ESSIC Database

Symptom Discussion for ESSIC 2008 meeting, Rome

Overall Initial Inclusion

- Pain or frequency or urgency
- Greater than 6 week duration
- Confusable disease determined to account for symptoms ends data collection with exceptions to be determined

Likert Scales

- Pain
- Perception of frequency
- Urgency
- Dyspareunia

Other data to be collected

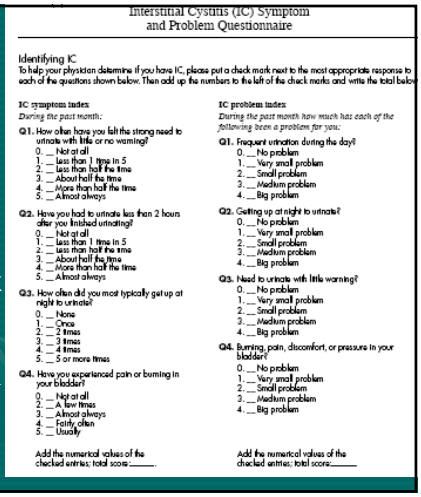
- 24 hours voiding diary
- Reason(s) for urgency
  - Fear of impending leakage
  - Worsening pain
  - Increasing pressure
  - Increasing discomfort

Characterization of Pain/Pressure/Discomfort

- Worsens with:
- Improves with:
- Sensation feels like (one or more):
  - Discomfort
  - Pain
  - Pressure
  - Sharp
  - Dull
  - Aching

O'Leary Sant Symptom and Problem Index

Men and women



Interstitial Cystitis (IC) Symptom and Problem Questionnaire

Identifying IC

To help your physician determine if you have IC, please put a check mark next to the most appropriate response to each of the questions shown below. Then add up the numbers to the left of the check marks and write the total below.

IC symptom index:

During the past month:

Q1. How often have you felt the strong need to urinate with little or no warning?
0. __ Not at all
1. __ Less than 1 time in 5
2. __ Less than half the time
3. __ About half the time
4. __ More than half the time
5. __ Almost always

Q2. How often had to urinate less than 2 hours after you finished urinating?
0. __ Not at all
1. __ Less than 1 time in 5
2. __ Less than half the time
3. __ About half the time
4. __ More than half the time
5. __ Almost always

Q3. How often did you most typically get up at night to urinate?
0. __ None
1. __ Once
2. __ 2 times
3. __ 3 times
4. __ 4 times
5. __ 5 or more times

Q4. Have you experienced pain or burning in your bladder?
0. __ Not at all
2. __ A few times
3. __ Almost always
4. __ Fairly often
5. __ Usually

Add the numerical values of the checked entries; total score _____.

IC problem index:

During the past month how much has each of the following been a problem for you:

Q1. Frequent urination during the day?
0. __ No problem
1. __ Very small problem
2. __ Small problem
3. __ Medium problem
4. __ Big problem

Q2. Getting up at night to urinate?
0. __ No problem
1. __ Very small problem
2. __ Small problem
3. __ Medium problem
4. __ Big problem

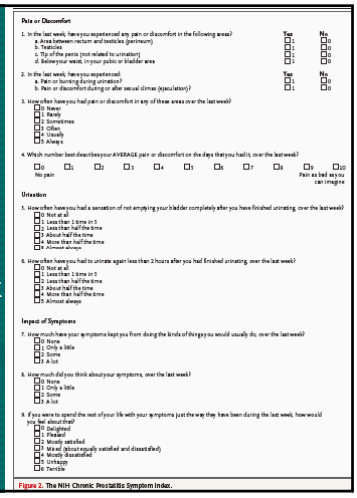
Q3. Need to urinate with little warning?
0. __ No problem
1. __ Very small problem
2. __ Small problem
3. __ Medium problem
4. __ Big problem

Q4. Burning, pain, discomfort, or pressure in your bladder?
0. __ No problem
1. __ Very small problem
2. __ Small problem
3. __ Medium problem
4. __ Big problem

Add the numerical values of the checked entries; total score _____

NIH Chronic Prostatitis Symptom Index

Men


Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following area?
a. Area between rectum and testicles (perineum)
b. Testicles
c. Tip of the penis (not related to urination)
d. Below your waist, in your pubic or bladder area

2. In the last week, have you experienced:
a. Pain or burning during urination?
b. Pain or discomfort during or after sexual climax (ejaculation)?

