

Supplementary Materials

Questionnaire for the therapy of non-melanoma skin cancer

First of all, thank you very much for your willingness to participate in this survey. The following questionnaire asks questions about your therapy against white skin cancer.

Answering this questionnaire is voluntary and will only take a few minutes. Please read the questions carefully and tick the answers that apply to you. The questionnaire comprises a total of **5 pages**. Your information will of course be treated **confidentially** and will only be processed **in anonymous** form. If you need help filling out the questions, please contact Ms. Krönert by e-mail: maila.kroenert@uni-rostock.de, telephone number: 015234102530.

*First, we ask you to answer a **few general questions**.*

(Please tick the appropriate box and, if necessary, add your own handwritten answers in the free text)

Age: _____ years

Gender: ☐ female ☐ male

Relationship status: ☐ single
☐ in a steady partnership

How would you describe your current employment status?

- ☐ Part-time job (up to 34 hours/week)
- ☐ Full-time job (35-42 hours/week)
- ☐ Full-time job (more than 42 hours/week)
- ☐ retired / not able to work
- ☐ no occupation, looking for work
- ☐ No occupation, not looking for work (e.g. parental leave, student)

Do you do sports in your free time?

- ☐ no
- ☐ yes, less than 1 hour/week
- ☐ yes, more than 1 hour/week

How long has your white skin cancer been known?

Selection: ☐ ☐ ☐
1 year 2 years > 2 years

What prior therapies have you received regarding your white skin cancer?

Selection: ☐ ☐ ☐ ☐ ☐
Laser therapy Cryotherapy Creams others none

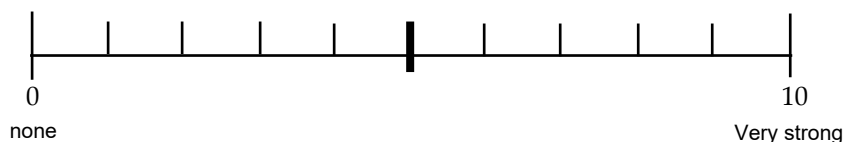
Which of the therapies listed below have you received?
Please tick all the applicable boxes.

Selection: ☐ ☐
OP Rhenium-SCT®

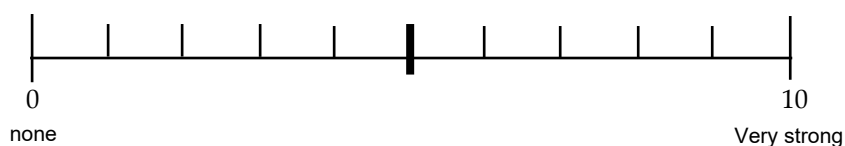
Now follow **specific questions** about your final therapy against white skin cancer.
Tick the number you feel is correct on the corresponding scales from 0-10.

Pain:

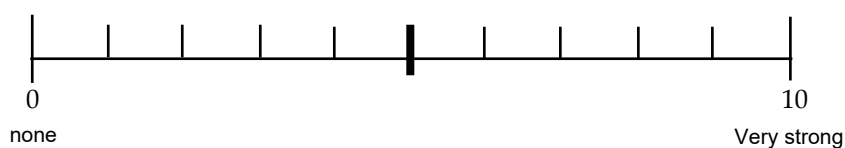
How severe was the pain under therapy/treatment?



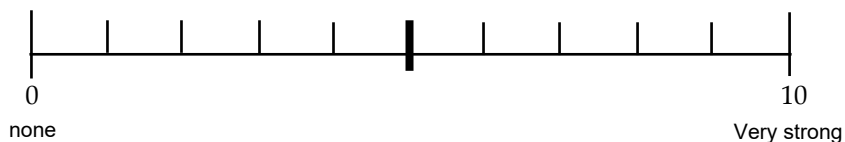
How severe was the pain 14 days after therapy?



How severe was the pain 4 months after therapy?

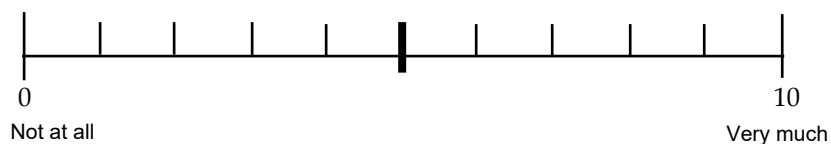


How severe was the pain 12 months after therapy?

