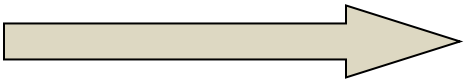
Appendix 5 -Questionnaires

 **RICK hospital**	**Patient Questionnaire Booklet**
	Symptoms study of Radiotherapy in Metastic Breast Cancer
Patient name	**Date of birth**
Trail number	**Patient code**
Week number	Baseline Week1 Week 5 Week 12

Tick when questionnaire complete	
BPI	
LANSS	
MPQ	
EQRTC QLQ C-30&C-13	

STUDY ID #: L141 DO NOT WRITE ABOVE THIS LINE HOSPITAL #: _____

Brief Pain Inventory (Short Form)

Date: ____/____/____ Time: _____

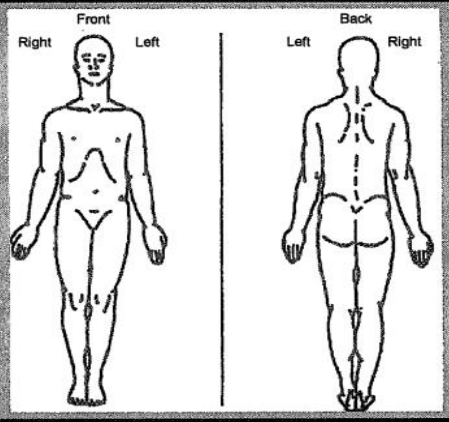
Name: _____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **average.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

STUDY ID #: 4141 DO NOT WRITE ABOVE THIS LINE HOSPITAL #: _____

Date: ____/____/____ Time: _____

Name: _____ _____ _____
Last First Middle Initial

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

B. Mood

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

C. Walking Ability

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

E. Relations with other people

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

F. Sleep

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

G. Enjoyment of life

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

MCGILL SHORT FORM PAIN QUESTIONNAIRE

Initials (forename, surname): ___ ___ **Today's Date:**___/___/_____

This abbreviated version of the McGill Pain Questionnaire (SF-MPQ) consists of 15 descriptors (11 sensory; 4 affective) which are rated on an intensity scale as 0 = none, 1 = mild, 2 = moderate or 3 = severe. In this study only the sensory component of the SF-MPQ are used as these are specific for neuropathic pain. This validated tool is useful in this situation where the standard MPQ would take a considerable time to administer yet data is desirable.

I. Pain Rating Index (PRI):

These words below describe pain in the past 24 hours. Please place a check mark (√) in the column that represents the degree to which you feel that type of pain.

	None		Mild		Moderate		Severe
Throbbing							
Shooting							
Stabbing							
Sharp							
Cramping							
Gnawing							
Hot-Burning							
Aching							
Heavy							
Tender							
Splitting							

THE LANSS PAIN SCALE

Leeds Assessment of Neuropathic Symptoms and Signs Pain Scale

Initials (forename, surname): ___ ___ Today's Date:___/___/_____

This pain scale can help to determine whether the nerves that are carrying your pain signals are working normally or not. It is important to find out in case different treatments are needed to control your pain.

A. PAIN QUESTIONNAIRE (to be completed by patient)

- Think about how your pain has felt over the last week.
- Please say whether any of the descriptions match your pain exactly by ticking either the NO or YES box for each question.

1) Does your pain feel like strange, unpleasant sensations in your skin? Words like prickling, tingling, pins and needles might describe these sensations.

a) NO – My pain doesn't really feel like this ..... ☐ (0)

b) YES – I get these sensations quite a lot ..... ☐ (5)

2) Does your pain make the skin in the painful area look different than normal? Words like mottled or looking more red or pink might describe the appearance.

a) NO – My pain doesn't affect the colour of my skin ..... ☐ (0)

b) YES – I've noticed that the pain does make my skin look different from normal .... ☐ (5)

3) Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations when lightly stroking the skin, or getting pain when wearing tight clothes might describe the abnormal sensitivity.

a) NO – My pain doesn't make my skin abnormally sensitive in that area ..... ☐ (0)

b) YES – My skin seems abnormally sensitive to touch in that area ..... ☐ (3)

4) Does your pain come on suddenly and in bursts for no apparent reason when you're still? Words like electric shocks, jumping and bursting describe these sensations.

a) NO – My pain doesn't really feel like this ..... ☐ (0)

b) YES – I get these sensations quite a lot ..... ☐ (2)

5) Does your pain feel as if the skin temperature in the painful area has changed abnormally? Words like hot and burning describe these sensations.

a) NO – I don't really get these sensations ..... ☐ (0)

b) YES – I get these sensations quite a lot ..... ☐ (1)

B. SENSORY TESTING (to be completed by Clinician)

Skin sensitivity can be examined by comparing the painful area with a contra lateral or adjacent non-painful area for the presence of allodynia and an altered pin-prick threshold (PPT).

