# Appendix H: Evidence Tables – Clinical Studies

## H.1 Self-management

### H.1.1 Randomised controlled trials

<table>
<tr><th>Reference</th><th>Study type</th><th>Number of patients</th><th>Patient characteristics</th><th>Intervention</th><th>Comparison</th><th>Length of follow-up</th><th>Outcome measures</th><th>Source of funding</th></tr>
<tr>
<td>N. J. Mork, J. Austad, and L. Brolund. An open, parallel groups, study of the importance of thoroughness of application in the treatment of psoriasis with a dithranol cream (Micanol). Acta</td>
<td>RCT<br><br>Single centre study, Norway<br><br>• Setting: outpatient<br><br>• Randomised:<br>Unclear method.<br><br>• Washout period:<br>unclear<br><br>• Unblinded.</td>
<td>N=29<br><br>Drop-outs (don’t complete the study):<br>N =2<br><br>1 in each group due to irritation – week 4 and week 2 (classified</td>
<td>Inclusion criteria<br>Chronic, stable, plaque-type psoriasis; 4-14 plaques of ≥6cm$^2$; severity of erythema and induration ≥2 on 0-3 scale and desquamation ≤1(permitted to receive salicylic acid or urea ointment before the study to reach this score)<br><br>Exclusion criteria<br>None stated<br><br>
<table>
<tr><th>Parameter</th><th>Micanol (N=14)</th><th>Micanol + info</th></tr>
</table>
</td>
<td>N=15<br><br>Micanol plus additional education (information about the importance of being thorough when rubbing the cream in to the lesions) – repeated at each follow-up visit<br><br>At the first visit the investigator applied</td>
<td>N=14<br><br>Micanol plus standard information</td>
<td>Treatment duration:<br>6 weeks (or until complete clearance [ TSS = 0])</td>
<td>Primary outcome:<br>Total severity score (sum of desquamation, erythema and induration each on 0-3 scale divided by 3) – assessed at baseline weeks 2, 4 and 6</td>
<td>None stated</td>
</tr>
</table>

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Derm.Venereol. Supplementum. 172:23-24, 1992. REF ID: MORK1992A | • **Allocation concealment** Not reported<br>• **Sample size calculation** no.<br>• **ITT analysis** unclear (may be ACA)<br>**Drop-outs/withdrawals**. N=2 | as treatment failures; all available data from these patients was included in analyses) | | | (n=15) | Micanol on one plaque to demonstrate correct application<br>**Both arms:**<br>Micanol 1% once daily, removed after 30 mins with water and mild soap<br>Emollients were permitted during the study | | | | |
| | | | **% male** | 42.9% | 46.7% | | | | | |
| | | | **Age (years)** | 43.8±14.1 (28-78) | 45.1±16.1 (25-79) | | | | | |
| | | | Duration of disease and body surface area affected were not different | | | | | | | |

**Effect Size**

Outcomes

| **TSS** | **Micanol** | **Micanol + extra info** | **p-value** |
|---|---|---|---|
| Baseline score | 1.98 | 1.91 | |
| % reduction at week 2 | 23% (1.52) | 34% (1.26) | |
| % reduction at week 4 | 31% (1.37) | 47% (1.01) | |
| % reduction at week 6 | 39% (1.21) | 67% (0.63) | <0.05 |

**Author's conclusion**

- Thoroughness of application is an important factor for rate of healing in short-contact dithranol treatment

| Reference | Study type | Number of patients | Patient characteristics | Intervention | Comparison | Length of follow-up | Outcome measures | Source of funding |
|---|---|---|---|---|---|---|---|---|
| C. Gradwell, K. S. Thomas, J. S. English, and H. C. Williams. A randomized controlled trial of nurse follow-up clinics: do they help patients and do they free up consultants ' time? Br.J.Dermatol. 147 (3):513-517, 2002. REF ID: GRADWELL | RCT<br><br>Single centre study, UK<br><br>Recruited over a 3-month period and enrolled for 6 weeks<br><br>• **Setting:** outpatient<br><br>• **Randomised**: Computer-generated list with block size of 8 (stratified by diagnosis).<br><br>• **Washout period**: N/A | N=66<br><br>**Note:** mixed population (psoriasis and eczema – 46% psoriasis)<br><br>**Drop-outs (don't complete the study):**<br><br>N =10<br><br>5 in each group did | **Inclusion criteria**<br><br>Newly referred patients aged ≥14 years with a diagnosis of psoriasis or eczema<br><br>**Exclusion criteria**<br><br>None stated | N=33<br><br>**Normal care plus session with dermatology nurse specialist**<br><br>20-min interview with dermatology nurse specialist in addition to initial consultation with dermatologist<br><br>An appropriate teaching aid was selected per patient (demo/leaflet, video, touch-screen computer or verbal<br><br>Information was given regarding the skin condition, | N=33<br><br>**Normal care**<br><br>Initial consultation and follow-up with a dermatologist | 6 weeks | **Primary outcome**:<br><br>Change in DLQI<br><br>**Other outcomes:**<br><br>Patient knowledge, number of consultations during follow-up | Crookes Healthcare |

