

THE UNIVERSITY OF TEXAS

MDAnderson
Cancer Center**Informed Consent****INFORMED CONSENT/AUTHORIZATION FOR
PARTICIPATION IN RESEARCH**

Evaluating the impact of perioperative antibiotic prophylaxis on the
microbiome in patients with cutaneous malignancy

2020-0265

Study Chair: Emily Keung

Participant's Name

Medical Record Number

This is an informed consent and authorization form for a research study. It includes a summary about the study. A more detailed description of procedures and risks is provided after the summary.

This research has been reviewed and approved by an Institutional Review Board (IRB – a committee that reviews research studies).

STUDY SUMMARY

The goal of this clinical research study is to learn if antibiotics, when given at the time of surgery, cause a significant change in the microbes (like bacteria and viruses) found in the stomach and intestines. Researchers then want to learn if any changes in microbes affect your body's ability to respond to surgery and cancer.

This is an investigational study. The antibiotic used in this study (cefazolin) is FDA approved and commercially available for the treatment of infections and to help prevent infections from surgery. It is investigational to use cefazolin to learn if antibiotics change the microbes of the digestive system. The study doctor can describe how the drug is designed to work.

There may be a benefit for you in this study if antibiotics are found to affect the microbes of the digestive system. Future patients may benefit from what is learned. There may be no benefits to you on this study.

Your participation is completely voluntary. Before choosing to take part in this study, you should discuss with the study team any concerns you may have, including side

effects, potential expenses, and time commitment. There is a low risk that not receiving antibiotics before surgery could increase the risk of surgical site infection.

You can read a full list of potential side effects below in the Possible Risks section of this consent.

Your active participation on the study will last about 90 days.

You and/or your insurance provider will be responsible for the costs of your standard surgery, hospitalization, and all drugs (including the cefazolin) you may receive while you are in the hospital.

You may choose not to take part in this study. You do not have to take part in this study to have surgery. Your decision on this study will not impact your surgeon's decision on surgery or the outcome of the actual operation. You will receive appropriate medical care, including treatment for pain and other symptoms related to your surgery. The study doctor will discuss the risks and benefits of this study compared to standard of care treatment with you.

1. STUDY DETAILS

Up to 20 participants will be enrolled in this study. All will take part at MD Anderson.

If you agree to take part in this study, you will then be randomly assigned (as in the flip of a coin) to receive or not receive cefazolin before surgery. You will have an equal chance of receiving the antibiotic or not. If you receive it, it will be given by vein during surgery.

You will receive a separate consent form explaining your standard surgery and its risks.

Study Procedures

Before surgery:

- You will have a physical exam.
- Blood (about 6 teaspoons) will be drawn for research tests of the immune system.
- You will provide a stool sample to check the microbes in your digestive system.

During surgery, blood (about 6 teaspoons) may be collected for research tests of the immune system.

Right after surgery:

- You may have a physical exam.
- Blood (about 6 teaspoons) may be drawn for research tests of the immune system.

Three (3) days after surgery:

- Blood (about 6 teaspoons) may be drawn for research tests of the immune system.
- You may be asked to provide a stool sample to check the microbes in your digestive system.

Two to three (2-3) weeks and then 3 months after surgery:

- You will have a physical exam.
- Blood (about 6 teaspoons) will be drawn for research tests of the immune system.
- You will provide a stool sample to check the microbes in your digestive system.

2. POSSIBLE RISKS

While on this study, you are at risk for side effects. You should discuss these with the study doctor. The more commonly occurring side effects are listed in this form, as are rare but serious side effects. You may also want to ask about uncommon side effects that have been observed in small numbers of patients but are not listed in this form. Many side effects go away shortly after treatment is stopped, but in some cases side effects may be serious, long-lasting or permanent, and may even result in hospitalization and/or death.

Side effects will vary from person to person, and some may occur after you have stopped receiving treatment. Tell the study staff about any side effects you may have, even if you do not think they are related to the study drugs/procedures.

Cefazolin Side Effects

It is not well known how often the side effects of cefazolin may occur.

<ul style="list-style-type: none"> • fever • seizure • skin rash • itching • very severe blistering skin disease (with ulcers of the skin and digestive tract) • diarrhea • nausea • vomiting • abdominal cramps 	<ul style="list-style-type: none"> • loss of appetite • inflammation of the intestines • vaginal inflammation • abnormal liver tests (possible liver damage) • liver damage due to inflammation • increase in infection-fighting cells • high blood platelet count (possible increased clotting) 	<ul style="list-style-type: none"> • vein inflammation • abnormal kidney test (possible kidney damage) • kidney failure • life-threatening allergic reaction (such as difficulty breathing, low blood pressure, and/or organ failure) • pain at injection site
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Cefazolin may cause low blood cell counts (platelets and white blood cells):

- A low platelet count increases your risk of bleeding (such as nosebleeds, bruising, stroke, and/or digestive system bleeding). You may need a platelet transfusion.

