Statistical Analysis Plan (SAP)

Version 1.0, 08 May 2019

Sponsor name: Neurofix S.L

Study Code: NFX88-2A-2018

EudraCT Nº: 2018-004792-13

"A Phase IIa (proof of concept), randomized, double blind, placebo controlled, multicenter clinical trial to evaluate the safety, tolerability and therapeutic efficacy of daily oral treatment with NFX88 on neuropathic pain in patients with spinal cord injury."

By signing below, I acknowledge my agreement with this plan.

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Glossary of Terms

AE	Adverse Event
ASIA	American Spinal Injury scale
DM	Data manager
ECG	Electrocardiogram
eCRF	Electronic Case Report Form
MAS	Modified Ashworth Scale
PD-Q	Pain – DETECTED
PGIC	Patient Global Impression of Change
PI	Principal Investigator
SAE	Serious Adverse Event
SCI	Spinal cord injury
VAS	Visual Analogic Scale

STUDY SYNOPSIS

Title	A randomized, double-blind, placebo controlled, parallel group, multicentric, phase IIa clinical trial to evaluate the safety, tolerability and therapeutic efficacy of daily oral treatment with NFX88 on neuropathic pain in patients with spinal cord injury.
Sponsor	NEUROFIX S.L.
Study code	NFX88-2A-2018
EudraCT nº	2018-004792-13
Ethic Committee	CEIm-R) de la Comunidad de Madrid
Clinical phase	IIa (proof of concept)
Study Design	Multicentric, Randomized, Double Blind, Controlled Clinical Trial. In 4 sites with competitive recruitment
Study Arms and sample sizes	Arm-1 Experimental: 1.05 g/day NFX88: 15 patients. Arm-2 Experimental: 2.10 g/day NFX88: 15 patients. Arm-3 Experimental: 4.20 g/day NFX88: 15 patients. Arm-4 Control: Placebo: 15 patients.
Study dates.	Recruitment ~6 months, end of study 4 months after the last patient enrolled. **Duration for each patient:** 1-7 screening days, 90 treatment days and 30 Follow-up days.
Objectives	**Primary**: Evaluate the safety and tolerability of NFX88 over 90 days. **Secondary**: Explore the preliminary therapeutic efficacy associated through analysis of validated scales (VAS, PD-Q, PGIC).
Study Population	Spinal cord injury patients with neuropathic pain. 18 to 65 years of age.
Study assessments	**Safety and tolerability:** Number, severity, and type of AE, including changes in vital signs, ECG, clinical laboratory parameters, spasticity score and sensory and motor function. **Efficacy:** Neuropathic pain reduction scales: VAS, PD-Q and PGIC
Planned analysis	The planned analysis for the primary and secondary endpoints will be done when the last patient has completed treatment period.
Statistical methods:	• Baseline description of variables in the 4 trial arms (no inference). continuous variables will be examined and suitable transformed. • Safety assessment (primary objective): each adverse event (AE) will be coded as binary (Present/Absent) or counts (if repeated) and tables with counts and proportions of AEs in each arm will be compiled. Exact confidence intervals will be estimated. Risk or rates of each AE will be compared between arms. • Efficacy assessment (secondary objective): Changes in VAS and PD-Q will be analysed with a regression model adjusted by baseline. PD-Q will be also analysed as a categorical variable with a multinomial regression. PGIC will be analysed as a categorical variable with multinomial logistic regression. All analyses will be done twice: first using the treatment variable as binary (placebo/intervention) and then coding the treatment into four categories of doses (where placebo arm has dose=0).

1. STUDY DESIGN

This is a Phase IIa (proof of concept), multicentric, double-blinded, randomized, clinical trial, with four trial arms (three doses of treatment and one placebo). The objectives are to evaluate the safety, tolerability and efficacy of daily oral treatment with NFX88 in patients SCI who present neuropathic pain. Treatment period is 90 days and post-treatment follow-up 30 days.

1.1 Schedule of visits and assessments

A schematic diagram of the study design is shown in Figure-1. Visit windows ± 3 days will be allowed for all the visits scheduled. Patients will be examined in 6 scheduled visits (see Table-1 for details on visits schedule and data collected in each visit)

