STUDY TITLE: SCREENING TO PROPHYLAX AGAINST *CLOSTRIDIUM DIFFICILE* INFECTION (StoP CDI)

NCT#: 02996487

Document Date: 5/20/2022

IRB NUMBER: 2016-254
IRB APPROVAL DATE: 05/20/2022
IRB EXPIRATION DATE: 05/19/2023

CONSENT FORM AND AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Hospital: specify location(s) by checking the box(s)
☒ William Beaumont Hospital (Royal Oak, Troy and Grosse Pointe)
☒ Beaumont Hospital - Dearborn
☐ Beaumont Hospital - Farmington
☐ Beaumont Hospital - Other _____
Individually and collectively referred to as "Beaumont" throughout this consent.

Study Sponsor: Agency for Healthcare Research and Quality (AHRQ)

INTRODUCTION

Why is this study being done?

You are being asked to participate in a research study. The purpose of research is to look at the nature of disease and try to develop improved methods to diagnose and treat disease. The doctor or clinician in charge of the study believes you meet the initial requirements to take part in the study. Before agreeing to participate, it is important for you to read and understand the following explanation of the research procedures. This Consent and Authorization form describes the purpose, procedures, benefits, risks and discomforts of the study. It also describes the alternatives available to you, and your right to withdraw (quit) from the study at any time.

Please read this information carefully and ask as many questions as you like before deciding whether or not you would like to take part in this research study.

Clostridium difficile (C. diff) is a germ which may cause diarrhea in patients who are treated with antibiotics. Many people carry C. diff in their stool, but it is simply there and does not cause disease. This is called being colonized with C. diff. When patients who are colonized are given antibiotics which kill the good bacteria in the colon, C. diff is left behind and may cause an infection. The C. diff infection (CDI) produces toxins which cause diarrhea and can be severe or even life threatening. When a person gets CDI a commonly used treatment is an antibiotic called vancomycin which is given orally.

The goal of this study is to evaluate whether using vancomycin orally can prevent CDI in patients who are colonized with C. diff who are admitted to the hospital and need antibiotics for another infection.

A total of 200 patients will take part in this portion of the study at Beaumont.

How long will I be in the study?

If you decide to take part in this study, your participation is expected to last 12 weeks from the time you finish your antibiotics. If you get CDI, you will continue to be followed for an additional 12 weeks for a total of 24 weeks of study participation. You may not take part in this study if you are currently enrolled in another related research study which could alter or influence the study results.

DESCRIPTION OF THE STUDY

What will happen if I take part in the research study?

You are being asked to take part in this research study because you have been diagnosed with an infection requiring antibiotics while in the hospital. Treatment with certain antibiotics, including those you are being treated with, have been shown to be a risk for developing CDI. Another risk for developing CDI is being colonized with C. diff when you receive antibiotics. You have previously been found to be colonized with C. diff so your risk to develop CDI is higher than normal.

If you agree to take part in this study, you will be randomly assigned to one of 2 treatment groups. Randomization is like "the flip of a coin".

The treatment groups are:

A. Vancomycin 125 mg by mouth every 6 hours.
B. Placebo by mouth every 6 hours. The placebo will look like the drug being studied, but will have no active ingredients, in this case it will be fruit punch with vitamins added to mimic the taste of vancomycin.

In case of an emergency, the treatment can be unblinded to determine which therapy you have been receiving.

Below is a table describing what will occur at each study visit:

Table 1: Schedule of Events

Protocol Activity	Screening Visit	While Inpatient	While Outpatient and on Study Medication	End of Treatment	Follow Up Week 1-Week 12	End of Follow Up	Extended Follow Up Week 13-Week 24	End of Extended Follow Up
All Patients								
Informed consent	X							
Inclusion/Exclusion criteria	X							
Collect baseline clinical data	X							
Collect baseline demographic data	X							
Weekly Visit for Questions		X						
Phone Call for Questions[3]					X			
Receive study medication every 6 hours		X	X					
Additional weekly phone call for questions			X				X	
Test stool sample for colonization with VRE[1]	X			X		X		X
Test stool sample for hypervirulent strain and toxin production[1,2]	X							
Collect blood to test for *C. difficile* toxin antibodies and serum HCG (if needed)	X							

1 – Stool tested at screening visit will already have been collected when screened for colonization and a new sample is not needed
2 – Stool will also be tested for toxin production at any time a randomized patient is suspected of having CDI.
3 – Follow up phone call for questions will occur on companion study weekly, while on study drug, at EOT, 4 weeks post,8 weeks post and 12 weeks post study drug completion. If subject qualifies for extended follow up, addition calls will be made monthly at weeks 16, 20, and 24.

The study team will instruct you on the location of where to submit the stool samples: Beaumont Hospital Royal Oak, Troy, or Dearborn.

FDA Clinical Trial Information

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.