- A low white blood cell count increases your risk of infection (such as pneumonia and/or severe blood infection). Infections may occur anywhere and become life-threatening (such as the bone, urinary tract, vagina, mouth, and so on). Symptoms of infection may include fever, pain, redness, and difficulty breathing.

Other Risks

Blood draws may cause pain, bleeding, and/or bruising. You may faint and/or develop an infection with redness and irritation of the vein at the site where blood is drawn. Frequent blood collection may cause anemia (low red blood cell count), which may create a need for blood transfusions.

Collecting a **stool sample** may cause you to feel uncomfortable.

Although every effort will be made to keep **study data** safe, there is a chance that your personal health information could be lost or stolen. All study data will be stored in password-protected computers and/or locked file cabinets and will continue to be stored securely after the study. Physical copies of data will be stored in an MD Anderson-approved long-term off-site storage center, and electronic data will be kept indefinitely (without time limit) on MD Anderson services behind an institutional firewall. Your study data and paper records will not be destroyed; they will be kept permanently.

This study may involve unpredictable risks to the participants.

Pregnancy Related Risks

Taking part in this study can result in risks to an unborn or breastfeeding baby, so you should not become pregnant or breastfeed a baby while on this study. You must use birth control during the study if you are sexually active.

Females: If you are pregnant, you will not be enrolled on this study. If you become pregnant or suspect that you are pregnant, you must tell your doctor right away.

Getting pregnant will result in your removal from this study.

3. COSTS AND COMPENSATION

If you suffer injury as a direct result of taking part in this study, MD Anderson health providers will provide medical care. However, this medical care will be billed to your insurance provider or you in the ordinary manner. You will not be reimbursed for expenses or compensated financially by MD Anderson for this injury. You may also contact the Chair of MD Anderson's IRB at 713-792-6477 with questions about study-related injuries. By signing this consent form, you are not giving up any of your legal rights.

Certain tests, procedures, and/or drugs that you may receive as part of this study may be without cost to you because they are for research purposes only. However, your

insurance provider and/or you may be financially responsible for the cost of care and treatment of any complications resulting from the research tests, procedures, and/or drugs. Standard medical care that you receive under this research study will be billed to your insurance provider and/or you in the ordinary manner. Before taking part in this study, you may ask about which parts of the research-related care may be provided without charge, which costs your insurance provider may pay for, and which costs may be your responsibility. You may ask that a financial counselor be made available to you to talk about the costs of this study.

Samples that are collected from you in this study may be used for the development of treatments, devices, new drugs, or patentable procedures that may result in commercial profit.

There are no plans to compensate you for any patents or discoveries that may result from your participation in this research.

You will receive no compensation for taking part in this study.

Additional Information

4. You may ask the study chair (Dr. Emily Keung, at 713-792-6940) any questions you have about this study. You may also contact the Chair of MD Anderson's Institutional Review Board (IRB - a committee that reviews research studies) at 713-792-6477 with any questions that have to do with this study or your rights as a study participant.
5. You may choose not to take part in this study without any penalty or loss of benefits to which you are otherwise entitled. You may also withdraw from participation in this study at any time without any penalty or loss of benefits. If you decide you want to stop taking part in the study, it is recommended for your safety that you first talk to your doctor. If you withdraw from this study, you can still choose to be treated at MD Anderson.

If you stop being in the research, already collected data may not be removed from the study database. You may be asked whether the study doctor can collect data from your routine medical care. If you agree, this data will be handled the same as research data.

6. This study or your participation in it may be changed or stopped without your consent at any time by the study chair, the U.S. Food and Drug Administration (FDA), the Office for Human Research Protections (OHRP), or the IRB of MD Anderson.
7. You will be informed of any new findings or information that might affect your willingness to continue taking part in the study, and you may be asked to sign another informed consent and authorization form stating your continued willingness to participate in this study.
8. MD Anderson may benefit from your participation and/or what is learned in this study.

Future Research

Data

Your personal information is being collected as part of this study. These data may be used by researchers at MD Anderson and/or shared with other researchers and/or institutions for use in future research.

Samples

Samples (such as blood) are being collected from you as part of this study. Researchers at MD Anderson may use any leftover samples that are stored at MD Anderson in future research.

Before being used or shared for future research, every effort will be made to remove your identifying information from any data and/or research samples. If all identifying information is removed, you will not be asked for additional permission before future research is performed.

In some cases, all of your identifying information may not be removed before your data or research samples are used for future research. If future research is performed at MD Anderson, the researchers must get approval from the Institutional Review Board (IRB) of MD Anderson before your data and/or research samples can be used. At that time, the IRB will decide whether or not further permission from you is required. The IRB is a committee of doctors, researchers, and community members that is responsible for protecting study participants and making sure all research is safe and ethical.