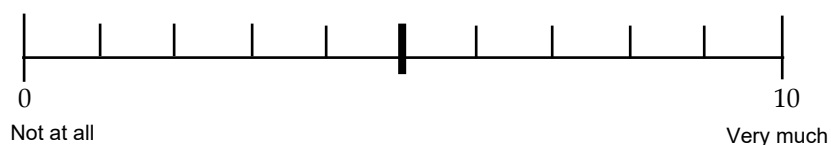


Itching:

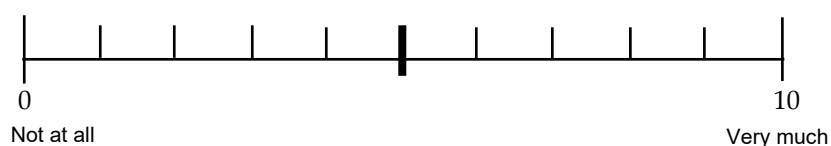
How much itching did you experience during therapy/treatment?



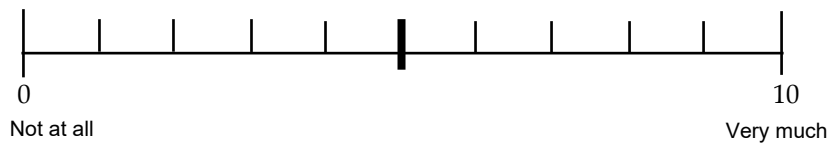
How much itching had you felt 14 days after therapy?



How much itching had you felt 4 months after therapy?

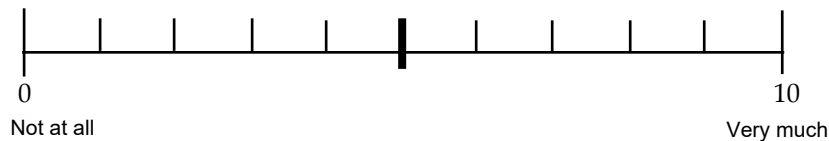


How much **itching** have you experienced **12 months after therapy?**

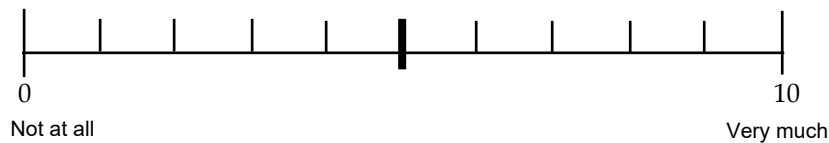


Burning:

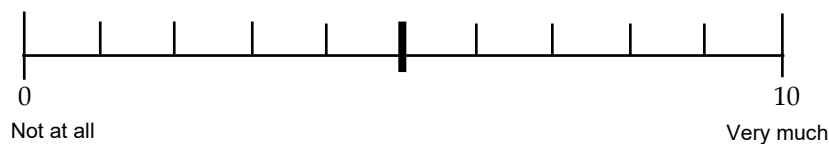
Did you experience **burning of the skin during therapy?**



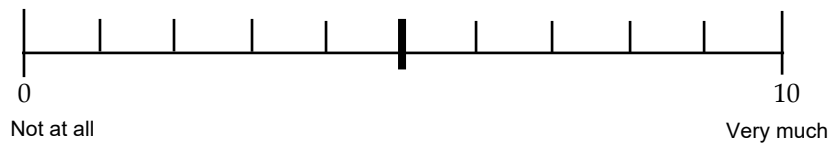
Did you feel **burning in the skin 14 days after the therapy?**



Did you feel any **burning of the skin 4 months after the therapy?**



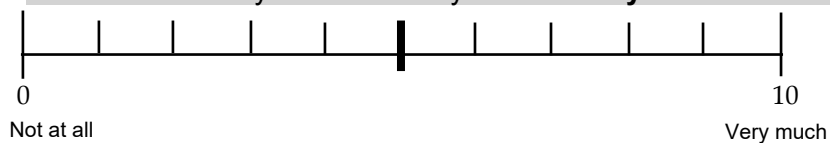
Did you feel any **burning of the skin 12 months after the therapy?**



Have you experienced any other side effects while on treatment, if so what are they? _____

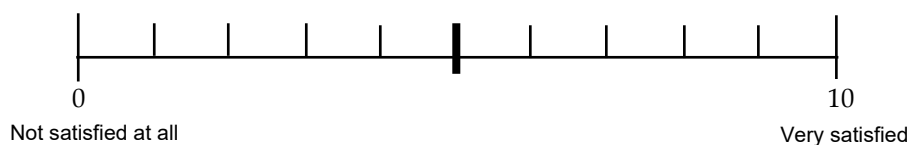
Wound care:

