



Informed Consent

INFORMED CONSENT/AUTHORIZATION FOR PARTICIPATION IN RESEARCH

Resection of Pulmonary Lesions Aided by Robotic Bronchoscopy with
Cone CT and INdocyanin Green (REPLACING) study
2021-0243

Study Chair: David Rice, MD

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 it is possible to use the Ion™ robotic bronchoscope or the Monarch™ bronchoscope with a mobile CT scanner to biopsy tumors and inject a fluorescent dye to mark the tumor.

Sometimes small tumors or those that are not on the surface of the lung can be challenging to remove without making larger incisions. Researchers hope that by injecting the dye, surgeons will be able to see the tumor more easily, which will allow for smaller incisions. Researchers also hope that by being able to see the tumor, the surgeon will be better able to decide where to make the incisions in order to get all of the tumor out.

These robotic bronchoscopes represent the latest advancements in this technology. Another goal of this study is to learn which device performs better in the operating room setting.

This is an investigational study. The bronchoscopy and CT scan are performed using FDA approved and commercially available methods. It is considered investigational to use these devices together along with the use of a biopsy needle to add the dye.

Future patients and surgeons may benefit from what is learned. There may be no benefits for you in 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.

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

There is no additional cost to you for taking part in this study. You and/or your insurance provider will be responsible for the cost of your routine surgery.

Your participation in this study will be over after your surgery.

You may choose not to take part in this study. You may choose to have lung surgery as part of your standard care without participating in this study.

1. STUDY DETAILS

Screening Tests

Signing this consent form does not mean that you will be able to take part in this study. The following screening tests will help the doctor decide if you are eligible:

- You will have a physical exam.
- You will have a standard of care CT scan within 60 days before the biopsy in order to locate the tumor.

The study doctor will discuss the screening test results with you. If the screening tests show that you are not eligible to take part in the study, you will not be enrolled. Other treatment options will be discussed with you.

Up to 84 participants will be enrolled in this study. All will take part at MD Anderson.

If you agree to take part in this study, before your surgery and after you have received general anesthesia, you will have a bronchoscopy performed using a robotic bronchoscope. The bronchoscope used during your case will be determined by a randomization program (50/50), based on the type of tumor that you have. During the bronchoscopy, the surgeon will attempt to perform a biopsy of the lesion. In order to confirm the location of the biopsy needle as it relates to the location of the lesion, as few as 1 and as many as 3 CT scans will be performed. After the biopsy is performed, the surgeon will then inject a small amount of a dye called indocyanin green to mark the location of the lesion. This dye glows under special light during the surgery. You will sign a separate consent form explaining your standard of care surgery and its risks, including the risks of general anesthesia (the medicine that makes you sleep during surgery).

During surgery, while you are under anesthesia, the surgeon will use a special light to try to see the dye and use this to help complete the surgical removal of the tumor.

After your surgery, a pathologist will look at the tissue that has been removed and will report how far from the edge of the tissue the tumor is located. This is standard procedure.

Your participation in this study will be over after your surgery is over. After your surgery, you may come back to the clinic as part of your standard post-surgery visits.

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.

CT scans send x-rays through the body at many different angles. You will be exposed to a small dose of radiation. All radiation adds up over a lifetime and may increase the risk of new cancer forming. Some people may feel “closed in” while lying in the scanner. However, the scanner is open at both ends, and an intercom allows you to talk with doctors and staff. If you feel ill or anxious during scanning, doctors and/or radiology technicians will give comfort, or the scanning will be stopped. Solution may also be given by vein to make the x-ray pictures more accurate. This may cause an uncomfortable feeling of warmth, nausea, and/or severe allergic reactions. The solution injection may also cause pain, bleeding, bruising, hives, and/or itching.

Indocyanin Green Dye Side Effects

It is not well known how often the following side effects of indocyanin green dye may occur.

<ul style="list-style-type: none">• headache• itching	<ul style="list-style-type: none">• sweating• hives• green stool color	<ul style="list-style-type: none">• life-threatening allergic reaction (such as difficulty breathing, low blood pressure, and/or organ failure)
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Robotic bronchoscopy

It is not known how often the following side effects of robotic bronchoscopy may occur.

<ul style="list-style-type: none">• irregular heartbeat• chest pain• fever• bleeding	<ul style="list-style-type: none">• collapsed lung (possible difficulty breathing)• possible need for a breathing tube	<ul style="list-style-type: none">• cough• difficulty breathing (possibly due to narrowing of the
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<ul style="list-style-type: none">• low oxygen level in the blood (possible lightheadedness)	<ul style="list-style-type: none">• sore throat	<ul style="list-style-type: none">airways)• blood in the mucus
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Robotic bronchoscopy may cause an increased risk of infection, such as pneumonia. This infection may occur anywhere. It may become life-threatening. Symptoms of infection may include fever, pain, redness, and difficulty breathing.

You may have stinging, burning, tingling, and/or tenderness of the mouth and/or difficulty swallowing when you gargle with the anesthetic before the procedure.

This study may involve unpredictable risks to the participants.

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.

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. David Rice, at 713-563-9153) 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.
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.

Before being used or shared for future research, every effort will be made to remove your identifying information from any data. 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 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 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.

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
- 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.
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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 **2021-0243**.

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 DATE
(OTHER THAN TRANSLATOR, PARENT/GUARDIAN,
OR STUDY CHAIR)

PRINTED NAME OF WITNESS TO THE VERBAL TRANSLATION