OBJECTIVES The objective of this analysis was to develop a new analytic methodology to identify a clinically relevant cut-off point in the EORTC QLQ-C30 ordinal pain score by comparing patient and clinician reporting for the same symptom. Ability to translate between clinician and patient reported symptoms will be useful in planned future analyses. METHODS Closed European Organisation for Research and Treatment of Cancer Randomized Controlled Trials, where the symptom pain was scored at baseline by the patient (EORTC QLQ-C30) and the clinician [Common Toxicity Criteria (CTC)], were pooled and analysed to test the optimal cut-off point. The CTC was dichotomized as 0,1,2 vs. 3,4; defined as a clinical relevant cut-off point for clinical practice. Percent agreement with various dichotomizations of the QLQ-C30 pain scale was calculated, and McNemar's test applied. Verification of the accuracy and generalizability of the findings was evaluated with a validation set and by applying the same cut-off point on another symptom, i.e. fatigue. RESULTS Data were available for pain [number of trials (t)= 8, number of patients (n)=1214] and fatigue [t=5, n =1237]. Model and validation set were obtained by splitting the dataset in half. Percentage agreement and p values for McNemar tests, between patient and clinician dichotomized scores using different cut-off points for the QLQ-scale, were: median (<2.19 vs. >2.19, 64%, p<.01), quartile (<=vs. >3.0, 81%, p=0.55), decile (<4.0 vs. 4.0, 85%, p<0.01). The quartile split reflects best the dichotomized CTC score. This was confirmed in the validation set (quartile cut-off point: 82%, p=0.86). However, when the quartile cut-off was applied to the QLQ-C30 fatigue scale, a significant difference (p<.01) between patient and clinician results was found. CONCLUSIONS Our results indicate that a quartile split of the QLQ-C30 pain score is optimal. However, a single cut-point may not generalize to other QLQ-C30 symptoms; symptom-specific cut-points may be required.
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