3. How often have you had pain or discomfort in any of these areas over the last week?
0 Never
1 Rarely
2 Sometimes
3 Often
4 Usually
5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?
0 No pain … 10 Pain as bad as you can imagine

Urination

5. How often have you had a sensation of not emptying your bladder completely after you have finished urinating, over the last week?
0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always

6. How often have you had to urinate again less than 2 hours after you had finished urinating, over the last week?
0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?
0 None
1 Only a little
2 Some
3 A lot

8. How much did you think about your symptoms, over the last week?
0 None
1 Only a little
2 Some
3 A lot

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?
0 Delighted
1 Pleased
2 Mostly satisfied
3 Mixed (about equally satisfied and dissatisfied)
4 Mostly dissatisfied
5 Unhappy
6 Terrible

Figure 2. The NIH Chronic Prostatitis Symptom Index.

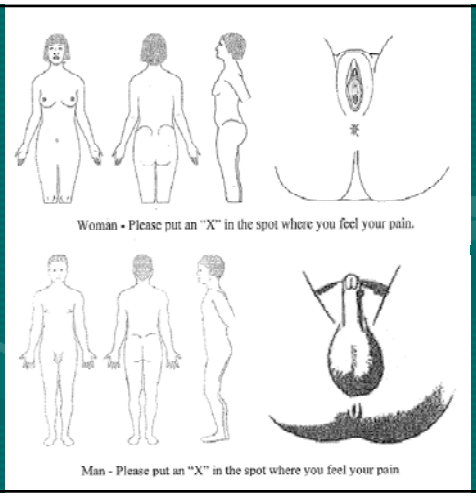
AUA Quality of Life Due to Urinary Symptoms:

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Delighted Pleased Mostly satisfied

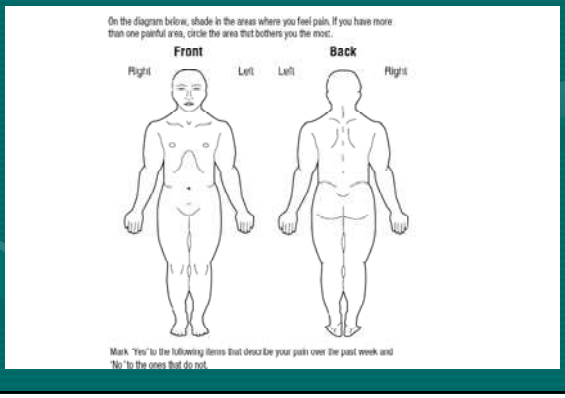
Mixed

Mostly dissatisfied Unhappy Terrible



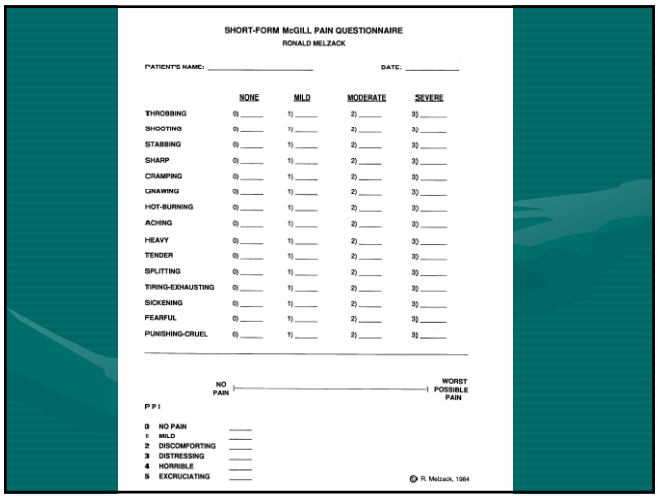
1. NPQ = neuropathic pain questionnaire
2. Pain Detect
3. ID-Pain
4. Short form McGill Pain Questionnaire
5. Beck Depression Index
6. Beck Anxiety Inventory
7. IAS= Illness Attitude Scale
8. PSQI= Pittsburg Sleep Quality Index
9. SSC=Somatic Symptoms Checklist
10. Life Events Inventory, List of Threatening Experiences

