

Attachment 1: American English Acute Cystitis Symptom Score (ACSS)

Adapted from: Alidjanov JF, Naber KG, Pilatz A, Wagenlehner FM. Validation of the American English Acute Cystitis Symptom Score. Antibiotics (Basel). 2020 Dec 19;9(12):929. DOI: 10.3390/antibiotics9120929

FIRST VISIT – Part A (diagnostic part)			Time: : Date of evaluation: / / (mm/dd/yyyy)			
Please indicate whether you have had the following symptoms during the past 24 hours, and how severe they were (<i>Please mark only one answer for each symptom</i>):						
			0	1	2	3
Typical symptoms	1	Frequent urination of small amounts of urine (<i>going to the toilet very often</i>)	<input type="checkbox"/> None <i>up to 4 times per day</i>	<input type="checkbox"/> Yes, mild <i>5–6 times/day</i>	<input type="checkbox"/> Yes, moderate <i>7–8 times/day</i>	<input type="checkbox"/> Yes, severe <i>9–10 or more times/day</i>
	2	Urgent urination (<i>a sudden and uncontrollable urge to urinate</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	3	Feeling burning pain when urinating	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	4	Feeling incomplete bladder emptying (<i>Still feel like you need to urinate after urination</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	5	Feeling pain not associated with urination in the lower abdomen (<i>below the belly button</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	6	Blood seen in urine (<i>without menses</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
			Sum of “Typical” scores=			points
Differential	7	Flank pain (<i>pain in one or both sides of the lower back</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	8	Abnormal vaginal discharge (<i>abnormal amount, color and/or odor</i>)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	9	Discharge from the urethra (<i>urinary opening</i>) without urination	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	10	Feeling high body temperature/fever Temperature measured <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> None (≤99.5°F)	<input type="checkbox"/> Yes, mild (99.6°F–100.2°F)	<input type="checkbox"/> Yes, moderate (100.3°F–102.0°F)	<input type="checkbox"/> Yes, severe (≥102.1°F)
			Sum of “Differential” scores=			points
Quality of life	11	Please rate how much discomfort you have experienced because of these symptoms in the past 24 hours (<i>Please mark only one answer</i>): <input type="checkbox"/> 0 No discomfort (<i>No symptoms at all. I feel as good as usual</i>) <input type="checkbox"/> 1 Mild discomfort (<i>I feel a little worse than usual</i>) <input type="checkbox"/> 2 Moderate discomfort (<i>I feel much worse than usual</i>) <input type="checkbox"/> 3 Severe discomfort (<i>I feel terrible</i>)				
	12	Please indicate how these symptoms have interfered with your everyday activities/work in the past 24 hours (<i>Please mark only one answer</i>): <input type="checkbox"/> 0 Did not interfere at all (<i>Working as usual on a working day</i>) <input type="checkbox"/> 1 Mildly interfered (<i>Due to the symptoms, I work slightly less</i>) <input type="checkbox"/> 2 Moderately interfered (<i>Daily work requires effort</i>) <input type="checkbox"/> 3 Severely interfered (<i>I almost cannot work</i>)				
	13	Please indicate how these symptoms have interfered with your social activities (<i>visiting people, meeting with friends, etc.</i>) in the past 24 hours (<i>Please mark only one answer</i>): <input type="checkbox"/> 0 Did not interfere at all (<i>My social activities did not change in any way, I live as usual</i>) <input type="checkbox"/> 1 Mildly interfered (<i>Insignificant decrease in activities</i>) <input type="checkbox"/> 2 Moderately interfered (<i>Significant decrease. I have to spend more time at home</i>) <input type="checkbox"/> 3 Severely interfered (<i>It's terrible. I barely left the house</i>)				
			Sum of “QoL” scores=			points
Additional	14	Please indicate whether you have the following at the time of completion of this questionnaire:				
		Menstruation (<i>menses</i>)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Premenstrual syndrome (<i>PMS</i>)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Signs of menopausal syndrome (<i>e.g. hot flashes</i>)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Pregnancy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
	Known (diagnosed) diabetes mellitus (<i>high sugar</i>)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

