Intraoperative Nerve Identification With Fluorescein Sodium

Informed Consent Form

NCT06054178

November 15, 2024

STANFORD CONSENT FORM with HIPAA Template

STANFORD UNIVERSITY
CONSENT TO BE PART OF A RESEARCH STUDY

Are you participating in any other research studies? _____ Yes _____No

PURPOSE OF RESEARCH

You are invited to participate in a research study of intraoperative imaging using sodium fluorescein. We hope to image nerves after administration of this compound during your surgery. You were selected as a possible participant in this study because you are undergoing a surgery where one of the nerves on the face (facial nerve) or neck will be exposed.

This medication is FDA approved. However, we will be utilizing this medication off-label (at a lower dose) to hopefully identify nerves during your surgery.

This research study is looking for 30 patients undergoing parotid or head and neck surgery. This study is limited to only Stanford University (USA). Stanford University expects to enroll 30 research study participants.

VOLUNTARY PARTICIPATION

Your participation in this study is entirely voluntary. Your decision not to participate will not have any negative effect on you or your medical care. You can decide to participate now, but withdraw your consent later and stop being in the study without any loss of benefits or medical care to which you are entitled.

DURATION OF STUDY INVOLVEMENT

This research study is expected to take approximately 1 year. Your participation will only last one day. There is no follow up period.

PROCEDURES

If you choose to participate, the Protocol Director and research study staff will perform the following.

You will receive a dose of intravenous sodium fluorescein (0.5 -3 mg/kg) at the time of your surgery. This is less than half the dose generally used for ophthalmic angiography. Intravenous refers to medications given directly to your veins.

Following this, intraoperative non-invasive imaging will then be performed to visualize nerves after its exposure. Non-invasive imaging refers to the use of a camera to take videos/pictures of nerves. This will be performed during a time your surgeon deems safe, and will add approximately 20 minutes to the entire duration of your surgery. Videos and images will be captured (avoiding full face images). No specimens or blood work will be collected.

Specifically for non-invasive imaging, we will utilize a LED light (blue light) with a camera that detects fluorescence to visualize nerves. We may also use the Zeiss Yellow 560 fluorescence system (blue light with a camera) on a microscope or a blue light endoscope that also sees fluorescence to visualize the nerves.

While sodium fluorescein is an FDA approved drug for angiography in ophthalmology, this specific indication for visualization of nerves is off-label.

Future Use of Private Information
Research using private information is an important way to try to understand human disease. You are being given this information because the investigators want to save private information for future research.

Identifiers might be removed from identifiable private information and, after such removal, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you.

People of Childbearing Potential
If you are pregnant or currently breast feeding, you may not participate in this study. Please know that if you are pregnant, if you become pregnant, or if you are breast-feeding during this study, you or your child may be exposed to an unknown risk.

PARTICIPANT RESPONSIBILITIES

As a participant, your responsibilities include:

- Follow the instructions of the Protocol Director and study staff.
- Tell the Protocol Director or research study staff about any side effects, doctor visits, or hospitalizations that you may have.
- Tell the Protocol Director or research staff if you believe you might be pregnant.
- Ask questions as you think of them.
- Tell the Protocol Director or research staff if you change your mind about staying in the study.

WITHDRAWAL FROM STUDY

If you first agree to participate and then you change your mind, you are free to withdraw your consent and discontinue your participation at any time. Your decision will not affect your ability to receive medical care for your disease and you will not lose any benefits to which you would otherwise be entitled.

If you decide to withdraw your consent to participate in this study, you should notify Dr. Tulio Valdez at 650-724-4800.

Subjects may refuse to participate or withdraw from the study at any time by notifying the protocol director as above without penalty or loss of benefits to which they are entitled. Any data at the time the subject withdraws will be deleted appropriately to ensure that the data is not used in the study. All attempts will be made to prevent data at the time the subject withdraws from being analyzed or included for publication; however no guarantee of this can be made since data may already have been published at the time the subject has withdrawn.

If you withdraw from the study,

- There are no consequences of withdrawing from the study

The Protocol Director may also withdraw you from the study without your consent for one or more of the following reasons:

- Failure to follow the instructions of the Protocol Director and study staff.
- History of kidney failure
- The Protocol Director decides that continuing your participation could be harmful to you.
- Pregnancy
- You need treatment not allowed in the study.
- The study is cancelled.
- Other administrative reasons.
- Unanticipated circumstances.

POSSIBLE RISKS, DISCOMFORTS, AND INCONVENIENCES

There are risks, discomforts, and inconveniences associated with any research study. These deserve careful thought. You should talk with the Protocol Director if you have any questions.