ID Pain



ID Pain

Question	Score	
	Yes	No
1. Did the pain feel like pins and needles?	1	0
2. Did the pain feel hot/burning?	1	0
3. Did the pain feel numb?	1	0
4. Did the pain feel like electrical shocks?	1	0
5. Is the pain made worse with the touch of clothing or bed sheets?	1	0
6. Is the pain limited to your joints?	–1	0



SHORT-FORM McGILL PAIN QUESTIONNAIRE

RONALD MELZACK

PATIENT'S NAME: _____ DATE: _____

	NONE	MILD	MODERATE	SEVERE
THROBBING	0)	1)	2)	3)
SHOOTING	0)	1)	2)	3)
STABBING	0)	1)	2)	3)
SHARP	0)	1)	2)	3)
CRAMPING	0)	1)	2)	3)
GNAWING	0)	1)	2)	3)
HOT-BURNING	0)	1)	2)	3)
ACHING	0)	1)	2)	3)
HEAVY	0)	1)	2)	3)
TENDER	0)	1)	2)	3)
SPLITTING	0)	1)	2)	3)
TIRING-EXHAUSTING	0)	1)	2)	3)
SICKENING	0)	1)	2)	3)
FEARFUL	0)	1)	2)	3)
PUNISHING-CRUEL	0)	1)	2)	3)

NO PAIN — WORST POSSIBLE PAIN

PPI

0 NO PAIN
1 MILD
2 DISCOMFORTING
3 DISTRESSING
4 HORRIBLE
5 EXCRUCIATING

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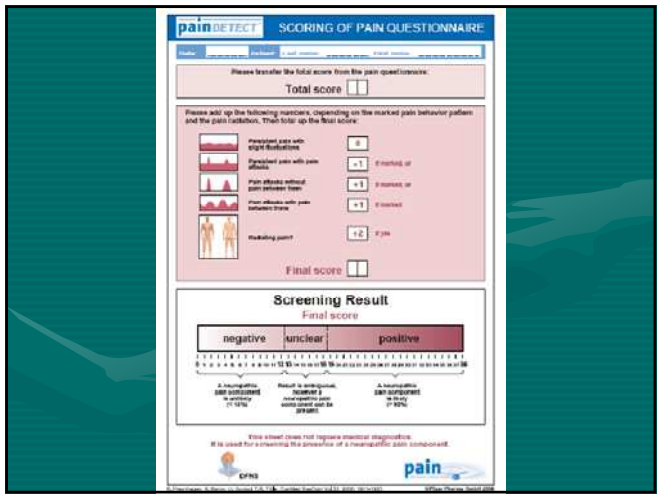


painDETECT SCORING OF PAIN QUESTIONNAIRE

Please transfer the total score from the pain questionnaire:

Total score

Please add up the following numbers, depending on the marked pain behavior pattern and the pain radiation. Then total up the final score:

Persistent pain with slight fluctuations — 0
Persistent pain with pain attacks — +1
Pain attacks without pain between them — +1
Pain attacks with pain between them — +1
Radiating pain? — +2

