The Ohio State University Combined Consent to Participate in Research and HIPAA Research Authorization

Study Title:	**The Impact of Total Intravenous Anesthesia Following Cancer Surgery (TIVACS) Study**
Principal Investigator:	**Aslam Ejaz, MD, MPH**
Sponsor:	**The Ohio State University**
Funding Support:	**Pelotonia**

- **This is a consent form for research participation.** It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.
- **Your participation is voluntary.** You may refuse to participate in this study. If you decide to take part in the study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your usual benefits. Your decision will not affect your future relationship with The Ohio State University. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.
- **You may or may not benefit as a result of participating in this study.** Also, as explained below, your participation may result in unintended or harmful effects for you that may be minor or may be serious depending on the nature of the research.
- **You will be provided with any new information that develops during the study that may affect your decision whether or not to continue to participate.** If you decide to participate, you will be asked to sign this form and will receive a copy of the form. You are being asked to consider participating in this study for the reasons explained below.

Key Information About This Study
The following is a short summary to help you decide whether or not to be a part of this study. More detailed information is listed later in this form.

You are being asked to take part in this study because you have been diagnosed with pancreatic cancer and will soon be undergoing surgery to remove the tumor. This study is being done to understand the safety and effectiveness of two types of anesthetics (volatile inhalation agents and total intravenous anesthesia (TIVA)) used for patients having abdominal cancer surgery. It is thought that TIVA lessons immune system suppression (weakness) which leads to better cancer outcomes. The anesthetic, Propofol, will be used for either delivery method.

- If you choose to participate, you will remain on the study for approximately 2 years. You will undergo several medical procedures during this study, including blood draws and physical exams.

- Side effects:

    - Common side effects of Propofol include: irregular heart rate, irregular blood pressure, injection site reactions, apnea (short stoppage of breathing), rash, itching, blurred vision, confusion, headache, nervousness, pounding in ears, problems with movement, sweating, and unusual tiredness or weakness.

    - Blood draw risks include: pain, swelling, bruising, and tissue discoloration or scarring around the vein used to draw the blood sample.

- You may or may not benefit directly from participating in the study. However, the study doctors hope that information gained in this clinical study will help determine the best method of anesthesia for patients with pancreatic cancer undergoing surgery to improve cancer outcomes.

- You do not have to take part in this clinical trial and may still receive cancer care at The Ohio State University without taking part.

1. Why is this study being done?

You are being asked to take part in this study because you have been diagnosed with pancreatic cancer that has not spread and will soon be undergoing surgery to remove the tumor.

This study is being done to understand the safety and effectiveness of two types of sedatives used for patients having abdominal cancer surgery. Surgical removal of abdominal solid organ cancers is the primary treatment for many of these types of cancers. However, almost one in three of these patients will have their cancer return after surgery. Patients who have surgery for pancreatic cancer may see progression of their cancer following surgery because their immune system is weakened. The normal sedative agents used for abdominal cancer surgeries are inhaled by patients. Studies show that the use of TIVA decreases immune system weakness and, therefore, may improve cancer outcomes.

TIVA is a method of general anesthesia that may have several benefits over inhaled sedatives. It reduces side effects such as nausea and vomiting, leads to quicker return of bowel function after surgery, and is less immunosuppressive than inhaled sedatives. It has also been shown to decrease cancer cell growth. However, even with these and other benefits, TIVA is not normally used.

One way to identify early cancer progression after pancreatic cancer surgery is through blood biomarkers (particles in the blood) that show there may be disease present. Early studies have shown that propofol decreases the formation of these biomarkers in animal models. This means that TIVA use during surgery may decrease the chance of the immune system being weakened.

This study is being done to assess how different sedatives can affect anesthetic and surgical outcomes by evaluating the level of inflammation and weakness of the immune system of patients having abdominal cancer surgery.

2. How many people will take part in this study?

Up to 96 participants may take part in this study at the Ohio State University. Some may not be eligible to participate or may decide on their own not to participate. Approximately 80 participants, 40 in each group, will undergo one of the study treatments and be followed for safety and effectiveness of the surgical methods.

