Annual Report 2017						
Document type	Annual Report WG/Committee SEAR					
Document reference	20181219-SEAR-Annual Report 2017	Approved by	Chair			
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### **S(P)EAR COMMITTEE ANNUAL REPORT 2017**

**Members of committee:** Jeff Szer, Bronwen Shaw, William Huang, Thilo Mengling, Matti Korhonen, Jerry Stein, Heidi Elmoazzen, Mirjam Fechter, Liz O'Flaherty, John Miller, Jeremy Chapman, Brian Lindberg, Ann Woolfrey, Rachel Pawson, Monique Jöris

The committee received and considered 367 incidents during 2017, compared to 254 in 2016. They were received from 23 organisations in 19 countries.

#### **1 Overview**

	Harm to donor	Harm to recipient	Risk of harm	Total
Total reported	323	12	32	367
<ul> <li>Considered not a SEAR (see separate headers)</li> </ul>	10	1	11	22
Timeframe (total)	313	11	21	345
- Before infusion	-	-	20	20
- During mobilisation	23	-	-	23
- During collection	17	-	-	17
- Short term (<30 days)	52	9	-	61
- Long term (>=30 days)	218	2	-	220
- UNK	2	-	1	3
Graft type (total)	313	11	21	345
- HPC-Marrow	66	5	8	79
- HPC-Apheresis	245	3	3	251
- HPC-Cord	-	2	10	12
- MNC-Apheresis	-	1	-	1
- DLI	2	-	-	2



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#### 2 Harm to donor

Three hundred and twenty-three (323) harm to donor incidents were considered. After evaluation 10 incidents were considered as 'not a SEAR', these will be discussed under a separate header.

Sixty-six (66) incidents occurred after HPC-Marrow harvest, 245 after HPC-Apheresis collections and 2 after DLI collection. One hundred and eighty-four (180) affected donors are male, 130 are female and 3 have no sex recorded.

#### 2.1 The following type of incidents were reported

### 2.1.1 Malignancy

One hundred and seven (107) malignancies occurred in the donor in 30 days or more after donation, 1 occurred within 30 days after donation and 2 are unknown.

Туре	n	Time after donation in months [median (range)]
Breast cancer	20	23 (5 – 204) 1 UNK
Melanoma	17	48 (11 – 180)
Haematological malignancies*	14	17 (1 – 120) 1 UNK
Testicular cancer	8	20 (0.5 – 48)
Thyroid cancer	7	24 (11 – 48)
Colorectal cancer	5	36 (4 – 132)
Seminoma	4	63 (9 – 132)
Renal cancer	4	42 (7 – 60)
Bladder cancer	3	12 (12 – 48)
Chondrosarcoma	3	24 (17 – 60)
Prostate cancer	3	36 (24 – 72)
Cervical cancer	2	18 (12 – 24)
Liposarcoma	2	14 (3 – 24)
Tongue cancer	2	66 (36 – 96)
	1	



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Glioblastoma	2	19 (1 – 36)
Oligoastrocytoma	2	39 (30 – 48)
Other^	12	24 (1 – 96)
Total	110	24 (0.5 – 204) 2 UNK

<sup>\*</sup>Haematological malignancies include 1 AML, 1 B-cell lymphoma, 1 CLL, 1 donor derived MDS, 1 histiocytosis X, 1 Hodgkin lymphoma, 1 MM, 5 NHL, 1 plasmocytoma and 1 T-cell large granular lymphocyte leukaemia. ^Other malignancies include 1 adenocarcinoma of unknown origin, 1 brain tumour, 1 cancer of the jaw, 1 cancer of unknown origin, 1 endometrial cancer, 1 oesophageal cancer, 1 fibrosarcoma, 1 grade II astrocytoma, 1 lung cancer, 1 pancreatic carcinoma, 1 squamous-cell carcinoma of sinus and 1 spinal ependymoma.



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#### 2.1.2 Autoimmune disorders

Sixty-nine (69) autoimmune disorders occurred in the donor in 30 days or more after donation, 5 occurred within 30 days after donation and 1 during mobilisation.