Final score

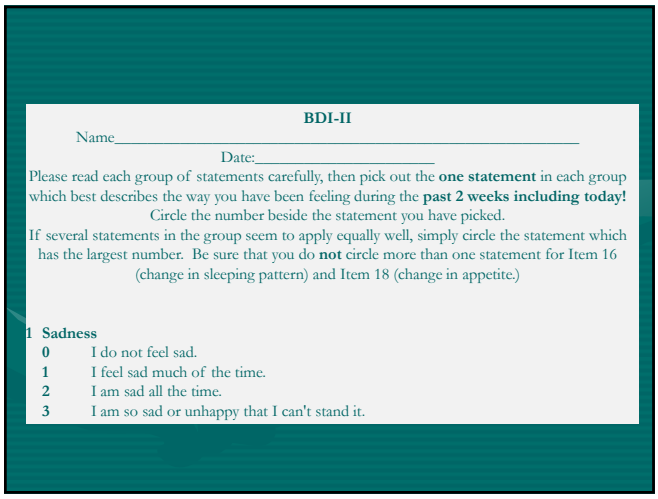
Screening Result

Final score

negative | unclear | positive

This sheet does not replace medical diagnostics. It is used for screening the presence of a neuropathic pain component.

painDETECT



BDI-II

Name_____

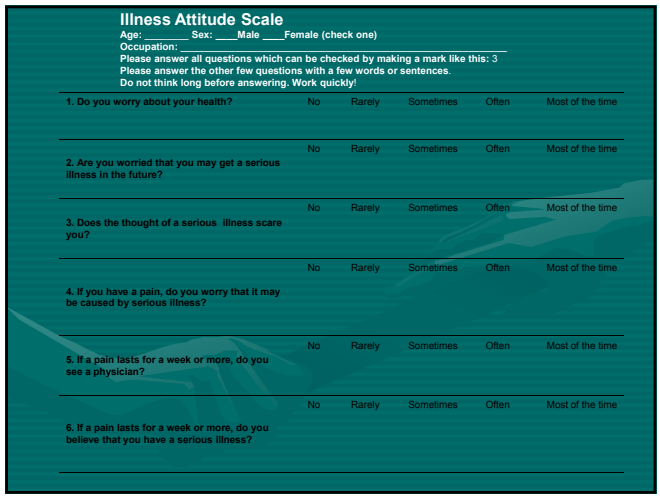
Date:_____

Please read each group of statements carefully, then pick out the **one statement** in each group which best describes the way you have been feeling during the **past 2 weeks including today!** Circle the number beside the statement you have picked.

If several statements in the group seem to apply equally well, simply circle the statement which has the largest number. Be sure that you do **not** circle more than one statement for Item 16 (change in sleeping pattern) and Item 18 (change in appetite.)

1 Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.



Illness Attitude Scale

Age: _____ Sex: ___Male ___Female (check one)