1) ALLODYNIA

Examine the response to lightly stroking cotton wool across the non-painful area and then the painful area. If normal sensations are experienced in the non-painful site, but pain or unpleasant sensations (tingling, nausea) are experienced in the painful area when stroking, allodynia is present.

a) NO – normal sensation in both areas..... ☐ (0)

b) YES – allodynia in painful area only..... ☐ (5)

2) ALTERED PIN-PRICK THRESHOLD

Determine the pin-prick threshold by comparing the response to a 23 gauge (blue) needle mounted inside a 2 ml syringe barrel placed gently on the skin in a non-painful and then painful areas.

If a sharp needle prick is felt in the non-painful are, but a different sensation is experienced in the painful area e.g. non/blunt only (raised PPT) or a very painful sensation (lowered PPT), an altered PPT is present.

If a pinprick is not felt in either area, mount the syringe onto the needle to increase the weight and repeat.

a) NO – equal sensation in both areas ..... ☐ (0)

b) YES – altered PPT in painful area ..... ☐ (3)

SCORING:

Add values in parentheses for sensory description and examination findings to obtain overall score.

TOTAL SCORE (maximum 24) ..... ☐

If score <12, neuropathic mechanisms are **unlikely** to be contributing to the patient's pain
If score >12, neuropathic mechanisms are **likely** to be contributing to the patient's pain

DATE *(dd/mon/yyyy)* _____ INVESTIGATOR'S SIGNATURE _____

EORTC QLQ-C30 (version 3)

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials: |_|_|_|

Your birthdate (Day, Month, Year): |_|_|_|_|_|_|

Today's date (Day, Month, Year): 31 |_|_|_|_|_|_|

		Not at All	A Little	Quite a Bit	Very Much
1.	Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2.	Do you have any trouble taking a long walk?	1	2	3	4
3.	Do you have any trouble taking a short walk outside of the house?	1	2	3	4
4.	Do you need to stay in bed or a chair during the day?	1	2	3	4
5.	Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the past week:

		Not at All	A Little	Quite a Bit	Very Much
6.	Were you limited in doing either your work or other daily activities?	1	2	3	4
7.	Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8.	Were you short of breath?	1	2	3	4
9.	Have you had pain?	1	2	3	4
10.	Did you need to rest?	1	2	3	4
11.	Have you had trouble sleeping?	1	2	3	4
12.	Have you felt weak?	1	2	3	4
13.	Have you lacked appetite?	1	2	3	4
14.	Have you felt nauseated?	1	2	3	4
15.	Have you vomited?	1	2	3	4
16.	Have you been constipated?	1	2	3	4

Please go on to the next page

During the past week:	Not at All	A Little	Quite a Bit	Very Much
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4
20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

30. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

ENGLISH

Initials (forename, surname): ___ ___ Today's Date:___/___/_____

EORTC QLQ - LC13

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems during the past week. Please answer by circling the number that best applies to you.

During the past week :	Not at All	A Little	Quite a Bit	Very Much
31. How much did you cough?	1	2	3	4
32. Did you cough up blood?	1	2	3	4
33. Were you short of breath when you rested?	1	2	3	4
34. Were you short of breath when you walked?	1	2	3	4
35. Were you short of breath when you climbed stairs?	1	2	3	4
36. Have you had a sore mouth or tongue?	1	2	3	4
37. Have you had trouble swallowing?	1	2	3	4
38. Have you had tingling hands or feet?	1	2	3	4
39. Have you had hair loss?	1	2	3	4
40. Have you had pain in your chest?	1	2	3	4
41. Have you had pain in your arm or shoulder?	1	2	3	4
42. Have you had pain in other parts of your body?	1	2	3	4
If yes, where _____				
43. Did you take any medicine for pain?				
1 No 2 Yes				
If yes, how much did it help?	1	2	3	4