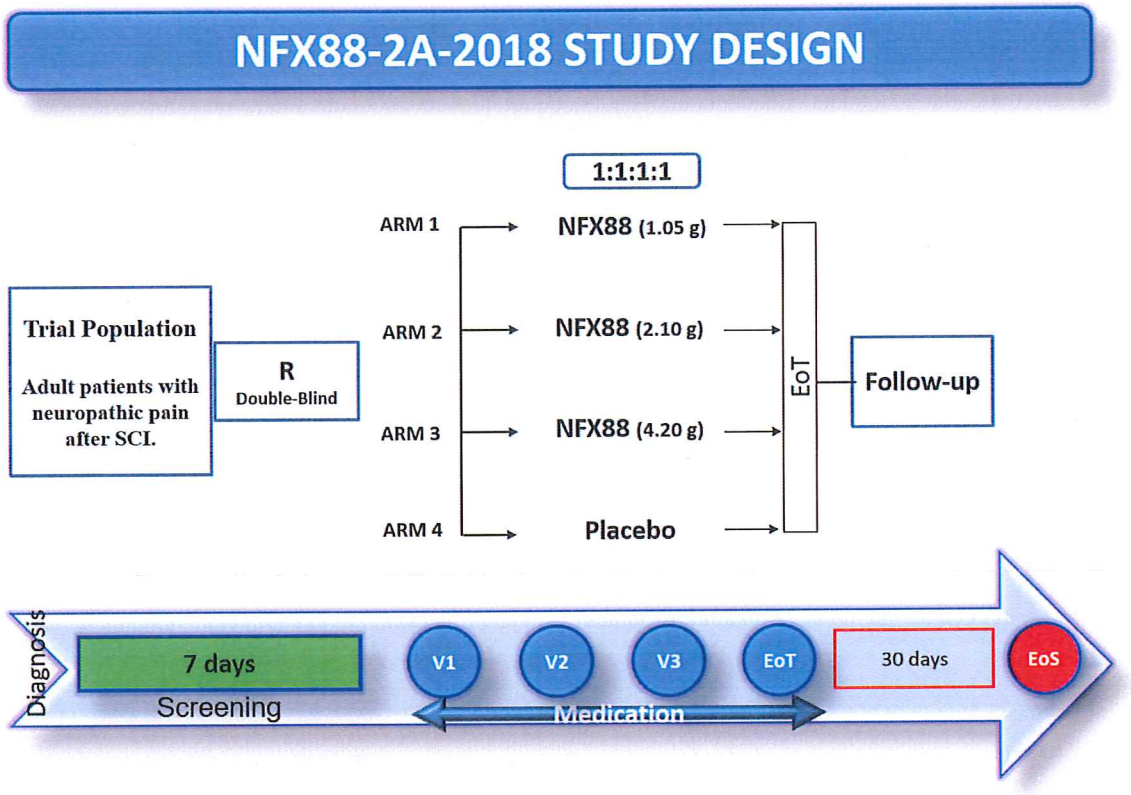


Figure 1. Schematic Diagram of the Study Design

Visits sequence:

- **SV: Screening/Baseline:** 7 days prior to randomization.
- **V1: Randomization:** Eligible patients are randomized and start with the study medication.
- **V2: Evaluation** visit on day 30 +/- 3 days after V1.

- **V3: Evaluation** visit on day 60 +/- 3 days after V1.
- **EOT: End of treatment** visit on day 90 +/- 3 days after V1.
- **FU: Follow-up** visit after end of treatment on day 120 +/- 3 days after V1
- **WV: Withdrawal visit** only for those patients who withdraw before EOT visit.

Treatment regimen: Patients will take four tablets three times a day of the investigational drug or placebo. The administration of the oral treatment will be carried out daily under the patient's responsibility. The accountability of study drug will be recorded by the study team in the medical record during study visits at site. The patient will also record every day treatment compliance, using a smartphone app designed specifically for the study.

Lost to follow-up patients: The patient can be considered evaluable when they adhere to the protocol for at least 75% of the allocated treatment (at least 68 days of complete doses treatment) and not interrupted more than one week of consecutive doses. Patients who become "not evaluable" for this reason will be considered as "drop outs" and will be substituted by a new patient allocated to the same treatment arm. However, data from drop out patients should be included for intention to treat analysis. A patient who withdraws subsequent to the screening assessments but before receiving the investigational product will not be considered in the statistical analyses, but they will be included in the eCRF as Screening Failure.

1.2 Study Population

Male or Female 18 to 65 years of age, with spinal cord injury due to complete or incomplete C4-T12 trauma for more than three months. Diagnosed of neuropathic pain with a pain score ≥ 4 in VAS scale during the last week prior to randomization date, and who have stable treatment, for at least the last month with pregabalin in the range of 150 up to 300 mg/day.

