Secondary versus Tertiary Wound Closure in High Risk Gynecologic Abdominal Surgical Incisions

Wake Forest Baptist Comprehensive Cancer Center (WFBCCC)

WFBCCC # 04418

ClinicalTrials.gov: NCT03861065

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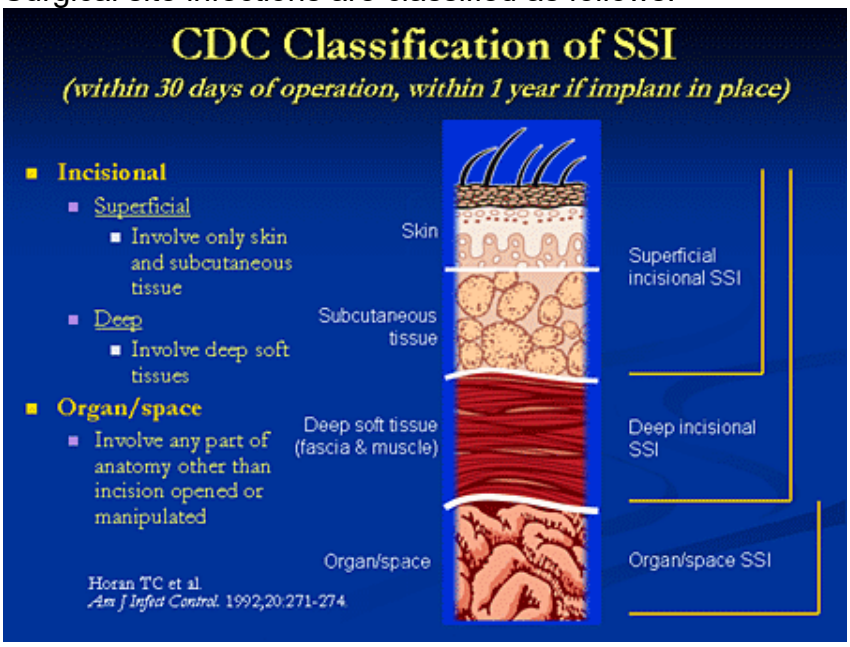
Confidential

Table of Contents

1.0 Introduction and Background

The Centers for Disease Control (CDC) estimates 1.9% of the estimated 16 million surgical procedures each year in the United States are complicated by a surgical site infection (SSI). The overall incidence of SSI with hysterectomy is between 1-2 %.[1,2]

Surgical site infections are classified as follows:



A 2011 study of postoperative surgical patients (general and vascular surgery) identified that and SSI resulted in $10,000 of excess hospital costs and prolonged hospital stay. [3] **In endometrial cancer patients, SSIs accounted for a $5447 median increase in the 30-day cost of care.[4]** A recent article in AJOG 2017 noted SSI rates of 2% associated with hysterectomy with an added cost of $5000 per case. [5] **Approximately 2/3 of gynecologic SSI are superficial incisional infections.[6]**

The Centers for Disease Control developed a Surgical Wound Classification system as outlined. This designed as a risk model for (SSI). As noted with an increase in the class there is an increase in the potential for infection.

Surgical Wound Classification

Wound Class	Definition	Examples	Reminders
Class I **Clean**	► Operative wound clean ► Non-traumatic, with no inflammation encountered ► No break in technique ► Respiratory, gastrointestinal and genitor-urinary tracts not entered ► Caesarean Section, elective, no pre-rupture of membranes or trial of labor	► Vascular Procedures ► Neurological procedures (inflamed II, infected III) ► Endocrine procedures ► Eye surgery (inflamed II, foreign body III, infected III) ► Orthopedic procedures (unless: trauma III, old wound IV, amputation II) ► Penile prosthesis ► Skin (mastectomy, lumpectomy, lesions, lipoma, cosmetic, I&D IV, old wounds III, inflamed III, infected IV) ► Exploratory Lap (no bowel involvement II) Miscellaneous procedures (lymph node excision/Bx unless inflamed III or infected IV, splenectomy, tenckhoff cath unless replacement II)	
Class II **Clean - contaminated**	► Operative wound clean-contaminated ► Non-traumatic wound with minor break in technique ► Gastrointestinal, respiratory or genitor-urinary tracts entered without significant spillage Includes: o Transection of appendix or cholecystic duct in the absence of infected bile or urine o Hysterectomy o Caesarean Section, emergency involving pre-rupture of membranes and / or trial of labor	► Thoracic procedures (except mediastinoscopy I, inflammation III, infected IV, foreign body III) ► GI procedures (including: laparoscopy, colonoscopy, gastroscopy) (gross spillage III, acute inflammation III, fresh accidental wound III) (itis III, Lithiasis II) ► GU procedures (infected III) ► Ear surgery (infected III) ► Nose/Oropharynx procedures (infected IV) ► GYN procedures (Oophorectomy I, inflamed III, infected IV)	► Any wound open for drainage II (except total hip / knee) ► Removing old implants (wires, pins, etc…) ► Re-operation at the same site
Class III **contaminated**	► Operative wound contaminated ► Fresh traumatic wound from clean source ► Operative wound with a major break in technique ► Gross spillage from the gastrointestinal tract ► Entrance into the genito-urinary or biliary tracts ► When infected urine or bile is present ► Incision encountering acute non-purulent inflammation.	► Inflammation ► Gross spillage ► Fresh accidental wound	► Foreign bodies in a wound (bullets, etc…)
Class IV **Dirty - infected**	► Operative wound dirty ► Traumatic wound from dirty source ► Traumatic wound with delayed treatment ► Fecal contamination ► Foreign body ► Retained devitalized tissue ► Operative wound w/ acute bacterial inflammation or perforated viscus ► Operative wound where clean tissue is transected to gain access to a collection of pus	► Infected ► I&D abscess ► Wound debridement	
Unclassified	► When unable to classify accurately an operative wound		► Communicable disease (aids, hepatitis, TB) is not classified the surgical wound is what is being classified

Classification of Surgical Wounds

Category	Criteria	Infection rate
Clean	No hollow viscus entered Primary wound closure No inflammation No breaks in aseptic tech Elective procedure	1 – 3%
Clean contaminated	Hollow viscus entered but controlled No inflammation Primary wound closure Minor breaks in aseptic tech Bowel prep preop	5-6%
Contaminated	Uncontrolled spillage from viscus Inflammation apparent Open,traumatic wound Major break in aseptic tech	20 – 25%
Dirty	Untreated, uncontrolled spillage Pus in op wound Open suppurative wound Severe inflammation	30 – 40%

Specifically related to gynecologic surgery, hysterectomy would be a clean contaminated or class II wound. Gross spillage from the gastrointestinal tract would be considered a contaminated or class III wound. A perforated viscus or abscess requiring surgery would be considered a dirty/infected or class IV wound. Prophylactic antibiotics are indicated for class II and III wounds; therapeutic antibiotics are necessary for class IV wounds.

Within the group of class II wounds (hysterectomy), there are a subset of patients in which there are factors that increase the risk of SSI above baseline. These include:

a. Hyperglycemia,
b. Smoking,
c. Obesity (BMI $\geq$ 30),
d. Depth of subcutaneous tissue $\geq$ 3 cm,
e. Coexistent infection at a remote body site,
f. Vaginal colonization (bacterial vaginosis),
g. ASA status > 2,
h. Immunodeficiency (chronic steroids, chemotherapy), and
i. MRSA.

