

Supplementary Appendix 1

QUEST and Acceptability and Satisfaction Questionnaire

		Notes
The situation compared to <u>before treatment</u> is now:	<input type="checkbox"/> better <input type="checkbox"/> same <input type="checkbox"/> worse	
The situation compared to <u>end of treatment</u> is now:	<input type="checkbox"/> better <input type="checkbox"/> same <input type="checkbox"/> worse	Indicate what treatment was used after end of treatment
The situation compared to <u>1 month after end of treatment</u> is now:	<input type="checkbox"/> better <input type="checkbox"/> same <input type="checkbox"/> worse	
During <u>last week</u> I experienced these eye symptoms:	<input type="checkbox"/> none <input type="checkbox"/> pain <input type="checkbox"/> burning <input type="checkbox"/> sand <input type="checkbox"/> dryness <input type="checkbox"/> photophobia <input type="checkbox"/> other (specify)	
During <u>last week</u> I used tear substitutes during the day:	<input type="checkbox"/> yes <input type="checkbox"/> no	Indicate no. of times eyedrops used per day
During <u>last week</u> I used tear substitutes during the evening / night:	<input type="checkbox"/> yes <input type="checkbox"/> no	
In the <u>last 2 months</u> I had eye problems other than dry eye:	<input type="checkbox"/> yes <input type="checkbox"/> no	
In the <u>last 2 months</u> I used tear substitutes:	<input type="checkbox"/> yes <input type="checkbox"/> no	
In the <u>last 2 months</u> I tried to suspend using tear substitutes	<input type="checkbox"/> yes, and it worked <input type="checkbox"/> yes, but it did not work and I resumed using tear substitutes <input type="checkbox"/> no	

Compared to <u>before treatment</u> my eyes now produce more tears	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Compared to <u>before treatment</u> my eyes now are more wet (tears are more effective):	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Compared to <u>before treatment</u> my eyes now feel better:	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Compared to <u>before treatment</u> I have reduced the use of tear substitutes:	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Overall, I judge the treatment as pleasant:	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> neutral	
Overall, I judge the treatment as effective:	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> neutral	
Overall, I judge the treatment as durable:	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> neutral	
Overall, I judge the treatment, with respect to other treatments I tried:	<input type="checkbox"/> better <input type="checkbox"/> same <input type="checkbox"/> worse	