1.3 Sample Size and Power

Patients will be included in the study up to achieve sixty (60) completed patients (1:1:1:1, ratio between the 3 treatment arms and 1 placebo group). The main objective of the trial is to detect adverse events (AE) in the combined group of the three arms with medication (45 patients) compared with placebo (15 patients). The power of this trial is the probability to see cases of AE caused by the drug in the treatment arms. This power depends on the true (unobservable) risks of those AE (the higher the risk the higher the chances of seeing at least 1 case). The table below shows the power of the trial to show cases of AEs depending of the true unobservable risk. For example, if the true risk of a certain AE while on treatment was 2.5% then we would have a probability of 68% of finding at least one of these events in the intervention arms, but if the true risk was 5% then we would have a 90% chance of finding this event in the trial. For higher true risks the power is even higher.

True unobservable Risk of AE of patient in treatment arm	2.5%	5%	10%	15%
Prob. of seeing at least one case of the AE (power)	68%	90%	99%	99.9%

1.4 Randomisation methods

Patients will be randomly assigned to one of the four trial arms (three NFX88 doses and the placebo) in a 1:1:1:1 ratio. A centralized randomization list will be generated as follows:

- To ensure blinding we will follow a central allocation procedure: A randomisation lists will be generated by the DM and incorporated into to the electronic data management system. When a new patient is recruited, the system will pull the next allocation in the list and will communicate the Site investigator what steps to follow. In this way, the allocation remains blinded.
- To ensure the 1:1:1:1 distribution we will use block randomization. Blocks will be of different sizes but always multiple of 4. The sequence of blocks will be kept secret by the DM to minimise chances of anyone guessing the allocation of a next patient. In the clinical study report the details of the block sizes will be revealed. Due to the small number of patients to be recruited in each group, the randomisation list will be unique and centralised with no stratification by patients and centres, to ensure equal numbers in all groups.

Patients enrolled in this study are not allowed to be randomised in this study again.

1.5 Study variables

1.5.1 Clinical assessment

- Concomitant medication will be documented at Screening.
- Demographics: age, sex, race, weight, alcohol and smoking habits
- Medical history: primary diagnosis and neuropathic pain, previous medication and underlying diseases
- Neurological examination to verify the patient's diagnosis using ASIA scale.
- Vital signs: Body temperature, blood pressure and pulse rate
- 12-lead ECGs, including assessment of QT Interval.

1.5.2 Laboratory Measurements

- HAEMATOLOGY: haemoglobin, haematocrit, red blood cell count, white blood cell count, white blood cell differential, and platelet count, erythrocyte sedimentation rate (ESR), and mean corpuscular volume (MCV).
- CLINICAL CHEMISTRY: serum glucose, urea, creatinine, sodium, potassium, chloride, calcium, phosphorus, Protein (total), albumin, cholesterol, triglycerides, aspartate aminotransferase (AST/SGOT), alanine aminotransferase (ALT/SGPT), gamma-glutamyl transferase (GGT), alkaline phosphatase and high-density lipoprotein (HDL).

- URIANALYSIS: colour, appearance, specific gravity, pH, leukocyte, protein, glucose, ketones, bilirubin, blood, nitrite, urobilinogen, creatinine.
- OTHER: Pregnancy tests

1.5.3 Safety Measurements

- ADVERSE EVENTS: duration (start and stop dates and times), severity/grade, outcome, treatment and relation to study drug will be recorded on the eCRF
- MAS scale: See the scale in Annex 2.
- ASIA Scale: See the scale in Annex 1.

1.5.4 Efficacy Measurements

- VAS: See the scale in Annex 3.
- PD-Q: See the scale in Annex 4.
- PGIC: See the scale in Annex 5.

2. DATA MANAGEMENT AND PROCESSING

2.1 Electronic CRF

Data will be entered by the investigator or delegate in the eCRF that will feed the study database. Investigator teams, trial monitor, statisticians and sponsor will have access to the data with different permits according to their role and their needs, but they will be blinded to the patient's allocation. Allocation information will be saved in a restricted table of the database that will be fully revealed only after the end of the trial when the main analysis has been performed. Un-blinding of a specific patient will be possible upon request of the trial investigator or the patient's physician if a SAE is detected, following procedures unblinding stated in the Unblinding Manual.

2.2 Mobile application

Patients will be closely monitored during treatment and follow-up periods of the study by means of an electronic application (app) which will work as both an electronic diary and a central system management alerts to remind patients some of the trial procedures. They must use this app daily for entering data on treatment compliance and to help with it, patient will receive daily remainders to take the study drug. Real-time data transmission from the app and central system management alerts, allow the site PI and appointed study staff to control patients closely and contact the subject in the case of warning signs. The subjects may also

receive warning messages from the electronic app advising them to contact the site PI or appointed study staff, if necessary.

