

Miltex®: Questionnaire on Compassionate Use

Treating Physician		
Title, Name:	Hospital/Department:	Address:
Patient:		
Initials (first/last name): _/_	Age (years):	Sex (m/f):
Diagnosis of Systemic Disease:		
Type of systemic disease (e.g. breast cancer):		
first diagnosed in (Month/Year):		
Diagnosis and prior Treatment of Cutaneous Disease		
Type of cutaneous disease (e.g. breast cancer skin metastases):		
first diagnosed in (Month/Year):		
Prior Therapy: no <input type="checkbox"/> yes <input type="checkbox"/> . If yes, please specify:		
Current Status of Cutaneous Disease		
Site(s) of skin involvement:		
<u>Total area to be treated:</u>		
Approx. No. of skin lesions:	Approx. diameter of largest skin lesion[cm]:	
Confluent lesions: yes <input type="checkbox"/> no <input type="checkbox"/>	Ulcerated lesions: yes <input type="checkbox"/> no <input type="checkbox"/>	
Additional Notes:		
Miltex® Therapy		
Start with Miltex® Therapy: / / / (day/month/year)		
Miltex® Dosage: drops per 10cm ² treated area:		
Frequency of Application: <input type="checkbox"/> once daily <input type="checkbox"/> twice daily <input type="checkbox"/> other; please specify:		

Response Evaluation

Please define a **marker lesion** within area to be treated and evaluate response according to following criteria: **CR**: complete disappearance of lesions within treated area; **PR**: $\geq 50\%$ decrease in lesions within treated area; **NC**: No change or $< 50\%$ decrease or $< 25\%$ increase in lesions within treated area; **PD**: $>25\%$ increase of a lesion in treated area or new lesions within treated area. Please indicate also longitudinal and transverse diameter of marker lesion.

Evaluation on (day/month/year)	Marker Lesion		Response
	longitudinal diameter [cm]	transverse diameter [cm]	
			baseline
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>
			CR <input type="checkbox"/> PR <input type="checkbox"/> NC <input type="checkbox"/> PD <input type="checkbox"/>

Concomitant Therapy: no yes . If yes, please specify (e.g. drug, treatment duration,...):

Adverse Drug Reactions

Type	Intensity	Date of first occurrence (day/month/year)
	mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>	
	mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>	
	mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>	

