

NATIONAL WILMS TUMOR STUDY

DATA AND STATISTICAL CENTER

FRED HUTCHINSON CANCER RESEARCH CENTER

1100 Fairview Avenue N, M2-A876, P.O. Box 19024, Seattle, Washington 98109

Telephone: (206) 667-4842, Message Line: (800) 553-4878, Fax #: (206) 667-6623, Web: <http://www.nwtsg.org>

Dear Participant:

The NWTSG has developed several treatment regimens since 1969 for the treatment of Wilms tumor and other kidney tumors of children. All of the regimens have been very effective for preventing the recurrence of kidney tumor. In the Late Effects Study we have now begun to request annual reports on participants' children. In the course of doing this, a question has arisen as to whether breastfeeding is affected by Wilms tumor treatment.

This is a new question for us. We have researched this topic in other health study reports and they provide little insight. As a result we have designed a survey to gather information. We would greatly appreciate your taking the time to complete and return the form(s) enclosed. Please complete one form for each of your children.

While we have no information that would make us believe that treatment for Wilms tumor affects young women's breastfeeding experience, we would like to learn more about our participants' experiences. Your cooperation in completing this survey will be invaluable. Thank you in advance for taking the time to make this contribution to the study.

Sincerely yours,



Daniel M. Green, MD

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NWTS Late Effects Study Breastfeeding Survey

Child's Birth Date: _____

Your name: _____

Thank you for taking the time to complete and return this questionnaire. If you have any questions please call our message line, 1-800-553-4878 or email us at nwtsg@fhcrc.org.

1. Did you have any breast conditions before or during pregnancy? No Yes

Please circle all applicable breast conditions.

Benign breast mass requiring surgery

Previous breast surgery

Scarring

One nipple larger than the other

Inverted nipple

Augmentation or reduction

Previous breast cancer

Other, specify _____

2. Did you have any illnesses during this pregnancy? No Yes

If yes, please specify type of illness: _____

3. Were you taking any medications during this pregnancy? No Yes

If yes, please specify name(s) of medication(s): _____

4. Please circle how you planned to feed your new baby. Breastfeed* Bottlefeed Combination

(*This includes pumping breast milk.)

5. Before or after the delivery of your baby did you receive any education or advice about breastfeeding/bottlefeeding? No Yes

The following questions apply to the time After Delivery

6. Which of these methods did you decide to use? (please circle all applicable) Breastfeed Bottlefeed Combination

7. Did you ever breastfeed or pump breast milk to feed your new baby after delivery? No Yes

IF NO, please describe your reason for selecting bottlefeeding, then please sign below and return this form.

Sign if never started breastfeeding: _____

Signature

_____ Date

IF YES, how soon after delivery: a) Immediately b) Within 24 hours c) Other, specify _____

Continue with Question 8 next page over