3. OBJECTIVES AND OUTCOME MEASURES

This proof-of-concept clinical trial is designed to establish the safety profile of NFX88 in neuropathic pain after spinal cord injury (SCI) and explore the relationship between three (1.05, 2.10 and 4.20 g) doses administered and the induction of improvement in neuropathic pain, based on the score obtained using the specific questionnaires to evaluate pain and patient perception of overall improvement

3.1 Primary objective:

To assess the safety and tolerability of NFX88 in spinal cord injury patients with neuropathic pain over ninety-day treatment period. The outcomes to analyse for this objective are:

- Adverse Events
- Changes in vital signs
- Safety laboratory values
- ECGs
- MAS score (e.g. to monitor spasticity worsening)
- ASIA score (e.g. to monitor neurological worsening)

3.2 Secondary objective:

To explore the preliminary therapeutic efficacy associated with NFX88 through the analysis of change in the following validated measurement scales:

- Change from V1 to EoT in pain intensity in the VAS scale.
- Change from V1 to EoT in the likelihood of neuropathic pain in PD-Q scale.
- Global change at EoT in patient's condition according to the PGIC scale.

4. STATISTICAL METHODS

4.1 Blinding the analytical process

Because of the existence of 4 trial arms, and the analysis will be done, either grouping the three treatment arms or coding them as an ordered variable for a dose-effect analysis, the statistician will not be blinded to patient allocation. To avoid bias in the analysis, we propose to break down the analysis in several phases where the true allocation is only added in the final one:

1. **Phase-1 data pre-processing and cleaning:** The data managers will produce a dataset (data-1) for pre-processing and cleaning (see section 4.2 below for details). This data-1 will NOT include the variable allocation as this is not needed for the cleaning. At the end of this process a "clean" dataset (data-2) will be produced by the statistician.

2. **Phase-2: programming of models, tables and graphs:** With the data-2 dataset the statistician will write the code for all statistical models, tables and graphs (see sections from 4.2 to 4.7 below). Because data-2 will NOT have the true allocation the statistician will generate a fake allocation variable, to test the code. Only once all the code is running without errors phase-3 can start.

3. **Phase-3: Running the code on unblinded data:** The data managers will now provide the true allocation variable to the statistician that will incorporate it to the clean data-2 producing the data-3 dataset. The code produced in phase-2 will be run in data-3 and a report will be automatically produced with the unblinded results of the analysis.

   It might not be possible to plan all analysis in phase-2. Some analytical decisions can only be made once the true trial groups are compared (such as whether to control for some variable that shows large imbalance at baseline between trial arms). Those decisions will be kept to a minimum and an explicit explanation will be provided

The purpose of this system is that the statistician should not play around and do exploratory analysis or try code on the unblinded data because this could lead to bias in selecting a model to produce the most convenient results. If new analyses were needed, the statistician will go back to phase-2 and write and test the code with data-2. Only then the code is ready it will be run once on the unblinded data-3 and a new report will be produced.

4.2 Variable processing and cleaning.

The eCRF will have data checking possibilities and will alert of any suspected incorrect value when the data is entered. The system will also have a facility for data validation by the trial monitor. Monitor will validate the data included in the eCRF following the Monitoring plan

and the SOP P1204-05 Site Monitoring Visit. Once the trial is finalised the dataset will be closed and passed to the statistician (data-1).

The statistician will proceed to do data checking running different statistical algorithms to detect impossible vales, highly improbable values, incompatible values between variables (i.e height = 1.5m with weight = 200kg), outliers in the distribution or extreme values of distributional parameters (means, variances, etc). If any of these are found, they will be checked back with the trial investigators and the patient's records. Key continuous outcome variables will be examined for skewness and suitable transformations (such as logarithms and roots) will be tried to normalize the variable or to deal with extreme values if needed. The distributional parameters of the continuous variables will be also checked looking for too low or high means and variances.

When all these issues are solved, a final data set for analysis will be saved and closed (data-2). On this data, the statistician will proceed to run the different analysis for main and secondary outcomes.

4.3 Variable examination and baseline comparisons.

A descriptive analysis of baseline variables and descriptive comparisons in the four trial arms will be performed. Categorical variables will be described with proportions and continuous variables will be described with means, standard deviations, medians and quartiles to examine their possible non-symmetrical distribution. Due to small number of patients a stratified analysis by study site it is unlikely to be done. No inference tests are needed at baseline as this is a randomized study, but if strong imbalances are found in some variables, the convenience of adjusting for these variables in the statistical models will be considered

4.4 Safety Assessment (Main Objective)

Sample: The safety population will include all patients who were randomised, including those that withdrew for any reasons (ITT analysis). As a sensitivity analysis, only those patients that complied with the protocol will be analysed (PP analysis).

