Please fax or mail to: FAP-World Transplant Register, Department of Transplantation Surgery F82, Karolinska University Hospital Huddinge, S-141 86 Stockholm, Sweden. Fax nr +46 8 774 31 91 **E-mail: fapwtr@fapwtr.org Web site: www.fapwtr.org**

Domino/Sequential Transplantation (DLTX) – world register

FORM 2 – UPDATE

(Please use one page for each patient)

Date of report: ___ ___ ___ (D M Y)

Name and location of TX center: _____

Contact person & Title: _____

Register use only

FAPWTR:

Pat key:

Pat ID ___ ___ ___ (Given name first letters) ___ ___ ___ (Family name first letters) Born ___ ___ ___ (D M Y) Nationality _____ Male ☐ Female ☐

Date of Domino LTX ___ ___ ___ (D M Y) Re-LTX: No ☐ Yes ☐ Date of Re-LTX: ___ ___ ___ (D M Y)

Cause of Re-LTX: _____ Domino Re-LTX: No ☐ Yes ☐

Recurrence of tumor: No ☐ Yes ☐ If yes, approx date: ___ ___ ___ (D M Y)

Recurrence of original disease other than tumor: No ☐ Yes ☐ If yes, approx date: ___ ___ ___ (D M Y)

Alive: Yes ☐ No ☐ Date of death ___ ___ ___ (D M Y) Cause of death: _____

MBMI: Body weight: _____ kg Height: _____ m Serum albumin: _____ units (Ref value: _____)

IF FAP DONOR: POST TRANSPLANT ONSET OF

	Yes	No	Approx date (D - M - Y)
PERIPHERAL NEUROPATHY			
• Sensory	☐	☐	_____
• Motor	☐	☐	_____
AUTONOMIC NEUROPATHY			
• Digestive	☐	☐	_____
• Urinary	☐	☐	_____
• Sexual dysfunction	☐	☐	_____
• Cardiovascular	☐	☐	_____
EXTRANEUROLOGICAL AMYLOIDOSIS			
• Renal	☐	☐	_____
• Ocular	☐	☐	_____
• Cardiac	☐	☐	_____

IF NON-FAP DONOR: POST TRANSPLANT SYMPTOMS OF DONOR DISEASE

No ☐ Yes ☐

If Yes, approx date (D - M - Y)

_____

Pharmacotherapy to prevent transmission of FAP after Domino LTx

Pharmacotherapy: Yes ☐ No ☐ No info ☐

If yes:	Started (mm/yy)	Discont. (mm/yy)	Reason for start/end of medication
Tafamidis	___/___	___/___	_____
Diflunisal	___/___	___/___	_____
TUDCA+Tetracycline	___/___	___/___	_____
Other	___/___	___/___	_____

If Other, specify: _____

COMMENTS: