

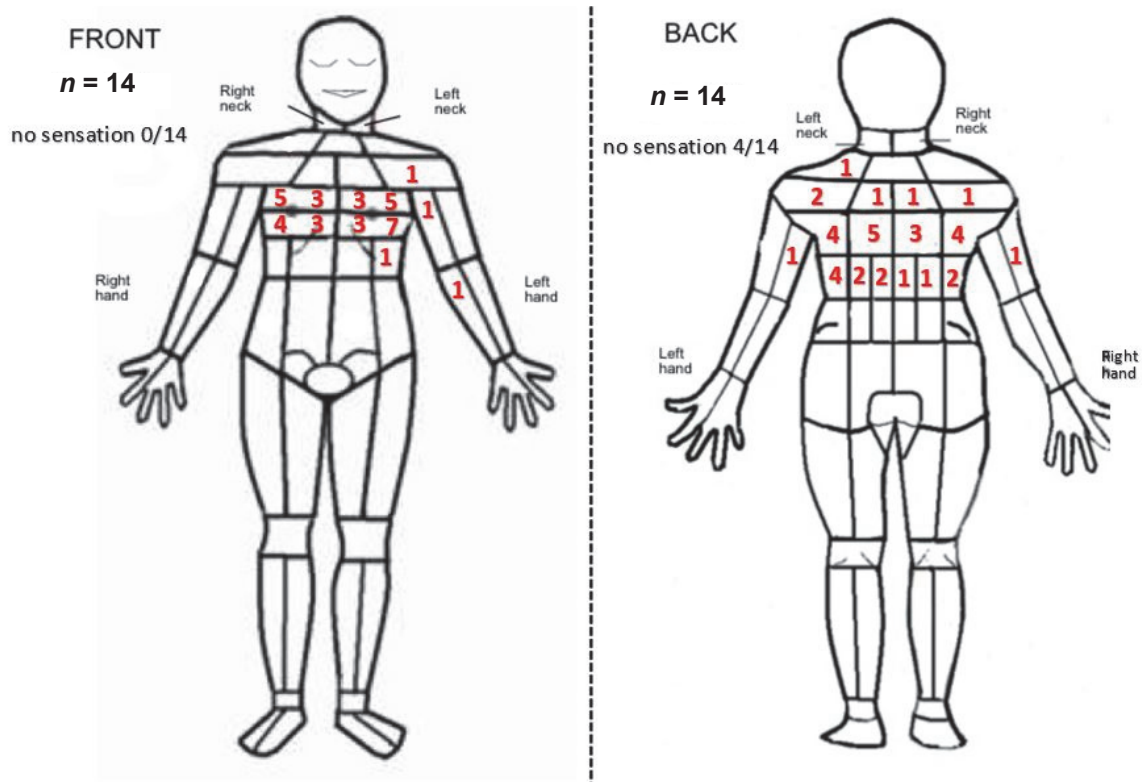
Supplementary material

Fig. S1. Distribution of perceived paraesthesia during dermatome mapping with standard lead configuration (targeting T1–4) and a stimulation amplitude of 90% of maximal tolerated. Numbers in red represent the amount of patients that perceived the paraesthesia in particular dermatome.