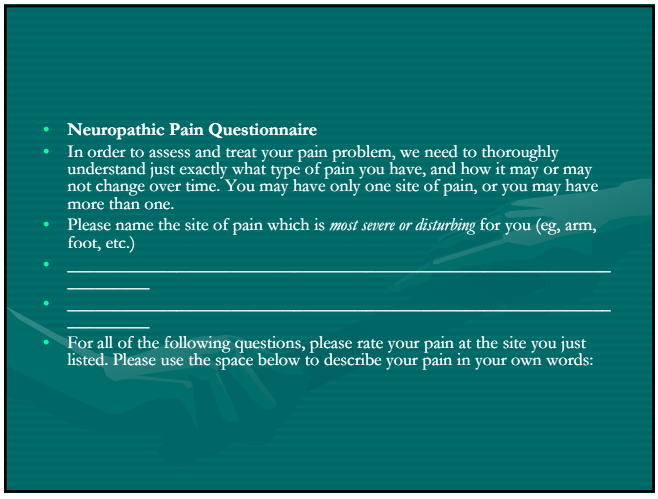
Occupation: _____

Please answer all questions which can be checked by making a mark like this: 3

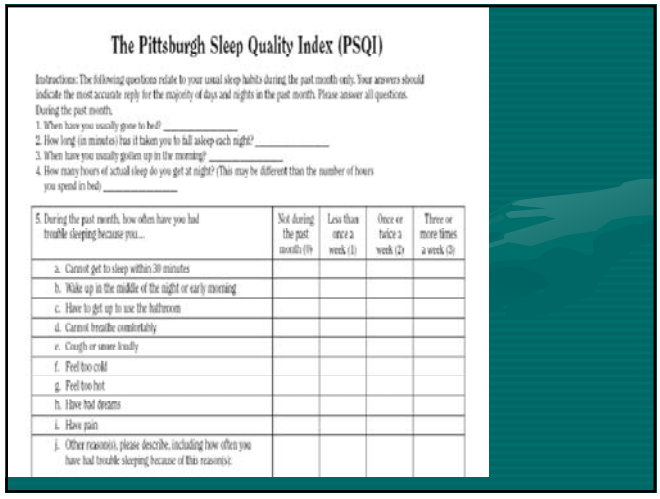
Please answer the other few questions with a few words or sentences.

Do not think long before answering. Work quickly!

1. Do you worry about your health?	No	Rarely	Sometimes	Often	Most of the time
2. Are you worried that you may get a serious illness in the future?	No	Rarely	Sometimes	Often	Most of the time
3. Does the thought of a serious illness scare you?	No	Rarely	Sometimes	Often	Most of the time
4. If you have a pain, do you worry that it may be caused by serious illness?	No	Rarely	Sometimes	Often	Most of the time
5. If a pain lasts for a week or more, do you see a physician?	No	Rarely	Sometimes	Often	Most of the time
6. If a pain lasts for a week or more, do you believe that you have a serious illness?	No	Rarely	Sometimes	Often	Most of the time



- **Neuropathic Pain Questionnaire**
- In order to assess and treat your pain problem, we need to thoroughly understand just exactly what type of pain you have, and how it may or may not change over time. You may have only one site of pain, or you may have more than one.
- Please name the site of pain which is *most severe or disturbing* for you (eg, arm, foot, etc.)
- _____
- _____
- For all of the following questions, please rate your pain at the site you just listed. Please use the space below to describe your pain in your own words:



The Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed) _____

5. During the past month, how often have you had trouble sleeping because you...	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				

Beck Anxiety Inventory

Name_____
___ Date:_____

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

		Not at all	Mildly it did not bother me much	Moderately it was very unpleasant but I could stand it	Severely I could barely stand it
1	Numbness or tingling				
2	Feeling hot				

Life Events Inventory, List of Threatening Experiences:

Twelve prescribed life event categories are rated by the examinee as having a long term threat rating of marked or moderate or mild or no threat

1. Serious illness or injury to subject*
2. Serious illness or injury to a close relative*
3. Death of first-degree relative including child or spouse*
4. Death of close family friend or second-degree relative*
5. Separation due to marital difficulties
6. Broke off a steady relationship
7. Serious problem with a close friend, neighbor or relative
8. Unemployed/seeking work for more than one month
9. Subject sacked from job
10. Major financial crisis
11. Problems with police and court appearance
12. Something valuable lost or stolen*

*events which are likely to be independent of the subject's response

Somatic Symptoms Checklist SSC

1. Have you ever had trouble breathing?
2. Have you ever had frequent trouble with menstrual cramps?
3. Have you ever had burning sensations in your sexual organs?
4. Have you ever had difficulties swallowing or had an uncomfortable lump in your throat that stayed with you for at least an hour?
5. Have you ever found that you could not remember what you had been doing for hours or days at a time? (If yes) Did this happen even though you had not been drinking or taking drugs?
6. Have you ever had trouble from frequent vomiting?
7. Have you ever had frequent pain in your fingers or toes?

Scoring: two positive symptoms gives a sensitivity for somatization disorder of 93% and a specificity of 59%. Three positive symptoms yields a sensitivity of 73% and a specificity of 94%. (Othmer, E and DeSouza, C: A screening test for somatization disorder (hysteria); Am J Psychiatry, 142:10, October 1985