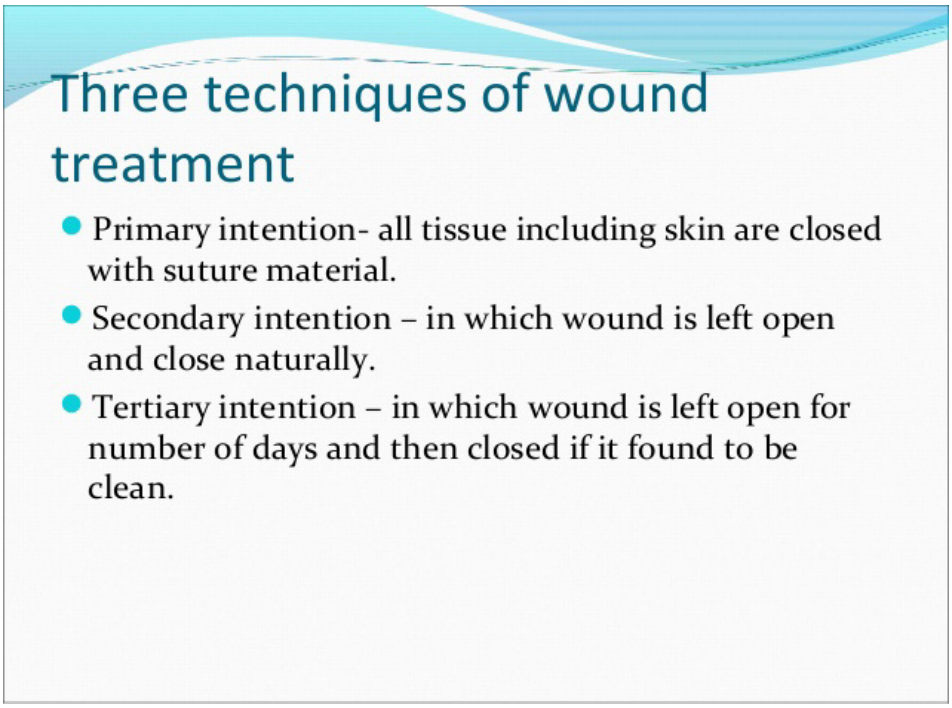
Numerous measures have been proved and/or recommended to decrease postoperative infection.

1. Preoperative Measures
    a. Treat remote infections
    b. Clippers if shaving needed
    c. Serum glucose control < 200 mg/dl
    d. Antimicrobial bath/shower
    e. Chlorhexidine abdominal/vaginal prep (70%/4%)
    f. Antibiotic prophylaxis

2. Intraoperative Measures
    a. Surgical technique
    b. Preventing hypothermia
    c. Appropriate re-dosing of prophylactic antibiotics
    d. Prevention of dead space and incisional seromas

Wound management techniques after fascial closure to address reduction in incisional infections especially in high risk class II and class III/IV wounds have included the following:

- Primary closure with subcutaneous drains and possibly incisional vacuum assisted closure device (VAC) for 3-4 days,
- Secondary closure with wound packing and dressing changes 2-3 times daily or VAC placement with changes 2-3 times weekly, and
- Tertiary or delayed primary closure.



The ***vacuum–assisted closure (VAC)*** as noted above involves placement of a sterile sponge with negative continuous pressure proven to remove tissue fluid, increase blood supple and stimulate the wound thus decreasing time to healing. [6,7]

Also, ETHICON has developed suture impregnated with TRICLOSAN as an antimicrobial proven to reduce some surgically related infections.

- CDC Guidelines for the Prevention of Surgical Site Infections 2017
  - Consider the use if triclosan-coated sutures for the prevention of SSI. [8]
- WHO Global Guidelines for The Prevention of Surgical Site Infection
  - The panel suggests the use of triclosan coated sutures for the purpose of reducing the risk of SSI, independent of type of surgery. [9]
- American College of Surgeons Surgical Infection Society
- The use of triclosan coated suture is recommended for wound closure in clean and clean contaminated cases when available. [10]

Abstract

Introduction
Surgical site infections (SSI) following gynecological abdominal surgeries are associated with prolonged wound healing, additional procedural costs and a lower quality of life. The purpose of this study is to describe an alternative wound closure

technique (tertiary closure) aimed at improving wound morbidity for high-risk patients compared to healing by secondary intention.

Methods
Patients undergoing surgery at high-risk (class III or III wound) for developing SSI were enrolled. Tertiary closure was performed by: 1) running a subcuticular absorbable monofilament suture with looping of the suture every 8-10 cm through the skin secured with hemoclips and by 2) placing a vacuum assisted closure (VAC) over the incision. On post-operative day four (POD #4), the incision was re-approximated at the bedside by removing the VAC and applying traction on the suture using hemoclips.

Results
Six consecutive patients undergoing gynecologic abdominal surgery had tertiary closure. The mean patient age and BMI were 51 and 28, respectively. Two patients had surgery for benign conditions and four for malignancy. Two of the six wounds were class IV (abscess) and the other four wounds were class III (GI contamination). The mean operative duration was 5.5 hours and the median length of stay was 4 days. At sixty days, no SSI or other wound complications were identified.

Conclusions
Tertiary closure of high-risk gynecological abdominal wounds is safe and feasible. Based on this data, we have designed a larger trial comparing outcomes of tertiary closure to secondary closure for high-risk patients undergoing gynecologic abdominal surgery.

2.0 Objectives

2.1 Primary Objective

2.1.1 To compare the percentage of patients whose wound remained closed on postoperative day #30 after tertiary closure compared to historical controls who underwent secondary would closure. We are primarily looking at time to wound closure. We will be able to abstract this information from the postoperative clinic visit notes from patients in the "historical control" cohort. We will identify 20 patients with characteristics described in the inclusion criteria of this study who underwent laparotomy with secondary would closure during the calendar year 2018.

2.2 Secondary Objective

2.2.1 To compare the proportion of acute and chronic wound infection in wounds closed with a tertiary closure technique to historical controls receiving a secondary wound closure.

2.2.2 To compare the length of stay of patients receiving a tertiary wound closure to historical controls receiving a secondary wound closure.

2.2.3 To describe the number of patients receiving a tertiary wound closure that return within 30 days of surgery as compared to historical controls receiving a secondary wound closure.

2.2.4 To describe the quality of life in patients receiving a tertiary wound closure.

3.0 Study Population

3.1 Inclusion Criteria

3.1.1 Patients with high risk class II, class III, class IV abdominal wounds

3.1.2 Undergoing laparotomy for gynecologic related disorders

Patients undergoing laparotomy for both benign and malignant diagnoses will be included in this study

3.2 Exclusion Criteria

3.2.1 Pregnancy

3.2.2 Allergy to triclosan

3.2.3 Patients undergoing HIPEC

3.3 Inclusion of Women and minorities

3.3.1 Women of all races and ethnicity who meet the above-described eligibility criteria are eligible for this trial.

3.3.2 The study consent form will also be provided in Spanish for Spanish-speaking participants. Based on WFBCCC population estimates, we expect approximately 25% Black or African American (N=5) and 10% of individuals to be combination of American Indian/Alaska Native, Asian and Hispanic/Latina ancestry. Should we not meet or exceed these estimates, the PI will engage the Cancer Center Health Equity Advisory Group to discuss strategies to enhance recruitment in these target populations.

4.0 Methods

4.1 Registration Procedures

All patients entered on any WFBCCC trial, whether treatment, companion, or cancer control trial, **must** be linked with a study protocol in EPIC within 24 hours of Informed Consent. Patients **must** be registered prior to the initiation of the study.

You must perform the following steps in order to ensure prompt registration of your patient:

1.0 Complete the Eligibility Checklist (Appendix A)
2.0 Complete the Protocol Registration Form (Appendix B)
3.0 Alert the Cancer Center registrar by phone, *and then* send the signed Informed Consent Form, Eligibility Checklist and Protocol Registration Form to the registrar, either by fax or e-mail.

Contact Information:
Protocol Registrar PHONE (336) 713-6767
Protocol Registrar FAX (336) 713-6772
Protocol Registrar E-MAIL (registra@wakehealth.edu)

*Protocol Registration is open from 8:30 AM - 4:00 PM, Monday-Friday.

4.0 Fax/e-mail ALL eligibility source documents with registration. Patients **will not** be registered without all required supporting documents.

Note: If labs were performed at an outside institution, provide a printout of the results. Ensure that the most recent lab values are sent.

To complete the registration process, the Registrar will:

- assign a patient study number
- register the patient on the study

4.2 Study Activities Table

	Pre-Study	At Surgery	2 weeks post-surgery (+/- 5 days)	4 weeks post-surgery (+/- 5 days)	3-month Follow-up (+/- 5 days)
Informed consent	X				
Demographics	X				
Medical history • Surgical History	X				
Concurrent meds	X				
Physical exam	X				X
Vital signs	X				X
Wound Characteristics • Wound Class • Wound Depth • Wound Size		X			
Duration of Surgery	X	X			
Wound Assessment			X	X	X
Quality of life (SF-36)	X		X	X	X
CBC w/diff, platelets	X				
Comprehensive Metabolic Panel	X				
B-HCG (urine or serum)	X				
Adverse event evaluation		X	X	X	X

4.3 Experimental Methods

4.3.1 Patients will undergo standard of care surgery.

4.3.2 Study Group:

4.3.2.1 High risk clean contaminated wounds (class II) as defined with one of the following:

4.3.2.1.1 Obesity (BMI ≥ 30)

4.3.2.1.2 Subcutaneous depth ≥ 4 cm

4.3.2.1.3 ASA class ≥ 2

4.3.2.1.4 Duration of surgery (from surgery to closure) > 180 min

4.3.2.2 Contaminated wounds (class III)

4.3.2.3 Dirty/infected wounds (class IV)

4.3.3 Closure Technique:

Tertiary closure would involve the following:

- Fascial closure with PDS Plus
- Possible subcutaneous tissue approximation with Monocryl Plus at the surgeon's discretion
- Placement of a running subcuticular skin suture using an absorbable monofilament material such as PDS or Monocryl Plus without skin approximation
- Placement of a vacuum-assisted closure device over the incision at 125 mm Hg

- On Day # 4-7 (surgeon's discretion) at the bedside using sterile technique remove the VAC and approximate the skin edges using the previously placed subcuticular suture by pulling the suture ends and placing a hemoclip on the suture ends.
- Sutures would not require removal

4.3.4 Patient Follow-up and Data Collection

4.3.4.1 After surgery, the removal of the VAC and closing of the superficial aspects of the wound will be performed based on the physician's discretion.

4.3.4.2 Patients will be monitored per standard of care procedures to assess infection, wound dehiscence, and wound complications.

4.3.4.3 Wound closure will be noted.

4.3.4.4 When the patient is discharged the time will be noted.

5.0 Outcome Measures

5.1 Primary Outcomes

5.1.1 The percentage of patients whose wound is closed on postoperative day # 30 after tertiary wound closurecompared to historical controls who underwent secondary would closure.

5.2 Secondary Outcomes

5.2.1 The proportion of SSI using a tertiary closure technique compared to historical controls receiving a secondary would closure.

5.2.2 The length of stay as defined by the time from surgery to discharge as compared to historical controls receiving a secondary would closure.

5.2.3 The proportion of patients that return within 30 days of surgery.

5.2.4 The quality of life in patients receiving a tertiary wound closure. It is expected that tertiary closure will be superior to secondary closure. The time to closure with the tertiary approach should be much shorter. It is unknown if wounds closed in a tertiary manner will remain closed. That was our rationale for choosing wound closure at 30 days as the primary endpoint. Differences in quality of life between the two approaches are also unknown. We have submitted an abstract from a chart review of 5 patients who have undergone tertiary closure. We are looking to expand this cohort of patients to generate more quantitative data.

6.0 Analytic Plan

6.1 Sample Size and Power

Twenty patients with a tertiary closure will be recruited (experimental group). The proportion of wound closure within 30 days for these patients will be compared to the proportion from 100 historical controls receiving a secondary wound closure. We anticipate closer to 100% of wound closure in the experimental group and closer to 0% of wound closure in the control group. Assuming the significance level at 0.05 and a two-sided test, we have greater than 90% power to claim that the proportions of wound closure within 30 days are different between the two groups.

6.2 Interim Analysis

6.2.1 After five patients an interim analysis will be performed to assess safety outcome of the trial. If all five patients are unhealthy the protocol will be suspended until independent review of outcomes. (an unhealthy patient is one with either a wound or systemic infection. A wound infection is an incision with skin erythema, purulent drainage, nonviable or necrotic subcutaneous tissue or a positive wound culture. Systemic infection is defined as a SIRS response with additional evidence of wound infection as the most likely source of the systemic infection). Amendments or closure will be made per the recommendation.

6.3 Analysis of Primary Outcome

The chi-squared test will be used to compare the proportions of wound closure within 30 days between the experimental group (i.e., patients receiving a tertiary wound closure) and the historical control group (i.e., patients receiving a secondary wound closure). Logistic regression models will be used when confounding variables such as age will be adjusted. Wound closure status is the outcome measure. Experimental group is the covariate of interest.

6.4 Analysis of Secondary Outcomes

6.4.1 The analysis approach for comparing the proportion of acute and chronic wound infection between the two groups is the same as that specified in 6.3.

6.4.2 The distribution of length of stay will be examined and transformed if needed. To compare the length of stay between the two groups, the 2-sample t-test will be used if the length of stay is normally distributed and the Wilxocon rank sum test will be used if it is not normally distributed. To adjust for confounding variables, a linear regression model will be used if the length of stay is normally distributed and a negative binomial model will be used if it is not normally distributed.

6.4.3 The analysis approach for comparing the proportion of patients that return within 30 days of surgery between the two groups is the same as that specified in 6.3.

6.4.4 Descriptive statistics, including mean, standard deviation, median, and interquartile range, will be calculated to describe the quality of life in patients receiving a tertiary wound closure,

6.5 Accrual Rate

6.5.1 Twenty in one year (approximately two per month)

6.6 Length of Study

6.6.1 The approximate length of the study will be one year.

7.0 Data Management

Informed consent document	EPIC
Protocol registration form (Appendix B)	WISER/OnCore
Baseline Data Collection (Appendix D)	WISER/OnCore
Surgery Form (Appendix E)	WISER/OnCore
Wound Form (Appendix F)	WISER/OnCore
30-Day Follow-up Form (Appendix G)	WISER/OnCore
Quality of Life (SF-36) (Appendix H)	WISER/OnCore
Adverse Events Log (Appendix I)	WISER/OnCore

8.0 Confidentiality and Privacy

Confidentiality will be protected by collecting only information needed to assess study outcomes, minimizing to the fullest extent possible the collection of any information that could directly identify subjects, and maintaining all study information in a secure manner. To help ensure subject privacy and confidentiality, only a unique study identifier will appear on the data collection form. Any collected patient identifying information corresponding to the unique study identifier will be maintained on a linkage file, store separately from the data. The linkage file will be kept secure, with access limited to designated study personnel. Following data collection, subject identifying information will be destroyed six years after closure of the study, by deleting the linkage files consistent with data validation and study design, producing an anonymous analytical data set. Data access will be limited to study staff. Data and records will be kept locked and secured, with any computer data password protected. No reference to any individual participant will appear in reports, presentations, or publications that may arise from the study.

9.0 Data Safety and Monitoring

The principal investigator will be responsible for the overall monitoring of the data and safety of study participants. The principal investigator will be assisted by other members of the study staff.