- The risks of sodium fluorescein per the Food and Drug Administration is the following:
  - Nausea, vomiting, upset stomach pain or irregular bowel movements (gastrointestinal distress), headache, fainting/lightheadedness (syncope), low blood pressure (hypotension), and symptoms and signs of hypersensitivity (allergic reactions including itchiness and skin rash) have occurred
  - Very rarely: respiratory reactions (difficulties with breathing, 1/3800), cardiac reactions (interrupted blood circulation due to heart not beating, 1/5300), tonic-clonic seizures (full body uncontrolled shaking, 1/13900)
  - In event of in-advertent delivery of drug into skin during administration to your veins: pain at injection site, sloughing of the skin, injury to nerves near injection site, skin reactions including (superficial phlebitis, subcutaneous granuloma

- The risks associated with the LED light, Camera, Zeiss Yellow 560 system, Blue light endoscope
  - Low powered LED light will be used to visualize the surgical area

- An additional 20 minutes will be added to your surgical procedure for imaging
- There may be unforeseeable risks related to the subject, which are currently unforeseeable.

POTENTIAL BENEFITS

- Participation in this study may improve visualization of the nerve branches during surgery, potentially leading to less injury and increased preservation

We cannot and do not guarantee or promise that you will receive any benefits from this study.

ALTERNATIVES

Participation as a research subject is voluntary. An alternative to participation in the study is to not enroll in the study. No treatments are withheld and participation in the study does not impact your clinical treatment.

PARTICIPANT'S RIGHTS

You should not feel obligated to agree to participate. Your questions should be answered clearly and to your satisfaction. If you decide not to participate, tell the Protocol Director.

You will be told of any important new information that is learned during the course of this research study, which might affect your condition or your willingness to continue participation in this study.

ClinicalTrials.gov

A description of this clinical trial will be available on *http://www.ClinicalTrials.gov*, as required by U.S. Law (NCT# 06054178). 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.

CONFIDENTIALITY

The results of this research study may be presented at scientific or medical meetings or published in scientific journals. Your identity and/or your personal health information will not be disclosed except as authorized by you or as required by law**.** However, there is always some risk that even de-identified information might be re-identified.

Patient information may be provided to Federal and other regulatory agencies as required. The Food and Drug Administration (FDA), for example, may inspect research records and learn your identity if this study falls within its jurisdiction.

CERTIFICATE OF CONFIDENTIALITY

This research is covered by a Certificate of Confidentiality from the National Institutes of Health. The researchers with this Certificate may not disclose or use information, documents, or specimens that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other action, suit, or proceeding, or be used as evidence, for example, if there is a court subpoena, unless you have consented for this use. Information, documents, or specimens protected by this Certificate cannot be disclosed to anyone else who is not connected with the research except, if there is a federal, state, or local law that requires disclosure (such as to report child abuse or communicable diseases but not for federal, state, or local civil, criminal, administrative, legislative, or other proceedings, see below); if you have consented to the disclosure, including for your medical treatment; or if it is used for her scientific research, as allowed by federal regulations protecting research subjects

The Certificate cannot be used to refuse a request for information from personnel of the United States federal or state government agency sponsoring the project that is needed for auditing or program evaluation by NIDCD/NIH which is funding this project or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it.

Authorization To Use Your Health Information For Research Purposes

Because information about you and your health is personal and private, it generally cannot be used in this research study without your written authorization. If you sign this form, it will provide that authorization. The form is intended to inform you about how your health information will be used or disclosed in the study. Your information will only be used in accordance with this authorization form and the informed consent form and as required or allowed by law. Please read it carefully before signing it.

What is the purpose of this research study and how will my health information be utilized in the study?

We aim to use fluorescein to help us visualize nerves during your surgery. Confidential videos and images (avoiding full face photos) will be captured and used for publication. Additional confidential information (age, sex, surgery) will be collected in the study, and will be coded.

Do I have to sign this authorization form?

You do not have to sign this authorization form. But if you do not, you will not be able to participate in this research study.
Signing the form is not a condition for receiving any medical care outside the study.

If I sign, can I revoke it or withdraw from the research later?

If you decide to participate, you are free to withdraw your authorization regarding the use and disclosure of your health information (and to discontinue any other participation in the study) at any time. After any revocation, your health information will no longer be used or disclosed in the study, except to the extent that the law allows us to continue using your information (e.g., necessary

to maintain integrity of research). If you wish to revoke your authorization for the research use or disclosure of your health information in this study, you must write to:
Dr. Tulio Valdez, tvaldez1@stanford.edu
Dr. Roy Park, [redacted]

What Personal Information Will Be Obtained, Used or Disclosed?

Your health information related to this study, may be used or disclosed in connection with this research study, including, but not limited to, Age, Sex, Medical Record Number, Date of Surgery, Diagnosis, Intraoperative surgical videos/images (no full face photos will be taken).

Who May Use or Disclose the Information?

The following parties are authorized to use and/or disclose your health information in connection with this research study:

- The Protocol Director: Tulio Valdez, MD
- The Stanford University Administrative Panel on Human Subjects in Medical Research and any other unit of Stanford University as necessary
- Research Staff

Who May Receive or Use the Information?