Туре	n	Time after donation in months [median (range)]
Multiple Sclerosis	18	24 (0.3 – 108)
Ulcerative Colitis	7	12 (3 – 60) 1 during mobilisation
Rheumatoid Arthritis	7	30 (6 – 36)
Psoriasis	5	3 (0.6 – 12)
Sarcoidosis	4	20 (8 – 46)
Crohn's disease	4	8 (6 – 23)
Vitiligo	2	10 (8 – 12)
Thrombocytopenic purpura	2	26 (9 – 42)
Diabetes Mellitus type 1	2	11 (10 – 12)
Graves' disease	2	27 (12 – 42)
Iritis	2	11 (10 – 12)
Alopecia	2	13 (12 – 13)
Other*	18	24 (0.07 – 60)
Total	75	13 (0.07 – 108) 1 during mobilisation

<sup>\*</sup>Other immune disorders include 1 ankylosing spondylitis, 1 autoimmune thrombocytopenia, 1 coeliac disease, 1 collagenous colitis, 1 CREST syndrome, 1 eczema, 1 eosinophilic esophagitis, 1 erythema nodosum, 1 Hashimoto's thyroiditis, 1 IgA-nephirtis, 1 inflammatory bowel disease, 1 lichen ruber planus, 1 morphea, 1 polyarthritis, 1 polymyalgia rheumatica, 1 sclerodermia circumscripta, 1 SLE and 1 thyroiditis de Quervain.



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#### 2.1.3 Other incidents

Forty-two (42) other incidents occurred in the donor in 30 days or more after donation, 46 occurred within 30 days after donation, 22 during mobilisation, 17 during collection and 1 UNK.

Туре	n	Mobilisation (n)	Collection (n)	Short term in days [n (range)]	Long term in months [n (range)]	UNK
Infection	17	2	2	7 (1 – 22)	6 (2 – 24)	-
Cardiovascular	17	3	3	7 (1 – 7)	4 (8 – 12)	-
Vascular	16	-	-	6 (5 – 16)	10 (3 – 60)	-
Allergy	11	7	1	1 (1)	2 (1 – 13)	-
Central Nervous System	6	-	1	1 (7)	4 (6 – 34)	-
Haematological	6	-	-	3 (1 – 3)	2 (45 – 48)	1
Gastrointestinal	6	-	1	3 (1 – 18)	2 (6 – 11)	-
Social/psychological	5	1	-	3 (2)	1 (1)	-
Peripheral Nervous System	5	-	3	1 (7)	1 (6)	-
Renal	3	1	-	-	2 (1 – 8)	-
Unnecessary donation/burden	3	1 (work up)	2	-	-	-
Product quality issue	2	1	-	1 (6)	-	-
Pulmonary	2	1	-	-	1 (2)	-
Other*	29	5	4	13 (1 – 18)	7 (1 – 42)	-
Total	128	22	17	46	42	1

<sup>\*</sup>Other incidents include 6 pain at collection site, 3 death of unknown cause, 2 falls, 2 back pain, 1 acute rotatory vertigo, 1 arthralgia, 1 fatigue fracture of fibula, 1 gout, 1 headache/dyspnoea, 1 hypocalcaemia, 1 hypogonadotropic hypogonadism, 1 lymphadenopathy, 1 non-malignant neoplasm, 1 pleomorphic adenoma, 1 pupillotonia/anisocoria, 1 severe menopausal complaints, 1 skeletal pain, 1 temporal meningioma, 1 traumatic hematoma and 1 toxic reaction during mobilisation.



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## 2.2 Assessment of imputability

The committee assessed each incident reported for causation. This service is designed to be advisory to the reporting registry.

Reported imputability	n	Assessed imputability	n	Imputability changed	n
Definite	33	Definite	31	Agreed	241
Probable	39	Probable	26	Upgraded*	21
Possible	46	Possible	38	Downgraded^	19
Unlikely	182	Unlikely	173	To excluded	31
Excluded	14	Excluded	43	To not assessable	1
Not assessable	9	Not assessable	2	Not a sear	10
		Not a SEAR	10		

<sup>\*</sup>e.g. unlikely to definite or possible to probable. ^e.g. definite to probable or probable to possible.



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## 2.3 Incidents considered not a SEAR

Туре	n	Why?	Report in the future?
Cytogenetic abnormality	3	No defined harm, and cannot be avoided	Report only if there is harm to the recipient
Infection	2	1 herpes simplex on lip after donation, not "severe" by any definition	No
		1 Dengue fever diagnosed on d3 GCSF, mobilisation aborted – not <u>caused</u> by donation	Yes, educational (consider Dengue if fever during GCSF)
Osteophyte	1	No plausible medical connection	Yes, educational (accepted nevertheless as invalidity and refunded!)
Labelling error	1	Not severe / no harm	Yes (new reporting system as Risk of Harm)
Thrombocytopenia	1	Not severe enough	Yes, educational (especially before – after)
Anaphylactic shock	1	No plausible medical connection 6 months after BM	No
Breast cancer	1	Did not donate due to newly diagnosed breast cancer	No



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#### 3 Harm to recipient

Twelve (12) harm to recipient incidents were reported. After evaluation 1 incident was considered as 'not a SEAR', this one will be discussed under a separate header.