10.0 Adverse Events List and Reporting Requirements

10.1 Adverse Event List for Tertiary Closure

10.1.1 Infection

As a result of enrollment onto this trial, there is a risk of developing a wound infection. This infection could be minor (skin redness). A wound infection could also involve the deeper tissues underneath the skin. It that occurs, the incision is typically re-opened and the deeper tissues are cleaned, irrigated and packed with a dressing. Rarely, a serious wound infection causes you to develop a fever or generalized infection. Treatment of a more serious wound infection could involve the following: re-admission to the hospital, intravenous antibiotics or additional surgery.

Enrolled patients will be at medium to high risk for wound complications in general. Wound complications usually occur within the first 30 days of surgery. Incisional hernia is a more "long-term" complication of a surgical wound. This complication can occur up to 1 year after surgery. Enrolled patients will be monitored carefully for wound complications using our standard care approach for patients with medium to high risk for wound complications.

10.2 Adverse Event Characteristics

- **CTCAE term (AE description) and grade:** The descriptions and grading scales found in the revised NCI Common Terminology Criteria for Adverse Events (CTCAE) version 4.0 will be utilized for AE reporting. All appropriate treatment areas should have access to a copy of the CTCAE version 4.0. A copy of the CTCAE version 4.0 can be downloaded from the CTEP web site (http://ctep.cancer.gov).
- **'Expectedness'**: AEs can be 'Unexpected' or 'Expected' (see Section 7.1 above) for expedited reporting purposes only.

- **Attribution** of the AE:

- Definite – The AE **is clearly related** to the study treatment.
- Probable – The AE **is likely related** to the study treatment.
- Possible – The AE **may be related** to the study treatment.
- Unlikely – The AE **is doubtfully related** to the study treatment.
- Unrelated – The AE **is clearly NOT related** to the study treatment.

10.3 STRC SAE Reporting Requirements

The Safety and Toxicity Reporting Committee (STRC) is responsible for reviewing SAEs for WFBCCC Institutional studies as outlined in Appendix C. STRC currently requires that all unexpected 4 and all grade 5 SAEs on these trials be reported to them for review. All WFBCCC Clinical Protocol and Data Management (CPDM) staff members assisting a Principal Investigator in investigating, documenting and reporting an SAE qualifying for STRC reporting are responsible for informing a clinical member of the STRC as well as the entire committee via the email notification procedure of the occurrence of an SAE.

10.4 WFUHS IRB AE Reporting Requirements

Any unanticipated problems involving risks to subjects or others and adverse events shall be promptly reported to the IRB, according to institutional policy. Reporting to the IRB is required regardless of the funding source, study sponsor, or whether the event involves an investigational or marketed drug, biologic or device. Reportable events are not limited to physical injury, but include psychological, economic and social harm. Reportable events may arise as a result of drugs, biological agents, devices, procedures or other interventions, or as a result of questionnaires, surveys, observations or other interactions with research subjects.

All members of the research team are responsible for the appropriate reporting to the IRB and other applicable parties of unanticipated problems involving risk to subjects or others. The Principal Investigator, however, is ultimately responsible for ensuring the prompt reporting of unanticipated problems involving risk to subjects or others to the IRB. The Principal Investigator is also responsible for ensuring that all reported unanticipated risks to subjects and others which they receive are reviewed to determine whether the report represents a change in the risks and/or benefits to study participants, and whether any changes in the informed consent, protocol or other study-related documents are required.

Any unanticipated problems involving risks to subjects or others occurring at a site where the study has been approved by the WFUHS IRB (internal events) must be reported to the WFUHS IRB within 7 calendar days of the investigator or other members of the study team becoming aware of the event.

Any unanticipated problems involving risks to subjects or others occurring at another site conducting the same study that has been approved by the WFUHS IRB (external events) must be reported to the WFUHS IRB within 7 calendar days of the investigator or other members of the study team becoming aware of the event.

Any event, incident, experience, or outcome that alters the risk versus potential benefit of the research and as a result warrants a substantive change in the research protocol or informed consent process/document in order to insure the safety, rights or welfare of research subjects.

11.0 Reporting of Unanticipated Problems, Adverse Events or Deviations

Any unanticipated problems, deviations or protocol changes will be promptly reported by the principal investigator or designated member of the research team to the IRB and sponsor or appropriate government agency if appropriate.

References

1. Wick EC, Hicks C, Bosk CL (2013) Surgical site infection monitoring: are 2 systems better than 1? JAMA Surg 148 (12):1085-1086. doi:10.1001/jamasurg.2013.3020
2. Letourneau AR, Calderwood MS, Huang SS, Bratzler DW, Ma A, Yokoe DS (2013) Harnessing claims to improve detection of surgical site infections following hysterectomy and colorectal surgery. Infect Control Hosp Epidemiol 34 (12):1321-1323. doi:10.1086/673975
3. Boltz MM, Hollenbeak CS, Julian KG, Ortenzi G, Dillon PW (2011) Hospital costs associated with surgical site infections in general and vascular surgery patients. Surgery 150 (5):934-942. doi:10.1016/j.surg.2011.04.006
4. Bakkum-Gamez JN, Dowdy SC, Borah BJ, Haas LR, Mariani A, Martin JR, Weaver AL, McGree ME, Cliby WA, Podratz KC (2013) Predictors and costs of surgical site infections in patients with endometrial cancer. Gynecol Oncol 130 (1):100-106. doi:10.1016/j.ygyno.2013.03.022
5. Steiner HL, Strand EA (2017) Surgical-site infection in gynecologic surgery: pathophysiology and prevention. Am J Obstet Gynecol 217 (2):121-128. doi:10.1016/j.ajog.2017.02.014
6. Lazenby GB, Soper DE (2010) Prevention, diagnosis, and treatment of gynecologic surgical site infections. Obstet Gynecol Clin North Am 37 (3):379-386. doi:10.1016/j.ogc.2010.05.001
7. Wilkes RP, Kilpad DV, Zhao Y, Kazala R, McNulty A (2012) Closed incision management with negative pressure wound therapy (CIM): biomechanics. Surg Innov 19 (1):67-75. doi:10.1177/1553350611414920
8. Masden D, Goldstein J, Endara M, Xu K, Steinberg J, Attinger C (2012) Negative pressure wound therapy for at-risk surgical closures in patients with multiple comorbidities: a prospective randomized controlled study. Ann Surg 255 (6):1043-1047. doi:10.1097/SLA.0b013e3182501bae
9. Rogers SO, Jr. (2017) Surgical Perspective: Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection 2017. Surg Infect (Larchmt) 18 (4):383-384. doi:10.1089/sur.2017.097
10. (2016). In: Global Guidelines for the Prevention of Surgical Site Infection. WHO Guidelines Approved by the Guidelines Review Committee. Geneva,

Appendix A – Subject Eligibility Checklist

IRB Protocol No. 00055298	**Protocol No CCCWFU 04418**
Study Title: Secondary versus Tertiary Wound Closure in High Risk Gynecologic Abdominal Surgical Incisions	
Principal Investigator: Michael G. Kelly, M.D.	

Inclusion Criteria (as outlined in study protocol)	**Criteria is met**	**Criteria is NOT met**	**Source Used to Confirm * (Please document dates and lab results)**
Patients with high risk class II, class III, class IV abdominal wounds	☐	☐	
Undergoing laparotomy for gynecologic related disorders	☐	☐	
Patients undergoing laparotomy for both benign and malignant diagnoses will be included in this study	☐	☐	
Exclusion Criteria (as outlined in study protocol)	**Criteria NOT present**	**Criteria is present**	**Source Used to Confirm * (Please document dates and lab results)**
Pregnancy	☐	☐	
Allergy to triclosan	☐	☐	
Patients undergoing HIPEC	☐	☐	

This subject is ☐ eligible / ☐ ineligible for participation in this study.