How much were you bothered by the **care of your wound after treatment?**

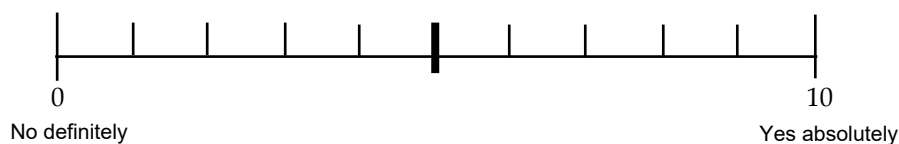


Aesthetics/Cosmetics:

How satisfied are you with the final cosmetic result of your skin lesion after therapy?

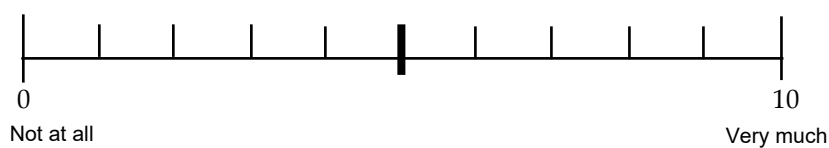


If a new white skin cancer lesion appeared, would you perform the treatment again?

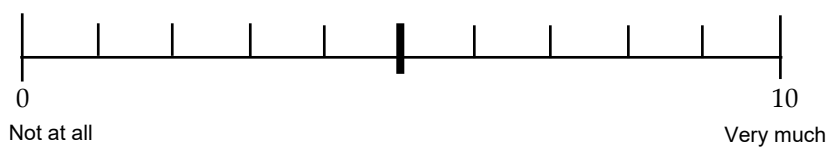


Quality of life:

How much did you feel limited by therapy in your free time?

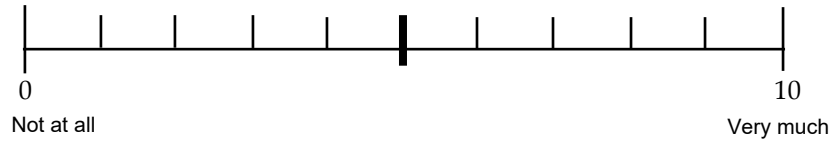


How much have you felt affected by therapy in the performance of your job/job-like tasks?

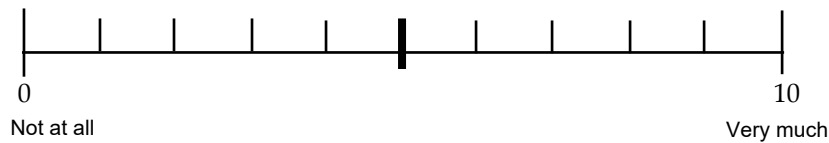


Mental stress:

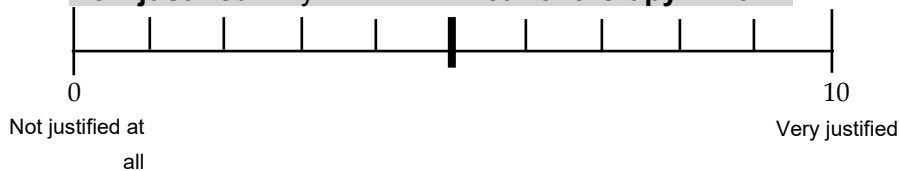
How afraid were you of the therapy application?



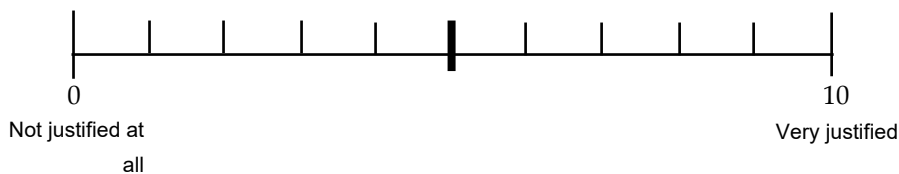
How afraid were you of complications?



How justified do you think the fear of therapy is now?



How justified do you think the fear of complications is now?



If you had to decide again to treat your white skin cancer, which treatment option would you choose?

Selection:

- | | | | |
|--------------------------|--------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rhenium-
SCT® | OP | neither
of the
two
therapies | both
therapies |

You have now reached the end of the questionnaire. Thank you for your participation.