Five (5) incidents followed after HPC-Marrow transplant, 3 after HPC-Apheresis transplant, 2 after HPC-Cord transplant and 1 after MNC-Apheresis transplant. Two (2) harm to recipient incidents occurred in 30 days or more after donation and 9 occurred within 30 days after donation.

#### 3.1 The following type of incidents were reported

Infusion related non-specific symptoms	5
Cytogenetic abnormality	2
Cardiovascular	1
Death	1
Product quality issue	1
Vascular	1



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## 3.2 Assessment of imputability

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Reported imputability	n	Assessed imputability	n	Imputability changed	n
Definite	2	Definite	4	Agreed	7
Probable	1	Probable	0	Upgraded*	2
Possible	7	Possible	5	Downgraded^	0
Unlikely	0	Unlikely	0	To excluded	0
Excluded	0	Excluded	0	To not assessable	2
Not assessable	2	Not assessable	2	Not a SEAR	1
		Not a SEAR	1		

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#### 3.3 Incidents considered not a SEAR

Туре	n	Why?	Report in the future?
Engraftment failure in 5 transplants	1	No pattern why 5 patients after CBU did not engraft, not assessable if something went "wrong"	Yes, cluster



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## 4. Risk of harm

Thirty-two (32) risk of harm incidents were reported. After evaluation 11 incidents were considered as 'not a SEAR', these will be discussed under a separate header.

Eight (8) incidents were concerning a HPC-Marrow donation, 3 concerning a HPC-Apheresis donation and 10 concerning a HPC-Cord product. Twenty (20) risk of harm incidents occurred before infusion and 1 was UNK.

### 4.1 The following type of incidents were reported

4.1.1 Product quality issues	14
Low cell count	3
Product bacterially contaminated	3
Coagulated product	2
Air bubble in bag	1
Alfa-thalassemia minor undetected	1
Bag leak	1
Discrepant CT typing	1
Low viability	1
Labelling error	1
4.1.2 Transport issues	7
Product arrived thawed	3
Product X-rayed	1
Damaged bag	1
No temperature registration	1
Sent to wrong address	1



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## 4.2 Assessment of imputability

The committee assessed each incident reported for causation. This service is designed to be advisory to the reporting registry.

n	Assessed imputability	n	Imputability changed	n
6	Definite	5	Agreed	12
3	Probable	1	Upgraded*	4
0	Possible	0	Downgraded^	0
1	Unlikely	0	To excluded	4
1	Excluded	4	To not assessable	1
21	Not assessable	11	Not a SEAR	11
	Not a SEAR	11		
	6 3 0 1	6 Definite 3 Probable 0 Possible 1 Unlikely 1 Excluded 21 Not assessable	6 Definite 5 3 Probable 1 0 Possible 0 1 Unlikely 0 1 Excluded 4 21 Not assessable 11	6 Definite 5 Agreed 3 Probable 1 Upgraded* 0 Possible 0 Downgraded^ 1 Unlikely 0 To excluded 1 Excluded 4 To not assessable 21 Not assessable 11 Not a SEAR

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# 4.3 Incidents considered not a SEAR

Type		n	Why?	Report in the future?
Product quality issue		6		
-	Low cell count	2	1 poor mobilizer	No, "happens"
			1 not possible to achieve the full requested dose but 3/5 of it; engrafted	No
-	Labelling error	1	Not severe	Yes (new reporting system as Risk of Harm)
-	Wrong papers accompanying product	1	Not severe	Yes (new reporting system as Risk of Harm)
-	Product bacterially contaminated	1	Not severe	Only if harm to recipient
-	Donor diagnosed with A gammaglobulinemia	1	Pre-malignancy per definition not a SEAR	No
Transport issues		2		
-	Sent to wrong address	1	Not severe	Yes (new reporting system as Risk of Harm)
-	Delay	1	Not severe	Yes (new reporting system as Risk of Harm)
Other		3		
-	Infection/death	1	Pat died due to infection before delivery (but after donation)	No, nothing went wrong or could be done different
-	Cytogenetic abnormality	1	No defined harm, and cannot be avoided	Report only if there is harm to the recipient
-	Transplant postponed	1	No sound reason, donation would have been possible with additional diagnostics	No