| Parameter | Usual (N=32) | Usual + nurse (n=33) |
|---|---|---|
| **% male** | 47% | 39% |
| **Age (years)** | 47.0± 19.0 | 31.8± 15.7 |
| **Diagnosis**: Psoriasis | 47% | 45% |
| Eczema | 53% | 49% |
| Other | 0 | 3% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 2002 | • **Unblinded.**<br>• **Allocation concealment** sealed, numbered opaque envelopes<br>• **Sample size calculation** no – pilot study (constrained by length of study)<br>• **ITT analysis** yes for DLQI – following DLQI instructions for missing fields and LOCF for other missing values<br>Participants with missing data at baseline were excluded from further analysis on that scale | not return the final questionnaire (in the control arm 2 of the 5 also had no baseline data) | **Disease severity**<br>Mild<br>Moderate<br>Severe | <br>6%<br>59%<br>34% | <br>24%<br>30%<br>45% | treatment application (including how much and where), where to receive support and how to get repeat prescriptions<br>Participants were also provided with an individualised booklet and treatment programme<br>Instructions about the quantity were based on the finger-tip unit or corticosteroids and used a teaspoon estimate for emollients | | | | |
| | | | Despite randomisation age and disease severity were notably different | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Drop-outs/withdrawals**. N=10 | | | | | | | |

**Effect Size**

Outcomes

**<u>Quality of life</u>**

| **DLQI** | **Baseline** | **Change at 6 weeks** | **Mean difference in change** | **95% CI** | **p-value** |
|---|---|---|---|---|---|
| **Normal care (n=31)** | 10.7 | -2.9 | 0.27 | -2.3 to 2.8 | 0.83 |
| **Normal care + nurse (n=31)** | 10.1 | -2.6 | | | |

**<u>Treatment concordance/knowledge</u>**

| **Numbers who adequately understood:** | **Normal care (n=28)** | **Normal care + nurse (n=28)** | **p-value** |
|---|---|---|---|
| - **How much treatment to apply** | 24/26 (92%) | 28/28 (100%) | 0.23 |
| - **How long to apply for** | 23/27 (85%) | 28/28 (100%) | 0.05 |
| - **How to obtain a repeat prescription** | 14/24 (58%) | 25/28 (89%) | 0.01 |
| - **Where to get support** | 14/26 (54%) | 26/27 (96%) | <0.001 |

**Note:** numbers vary for individual questions because of missing values

**Impact on service use**

| | Normal care (n=28) | Normal care + nurse (n=28) | p-value |
|---|---|---|---|
| **% follow-up appointments with dermatologist cancelled because nurse could perform the assessment** | 0% | 33% | |
| **Visited GP during 6-wk follow-up** | 11 (39%) | 3 (11%) | 0.01 |

**Author's conclusion**

- Dermatology nurses can add to a dermatology consultation and provide effective patient education and support in managing a skin condition.
- With this added service nurses could help to free up dermatologists' time, thus allowing them to see more new patients.
- Cost-effectiveness studies are now needed