FOLLOW-UP VISIT – Part B (patient-reported outcome)		Time: :	Date of evaluation: / /			
Please indicate if you experienced any changes in your symptoms since the first time you completed this						
Dynamics	<input type="checkbox"/> 0 Yes, I feel back to normal (<i>All symptoms are completely gone</i>) <input type="checkbox"/> 1 Yes, I feel much better (<i>Most of the symptoms are gone</i>) <input type="checkbox"/> 2 Yes, I feel somewhat better (<i>Only some symptoms are gone</i>) <input type="checkbox"/> 3 No, there are barely any changes (<i>I still have about the same symptoms</i>) <input type="checkbox"/> 4 Yes, I feel worse (<i>My condition is worse</i>)					
	Please indicate whether you have had the following symptoms during the past 24 hours, and how severe they were					
	(Please mark only one answer for each symptom):					
		0	1	2	3	
		<input type="checkbox"/> None <i>up to 4 times per day</i>	<input type="checkbox"/> Yes, mild <i>5–6 times/day</i>	<input type="checkbox"/> Yes, moderate <i>7–8 times/day</i>	<input type="checkbox"/> Yes, severe <i>9–10 or more times/day</i>	
Typical symptoms	1	Frequent urination of small amounts of urine (<i>going to the toilet very often</i>)				
	2	Urgent urination (<i>a sudden and uncontrollable urge to urinate</i>)				
	3	Feeling burning pain when urinating				
	4	Feeling incomplete bladder emptying (<i>Still feel like you need to urinate again after urination</i>)				
	5	Feeling pain not associated with urination in the lower abdomen (<i>below the belly button</i>)				
	6	Blood seen in urine (<i>without menses</i>)				
		Sum of “Typical” scores=			points	
Differential	7	Flank pain (<i>pain in one or both sides of the lower back</i>)				
	8	Abnormal vaginal discharge (<i>abnormal amount, color and/or odor</i>)				
	9	Discharge from the urethra (<i>urinary opening</i>) without urination				
	10	Feeling high body temperature/fever Temperature measured <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> None ($\leq 99.5^{\circ}\text{F}$)	<input type="checkbox"/> Yes, mild ($99.6^{\circ}\text{F} - 100.2^{\circ}\text{F}$)	<input type="checkbox"/> Yes, moderate ($100.3^{\circ}\text{F} - 102.0^{\circ}\text{F}$)	<input type="checkbox"/> Yes, severe ($\geq 102.1^{\circ}\text{F}$)
		Sum of “Differential” scores=			points	
Quality of life	11	Please rate how much discomfort you have experienced because of these symptoms in the past 24 hours (Please mark only one answer): <input type="checkbox"/> 0 No discomfort (<i>No symptoms at all. I feel as good as usual</i>) <input type="checkbox"/> 1 Mild discomfort (<i>I feel a little worse than usual</i>) <input type="checkbox"/> 2 Moderate discomfort (<i>I feel much worse than usual</i>) <input type="checkbox"/> 3 Severe discomfort (<i>I feel terrible</i>)				
	12	Please indicate how these symptoms have interfered with your everyday activities/work in the past 24 hours (Please mark only one answer): <input type="checkbox"/> 0 Did not interfere at all (<i>Working as usual on a working day</i>) <input type="checkbox"/> 1 Mildly interfered (<i>Due to the symptoms, I work slightly less</i>) <input type="checkbox"/> 2 Moderately interfered (<i>Daily work requires effort</i>) <input type="checkbox"/> 3 Severely interfered (<i>I almost cannot work</i>)				
	13	Please indicate how these symptoms have interfered with your social activities (visiting people, meeting with friends, etc.) in the past 24 hours (Please mark only one answer): <input type="checkbox"/> 0 Did not interfere at all (<i>My social activities did not change in any way, I live as usual</i>) <input type="checkbox"/> 1 Mildly interfered (<i>Insignificant decrease in activities</i>) <input type="checkbox"/> 2 Moderately interfered (<i>Significant decrease. I have to spend more time at home</i>) <input type="checkbox"/> 3 Severely interfered (<i>It's terrible. I barely left the house</i>)				
		Sum of “QoL” scores=			points	
Additional	14	Please indicate whether you have the following at the time of completion of this questionnaire:				
		Menstruation (<i>Menses</i>)?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
		Premenstrual syndrome (<i>PMS</i>)?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
		Signs of menopausal syndrome (<i>e.g. hot flashes</i>)?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
		Pregnancy?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
		Known (<i>diagnosed</i>) diabetes mellitus (<i>high sugar</i>)?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	