OnCore Assigned PID: ___ ___ ___ ___ ___ ___ ___ ___

Signature of research professional confirming eligibility: _____

Date: ___ ___/___ ___/___ ___

Signature of Treating Physician**: _____

Date: ___ ___/___ ___/___ ___

* Examples of source documents include clinic note, pathology report, laboratory results, etc. When listing the source, specifically state which document in the medical record was used to assess eligibility. Also include the date on the document. Example: “Pathology report, 01/01/14” or “Clinic note, 01/01/14”

**Principal Investigator signature can be obtained following registration if needed

Appendix B – Protocol Registration Form

DEMOGRAPHICS

Patient: Last Name: _____ First Name: _____

MRN: ___ ___ ___ ___ ___ ___ ___ ___ DOB (mm/dd/yy): ___ ___ / ___ ___ / ___ ___

ZIPCODE: ___ ___ ___ ___ ___

SEX: ☐ Male ☐ Female Ethnicity (choose one): ☐ Hispanic ☐Non-Hispanic

Race (choose all that apply): ☐ WHITE ☐BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ NATIVE AMERICAN

Height: ___ ___.___ inches Weight: ___ ___ ___.___lbs.(actual)

Surface Area: ___ ___.___m^2

Primary Diagnosis: _____

Date of Diagnosis: ___ ___ /___ ___/___ ___

Performance Status: ___ ___ ___ ☐ ECOG

PROTOCOL INFORMATION

Date of Registration: ___ ___ / ___ ___ / ___ ___

MD Name (last) : _____

Informed written consent: ☐ YES ☐ NO

(consent must be signed prior to registration)

Date Consent Signed: ___ ___ / ___ ___ / ___ ___

PID # (to be assigned by OnCore): ___ ___ ___ ___ ___ ___ ___ ___

Protocol Registrar can be contact by calling 336-713-6767 between 8:30 AM and 4:00 PM, Monday – Friday.

Completed Eligibility Checklist and Protocol Registration Form must be hand delivered, faxed or e-mailed to the registrar at 336-7136772 or registra@wakehealth.edu.

Appendix C – Mandatory STRC SAE Reporting Guidelines

Safety and Toxicity Review Committee (STRC; previously known as CROC) Serious Adverse Event (SAE) Notification SOP	**Date: 07/10/2019**

Mandatory STRC SAE Reporting Requirements in WISER

This document describes reporting requirements of adverse events from **WFBCCC Investigator Initiated interventional trials to the Safety and Toxicity Review Committee (STRC).** A trial is considered a **WFBCCC Investigator Initiated interventional trial** if the following criteria are met:

1) The Principal Investigator (PI) of the trial is a member of a department at the Wake Forest University Baptist Medical Center.
2) WFBCCC is considered as the primary contributor to the design, implementation and/or monitoring of the trial.
3) The trial is designated as "Interventional" using the Clinical Research Categories definitions provided by the NCI in the Data Table 4 documentation. (https://cancercenters.cancer.gov/GrantsFunding/DataGuide#dt4)

There are two distinct types of WFBCCC Investigator Initiated interventional trials based on where patient enrollment occurs. These include:

1) Local WFBCCC Investigator Initiated interventional trials defined as trials where **all patients are enrolled from one of the WFBCCC sites.** These include the main outpatient Cancer Center clinics (located in Winston-Salem) as well as WFBCCC affiliate sites located in Bermuda Run (Davie Medical Center), Clemmons, Lexington, High Point, or Wilkesboro.
2) Multi-Center WFBCCC Investigator Initiated interventional trials defined as trials where patients are enrolled from other sites in addition to WFBCCC sites. There are three types of trials that are included in this category:
    a. Trials sponsored by the NCI Community Oncology Research Program (NCORP) that are conducted at multiple sites where the PI is a member of a department at the Wake Forest University Baptist Medical Center.
    b. Trials sponsored by Industry that are conducted at multiple sites and the PI is a member of a department at the Wake Forest University Baptist Medical Center.
    c. Trials sponsored by WFBCCC that are conducted at multiple sites and the PI is a member of a department at the Wake Forest University Baptist Medical Center.

All Adverse Events (AEs) and Serious Adverse Events (SAEs) that occur on any patients enrolled on WFBCCC Investigator Initiated Interventional trials must be entered into the WISER system. The only exception to this requirement is for patients enrolled on NCORP trials at non- WFBCCC sites. AEs and SAEs for NCORP patients enrolled at WFBCCC sites must be entered into the WISER system. Once these AEs and SAEs are entered in WISER, certain actions must be taken regarding the reporting of specific Adverse Events to the STRC.

All Adverse Events that occur during protocol intervention (defined below) and are coded as either 1) **unexpected grade 4,** 2) **unplanned inpatient hospitalization > 24 hours (regardless of grade)**, or **grade 5 (death)** must be reported to the STRC using the using the SAE console in WISER.

A research nurse or clinical research coordinator when made aware that an adverse event meets one of the above criteria has occurred on a WFBCCC Investigator Initiated interventional trial, is responsible for informing a clinical member of the STRC by phone (or in-person) about the adverse event. The nurse/coordinator should contact the treating physician prior to calling the STRC clinical member to obtain all details of the SAE, as well as all associated toxicities to be recorded along with the SAE. In addition, this nurse or coordinator is responsible for entering the adverse event information into the SAE console in WISER. Once the adverse event has been entered into the SAE console an email informing the entire STRC committee will be generated.

THESE REPORTING REQUIREMENTS APPLY TO any staff member on the study team for a WFBCCC Institutional Interventional trial. Ultimately, the protocol PI has the primary responsibility for AE identification, documentation, grading and assignment of attribution to the investigational agent/intervention. However, when an AE event as described above is observed, it is the responsibility of the person who observed the event to be sure that it is reported to the STRC.

What is considered during protocol intervention?

During protocol intervention is considered to be the time period while a patient is on study treatment or during the time period within 30 days of last study treatment (even if patient begins a new (non-study) treatment during the 30 days). This window of 30 days should be the standard window to be used in all protocols unless a specific scientific rationale is presented to suggest that a shorter window can be used to identify events. If it is a trial sponsored by Industry and the sponsor requires a longer window for monitoring of SAEs, then the longer window of time specified by the sponsor should be followed.

What is considered as an Unexpected Grade 4 event?

Any grade 4 event that was not specifically listed as an expected adverse event in the protocol should be considered as unexpected. A grade 4 adverse event can be considered to be unexpected if it is an event that would not be expected based on the treatment being

received or if it is unexpected based on the health of the patient. In either case, if there is any uncertainty about whether a grade 4 adverse event is expected or unexpected it should be reported to STRC.

STRC notification responsibilities of the person (e.g., nurse) handling the reporting/documenting of the SAE in WISER:

1. Make a phone call (or speak in person) to the appropriate clinical member of the STRC as listed below (page if necessary)
2. Enter a new SAE into the SAE module that is located in the Subject>> CRA Console in WISER WITHIN 24 HOURS of first knowledge of the event. Information can be entered and saved, but the STRC members will not be notified until a date is entered into the STRC Notification Date Field. This will ensure that all persons that need to be made aware of the event (i.e., study team members and STRC members) will be notified; remember to file a copy of the confirmation.
3. Document that the appropriate person(s) on the STRC has been contacted. Indicate the name of the STRC clinician that was contacted in the Event Narrative field in the SAE console of the particular subject.
4. Document whether or not the protocol should be suspended based on the discussion with the STRC clinician. This is the major function of the email notification. Enter whether the protocol should be suspended in the Event Narrative Field.
5. Follow up/update the clinical member(s) of STRC regarding any new developments or information obtained during the course of the SAE investigation and reporting process.