Coding: For the analysis, each adverse event (AE) will be coded as a binary variable (Present/Absent) in each study subject. AEs defined as "unsafe levels" of some lab parameter or clinical outcome (vital signs, ECGs, ASIA and MAS scales) will be also coded as binary. If the same AE can occur at different degrees of severity several binary variables will be calculated.

Analysis: Tables with counts and proportions of each AE in each arm will be compiled. For the intervention arms, exact confidence intervals for the proportion of each AE will be estimated. Comparison of the risk of each AE between arms will be done with Fisher's exact

tests. To increase power, the patients from the three intervention doses will be analyse together in one intervention arm. If some AE turned out to be relatively common, a logistic regression model will be built to examine if there is a dose-response effect on the probability of such adverse event.

If there is interest in comparing AEs that can happen more than once in an individual a variable with the count of repetitions will be created. For the intervention arms, confidence intervals for the rates will be calculate, and rates between arms will be compare with a Poisson regression.

Drop-out patients: Patients lost to follow up (and replaced with other patients) are also included in the ITT analysis of safety. In this analysis there is a potential for bias if the total patient-time in each trial arm varies considerably because of the differences in number of patients and withdrawal times. If such situation is found, a sensitivity analysis will be done considering patients time within the study by using rates of AEs over person-time in the study in Poisson models.

4.5 Efficacy Assessment (Secondary Objective)

Sample: The efficacy analysis will include all patients who were randomised, had at least 75% of treatment compliance and completed the appropriate questionnaires of VAS, PD-Q and PGIC.

Coding: The efficacy variable VAS will be coded as a continuous variable. It cannot have outliers as is limited between 0 and 1 by construction. PD-Q will be coded as continuous (from 0 to 38) but also a categorical variable with categories ($\leq$12, 13-18 and $\geq$19) as explained in annex 4). PGIC will be coded as a categorical.

Analysis: Efficacy variables VAS and PD-Q will be analysed with a regression model to evaluate if changes from baseline (V1) to the last available questionnaire (ideally EOT) depend on treatment. The models will be adjusted for baseline to account for the possible "regression to the mean" effect [Senn SS, 2007]. If there were large imbalances of times between the two questionnaires between the trial arms, the models for this covariate will be adjusted. Model residuals will be checked visually and through normality tests. Separate models will be built using the original scale of the variable and its log-transformation, to study the possible proportional effect of the intervention.

PD-Q will be also analysed as a categorical variable with the following cut-offs: a score of $\leq$ 12 indicates that pain is unlikely to have a neuropathic component, a score of $\geq$ 19 suggests that pain is likely to have a neuropathic component and a score between these values (13-18) indicates that the result is uncertain. Multinomial regression will be used to evaluate if the probability of having a neuropathic component of the pain depends on treatment. PGIC will be

analysed as a categorical variable with multinomial logistic regression (recoding in three categories: worsening, no change and improvement due to the small sample size).

Dose-response analysis: All analyses will be done twice: first using the treatment variable as binary (placebo/intervention) and then coding the treatment into four categories of doses (where placebo arm has dose =0).

Drop-out patients: Patients lost to follow up (and replaced with other patients) will not be used for this analysis if they do not have complete data.

4.6 Subgroup analysis

Due to the small sample size, it is not expected to have enough power for any subgroup analysis to be done and even less to find differences with statistical significance between subgroups of the population. However, after seeing the characteristics of the recruited patients, and before any outcome analysis is done, the medical experts will judge whether there happen to be any subgroups that are clinically relevant to look at separately. These will be specified in the final report, clearly stating the clinical reasons why they were analysed. The final subgroup analysis will be however, interpreted with caution.

4.7 Sensitivity analysis

Sensitivity analysis are repetitions of the main analyses explained above but with the variables recalculated in some different way from the original. For example, if Adverse Events were redefined according to, for example, a threshold of severity, then the safety analysis could be redone with the new AE definitions. All sensitivity analysis cannot be anticipated before the trial is finished because as the data comes through it might suggest the different needs. Some sensitivity analysis that might be needed are:

- Redefining AE with different criteria for: Changes in vital signs, physical examination, safety laboratory values.
- Comparing AE between groups at different severity levels
- Removing patients lost to follow-up (per protocol analysis)
- Checking potential effects of transforming variables prior to the analysis to remove or modify outliers or to improve normality.

