



Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

CONTRAINDICATIONS

Absolute contraindications for the Six-Minute Walk Test (6MWT) include the following: unstable angina during the previous month and myocardial infarction during the previous month. Relative contraindications include a resting heart rate of more than 120, a systolic blood pressure of more than 180 mm Hg, and a diastolic blood pressure of more than 100 mm Hg.

Patients with any of these findings should be referred to the physician ordering or supervising the test for individual clinical assessment and a decision about the conduct of the test. The results from a resting electrocardiogram done during the previous 6 months should also be reviewed before testing. Stable exertional angina is not an absolute contraindication for a 6MWT, but patients with these symptoms should perform the test after using their antiangina medication, and rescue nitrate medication should be readily available.

SAFETY ISSUES

1. Testing should be performed in a location where a rapid, appropriate response to an emergency is possible. The appropriate location of a crash cart should be determined by the physician supervising the facility.
2. Supplies that must be available include oxygen, sublingual nitroglycerine, aspirin, and albuterol (metered dose inhaler or nebulizer). A telephone or other means should be in place to enable a call for help.
3. The technician should be certified in cardiopulmonary resuscitation with a minimum of Basic Life Support by an American Heart Association-approved cardiopulmonary resuscitation course. Advanced cardiac life support certification is desirable. Training, experience, and certification in related health care fields (registered nurse, registered respiratory therapist, certified pulmonary function technician, etc.) are also desirable. A certified individual should be readily available to respond if needed.

4. Physicians are not required to be present during all tests. The physician ordering the test or a supervising laboratory physician may decide whether physician attendance at a specific test is required.

5. If a patient is on chronic oxygen therapy, oxygen should be given at their standard rate or as directed by a physician or a protocol.

Reasons for immediately stopping a 6MWT include the following:

- (1) Chest pain,
- (2) Intolerable dyspnea,
- (3) Leg cramps,
- (4) Staggering,
- (5) Diaphoresis, or
- (6) Pale or ashen appearance.
- (7) SpO₂ <80% when continuous oximetry is available.

Technicians must be trained to recognize these problems and the appropriate responses. If a test is stopped for any of these reasons, the patient should sit or lie supine as appropriate depending on the severity of the event and the technician's assessment of the severity of the event and the risk of syncope. The following should be obtained based on the judgment of the technician: blood pressure, pulse rate, oxygen saturation, and a physician evaluation. Oxygen should be administered as appropriate.

Technical Aspects of the Six-Minute Walk Test

Location

The 6MWT should be performed indoors, along a long, flat, straight, enclosed corridor with a hard surface that is seldom traveled. If the weather is comfortable, the test may be performed outdoors. The walking course should be 30 m in length with no bends or pedestrian traffic. A 100-ft hallway is, therefore, suggested. Shorter course length, not less than 20 meters can be considered per protocol in individual sites. The length of the corridor should be marked every 3 m. The turnaround points should be marked with a cone (such as an orange traffic cone). A starting line, which marks the beginning and end of each 60-m lap, should be marked on the floor using brightly colored tape.

Rationale. A shorter corridor requires patients to take more time to reverse directions more often, reducing the 6MWD. Most studies have used a 30-m corridor,

but some have used 20- or 50-m corridors. A recent multicenter study found no significant effect of the length of straight courses ranging from 50 to 164 ft, but patients walked farther on continuous (oval) tracks (mean 92 ft farther).

The use of a treadmill to determine the 6MWD might save space and allow constant monitoring during the exercise, but the use of a treadmill for 6-minute walk testing has been limited and should not be assumed to have similar test characteristics with corridor testing.

REQUIRED EQUIPMENT

1. Countdown timer (or stopwatch)
2. Mechanical lap counter
3. Two small cones to mark the turnaround points
4. A chair that can be easily moved along the walking course
5. Worksheets on a clipboard
6. A source of oxygen
7. Sphygmomanometer
8. Telephone
9. Automated electronic defibrillator

PATIENT PREPARATION

1. Comfortable clothing should be worn.
2. Appropriate shoes for walking should be worn.
3. Patients should use their usual walking aids during the test (cane, walker, etc.).
4. The patient's usual medical regimen should be continued.
5. A light meal is acceptable before early morning or early afternoon tests.
6. Patients should not have exercised vigorously within 2 hours of beginning the test.

MEASUREMENTS

1. Repeat testing should be performed about the same time of day to minimize intraday variability.

2. A "warm-up" period before the test should not be performed.

3. The patient should sit at rest in a chair, located near the starting position, for at least 10 minutes before the test starts. During this time, check for contraindications, measure pulse and blood pressure, and make sure that clothing and shoes are appropriate. Complete the first portion of the worksheet (see Table 1).