<table>
<tr><th>Reference</th><th>Study type</th><th>Number of patients</th><th>Patient characteristics</th><th>Intervention</th><th>Comparison</th><th>Length of follow-up</th><th>Outcome measures</th><th>Source of funding</th></tr>
<tr>
<td>S. J. Ersser, F. C. Cowdell, P. G. Nicholls, S. M. Latter, and E. Healy. A pilot randomized controlled trial to examine the feasibility and efficacy of an educational nursing intervention to improve self-management practices in patients with mild-moderate psoriasis. J Eur Acad Dermatol Venereol, 2011.<br>REF ID: ERSSER2011</td>
<td>RCT<br><br>Multicentre study (8 centres), UK<br><br>Conducted June and September 2009<br><br>• Setting: primary care<br><br>• Randomised:<br>Cluster randomisation by toss of a coin (inadequate)<br><br>• Washout period:<br>N/A</td>
<td>N=64<br><br>Drop-outs (don’t complete the study):<br>N =5<br><br>2 (7.1%) in experimental and 3 (8.3%) in control group<br><br>Note: of those invited to participate (n=340) 53.2% did not respond and another 22.1% declined to participate of the 24.7% positive</td>
<td>Inclusion criteria<br>Age ≥18 years, mild-moderate plaque psoriasis (currently using topical therapies only and having no contact with secondary care in<br>3 months before or after recruitment)<br><br>Exclusion criteria<br>None stated
<table>
<tr><th>Parameter</th><th>Usual (N=36)</th><th>Usual + nurse (n=28)</th><th>p-value</th></tr>
<tr><td>% male</td><td>55%</td><td>29%</td><td>0.031</td></tr>
<tr><td>Age (years)</td><td>59.03 ± 13.53</td><td>56.86 ± 12.67</td><td>0.515</td></tr>
<tr><td>Mean disease duration</td><td>24.17 ±18.63</td><td>22.68 ±17.99</td><td>0.749</td></tr>
</table>
</td>
<td>N=28<br><br>Normal care plus session with dermatology specialist nurse and education materials<br><br>The intervention has three components: (i) structured, nurse-led group learning experience; (ii) supporting written and audiovisual material to provide additional information and a relaxation resource and</td>
<td>N=36<br><br>Normal care<br><br>Initial visit and follow-up for data collection only</td>
<td>6 weeks</td>
<td>Primary outcome:<br>Change in DLQI<br><br>Other outcomes:<br>Change in PASI</td>
<td>Psoriasis Association</td>
</tr>
</table>

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | • **Unblinded**.<br>• **Allocation concealment** unclear (randomisation performed by an independent investigator)<br>• **Sample size calculation** no – pilot study<br>• **ITT analysis** no – available case<br>**Drop-outs/withdrawals**. N=5 | responses 23.8% were unable to attend | **Current topicals**<br>None<br>Emollients only<br>GP prescribed active therapies | <br>2<br>2<br>32 | <br>2<br>6<br>20 | | (iii) Follow-up telephone consultation.<br>A dermatology specialist nurse and the research nurse attended training on self-efficacy based education. The specialist nurse delivered each group session | | | |

| Effect Size<br>Outcomes | | | | |
|---|---|---|---|---|
| **Full group** | **Intervention (n=26)** | **Control (n=33)** | **95% CI** | **p-value** |

| | Baseline | Final | Change | Baseline | Final | Change | | |
|---|---|---|---|---|---|---|---|---|
| Mean DLQI (SD) | 4.86±5.14 | 4.58±5.05 | 0.28±2.16 | 4.18±3.91 | 3.70±3.71 | 0.48±3.02 | -1.20 to 1.61 | 0.772 |
| Mean PASI (SD) | 2.34±2.66 | 1.78±1.62 | 0.56±1.42 | 3.22±2.26 | 2.82±2.20 | 0.40±1.06 | -0.81 to 0.49 | 0.619 |

**Post-hoc subgroup analysis for those with moderate disease severity/impact**

| **Baseline DLQI or PASI >6** | **Intervention (n=9)** | | | **Control (n=13)** | | | 95% CI for change | **p-value** |
|---|---|---|---|---|---|---|---|---|
| | **Baseline** | **Final** | **Change** | **Baseline** | **Final** | **Change** | | |
| Mean DLQI (SD) | 9.56±5.96 | 9.22±5.14 | 0.33±2.50 | 7.15±4.34 | 5.62±4.11 | 1.54±3.93 | -1.90 to 4.31 | 0.427 |
| Mean PASI (SD) | 4.61±3.33 | 3.17±1.67 | 1.44±2.06 | 4.75±2.68 | 4.14±2.60 | 0.62±1.30 | -2.32 to 0.66 | 0.259 |

**Usefulness of intervention (n=26)**

| **Score** | **Group learning** | **DVD** | **Workbook** | **Telephone conversation** |
|---|---|---|---|---|
| Not useful | 3.8% | 3.8% | 3.8% | 7.7% |
| Moderately useful | 30.8% | 26.9% | 38.5% | 30.8% |
| Very useful | 65.4% | 26.9% | 57.7% | 53.8% |
| No response | 0% | 42.3% | 0% | 7.7% |

**Author's conclusion**

- This study highlights the feasibility of delivering a self-efficacy based educational intervention for people with mild-moderate psoriasis in primary care establishing the numbers and design required for an adequately powered multi-centred trial.
- People with moderate disease severity may be most likely to benefit from this intervention.