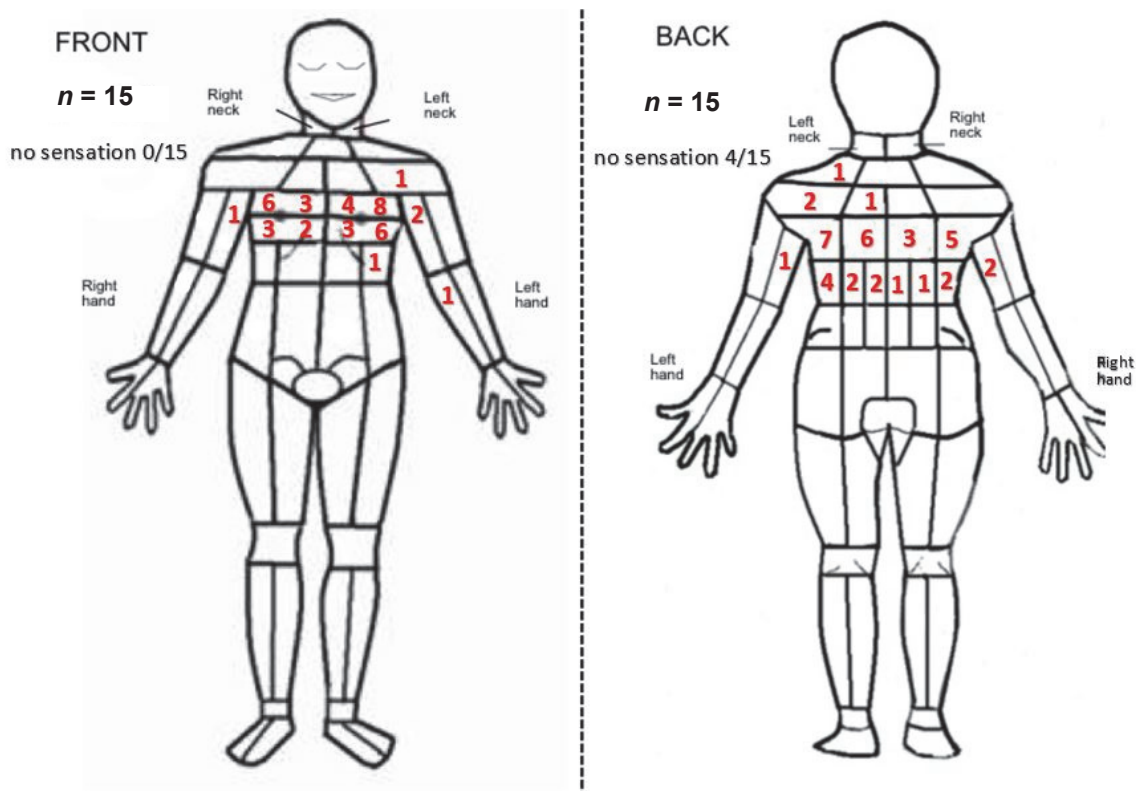


Fig. S2. Distribution of perceived paraesthesia during dermatome mapping with cranial lead configuration and spinal cord stimulation at 90% of maximal tolerated amplitude. Numbers in red represent the amount of patients that perceived the paraesthesia in particular dermatome.

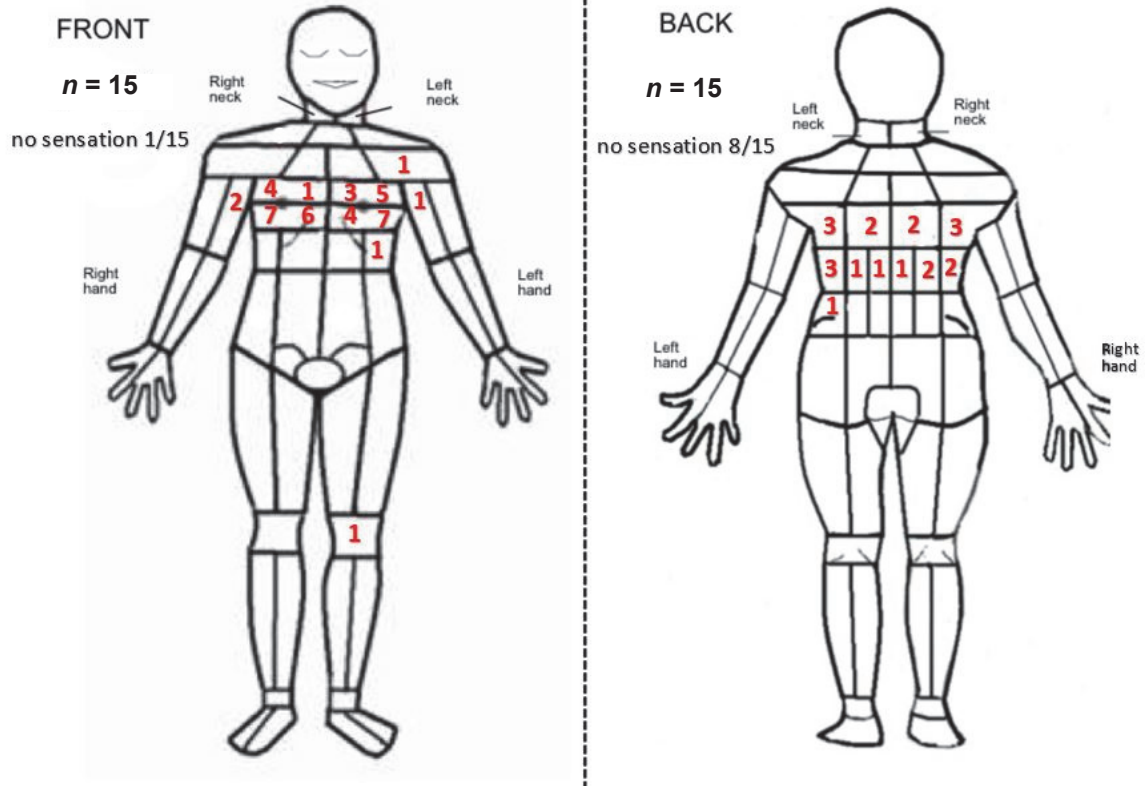


Fig. S3. Distribution of perceived paraesthesia during dermatome mapping with caudal lead configuration and spinal cord stimulation at 90% of maximal tolerated amplitude. Numbers in red represent the amount of patients that perceived the paraesthesia in particular dermatome.