TABLE 1. 6MWT WORKSHEET

The following elements should be present on the 6MWT worksheet and report:

Lap counter: _____

Patient name: _____ Patient ID# _____

Walk # _____ Tech ID: _____ Date: _____

Gender: M F Age: _____ Race: _____ Height: ___ft ___in, ___ meters

Weight: _____ lbs, _____ kg Blood pressure: _____ / _____

Medications taken before the test (dose and time): _____

Supplemental oxygen during the test: No Yes, flow _____ L/min, type _____

Baseline	End of Test
Time __:__:__	Time __:__:__
Heart Rate _____	Heart Rate _____
Dyspnea _____ (Borg scale)	Dyspnea _____ (Borg scale)
Fatigue _____ (Borg scale)	Fatigue _____ (Borg scale)
SpO ₂ _____ % _____%	SpO ₂ _____ % _____%

Stopped or paused before 6 minutes? No Yes, reason: _____

Other symptoms at end of exercise: angina dizziness hip, leg, or calf pain

Number of laps: _____ (X 60 meters) + final partial lap: _____ meters =

Total distance walked in 6 minutes: _____ meters

Predicted distance: _____ meters Percent predicted: _____%

Tech comments:

Interpretation (including comparison with a preintervention 6MWD):

4. Pulse oximetry is optional. If it is performed, measure and record baseline heart rate and oxygen saturation (SpO₂) and follow manufacturer's instructions to maximize the signal and to minimize motion artifact. Make sure the readings are stable before recording. Note pulse regularity and whether the oximeter signal quality is acceptable. The rationale for measuring oxygen saturation is that although the distance is the primary outcome measure, improvement during serial evaluations may be manifest either by an increased distance or by reduced symptoms with the same distance walked. Continuous recording of oximetry is recommended but not necessary. Exercise-induced desaturation provides additional test information and is associated with worse disease prognosis. The technician is discouraged from walking with the patient to observe the SpO₂, however if this is necessary he/she should walk slightly behind the patient so as not to set the pace. If worn during the walk, the pulse oximeter must be lightweight (less than 2 pounds), battery powered, and held in place (perhaps by a "fanny pack") so that the patient does not have to hold or stabilize it and so that stride is not affected. Many pulse oximeters have considerable motion artifact that prevents accurate readings during the walk.

5. Have the patient stand and rate their baseline dyspnea and overall fatigue using the Borg scale (see Table 2 for the Borg scale and instructions).

6. Set the lap counter to zero and the timer to 6 minutes. Assemble all necessary equipment (lap counter, timer, clipboard, Borg scale, worksheet) and move to the starting point.

7. Instruct the patient as follows:

"The object of this test is to walk as far as possible for 6 minutes. You will walk back and forth in this hallway. Six minutes is a long time to walk, so you will be exerting yourself. You will probably get out of breath or become exhausted. You are permitted to slow down, to stop, and to rest as necessary. You may lean against the wall while resting, but resume walking as soon as you are able. You will be walking back and forth around the cones. You should pivot briskly around the cones and continue back the other way without hesitation. Now I'm going to show you. Please watch the way I turn without hesitation." Demonstrate by walking one lap yourself. Walk and pivot around a cone briskly. "Are you ready to do that? I am going to use this counter to keep track of the number of laps you complete. I will click it each time you turn around at this starting line. Remember that the object is to walk AS FAR AS POSSIBLE for 6 minutes, but don't run or jog. Start now or

whenever you are ready."

TABLE 2. THE BORG SCALE

0	Nothing at all
0.5	Very, very slight (just noticeable)
1	Very slight
2	Slight (light)
3	Moderate
4	Somewhat severe
5	Severe (heavy)
6	
7	Very severe
8	
9	
10	Very, very severe (maximal)

This Borg scale should be printed on heavy paper (11 inches high and perhaps laminated) in 20-point type size. At the beginning of the 6-minute exercise, show the scale to the patient and ask the patient this: "Please grade your level of shortness of breath using this scale." Then ask this: "Please grade your level of fatigue using this scale." At the end of the exercise, remind the patient of the breathing number that they chose before the exercise and ask the patient to grade their breathing level again. Then ask the patient to grade their level of fatigue, after reminding them of their grade before the exercise.

8. Position the patient at the starting line. You should also stand near the starting line during the test. Do not walk with the patient. As soon as the patient starts to walk, start the timer.

9. Do not talk to anyone during the walk. Use an even tone of voice when using the standard phrases of encouragement. Watch the patient. Do not get distracted and lose count of the laps. Each time the participant returns to the starting line, click the lap counter once (or mark the lap on the worksheet). Let the participant see you do it. Exaggerate the click using body language, like using a stopwatch at a

race.

After the first minute, tell the patient the following (in even tones): "You are doing well. You have 5 minutes to go."

When the timer shows 4 minutes remaining, tell the patient the following: "Keep up the good work. You have 4 minutes to go."