<table>
<tr><th>Reference</th><th>Study type</th><th>Number of patients</th><th>Patient characteristics</th><th>Intervention</th><th>Comparison</th><th>Length of follow-up</th><th>Outcome measures</th><th>Source of funding</th></tr>
<tr>
<td>D. Kernick, A. Cox, R. Powell, D. Reinhold, J. Sawkins, and A. Warin. A cost consequence study of the impact of a dermatology-trained practice nurse on the quality of life of primary care patients with eczema and psoriasis. Br.J.Gen.Pract. 50:555-558, 2000.</td>
<td>RCT<br><br>Single centre study, UK<br><br>• Setting: primary care<br><br>• Randomised:<br>Computer-generated random numbers<br><br>• Washout period:<br>N/A<br><br>• Unblinded.</td>
<td>N=109<br><br>Note: mixed population (psoriasis and eczema – 41% psoriasis)<br><br>Drop-outs (don’t complete the study):<br>N =28<br><br>9 (16%) in intervention group refused the initial appointment</td>
<td>Inclusion criteria<br>Routine GP care for 4 months before seeing the nurse; minimum of 3 repeat prescriptions for topical medication in the last year; aged 18-65 years; diagnosis of psoriasis or eczema<br><br>Exclusion criteria<br>None<br><br>
<table>
<tr><th>Parameter</th><th>Usual + nurse (n=46)</th><th>Usual (n=54)</th></tr>
<tr><td>% male</td><td>39%</td><td>48%</td></tr>
<tr><td>Age (years)</td><td>47.4±18.4</td><td>51.7±15.8</td></tr>
<tr><td>Diagnosis:<br>Psoriasis<br>Eczema<br>Mixed</td><td><br>35%<br>57%</td><td><br>37%<br>61%</td></tr>
</table>
</td>
<td>N=55<br><br>Routine GP care + sessions with trained practice nurse<br><br>Practise nurses attended a structured training programme at a local hospital dermatology department over 87 hours<br><br>This included tuition, ward and out-patient attendance and background reading around the treatment, education and psychological</td>
<td>N=54<br><br>Routine GP care (delayed intervention – received routine GP care for 4 months before seeing a nurse)</td>
<td>4 months</td>
<td>Primary outcome:<br>Change in DLQI<br><br>Other outcomes:<br>Visual analogue scale from Euroqol;<br><br>Response to care;<br><br>Disease severity (assessed by patient-assessment of 3 signs from scaling, redness,</td>
<td>Leo Pharmaceuticals</td>
</tr>
</table>

<table>
<tr>
<td>REF ID: KERNICK2000</td>
<td>• Allocation concealment unclear<br><br>• Sample size calculation yes<br><br>• ITT analysis yes – assumptions not stated<br><br>Participants who did not attend the initial clinic visit were excluded from further analysis<br><br>Drop-outs/withdrawals. N=28</td>
<td>11 (24%) in the intervention group and 8 (15%) in the control group were lost to follow-up (4-month questionnaire was not completed); there were no differences in initial DLQI between these groups</td>
<td>
<table>
<tr><td></td><td>9%</td><td>2%</td></tr>
<tr><td>Previous consultant referral</td><td>48%</td><td>50%</td></tr>
<tr><td>DLQI (0-30)</td><td>6.1 ± 4.9</td><td>6.8 ± 5.0</td></tr>
<tr><td>Clinical score (3-15)</td><td>9.3 ± 2.9</td><td>8.4 ± 3.1</td></tr>
<tr><td>Euroqol (0-100)</td><td>69.2±20.8</td><td>62.5±23.1</td></tr>
<tr><td colspan="3">Despite randomisation % male and disease severity were notably different</td></tr>
</table>
</td>
<td>support of patients, carers and families<br><br>The nurse was able to offer as many consultations over 4 months as she deemed necessary (GPs signed prescriptions as indicated by the nurse without seeing the patients)</td>
<td></td>
<td></td>
<td>itchiness, pustules, swelling, dryness, extent of rash and thickness of rash. Each was scored as mild (1) to very severe (5). The sum was used as the clinical score and ranged from 3-15</td>
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<tr>
<td colspan="7">Effect Size<br><br>Outcomes</td>
</tr>
</table>