If this research is not performed at MD Anderson, MD Anderson will not have oversight of any data and/or samples.

You may withdraw your consent to future research at any time. If you do not want your data to be used for future research, tell the study coordinator. However, any data that has already been released and used in research may continue being used, to preserve the scientific integrity of the analysis.

Genetic Research

Samples collected from you as part of this study may be used for genetic research, which may include whole genome sequencing. Whole genome sequencing is a type of testing in which researchers study your entire genetic makeup (DNA). This may help researchers learn how changes in the ordering of genes may affect a disease or response to treatment. If genetic research is done with your samples, those who have access to those samples may be able to identify you. The results of this research may also be able to be linked to you. If genetic research is done with your samples, those who have access to those samples may be able to identify you. The results of this research may also be able to be linked to you. The same level of data protection that covers your individual data does not apply to summary results (when data from the whole study is combined).

This research study involves genetic testing. The Genetic Information Nondiscrimination Act (GINA) prohibits health insurers or health plan administrators from requesting or requiring genetic information of you or your family members or using such information for decisions regarding your eligibility for insurance or your premiums. However, this law does not provide the same protection for disability, life insurance, or long-term care insurance. GINA also prohibits most employers (with 15 employees or more) from using genetic information when making decisions on your employment, including decisions related to hiring, firing, promotion, pay, and job assignments. Please contact the study doctor if you would like more information about GINA and how it protects you from genetic discrimination.

Authorization for Use and Disclosure of Protected Health Information (PHI):

- A. During the course of this study, MD Anderson will be collecting and using your PHI, including identifying information, information from your medical record, and study results. For legal, ethical, research, and safety-related reasons, your doctor and the research team may share your PHI with:

- Federal agencies that require reporting of clinical study data (such as the FDA, National Cancer Institute [NCI], and OHRP)
- The IRB and officials of MD Anderson
- Study monitors and auditors who verify the accuracy of the information
- Individuals who put all the study information together in report form

Study sponsors and/or supporters receive limited amounts of PHI. They may also view additional PHI in study records during the monitoring process. MD Anderson's contracts require sponsors/supporters to protect this information and limit how they may use it.

The results of this research may be published in scientific journals or presented at medical meetings, but your identity will not be disclosed.

- B. Signing this consent and authorization form is optional but you cannot take part in this study or receive study-related treatment if you do not agree and sign.
- C. MD Anderson will keep your PHI confidential when possible (according to state and federal law). However, in some situations, the FDA could be required to reveal the names of participants.

Once disclosed outside of MD Anderson, federal privacy laws may no longer protect your PHI.

- D. The permission to use your PHI will continue indefinitely unless you withdraw your authorization in writing. Instructions on how to do this can be found in the MD Anderson Notice of Privacy Practices (NPP) or you may contact the Chief Privacy Officer at 713-745-6636. If you withdraw your authorization, you will be removed from the study and the data collected about you up to that point can be used and included in data analysis. However, no further information about you will be collected.

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

CONSENT/AUTHORIZATION

I understand the information in this consent form. I have had a chance to read the consent form for this study, or have had it read to me. I have had a chance to think about it, ask questions, and talk about it with others as needed. I give the study chair permission to enroll me on this study. By signing this consent form, I am not giving up any of my legal rights. I will be given a signed copy of this consent document.

SIGNATURE OF PARTICIPANT

DATE

PRINTED NAME OF PARTICIPANT**WITNESS TO CONSENT**

I was present during the explanation of the research to be performed under Protocol 2020-0265.

SIGNATURE OF WITNESS TO THE VERBAL CONSENT
PRESENTATION (OTHER THAN PHYSICIAN OR STUDY CHAIR)

DATE

A witness signature is only required for vulnerable adult participants. If witnessing the assent of a pediatric participant, leave this line blank and sign on the witness to assent page instead.

PRINTED NAME OF WITNESS TO THE VERBAL CONSENT**PERSON OBTAINING CONSENT**

I have discussed this research study with the participant and/or his or her authorized representative, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks and that the participant understood this explanation.

PERSON OBTAINING CONSENT

DATE

PRINTED NAME OF PERSON OBTAINING CONSENT

TRANSLATOR

I have translated the above informed consent as written (without additions or subtractions) into _____ and assisted the people
(Name of Language)
obtaining and providing consent by translating all questions and responses during the consent process for this participant.

NAME OF TRANSLATOR_____
SIGNATURE OF TRANSLATOR_____
DATE

☐ Please check here if the translator was a member of the research team. (If checked, a witness, other than the translator, must sign the witness line below.)

SIGNATURE OF WITNESS TO THE VERBAL TRANSLATION
(OTHER THAN TRANSLATOR, PARENT/GUARDIAN,
OR STUDY CHAIR)_____
DATE_____
PRINTED NAME OF WITNESS TO THE VERBAL TRANSLATION