Elements needed to complete the SAE form in the Subject Console in WISER (see Screen Shot 3):

1. Event Date
2. Reported Date
3. Reported by
4. If Grade 5, enter Death Date
5. If Grade 5, enter Death occurred: within 30 days
6. Event Narrative: Brief description (include brief clinical history relevant to this event, including therapies believed related to event). Begin narrative with the STRC clinician who was notified and Date/Time notified. In addition, state attribution by STRC clinician as either “Unrelated”, “Unlikely”, “Possibly”, “Probably”, or “Definitely”. Always include the following here:
    i. STRC clinician name and comments
    ii. Date of last dose before the event
    iii. Is suspension of the protocol needed? Y/N
7. Treating Physician comments
8. PI comments, if available
9. Protocol Attribution after discussion with STRC clinician

10. Outcome (Fatal/Died, Intervention for AE Continues, Migrated AE, Not Recovered/Not Resolved, Recovered/Resolved with Sequelae, Recovered/Resolved without Sequelae, Recovering and Resolving)
11. Consent form Change Required? Y/N
12. SAE Classification *This is required in order for the email notification to be sent*
13. Adverse Event Details – Enter all details for each AE associated with the SAE.
    a. Course start date
    b. Category
    c. AE Detail
    d. Comments
    e. Grade/Severity
    f. Unexpected Y/N
    g. DLT Y/N
    h. Attributions
    i. Action
    j. Therapy
    k. Click ADD to attach the AE Detail to the SAE.
14. Enter Date Notified STRC -- *This is required for the email notification to be sent*
15. Click Submit. The auto-generated notification email will disseminate within 5 minutes. If you do not receive an email within 5 minutes, check that you have entered the "Date Notified STRC" and the "SAE Classification". If these have been entered and the email still has not been received, take a screen shot of the SAE in WISER and immediately email it out to all of the STRC members listed in this SOP. In the subject line, indicate that this is a manual transmission of the SAE in lieu of the auto-generated email. It is required that a notification goes to the STRC members immediately so that their assessment can be obtained within the 24 hour time frame requirement. Contact the Cancer Center Programmer/Analyst to alert that there is an issue with the auto-generated email.

The Clinical Members of STRC to Notify by Phone or Page:

Bayard Powell, MD – Director-at-Large, WFBCCC; Section Head, Hematology/Oncology
Glenn Lesser, MD – Hematology Oncology
Stefan Grant, MD, JD-Hematology
Jimmy Ruiz, MD-Hematology Oncology
Mercedes Porosnicu, MD- Hematology Oncology
Michael Farris, MD – Radiation Oncology

Definition of Unavailable:

As a general guideline if the first clinician that is contacted does not respond to the phone call or page within 30 minutes, then initiate contact with a different STRC clinician. Allow up to 30 minutes for the new STRC clinician to respond to a phone call or page before contacting another member. These times (30 minutes) are a general guideline. Best judgment as a

clinical research professional should be used giving considerations of the time of day, severity of the SAE, and other circumstances as to when it is appropriate to contact backup clinicians. If the event occurs near the end of day, then leave messages (voice or email) as appropriate and proceed with submitting the STRC notification form. It is important to take reasonable steps and to document that some type of contact has been initiated to one or more of the clinical members of STRC.

STRC CLINICAN RESPONSIBILITY:

It is the responsibility of the STRC clinician to review all reported events, evaluate the events as they are reported; and communicate a response to the Investigator, event reporter and the members of STRC. The review will include but not be limited to the information reported; there may be times when additional information is needed in order for an assessment to be made and further communication directly with the investigator may be warranted. STRC reserves the right to disagree with the Investigator's assessment. If STRC does not agree with the Investigator, STRC reserves the right to suspend the trial pending further investigation. If there is any immediate danger or harm that could be present for a future patient based on the information provided in the STRC report then an immediate suspension of enrollment shouldbe considered.

AMENDMENTS TO PREVIOUS REPORTS

If all pertinent information is unavailable with the initial submission, once the additional information is available **do not submit a new report**. Rather, go to the original email that was sent to the STRC and using that email "reply to all". Entitle this new email "**Amendment** for (list date of event and patient ID)" this will avoid duplications of the same event. List the additional information being reported. This information needs to be entered into WISER as well. To do this, go to the Subject console and click SAEs on the left column. Click on the appropriate SAE number that needs updating. Then click update. This will allow additional information to be added

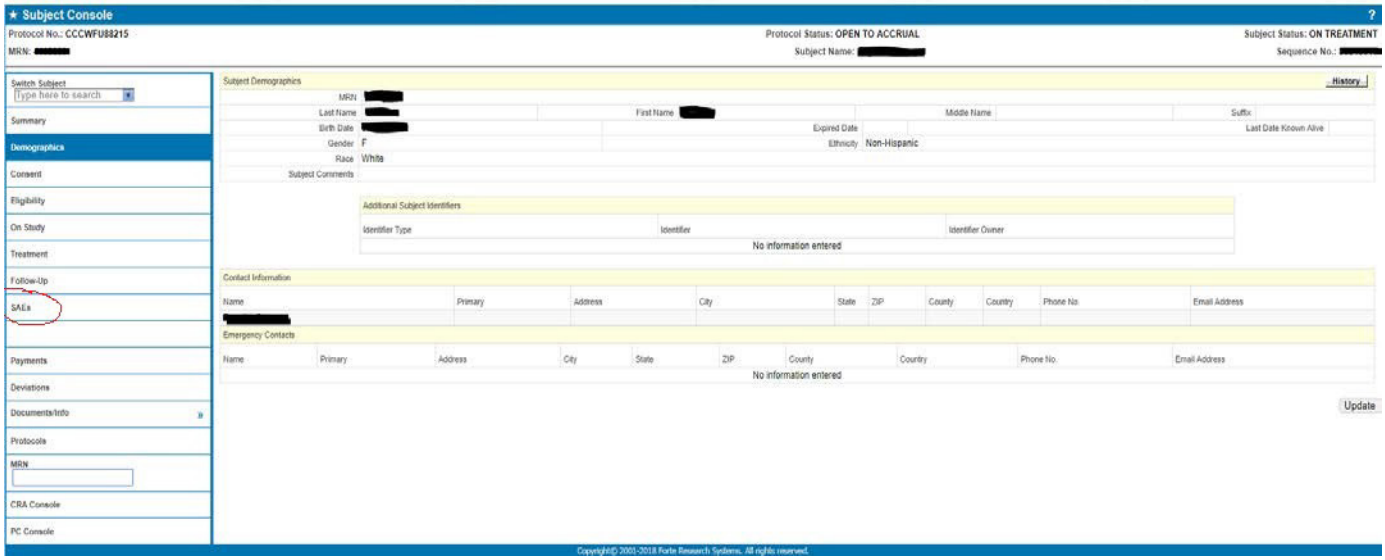
Acronyms

AE – Adverse Event
STRC-Safety and Toxicity Review Committee
SAE-Serious Adverse Event
WFBCCC – Wake Forest Baptist Comprehensive Cancer Center
NCI-National Cancer Institute
WISER –Wake Integrated Solution for Enterprise Research