The parties listed in the preceding paragraph may disclose your health information to the following persons and organizations for their use in connection with this research study:

- The Office for Human Research Protections in the U.S. Department of Health and Human Services
- The Food and Drug Administration
- National Institute of Health/National Institute on Deafness and Other Communication Disorders

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

When will my authorization expire?
Your authorization for the use and/or disclosure of your health information will end on February 28, 2050 or when the research project ends, whichever is earlier.

Will access to my medical record be limited during the study?
To maintain the integrity of this research study, you may not have access to any health information developed as part of this study until it is completed. At that point, you would have access to such health information if it was used to make a medical or billing decision about you (e.g., if included in your official medical record).

_____ _____
Signature of Adult Participant Date

_____
Print Name of Adult Participant

_____ _____
Signature of Legally Authorized Representative (LAR) Date
(e.g., parent, guardian or conservator)

_____
Print Name of LAR

LAR's Authority to Act for Participant
(e.g., parent, guardian or conservator)

FINANCIAL CONSIDERATIONS

Payment
You will not be paid to participate in this research study.

Costs
There is no cost to you for participating in this study, other than basic expenses like transportation and the personal time it will take to come to all of the study visits.

Sponsor
This study is internally funded by the department of Otolaryngology – Head and Neck Surgery at Stanford and National Institute on Deafness and Other Communication Disorders

Consultative or Financial Relationships
No consultative or financial relationships exist for any of the research investigators.

COMPENSATION FOR RESEARCH-RELATED INJURY

All forms of medical diagnosis and treatment – whether routine or experimental – involve some risk of injury. In spite of all precautions, you might develop medical complications from participating in this study. If such complications arise, the Protocol Director and the research study staff will assist you in obtaining appropriate medical treatment. In the event that you have an injury or illness that is directly caused by your participation in this study, reimbursement for all related costs of care first will be sought from your insurer, managed care plan, or other benefits program. **You will be responsible for any associated co-payments or deductibles as required by your insurance.**

If costs of care related to such an injury are not covered by your insurer, managed care plan or other benefits program, you may be responsible for these costs. If you are unable to pay for such costs, the Protocol Director will assist you in applying for supplemental benefits and explain how to apply for patient financial assistance from the hospital.

You do not waive any liability rights for personal injury by signing this form.

CONTACT INFORMATION

Questions, Concerns, or Complaints: If you have any questions, concerns or complaints about this research study, its procedures, risks and benefits, or alternative courses of treatment, you should ask the Protocol Director, 650-724-4800. You may contact him now or later at 650-724-4800.

Injury Notification: If you feel you have been hurt by being a part of this study, please contact the Protocol Director, Dr. Tulio Valdez at 650-724-4800.

Independent Contact: If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the Stanford Institutional Review Board (IRB) to speak to someone independent of the research team at (650)-723-5244 or toll free at 1-866-680-2906. You can also write to the Stanford IRB, Stanford University, 1705 El Camino Real, Palo Alto, CA 94306.

Alternate Contact: If you cannot reach the Protocol Director, please contact Roy Park at [redacted] (ask phone operator to page #[redacted])

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

As a research participant you have the following rights. These rights include but are not limited to the participant's right to:

- be informed of the nature and purpose of the experiment;
- be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized;

- be given a description of any attendant discomforts and risks reasonably to be expected;
- be given an explanation of any benefits to the subject reasonably to be expected, if applicable;
- be given a disclosure of any appropriate alternatives, drugs or devices that might be advantageous to the subject, their relative risks and benefits;
- be informed of the avenues of medical treatment, if any available to the subject after the experiment if complications should arise;
- be given an opportunity to ask questions concerning the experiment or the procedures involved;
- be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation without prejudice;
- be given a copy of the signed and dated consent form; and
- be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion or undue influence on the subject's decision.

Signing your name means you agree to be in this study and that you will receive a copy of this signed and dated consent form.

_____ _____
Signature of Adult Participant Date

_____
Print Name of Adult Participant

_____ _____
Signature of Legally Authorized Representative (LAR) Date
(e.g., parent, guardian or conservator)

_____
Print Name of LAR

_____
LAR's Authority to Act for Participant
(e.g., parent, guardian or conservator)

_____ _____
Signature of Person Obtaining Consent Date

_____
Print Name of Person Obtaining Consent

The following witness line is to be signed only if the consent is provided as a summary form and accompanied by a short form foreign language consent.

_____ _____
Signature of Witness Date

_____
Print Name of Witness

(e.g., staff, translator/interpreter, family member)

- *Translated short form must be signed and dated by both the participant (or their LAR) AND the witness.*
- *The English consent form (referred to as the "Summary Form" in the regulations):*
  - *Must be signed by the witness AND the person obtaining consent (POC).*
  - *The non-English speaking participant/LAR does not sign the English consent.*
  - *The non-English speaking participant/LAR should not sign the HIPAA participant line*
  - *If the participant or the LAR is non-English speaking, the person obtaining consent (POC) must ensure that 1) the LAR's Description of Authority is completed and 2) that any questions or options presented by the consent form are documented and initialed by the POC on the Summary Form, per the participant's wishes, as they are understood during the consent process.*