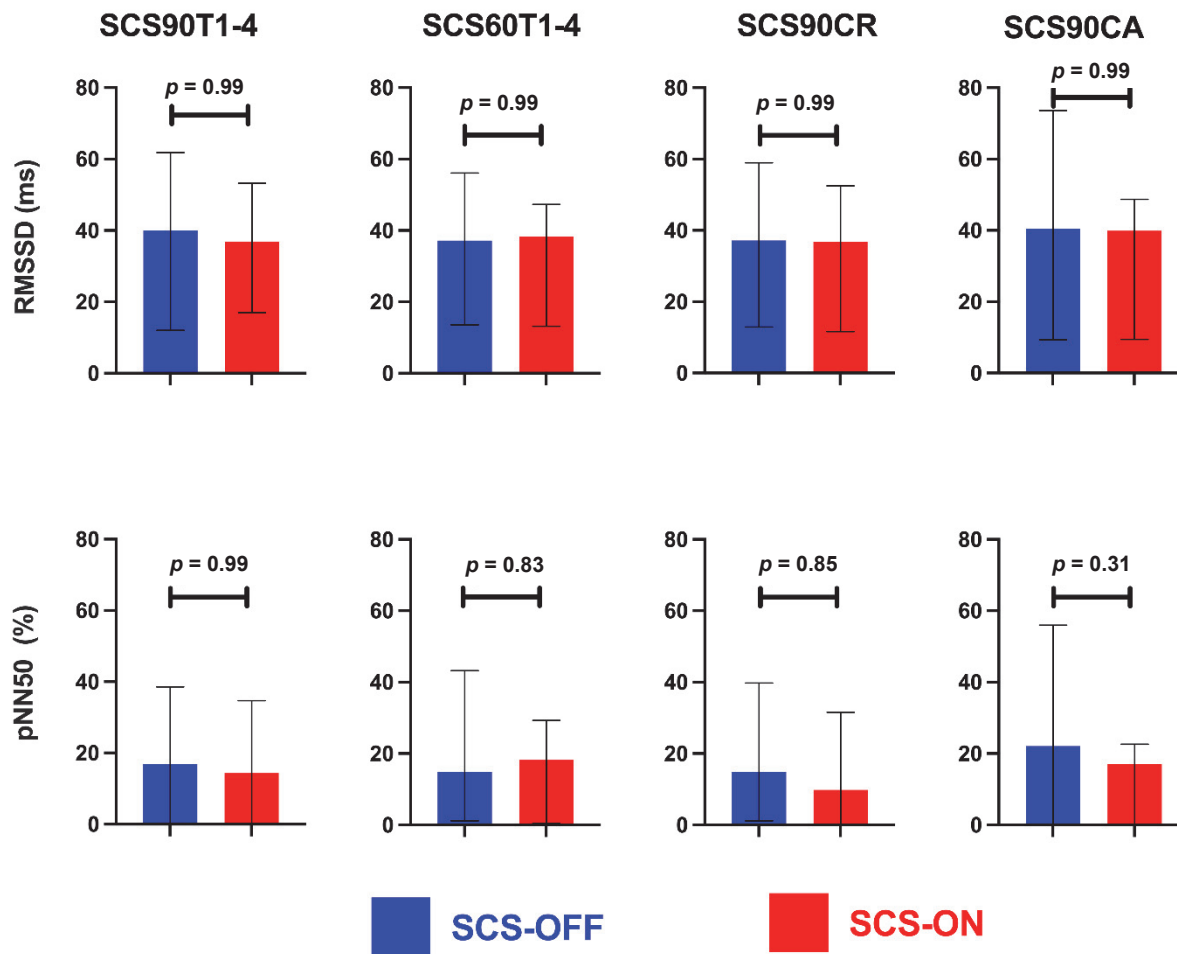


Fig. S4. Acute effect of SCS with different stimulation amplitudes and electrode configurations on RMSSD and pNN50. Data are expressed as median with 95% confidence interval. pNN50 – number of pairs of adjacent NN intervals differing by more than 50 ms divided by the total number of all NN intervals; RMSSD – square root of the mean of the sum of the squares of differences between adjacent NN intervals.