3. What will happen if I take part in this study?

If you agree to take part in this study, you will first be asked to sign this consent form. Your medical records will be reviewed for eligibility. If you meet the eligibility criteria needed to participate in the study, you will then be enrolled.

Once it has been determined that you are eligible to participate in this study, you will be randomized to one of the two study arms. The randomization process is similar to a coin flip. You will be randomized to either the control arm which is surgical resection with volatile inhalation agents or the treatment arm which is surgical resection with total intravenous anesthesia (TIVA). This randomization will be based on the receipt of neoadjuvant chemotherapy (chemotherapy given before surgery), your clinical stage when you were diagnosed, and the type of surgical procedure you will be undergoing. Neither you nor your surgeon will know which type of anesthesia was delivered. The study team will inform the anesthesiologist who will be delivering the anesthesia to you during the surgery the day before the surgery.

You will have research labs drawn before your surgery, immediately after your surgery, on post-operative days 1 during morning laboratory evaluations, at post-operative visits at 4 weeks and 3 months. Your lab samples will be stored until study completion. You will be followed for recurrence of your cancer and survival every 3 months for two years after your surgery.

At each study visit your doctor will ask you if you have experienced any side effects that are listed in Section 6 of this document or if you have experienced any other side effects.

Study visits:

Visit 0:

- Study consent form will be discussed with you.
- Your current medications will be recorded.
- You will complete a physical examination.
- Your blood will be drawn.
- Randomization (random assignment to one of two anesthetic measures, similar to a coin flip)

Visit 1 (Date of surgery):

- Your blood will be drawn.
- Your side effects will be assessed.

Visit 2 (Post-Operative Days 1):

- Your blood will be drawn.
- Your side effects will be assessed.

Visit 3 (4 weeks [+/- 2 weeks] after surgery):

- Your blood will be drawn.
- Your medical records will be reviewed to evaluate your health status as well as to assess if your cancer has returned.
- Your side effects will be assessed.

Visit 4 (3 months [+/- 4 weeks] after surgery):

- Your blood will be drawn.
- Your medical records will be reviewed to evaluate your health status as well as to assess if your cancer has returned.
- Your side effects will be assessed.

Visit 5 (1 year [+/- 4 week])

- Your blood will be drawn.
- Your medical records will be reviewed to evaluate your health status as well as to assess if your cancer has returned.

Every 3 months for 2 years (Long Term Follow-Up [LTFU]):

Your medical records will be reviewed to evaluate your health status as well as to assess if your cancer has returned.

STUDY CALENDAR:

	Visit 0	Visit 1 (Day of surgery)	Visit 2 (post-op Day 1)	Visit 3 (4 weeks after surgery) (+/- 2 weeks)	Visit 4 (3 months after surgery) (+/- 4 weeks)	V5 1 yr (± 4 week)	Long Term Follow-up/End of Study
Consent	x						
Eligibility	x						
Med History / Physical Exam	x						
Medications	x						
Randomization	x						
Blood draw	x	x	x	x	x	X	
Med Record Review	x			x	x	X	x
Side Effect Review		x	x				

4. How long will I be in the study?

You will be on the study for approximately 2 years. You will have blood draws done prior to your surgery, immediately after the surgery, at 4 weeks and at 3 months. Your medical records will be reviewed approximately every 3 months for a total of 2 years to assess if your cancer has returned and to evaluate your health status.

5. Can I stop being in the study?

You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

The study doctor may take you out of the study:

- If your health changes and the study is no longer in your best interest
- If new information becomes available
- If you do not follow the study rules
- If the study is stopped by the Sponsor or any of the regulatory bodies overseeing the study such as the IRB

By signing this consent form, you give your permission for your information to be used and shared for the purposes of this study at any time in the future. This means your authorization for release of your health information has no expiration date.