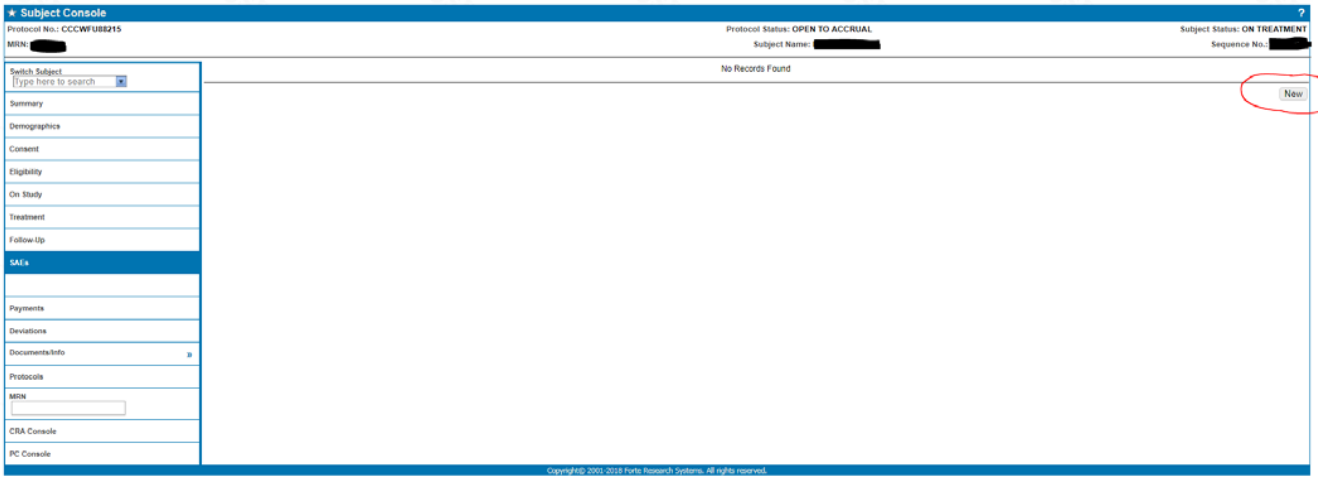
Screen Shots:

The following screen shots come from the SAE Console within the Subject Console in WISER.

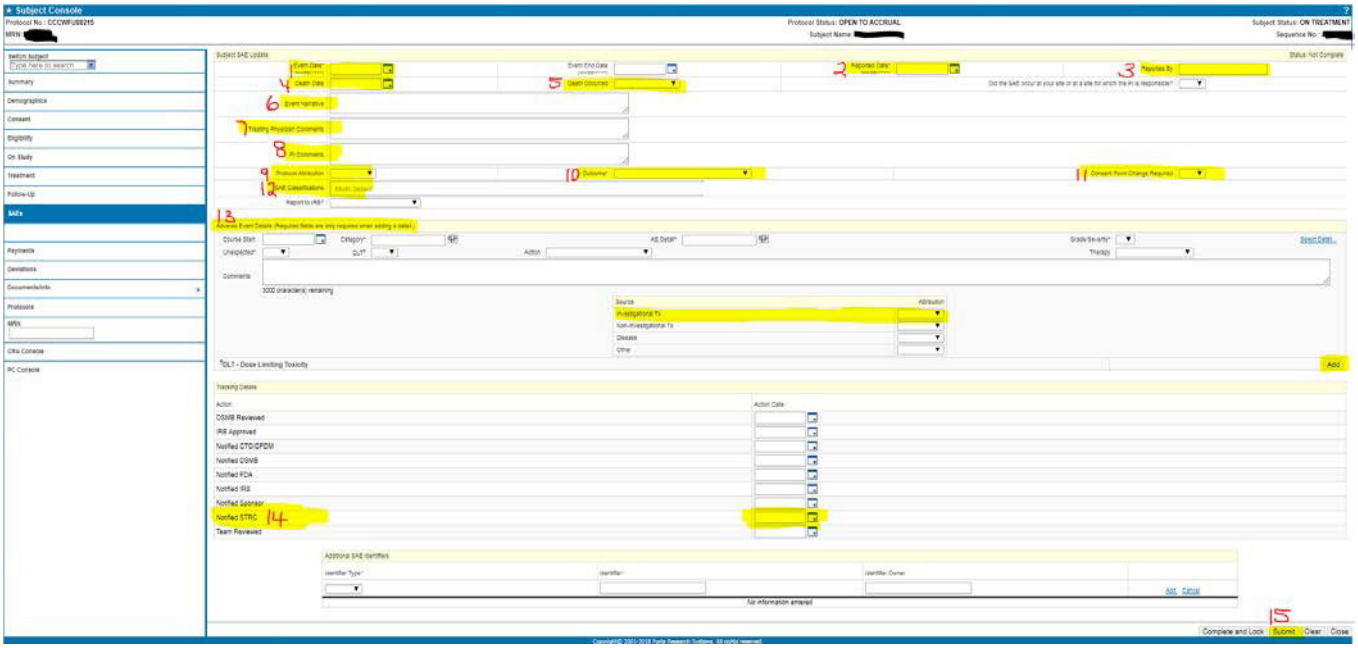
Screen Shot 1:



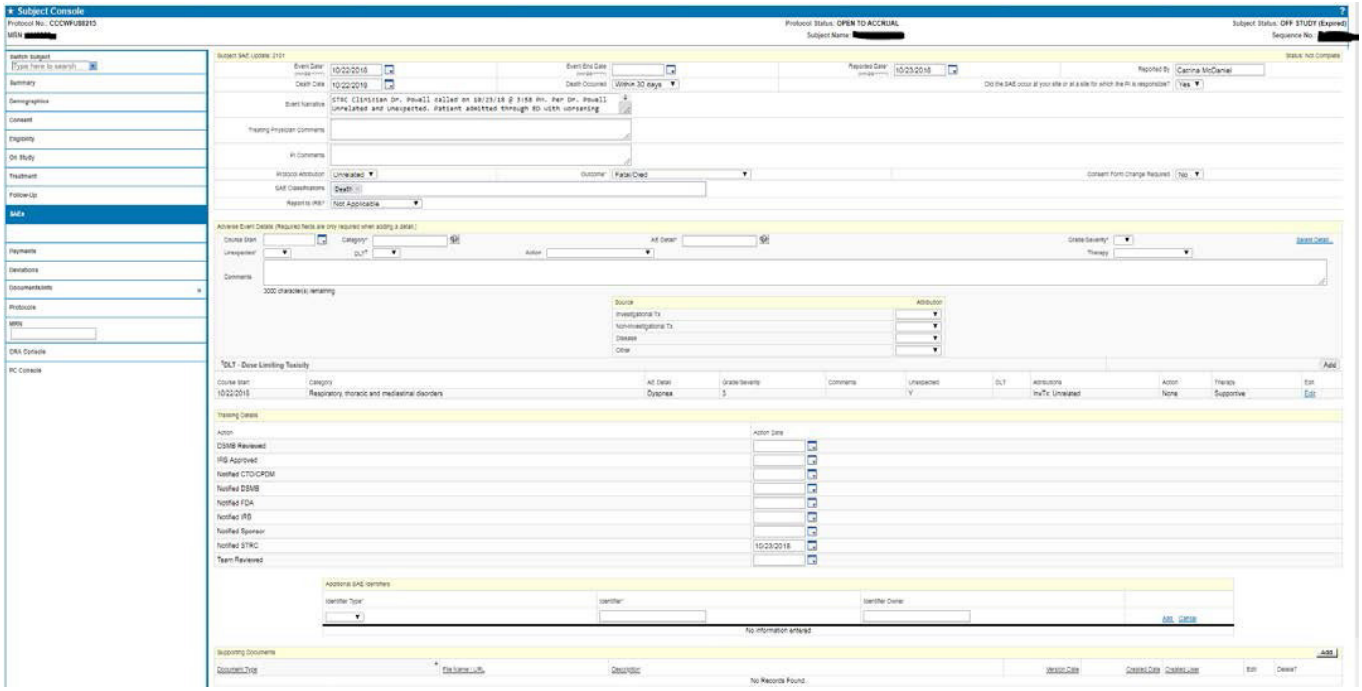
Screen Shot 2:



Screen Shot 3:



Screen Shot 4:



