

# 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. If you prefer, you can complete the survey electronically by using Survey Monkey. Simply click Survey Monkey on our website, [www.nwtsg.org](http://www.nwtsg.org), and complete a form for each child.

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](mailto: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

One nipple larger than the other

Scarring

Augmentation or reduction

Inverted nipple

Left breast not developed

Previous breast cancer

Right breast not developed

Previous breast surgery

Other, specify \_\_\_\_\_

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

If yes, please specify type(s) of illness(es): \_\_\_\_\_

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 (before birth) to feed your new baby.      Breast milk      Formula      Combination

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

### **The following questions apply to the time After Delivery**

6. Which of these choices did you decide to use? (please circle all applicable)      Breast milk      Formula      Combination

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

8. If you had trouble breastfeeding your first child, did that experience influence your decision to breastfeed or formula-feed this child? No      Yes      NA

If yes, what effect did it have?

9. Following delivery, was your baby in the Neonatal Intensive Care Unit (NICU)? No      Yes

10. Did the NICU stay affect your decision to breastfeed or formula-feed? No      Yes      NA

If yes, what effect did it have?

**If you chose to not breastfeed this baby**, please describe your reason for selecting formula-feeding, then please sign below and return this form.

**Sign if never started breastfeeding:** \_\_\_\_\_  
Signature Date

11. If you ever breastfed or pumped breast milk to feed this baby, how soon after delivery?

a) Immediately                      b) Within 24 hours                      c) Other, specify \_\_\_\_\_

12. Did your child have any difficulty with breastfeeding, such as inability to suck, to swallow or to latch on?

No                      Yes

If yes, please circle the correct answer for each breast.

Right breast                      No                      Yes  
Left breast                      No                      Yes

13. Did you have problems with milk production?                      No                      Yes

If yes, please specify: \_\_\_\_\_

14. How long have you been breastfeeding/did you breastfeed your baby?                      \_\_\_\_\_ days/weeks/months/years

15. Are you still breastfeeding?                      No                      Yes

**If YES, please stop completing the survey, sign below and return it to us in the envelope provided.**

**If NO, continue below.**

- Stopping breastfeeding: Please check all the reasons below that describe why you decided to stop breastfeeding.

- |   |   |
|---|---|
| <input type="checkbox"/> Decided to wean due to baby's growth and development       | <input type="checkbox"/> Unable to latch on         |
| <input type="checkbox"/> Had problems producing enough milk to meet baby's needs    | <input type="checkbox"/> Repeated breast infections |
| <input type="checkbox"/> Had to take medication that can be passed into breast milk | <input type="checkbox"/> Went to work               |
| <input type="checkbox"/> Lifestyle change, please explain: _____                    |   |
| <input type="checkbox"/> Personal preference: _____                                 |   |
| <input type="checkbox"/> Other, please specify: _____                               |   |

Please sign below and return in the business envelope provided.

\_\_\_\_\_  
Signature Date

**Thank you for taking the time to complete and return this survey.**