When the timer shows 3 minutes remaining, tell the patient the following: "You are doing well. You are halfway done."

When the timer shows 2 minutes remaining, tell the patient the following: "Keep up the good work. You have only 2 minutes left."

When the timer shows only 1 minute remaining, tell the patient: "You are doing well. You have only 1 minute to go."

Do not use other words of encouragement (or body language to speed up).

If the patient stops walking during the test and needs a rest, say this: "You can lean against the wall if you would like; then continue walking whenever you feel able." Do not stop the timer. If the patient stops before the 6 minutes are up and refuses to continue (or you decide that they should not continue), wheel the chair over for the patient to sit on, discontinue the walk, and note on the worksheet the distance, the time stopped, and the reason for stopping prematurely.

When the timer is 15 seconds from completion, say this: "In a moment I'm going to tell you to stop. When I do, just stop right where you are and I will come to you."

When the timer rings (or buzzes), say this: "Stop!" Walk over to the patient. Consider taking the chair if they look exhausted. Mark the spot where they stopped by placing a bean bag or a piece of tape on the floor.

10. Posttest: Record the postwalk Borg dyspnea and fatigue levels and ask this: "What, if anything, kept you from walking farther?"

11. If using a pulse oximeter, measure SpO₂ and pulse rate from the oximeter and then remove the sensor.

12. Record the number of laps from the counter (or tick marks on the worksheet).

13. Record the additional distance covered (the number of meters in the final partial lap) using the markers on the wall as distance guides. Calculate the total distance walked, rounding to the nearest meter, and record it on the worksheet.

14. Congratulate the patient on good effort and offer a drink of water.

QUALITY ASSURANCE

Sources of Variability

There are many sources of 6MWD variability (see Table 3). The sources of variability caused by the test procedure itself should be controlled as much as possible. Identical conditions are essential in serial testing to determine disease progression or in assessing outcome following an intervention. This is done by following the standards found in this document and by using a quality-assurance program.

Practice Tests

A practice test is recommended for six minute walk testing to reduce test variability and thus to increase the responsiveness of a test to an intervention. A practice test is less critical for patient stratification in cohort studies or as a measure of prognosis. If a practice test is done, wait for at least 1 hour before the second test and report the highest 6MWD as the patient's 6MWD baseline.

Rationale. Two tests performed before and again following an intervention can increase power and thus decrease sample size by up to 27%; and thus is strongly encouraged in interventional trials powered on 6MWD as the primary outcome measure. The 6MWD is only slightly higher for a second 6MWT performed a day later. The mean reported increase ranges from 0 to 17%. A multicenter study of 470 highly motivated patients with severe COPD performed two 6MWTs 1 day apart, and on average, the 6MWD was only 66 ft (5.8%) higher on the second day. Performance (without an intervention) usually reaches a plateau after two tests done within a week. The training effect may be due to improved coordination, finding optimal stride length, and overcoming anxiety.

Technician Training and Experience

Technicians who perform 6MWTs should be trained using the standard protocol and then supervised for several tests before performing them alone. They should also have completed cardiopulmonary resuscitation training.

Rationale. One multicenter study of older people found that after correction for many other factors, two of the technicians had mean 6MWDs that were approximately 7% lower than the other two sites.

Encouragement

Only the standardized phrases for encouragement (as specified previously here) must be used during the test.

Rationale. Encouragement significantly increases the distance walked. Reproducibility for tests with and without encouragement is similar. Some studies

have used encouragement every 30 seconds, every minute, or every 2 minutes. We have chosen every minute and standard phrases. Some studies have instructed patients to walk as fast as possible. Although larger mean 6MWDs may be obtained thereby, we recommend that such phrases not be used, as they emphasize initial speed at the expense of earlier fatigue and possible excessive cardiac stress in some patients with heart disease.

TABLE 3. 6MWD SOURCES OF VARIABILITY

Factors reducing the 6MWD

Shorter height

Older age

Higher body weight

Female sex

Impaired cognition

A shorter corridor (more turns)

Pulmonary disease (COPD, asthma, cystic fibrosis, interstitial lung disease)

Cardiovascular disease (angina, MI, CHF, stroke, TIA, PVD, AAI)

Musculoskeletal disorders (arthritis, ankle, knee, or hip injuries, etc.)

Factors increasing the 6MWD

Taller height (longer legs)

Male sex

High motivation

A patient who has previously performed the test

Medication for a disabling disease taken just before the test

Oxygen supplementation in patients with exercise-induced hypoxemia

Definition of abbreviations: COPD chronic obstructive pulmonary disease; 6MWD 6-minute walking distance.

