
Patient: **Last name, First name, Date of birth**

1. Is the patient still alive?

☐ Yes → Date of the last medical visit:

☐ No → Date of death:

Cause of death:

2. Did the patient clinically benefit from the DOTATOC therapy?

☐ no benefit ☐ minor benefit ☐ moderate benefit ☐ major benefit

3. Did the patient receive any somatostatin analogues after completion of DOTATOC therapy?

☐ Yes ☐ No

Thank you for your efforts and collaboration.

Supplementary Figure 1. Standardized questionnaire for the treating physicians used for the clinical response assessment.