Appendix D – Baseline Data Collection Form

Instructions: Fill this form out to collect baseline data

1. BMI: ___ ___ .___

2. ASA Class
   - ☐ II
   - ☐ III
   - ☐ IV
   - ☐ V
   - ☐ VI

3. Medical Comorbidities
   - ☐ Acute Myocardial Infarction
   - ☐ History of Myocardial Infarction
   - ☐ Congestive Heart Failure
   - ☐ Peripheral Vascular Disease
   - ☐ Cerebrovascular Disease
   - ☐ Chronic Obstructive Pulmonary Disease (COPD)
   - ☐ Dementia
   - ☐ Paralysis (Hemiplegia or Paraplegia)
   - ☐ Diabetes
   - ☐ Diabetes with Complications
   - ☐ Renal Disease
   - ☐ Mild Liver Disease
   - ☐ Moderate/Severe Liver Disease
   - ☐ Peptic Ulcer Disease
   - ☐ Rheumatologic Disease
   - ☐ AIDS

   (Additional)
   _____
   _____
   _____
   _____

4. Surgical History

   a. Has the patient had previous surgery? ☐ Yes ☐ No
   b. If Yes, please describe:
      _____
      _____
      _____
      _____

5. Tobacco Use (Check all that apply):
   Smoking Status:
   ☐ Current Every day smoker,
   ☐ Current some day smoker,
   ☐ Former smoker,
   ☐ Heavy Tobacco smoker,
   ☐ Light Tobacco smoker,
   ☐ Never assessed,
   ☐ Never Smoker,
   ☐ Passive smoke exposure-
   ☐ Never smoker,
   ☐ Smoker-current status unknown,
   ☐ Unknown if ever smoked

   Start date (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___

   Quit date (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___

   Types (Check all that apply):
   ☐ Cigarettes,
   ☐ Pipe,
   ☐ Cigars,
   ☐ E-cig/Vapor w/nicotine,
   ☐ E-cig/Vapor w/o

   Pack/Day: __

   Years: ___ ___

   Smokeless Tobacco: ☐ Current user, ☐ Former user, ☐ Never used, ☐ Unknown

   Types: ☐ Snuff, ☐ Chew

   Quit date (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___

   Comment:
   _____
   _____
   _____
   _____
   _____

Appendix E – Surgery Form

Instructions: Use this form to fill out relevant surgery information

1. Date of Surgery (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___
2. Wound Measurements
    a. Subcutaneous depth: _ ___ ___ cm
    b. Length: ___ ___ .___ cm
    c. Width: ___ ___.___ cm
3. Procedure
    a. Colon bundle used? ☐ Yes ☐No
    b. Antibiotic use: ☐ Yes ☐No
        i. If Yes, name type, dose and frequency:
        ii. Type: _____
        iii. Dose: _____
        iv. Frequency: _____
    c. Is the antibiotic type appropriate? ☐ Yes ☐No
4. Length of Surgery
    a. Surgery Start Time (hh:mm): ___ ___:___ ___
    b. Surgery Stop (hh:mm): ___ ___:___ ___
    c. Time total time (hh:mm): ___ ___:___ ___
5. Wound Class
    ☐ II
    ☐ III
    ☐ IV
6. Intraoperative Complications (free text):

_____
_____
_____
_____

Appendix F - Wound Form

Visit: ☐ 2 weeks ☐ 4 weeks ☐ 3 months

Date of encounter (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___

1. Infection: ☐ Yes ☐ No
   If yes, date infection occurred: (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___
2. Did Wound Dehiscence occur? ☐ Yes ☐ No
   If yes, date: (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___
   Physician's assessment of why dehiscence occurred:
   _____
   _____
   _____
   _____
3. Percentage of wound healing: _____%
4. Day of hospital discharge (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___
5. Post-surgery date wound is closed
   (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___
6. Is the wound closed on POD # 30? ☐ Yes ☐ No
7. Wound Complications (free text):

_____
_____
_____
_____

Appendix G - Quality of Life (SF-36)

Instructions: Have the patient compete this evaluation at baseline, 2, 4, 6 and at 3 months follow-up

Standard Form – 36 (SF-36)	
OnCore PID:	Date:
Standard Form 36 Survey: The SF-36 Form is one of many outcomes assessments designed by the Medical Outcomes Trust in Boston, MA. It is designed to approximate the improvement in health status from a medical intervention. INSTRUCTIONS: **This survey asks for views about your health. This information will help keep track of how you feel and how well you are able to do your usual daily activities. Answer every question marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.**	
1. In general, would you say your health is: (Circle One)	1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

2. Compared to one year ago, how would you rate your health in general at this time? (Circle One)	1. Much better now than one year ago 2. Somewhat better now than one year ago 3. About the same as one year ago 4. Somewhat worse that one year ago 5. Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Circle the appropriate number for each question)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited
a. **Vigorous activities**, such as running, lifting heavy objects, or participation in strenuous sports	1	2	3
b. **Moderate activitie**s, such as moving a table, Vacuuming, bowling or golfing	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing **several** flights of stairs	1	2	3
e. Climbing **one** flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking **more than a mile**	1	2	3

h. Walking **several blocks**	1	2	3
i. Walking **one block**	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular activities **as a result of your physical health**? (Circle the appropriate number for each question)		
a. Cut down on the **amount of time** you spent on work or other activities	Yes = 1	No = 2
b. **Accomplished less** than you would like	Yes = 1	No = 2
c. Were limited in the **kind** of work or other activities	Yes = 1	No = 2
d. Had **difficulty** performing the work or other activities (For example – requiring an extra effort)	Yes = 1	No = 2

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Circle the appropriate number for each question)		
a. Cut down on the **amount of time** you spent on work or other activities	Yes = 1	No = 2
b. **Accomplished less** than you would like	Yes = 1	No = 2
c. Didn't do work or other activities as **carefully** as usual	Yes = 1	No = 2

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? **(Circle one)**	1. Not at all 2. Slightly 3. Moderately 4. Quite a bit 5. Extremely

7. How much **bodily** pain have you had during the **past 4 weeks**? **(Circle one)**	1. None 2. Very mild 3. Mild 4. Moderate 5. Severe 6. Very severe

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? **(Circle one)**	1. Not at all 2. Slightly 3. Moderately 4. Quite a bit 5. Extremely

9. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**: **(Circle one number on each line)**

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting friends, relatives etc.)? **(Circle one)**	1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

11. How TRUE or FALSE is **each** of the following statements to you? **(Circle one for each line).**

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

Appendix H – Adverse Event Log

WFBCCC Adverse Event (AE) Log														
PI: _____ Subject PID: _____					**MRN: _____**									
Cycle #: _____ Cycle Start Date: _____ Cycle Start Time: _____ Cycle End Date: _____ Cycle End Time: _____														
Adverse Event CTC Term	**Lab Value**	**Grade** (1-5) per CTC	**Start Date**	**End Date**	**Attribution** DEF=Definite PROB=Probable POSS=Possible UNLK=Unlikely UNRL=Unrelated	**Expected** N=No Y=Yes	**Serious Adverse Event Detail** NO=No LT=Life Threatening DTH=Death DIS=Disability HOS=Hospitalization CA=Caused congenital anomaly RI=Required intervention to prevent impairment	**Dose Limiting Toxitity (DLT)** N=No Y=Yes	**Action Taken** NO=None DR=Dose Reduced RI=Regimen Interrupted TD=Therapy discontinued INTR=Interrupted then reduced	**Therapy Given** NO=None SYM=Symptomatic SUP=Supportive VSUP=Vigorous supportive	**Reportable?** IRB-IRB STRC-STRC FDA-FDA SPON-Sponsor (Mark all that apply)	**Adverse Event Report (AER) Filed** N=No Y=Yes	**Outcome** R=Recovered TX=Still under treatment/ observation A=Alive with sequalae D=Died	**Treating MD Initials/Date**
Serious Adverse Event: Hospitalization; Disability; Birth Defect; Life-threatening; Death.														
CTCAE Version 4 - http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE_4.03_2010-06-14_QuickReference_8.5x11.pdf														
STRC- Safety and Toxicity Review Committee											Version 1/10/18			