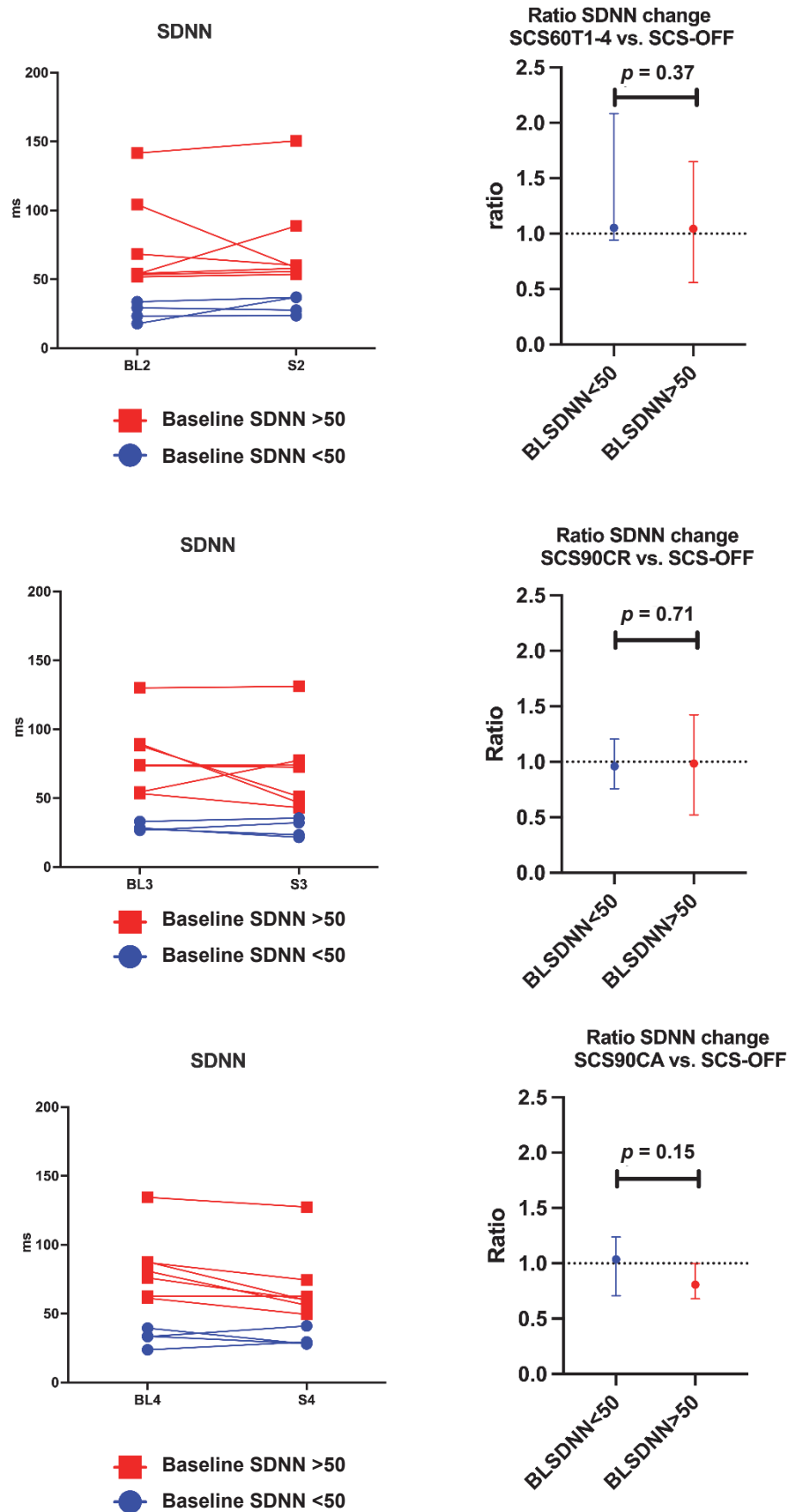


Fig. S5. Acute effect of SCS with reduced amplitude (60%) and cranial and caudal electrode configuration on SDNN in patients with low (<50 ms) versus high (>50 ms) baseline SDNN. Data are displayed as individual changes and median with 95% confidence interval of delta ratios. SDNN – standard deviation of intervals between normal beats.