Note that the median number of clinic attendances was 2 and during the trial 2 patients saw the GP for eczema or psoriasis in the intervention group compared with 14 in the control group (p<0.005)

**Quality of life**

| **Outcome** | **Intervention group (n=46)** | | **Control group (n=54)** | | **Change (p-value)** |
|---|---|---|---|---|---|
| | **Entry** | **Completion** | **Entry** | **Completion** | |
| **DLQI** | 6.1 ±4.9 | 4.6 ±4.7 | 6.8 ±5.0 | 6.2 ±5.2 | -1.5 vs -0.6 (NS) |
| **Clinical score (0-15)** | 9.3 ±2.9 | 7.6 ±3.3 | 8.4 ±3.1 | 8.1 ±3.3 | -1.7 vs -0.3(<0.05) |
| **Euroqol generic QoL (0-100)** | 62.9±20.8 | 68.4 ±20.8 | 62.5 ±23.1 | 65.1 ±23.8 | +5.5 vs +2.6 (NS) |

**Authors conclusion**

- The study was underpowered to detect the change in DLQI (power calculation based on 50% reduction in DLQI based on nurse intervention) but the intervention did achieve a 25% reduction in DLQI
- Nurse intervention significantly reduced clinical burden

**H.1.1.1 Cohort study**

<table>
<tr><th>Reference</th><th>Study type</th><th>Number of patients</th><th>Patient characteristics</th><th>Intervention</th><th>Comparison</th><th>Length of follow-up</th><th>Outcome measures</th><th>Source of funding</th></tr>
<tr>
<td>C. Renzi, Pietro C. Di, P. Gisondi, L. M. Chinni, M. Fazio, A. Ianni, and S. Tabolli. Insufficient knowledge among psoriasis patients can represent a barrier to participation in decision-making. Acta Derm.Venereol. 86 (6):528-534, 2006. REF ID: RENZI2006</td>
<td>Cohort study (2 consecutive phases; initial control phase followed by later experimental phase)<br><br>Single centre study, Italy (recruited n waiting rooms of out-patient clinic and at hospital admission)<br><br>• Setting: outpatients and in-patients<br><br>• Representative</td>
<td>N=402<br><br>Drop-outs (don't complete the study):<br><br>N =0</td>
<td>Inclusion criteria<br><br>Attending Istituto Dermopatico<br><br>dell'Immacolata (IDI-IRCCS) for out-patient visit or in-patient admission for psoriasis<br><br>Exclusion criteria<br><br>age < 18 years; having visited the clinic during the last 3 months, (to exclude<br><br>those attending for a follow-up visit)<br><br>
<table>
<tr><th>Parameter</th><th>Routine (n=231)</th><th>Decision board (n=171)</th></tr>
<tr><td>% male</td><td>68%</td><td>62%</td></tr>
<tr><td>Age (years)</td><td>45±15</td><td>43±13</td></tr>
<tr><td>Severity*:</td><td colspan="2">Approximate values</td></tr>
</table>
</td>
<td>N=171 (87 out-patients and 84 in-patients)<br><br>Decision board aid<br><br>(Sept 2003-Jan 2004)<br><br>Decision board designed using information from literature review by a group including one dermatologist, one internist, one medical epidemiologist and one physician specialized in public health and preventive medicine. The draft was then</td>
<td>N=231 (116 out-patients and 115 in-patients)<br><br>Routine clinical practice<br><br>(Jan-April 2004)</td>
<td>Unclear</td>
<td>Satisfaction with decision making process<br><br>Overall satisfaction with care<br><br>(outcomes were assessed using a modified version of validated questionnaires, which was piloted before the study and included 25</td>
<td>Italian Ministry of Health</td>
</tr>
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| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **population sample:** yes – consecutive (but high proportion of in-patients)<br><br>• **Confounders accounted for:** no | | Mild<br>Moderate<br>Severe | 28%<br>53%<br>18% | | discussed separately with five dermatologists and five patients and refined. The aim was to present all the important information on different treatment options in a simple easily comprehensible and visually clear manner. | | | questions)<br><br>Note: 5 dermatologists visiting out-patients and 6 treating in-patients were included | |
| | | | **Diagnosis:**<br>Diffuse CPP (>10% BSA)<br>Localised CPP (<10% BSA)<br>PsA | <br>47.3%<br>36%<br>6.8% | <br>42.9%<br>33.9%<br>10.7% | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | • **Minimal attrition bias:** N/A – patients and dermatologists completed questionnaire either at discharge or after the out-patient visit<br><br>Response rate was 88% in control and 86% in intervention groups<br><br>• **Outcomes adequately measured:** Yes<br><br>• **Appropriate statistical analysis:** yes | | *Based on a 5-point scale according to dermatologists answer to the following question "In your experience, among all patients you have seen with this condition, how severe is the patient's condition"?<br><br>Patient characteristics were not significantly different between the groups<br><br>However, in- and out-patients differed significantly in severity of disease: the majority of outpatients had mild (44.6%) and moderate (40.9%) disease, compared with the majority of inpatients having moderate (65.0%) and severe (22.3%) disease (p <0.001). | The revised decision-board was piloted among 30 patients and minor corrections were made<br><br>The final version consisted of an A4-page printed on both sides separated in to topics, phototherapy and systemics.<br><br>Possible side-effects of each treatment option were colour-coded, depending on whether they occur frequently, sometimes or rarely.<br><br>Additional information that could influence treatment choices was also included | | | | |