You may cancel your authorization at any time. You can do this by notifying your study doctor via in-person communication, phone, or sending a written notice:

Aslam Ejaz, MD
614-293-7171
2050 Kenny Rd.
7th Floor
Columbus, Ohio 43221
United States

6. What risks, side effects or discomforts can I expect from being in the study?

Side effects of Propofol:

COMMON:

- fast or slow heart rate
- high or low blood pressure
- injection site reactions (burning, stinging, or pain)
- apnea (short stoppage of breathing)
- rash
- itching
- blurred vision
- confusion
- headache
- nervousness
- pounding in the ears
- problems with movement
- sweating
- unusual tiredness or weakness

LESS COMMON:

- bluish lips or skin
- chest pain or discomfort
- difficulty breathing
- lightheadedness, dizziness, or fainting

RARE:

- anxiety
- bleeding gums
- burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings
- changes in vision
- chills
- cloudy urine
- cough
- coughing up blood
- delirium or hallucinations
- difficult urination
- difficulty swallowing
- dry eyes, mouth, nose, or throat
- excessive muscle tone
- eye pain
- fever
- flushing or redness of the face
- general feeling of illness
- hives, itching, skin rash
- inability to move the eyes
- increased blinking or spasms of the eyelid
- increased menstrual flow or vaginal bleeding
- increased watering of the mouth
- irritability
- joint pain or swelling
- loss of appetite
- mood or mental changes
- muscle aches, cramps, or pains
- muscle spasms or twitching
- muscle stiffness, tension, or tightness
- nausea or vomiting
- nosebleeds
- pain in the arms or legs

- prolonged bleeding from cuts
- puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue
- red or dark brown urine
- red or black, tarry stools
- restlessness
- shaking
- sleepiness or unusual drowsiness
- sore throat
- sticking out of tongue
- tightness in the chest
- trembling
- trouble sleeping
- trouble speaking
- uncontrolled twisting movements of the neck, trunk, arms, or legs
- unusual facial expressions

Blood Draw Risks:

You may experience side effects of having your blood drawn. These include pain, swelling, bruising, tissue discoloration or scarring around the vein that is used to draw the blood sample. There is a possibility that some of these tissue changes and scarring could become permanent. There may be the risk of infection at the site where the needle is inserted into the vein. There is also the possibility that you may faint during or shortly after the needle is inserted. If you feel dizzy, you should tell someone and lie down to avoid falling and hurting yourself. These are the same risks that are associated with any blood drawing from your vein. All blood draws will be timed to routine blood work that you would normally undergo.

7. What benefits can I expect from being in the study?

You may or may not benefit directly from participating in the study. It is the researchers' hope that information gained in this clinical study will help determine the best way to provide anesthesia for future patients undergoing abdominal cancer resection in order to decrease inflammation and lessen the effect on patients' immune system so that they can better fight infections and other diseases.

8. What other choices do I have if I do not take part in the study?

You may choose not to participate without penalty or loss of benefits to which you are otherwise entitled.

9. What are the costs of taking part in this study?

You or your insurance company will not be billed for the cost of any tests or procedures that are required as part of this research study and are not the standard of care for your condition.

You or your insurance company will still be responsible for the cost of routine medications, tests, and procedures that you would receive even if you were not in this research study. You or your insurance company will be billed for the costs of these routine tests and procedures in the usual manner. You will be responsible for any co-payments, co-insurance and deductibles that are standard for your insurance coverage. You will be responsible for any charges not paid by your insurance company.

Insurance companies will not pay for routine costs for people taking part in research studies. Before deciding to be in this research study, you should check with your insurance company to find out what they will pay. Being in this research study may lead to additional costs to you. In some cases, it is possible that your insurance company will not pay for these costs because you are in a research study

The study doctor will explain to you which procedures, tests, and doctor visits are considered standard of care, including the propofol anesthesia and general lab tests needed for this study.

10. Will I be paid for taking part in this study?

You will not be paid for your participation in this study

11. What happens if I am injured because I took part in this study?

If you suffer an injury from participating in this study, you should notify the researcher or study doctor immediately, who will determine if you should obtain medical treatment at The Ohio State University Wexner Medical Center.

The cost for this treatment will be billed to you or your medical or hospital insurance. The Ohio State University has no funds set aside for the payment of health care expenses for this study.

12. What are my rights if I take part in this study?

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

You will be provided with any new information that develops during the course of the research that may affect your decision whether or not to continue participation in the study.

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of research participants.

13. Will my de-identified information and bio-specimens be used or shared for future research?

No.

14. Will my study-related information be kept confidential?

Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law.

Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- U.S. Food and Drug Administration;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
- The sponsor supporting the study, their agents or study monitors; and
- Your insurance company (if charges are billed to insurance).

A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search the website at any time.

15. HIPAA AUTHORIZATION TO USE AND DISCLOSE INFORMATION FOR RESEARCH PURPOSES

I. What information may be used and given to others?

- Past and present medical records;
- Research records;
- Records about phone calls made as part of this research;
- Records about your study visits;
- Information that includes personal identifiers, such as your name, or a number associated with you as an individual;
- Information gathered for this research about:
  Physical exams
  Laboratory, x-ray, and other test results
  The diagnosis and treatment of a mental health condition
- Records about any anesthetic drug you received;

II. Who may use and give out information about you?

Researchers and study staff.

III. Who might get this information?

- The sponsor of this research. "Sponsor" means any persons or companies that are:
  - working for or with the sponsor; or
  - owned by the sponsor.
- Authorized Ohio State University staff not involved in the study may be aware that you are participating in a research study and have access to your information;
- If this study is related to your medical care, your study-related information may be placed in your permanent hospital, clinic, or physician's office record;

IV. Your information <u>may</u> be given to:

- The U.S. Food and Drug Administration (FDA), Department of Health and Human Services (DHHS) agencies, and other federal and state entities;
- Governmental agencies in other countries;
- Governmental agencies to whom certain diseases (reportable diseases) must be reported; and

- The Ohio State University units involved in managing and approving the research study including the Office of Research and the Office of Responsible Research Practices.

V. Why will this information be used and/or given to others?

- To do the research;
- To study the results; and
- To make sure that the research was done right.

VI. When will my permission end?

There is no date at which your permission ends. Your information will be used indefinitely. This is because the information used and created during the study may be analyzed for many years, and it is not possible to know when this will be complete.

VII. May I withdraw or revoke (cancel) my permission?

Yes. Your authorization will be good for the time period indicated above unless you change your mind and revoke it in writing. You may withdraw or take away your permission to use and disclose your health information at any time. You do this by sending written notice to the researchers. If you withdraw your permission, you will not be able to stay in this study. When you withdraw your permission, no new health information identifying you will be gathered after that date. Information that has already been gathered may still be used and given to others.

VIII. What if I decide not to give permission to use and give out my health information?

Then you will not be able to be in this research study and receive research-related treatment. However, if you are being treated as a patient here, you will still be able to receive care.

IX. Is my health information protected after it has been given to others?

There is a risk that your information will be given to others without your permission. Any information that is shared may no longer be protected by federal privacy rules.

X. May I review or copy my information?

Signing this authorization also means that you may not be able to see or copy your study-related information until the study is completed.

16. Who can answer my questions about the study?

For study questions, concerns, or complaints, to withdraw consent and HIPAA authorization, or if you feel you have been harmed as a result of study participation, you may contact Dr. Aslam Ejaz at 614-293-7171 (office hours) or 614-293-8000 (24 hours) or Aslam.Ejaz@osumc.edu.

For questions related to your privacy rights under HIPAA or related to this research authorization, please contact the HIPAA Privacy Officer at 614-293-6482 or by mail at:
600 Ackerman Rd
Room E2000
Columbus, OH 43202

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Office of Responsible Research Practices at 1-800-678-6251.

If you are injured as a result of participating in this study or for questions about a study-related injury, you may contact Dr. Aslam Ejaz at 614-293-7171 (office hours) or 614-293-8000 (24 hours) or Aslam.Ejaz@osumc.edu.

Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this combined consent and HIPAA research authorization form**.**

Printed name of participant	**Signature of participant**
	AM/PM
	Date and time
Printed name of person authorized to consent for participant (when applicable)	**Signature of person authorized to consent for participant (when applicable)**
	AM/PM
Relationship to the participant	**Date and time**

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

Printed name of person obtaining consent	**Signature of person obtaining consent**
	AM/PM
	Date and time

Witness(es) - *May be left blank if not required by the IRB*

Printed name of witness	**Signature of witness**
	AM/PM
	Date and time
Printed name of witness	**Signature of witness**
	AM/PM
	Date and time