5. REFERENCES

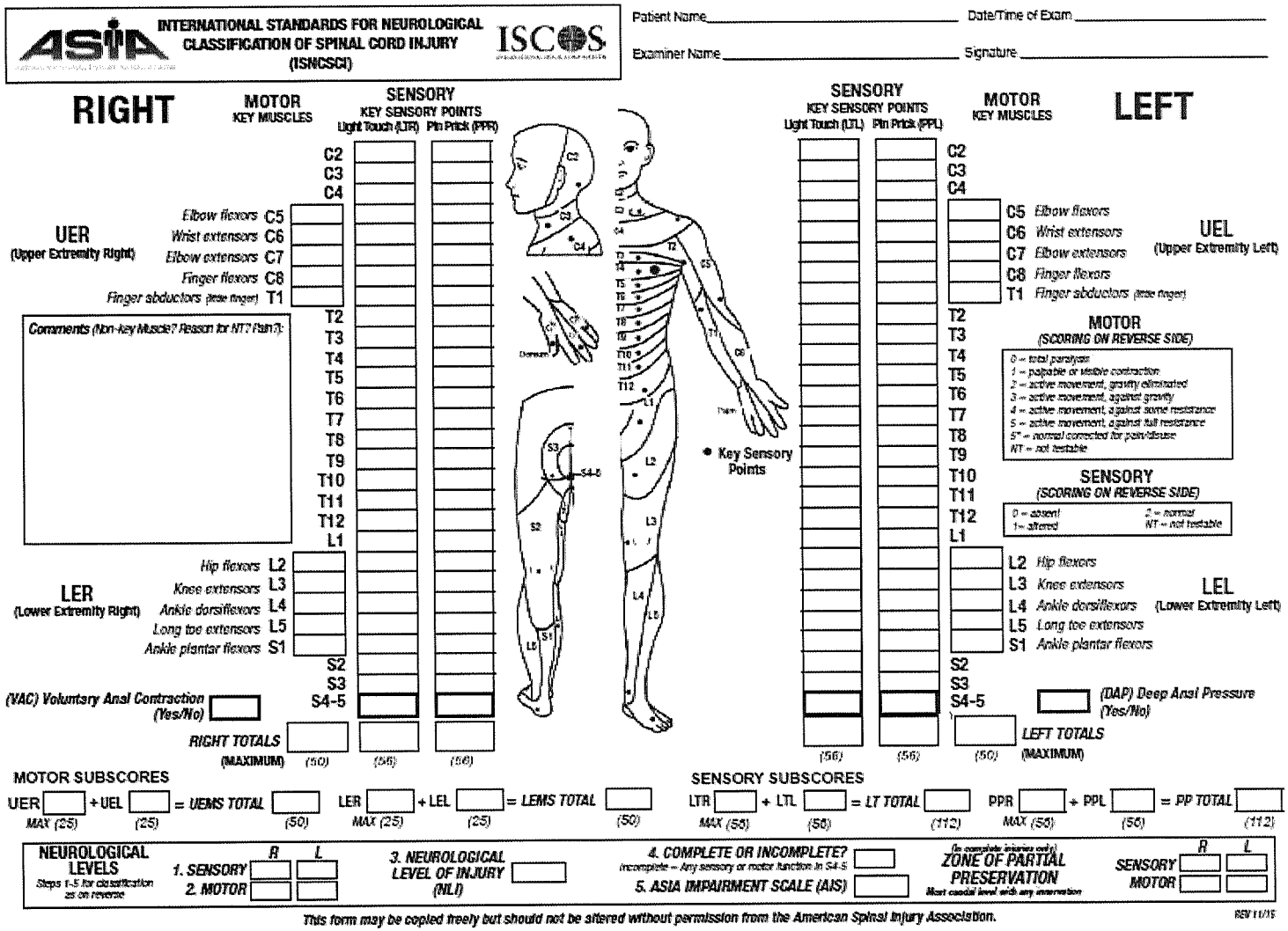
1. Senn (2007). Statistical issues in drug development (2nd edn). Stephen Senn, John Wiley & Sons Ltd, Chichester, 2007