**Effect Size**

Outcomes

Note that the proportion of patients in the control group wanting to be more involved in decision making was significantly higher among in-patients than out-patients (42.7% vs. 24.8%; p = 0.002).

However, satisfaction with all aspects of doctor-patient communication in the control group was always significantly higher (p < 0.001) for outpatients compared with inpatients, except for overall satisfaction

There was no significant differences between in-patients and out-patients among the decision-board group regarding the preferred role in decision making and aspects of doctor-patient communication, except that fewer in-patients were completely satisfied with the opportunity the had to express an opinion about treatment (p=0.002)

**Satisfaction**

| **Outcome** | **Control group (n=231)** | **Decision-board group (n=171)** | **p-value** |
|---|---|---|---|
| **Satisfaction with decision-making** | | | |
| Wanted to be more involved | 76 (33.0%) | 59 (34.7%) | |
| Satisfied | 146 (63.2%) | 107 (62.6%) | |
| Wanted to be less involved | 9 (3.8 %) | 5 (2.7%) | 0.823 |
| **Opportunity to express opinion/doubts** | | | |
| Completely satisfied | 107 (46.5%) | 83 (48.7%) | |
| Fairly satisfied | 63 (27.2%) | 46 (26.9%) | |
| Not satisfied | 34 (14.8%) | 19 (10.9%) | |

| | | | |
|---|---|---|---|
| Had no doubts | 27 (11.5%) | 23 (13.5%) | 0.707 |
| **Information on treatment options** | | | |
| Completely satisfied | 126 (54.7%) | 98 (57.1%) | |
| Fairly satisfied | 82 (35.4%) | 61 (35.9%) | |
| Not satisfied | 23 (9.9%) | 12 (7.1%) | 0.626 |
| **Doctor considered patient's preferences** | | | |
| Very much | 130 (56.2%) | 96 (55.9%) | |
| Somewhat | 43 (18.6%) | 34 (19.6%) | |
| Very little/not at all | 58 (25.2%) | 96 (24.5%) | 0.967 |
| **Information on treatment side-effects** | | | |
| Completely satisfied | 118 (51.0%) | 42 (56.1%) | |
| Fairly satisfied | 77 (33.2%) | 62 (36.5%) | |
| Not satisfied | 37 (15.9%) | 13 (7.4%) | 0.059 |
| **Overall patient satisfaction with care** | | | |
| Completely satisfied | 144 (62.5%) | 114 (66.7%) | |
| Not completely satisfied | 87 (37.5%) | 57 (33.3%) | 0.408 |

**Authors' conclusion**

- Satisfaction with specific aspects of doctor-patient communication was not significantly different between the control and the decision-board.
- A higher proportion of patients were satisfied with information on treatment side-effects among the decision-board group compared with the control group (this reached borderline significance)