Supplemental Oxygen

If oxygen supplementation is needed during the walks and serial tests are planned (after an intervention other than oxygen therapy), then during all walks by that patient oxygen should be delivered in the same way with the same flow. If the flow must be increased during subsequent visits due to worsening gas exchange, this should be noted on the worksheet and considered during interpretation of the change noted in 6MWD. The type of oxygen delivery device should also be noted on the report: for instance, the patient carried liquid oxygen or pushed or pulled an oxygen tank, the delivery was pulsed or continuous, or a technician walked behind the patient with the oxygen source (not recommended). Measurements of pulse and SpO₂ should be made after waiting at least 10 minutes after any change in oxygen delivery.

Rationale. For patients with COPD or interstitial lung disease, oxygen supplementation increases the 6MWD. Carrying a portable gas container (but not using it for supplemental oxygen) reduced the mean 6MWD by 14% in one study of patients with severe respiratory disability, but using the container to deliver supplemental oxygen during the exercise increased the mean 6MWD by 20-35%.

Medications

The type of medication, dose, and number of hours taken before the test should be noted.

Rationale. Significant improvement in the distance walked, or the dyspnea scale, after administration of bronchodilators has been demonstrated in patients with COPD, as well as cardiovascular medications in patients with heart failure.

INTERPRETATION

6MWD can be used in stratifying populations, in determining an individual patient's risk, or as an outcome in a clinical trial to determine mean change after an intervention or responder rate (proportion of subjects achieving a clinically meaningful improvement). With a good quality-assurance program, with patients tested by the same technician using identical methodology, and using practice tests, short-term reproducibility of the 6MWD is excellent. It is not known whether it is best for clinical purposes to express change in 6MWD as (1) an absolute value or (2) a percentage change. Expression as a change in % predicted is discouraged because of significant variation in current prediction equations. Until further research is available, we recommend that change in 6MWD be expressed as an absolute value (e.g., the patient walked 50 m farther).

A statistically significant mean increase in 6MWD in a group of study participants is often much less than a clinically significant increase in an individual patient. Recent studies have determined a clinically meaningful response to 6MWD to be approximately 30 meters. Comparison between the proportion of individuals achieving this meaningful difference between study groups should be a primary or

secondary outcome measure when 6MWT is used. The 6MWD was more responsive to deterioration than to improvement in heart failure symptoms. Additional research is necessary to determine whether clinically meaningful deterioration differs from clinically meaningful improvement within different disease populations.

Reported Mean Changes in 6MWD After Interventions

Supplemental oxygen (4 L/min) during exercise in patients with COPD or interstitial lung disease increased mean 6MWD by approximately 95 m (36%) in one study. Patients with COPD in a study of the effects of exercise and diaphragmatic strength training experienced a mean increase in 6MWD of 50 m (20%). Lung volume reduction surgery in patients with very severe COPD has been reported to increase 6MWD by a mean of 55 m (20%). Cardiac rehabilitation in patients referred with various heart diseases increased 6MWD by a mean of 170 m (15%) in a recent study. In 25 older patients with heart failure, an angiotensin converting enzyme inhibitor medication (50 mg captopril per day) improved 6MWD a mean of 64 m (39%) compared with a mean increase of only 8% in those receiving a placebo. 6MWD on the other hand has been shown to be poorly responsive to bronchodilator therapy in COPD patients. Further, because walking distance has a ceiling effect in relatively normal or mildly impaired populations, the test may be poorly responsive to interventions in mildly impaired patient populations.

Interpreting Single Measurements of Functional Status

Optimal reference equations from healthy population-based samples using standardized 6MWT methods are not yet available. In one study, the median 6MWD was approximately 580 m for 117 healthy men and 500 m for 173 healthy women. A mean 6MWD of 630 m was reported by another study of 51 healthy older adults. Differences in the population sampled, type and frequency of encouragement, corridor length, and number of practice tests may account for reported differences in mean 6MWD in healthy persons. Age, height, weight, and sex independently affect the 6MWD in healthy adults; therefore, these factors should be taken into consideration when interpreting the results of single measurements made to determine functional status. We encourage investigators to publish reference equations for healthy persons using the previously mentioned standardized procedures.

6MWD of less than 350 meters has been shown to significantly increase the risk of mortality or hospitalization at 6 and 12 months. A low 6MWD, however is nonspecific and nondiagnostic. When the 6MWD is reduced, a thorough search for the cause of the impairment is warranted. The following tests may then be helpful: pulmonary function, cardiac function, ankle-arm index, muscle strength, nutritional status, orthopedic function, and cognitive function.

Conclusions

The 6MWT is a useful measure of functional capacity targeted at people with at least moderately severe impairment. The test has been widely used for preoperative and postoperative evaluation and for measuring the response to therapeutic interventions for pulmonary and cardiac disease. These guidelines provide a standardized approach to performing the 6MWT. The committee hopes that these guidelines will encourage further research into the 6MWT and allow direct comparisons among different studies.

Protocol source: <https://www.phenxtoolkit.org/protocols/view/90602>