Table 1. Schedule of Study Visits

ASSESSMENTS	SCREENING VISIT	START OF TREATMENT /BASELINE	TREATMENT VISIT	TREATMENT VISIT	END OF TREATMENT	FOLLOW-UP VISIT/END OF STUDY	WITHDRAWAL VISIT
	SV	V1	V2	V3	V4/EOT	V5/FU/EoS	WV
	D -7	D 1 [a]	D 30 [a]	D 60[a]	D 90[a]	D 120[a]	
Informed Consent	X						
Inclusion/exclusion criteria	X	X					
Randomization		X					
Training in mobile app		X					
Medical history	X						
Demographic, alcohol and smoking habits	X						
Neurological examination (ASIA scale)	X	X	X	X	X	X	X
VAS questionnaire	X	X	X	X	X	X	X
Vital signs (temperature, blood pressure, pulse rate)	X	X	X	X	X	X	X
Urinalysis, haematology and chemistry sample collection	X		X	X	X	X	X
Pregnancy test sample collection (blood)	X					X	X
Pregnancy test sample collection (Urine)		X					
12-lead ECG, QT interval	X		X	X	X	X	X
PD-Q questionnaires		X	X	X	X	X	X
MAS scale		X	X	X	X	X	X
Adverse events		X	X	X	X	X	X
Concomitant medication review	X	X	X	X	X	X	X
Intercurrent illness (es), concomitant diseases.	X	X	X	X	X	X	X
Drug dispensation		X	X	X			
Drug accountability			X	X	X		X
Subject dosing compliance			X	X	X		X
PGIC questionnaire				X	X		X
Training session for mobile device App		X					
Creating patient´s profile in the study PI´s webpage		X					
Close-out patient´s profile in the study PI´s webpage						X	X

[a] ±3 days

Annex 1. ASIA-ISNSCI Scale



Annex 2. Modified Ashworth Scale (MAS)

ESCALA DE ASHWORTH MODIFICADA	
Fecha:	
Código del paciente:	
Nombre del Centro, Ciudad:	
Espasticidad según la Escala de Ashworth: [0] [1] [1+] [2] [3] [4] marcar lo que proceda	
No hay cambios en la respuesta del músculo en los movimientos de flexión o extensión.	0
Ligero aumento en la respuesta del músculo al movimiento, solo mínima resistencia (catch).	1
Ligero aumento en la resistencia del músculo al movimiento en todo el resto del arco de movimiento.	1+
Moderado incremento en la resistencia del músculo durante la mayor parte del arco de movimiento articular, pero se puede completar el arco de movimiento.	2
Marcado incremento en la resistencia del músculo; el movimiento pasivo es difícil.	3
Las partes afectadas están rígidas cuando se mueven pasivamente.	4

	MIEMBRO SUPERIOR	MIEMBRO INFERIOR	NOTAS
DERECHA			
IZQUIERDA			

Annex 3. Visual Analogue Scale (VAS)

ESCALA VISUAL ANALÓGICA (EVA)

Fecha: _____

Código del paciente: _____

Nombre del Centro, Ciudad: _____

Marque sobre la línea, entre los dos extremos, cuánto dolor siente en esta última semana.

Firma del paciente: _____

Annex 4. PainDETECT Scale

painDETECT CUESTIONARIO DE EVALUACION DEL DOLOR

Fecha: ..... Paciente: Nombre: ..... Apellidos: .....

¿Cómo valoraría el dolor que siente **HOY**, en este momento?

0 1 2 3 4 5 6 7 8 9 10

Ningún dolor Máximo dolor

¿Cuál ha sido la intensidad del dolor **más fuerte** que ha sentido en las últimas 4 semanas?

0 1 2 3 4 5 6 7 8 9 10

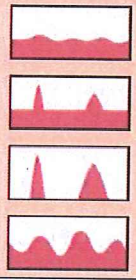
Ningún dolor Máximo dolor

¿Cuál ha sido la intensidad MEDIA de su dolor DURANTE las últimas 4 semanas?

0 1 2 3 4 5 6 7 8 9 10

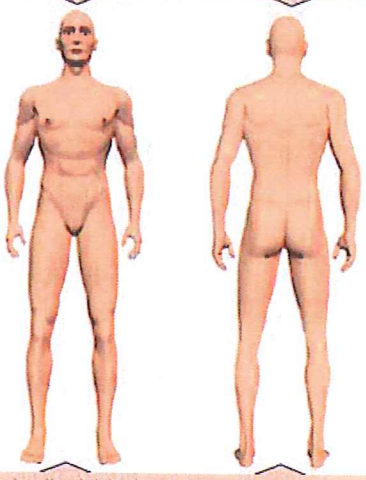
Ningún dolor Máximo dolor

Marque con una cruz la imagen que mejor describa el patrón de su dolor:



- **Dolor constante con ligeras variaciones** ☐
- **Dolor constante con crisis de dolor** ☐
- **Crisis de dolor , sin dolor entre las crisis** ☐
- **Crisis de dolor , con dolor entre las crisis** ☐

Marque **la principal zona de su dolor**



¿Se irradia el dolor hacia otras partes de su cuerpo? sí ☐ no ☐

Si la respuesta es sí, indique con una flecha la dirección hacia la que se irradia el dolor.

¿Tiene una sensación de quemazón (p.ej. como por roce de ortigas) en la zona marcada?

no ☐ Muy ligera ☐ Ligera ☐ moderada ☐ intensa ☐ muy intensa ☐

¿Tiene una sensación de hormigueo o cosquilleo (como una corriente eléctrica) en la zona de dolor?

no ☐ Muy ligera ☐ Ligera ☐ moderada ☐ intensa ☐ muy intensa ☐

¿Le produce dolor cualquier ligero roce (p.ej. la ropa o las sábanas) en esta zona?

no ☐ Muy ligera ☐ Ligera ☐ moderado ☐ intenso ☐ muy intenso ☐

¿ En la zona de dolor marcada, tiene crisis de dolor repentinas, como descargas eléctricas,?

no ☐ Muy ligera ☐ Ligera ☐ moderados ☐ intensos ☐ muy intensos ☐

¿En la zona del dolor , en alguna ocasión le produce dolor el contacto del frio o el calor (p.ej. el agua de la

no ☐ Muy ligera ☐ Ligera ☐ moderado ☐ intenso ☐ muy intenso ☐

¿Tiene una sensación de entumecimiento en la zona de dolor marcada?

no ☐ Muy ligera ☐ Ligera ☐ moderada ☐ intensa ☐ muy intensa ☐

¿Se desencadena el dolor con solo una ligera presión en la zona de dolor marcada (p. ej. con el dedo)?

no ☐ Muy ligera ☐ Ligera ☐ moderado ☐ intenso ☐ muy intenso ☐

(a rellenar por el médico)

nunca	Muy ligera	Ligera	moderada	intensa	muy intensa
x 0 = 0	x 1 =	x 2 =	x 3 =	x 4 =	x 5 =

Puntuación total ____ **sobre 35**

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painDETECT

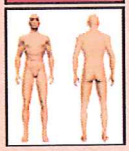
Puntuación del Cuestionario de evaluación del dolor

Fecha: ..... Paciente: Nombre: ..... Apellidos: .....

Transcriba la puntuación total del cuestionario de evaluación del dolor:

Puntuación total ☐☐

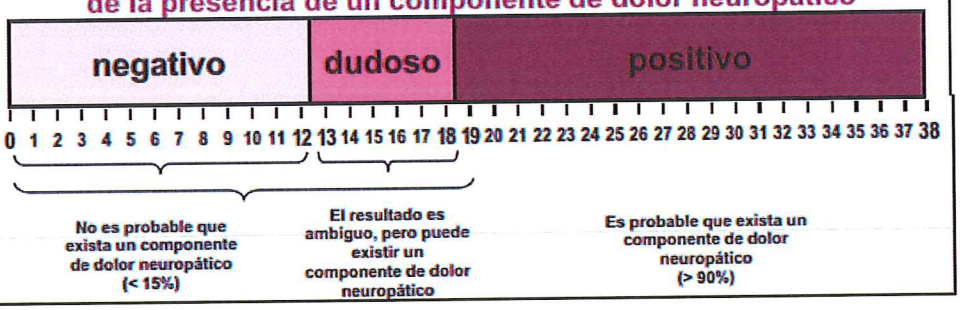
Añada a la puntuación anterior las siguientes cifras en función del patrón de dolor marcado y de la presencia o ausencia de dolor irradiado. A continuación calcule la puntuación final:

	Dolor constante con ligeras variaciones	0
	Dolor constante con crisis de dolor	- 1 si se ha marcado esta imagen, o
	Crisis de dolor , sin dolor entre las crisis	+ 1 si se ha marcado esta imagen, o
	Crisis de dolor , con dolor entre las crisis	+ 1 si se ha marcado esta imagen
	¿Dolor irradiado?	+ 2 si la respuesta es sí

Puntuación final ☐☐

Resultado del análisis

de la presencia de un componente de dolor neuropático



Este cuestionario no sustituye el diagnóstico médico.
Se utiliza para analizar la presencia de un componente de dolor neuropático.

DFNS

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Annex 5. Patient Global Impression of Change (PGIC) Scale

ESCALA DE IMPRESIÓN DEL CAMBIO GLOBAL DEL PACIENTE

Fecha: _____

Código del paciente: _____

Nombre del Centro, Ciudad: _____

Desde el comienzo del tratamiento en este hospital hasta ahora, ¿cómo describiría el cambio (si existe) en el dolor relacionado con su condición post traumática?

Marque con una (X) una sola respuesta.

Muy mejorado	
Mucho mejor	
Mínimamente mejorado	
Ningún cambio	
Mínimamente peor	
Mucho peor	
Muy empeorado	

Firma del paciente: _____