PARTICIPANT RESPONSIBILITIES

You will be asked to note any side effects or medical problems you may experience while you are taking part in this study. For any illnesses or injuries, you should contact the study doctor immediately at the number listed in this Consent and Authorization form or in an emergency situation call 911 (or go to the nearest hospital emergency room).

BIOLOGICAL SPECIMEN BANKING

In this study, a sample of your stool will be kept for possible future research. The sample will have a code that only Dr. Sims will be able to link back to you as a patient and will not have your personal information on the tube in which it is stored. The future research may involve determining what other bacteria are in the stool of patients who are colonized with C. diff or develop CDI, all future research with the sample will be related to C. diff and CDI. No genetic testing of human cells will be performed as part of future research. Only Dr. Sims and his team will have access to the samples, and you may change your mind at any point and request the sample to be destroyed. The samples will be kept a maximum of 10 years from the end of the study. You will not be notified of any findings.

Do you wish to take part in this additional, optional part of this study?

☐ Yes
☐ No

_____
Participant's Signature

RISKS, SIDE EFFECTS AND DISCOMFORTS

Ask your doctor what the standard of care risks are as well as the study risks.
What side effects or risks can I expect from being in the study?

Risks of Oral Vancomycin:
Less Frequent (occurring from 1% to 10% of the time):

- Indigestion
- Stomach ache
- Nausea
- Vomiting
- Diarrhea

Rare (occurring less than 1% of the time):

- Severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue)

There are a number of risks associated with giving vancomycin intravenously (directly into the body using a vein) such as kidney failure and hearing loss. Since oral vancomycin does not easily get absorbed into the body, these side effects are not expected to occur

Since all antibiotics can cause bacteria exposed to them to become resistant to the antibiotic there is a chance that some of the bacteria in your colon may become resistant to vancomycin. It is very rare that C. diff itself becomes resistant to vancomycin but there is another bacteria in the colon called *Enterococcus* which can become resistant to vancomycin and there is a risk, though how significant is unknown, that you may acquire vancomycin resistant *Enterococcus* from being exposed to vancomycin. This has not been a significant clinical concern in patients treated for CDI with vancomycin.

There is a rare risk of breach of confidentiality (release of information which personally identifies you).

Risks of Blood Drawing:
Most Frequent (occurring more than 10% of the time):

- Pain
- Bleeding
- Bruising at the needle puncture site

Rare (occurring less than 1% of the time):

- Blood clot
- Infection

- Feeling lightheaded
- Fainting

Not all possible effects are known. With any drug unusual, unexpected or previously unreported side effects may occur. You will be informed of any significant new findings, which develop during the course of this research study which may change your decision to continue participating in this study.

Pregnancy Warning

If you are a woman who is pregnant or becomes pregnant during the research study, there could be harmful effects to you or your unborn child. It is important you are not pregnant or breast-feeding during the approximately 10-17 days you are taking the study medication. Women of childbearing potential must agree to use birth control**.** If you are a woman of childbearing potential, you must have a negative pregnancy test before entering the study.

BENEFITS

What are the benefits of taking part in this study?

We expect that using vancomycin prophylaxis will lower your chance to develop CDI however there may be no direct benefit to you from taking part in this study. Information gained from the results of this study may be of benefit to others in the future, with a similar medical condition**.**

ALTERNATIVE OPTIONS

What are my choices other than taking part in this study?

You do not have to take part in this study to receive treatment for your condition. There are no current ways to screen for and prevent CDI in patients receiving antibiotics.

ECONOMIC CONSIDERATIONS

What are the costs of taking part in this study?

The study medication will be provided to you at no cost. There will be no cost to you for the study procedures described in this consent (e.g., pregnancy test, stool collection and testing, blood samples collected and tested, and questionnaires). Routine procedures you would have had done even if you were not taking part in this study will be billed to your health insurance company and/or group health plans as usual. If these routine care costs are not covered by your health insurance/group health plan, the cost will be your responsibility.

You are asked to attend a visit to the Research office at the end of the study. You will need to bring a stool sample. You will be reimbursed $50 for your time and travel for this visit which will be paid by a check sent via the mail after the visit.

COMPENSATION

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

Your involvement in this study is voluntary. The possible risks and side effects which might occur during the course of the research study have been described in this Consent and Authorization form.

A research injury is any physical injury or illness caused by the medications, devices, or procedures required by the study which are administered, used, or performed appropriately. These medications, devices, or procedures are different from the medical treatment you would have received if you had not taken part in the study.

Should you experience a research injury, there are no designated funds provided for subsequent medical care or compensation by either the study doctor/clinician or Beaumont.

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

You are not giving up any of your legal rights by signing this form.

CONFIDENTIALITY, DISCLOSURE AND USE OF YOUR INFORMATION

Will my medical information be kept private?

We will keep your personal health information as confidential as possible. It is not likely your information will be given to others without your permission. In order for this research study to take place, you must also authorize the researchers to access and use some of your protected health information (PHI). PHI is information which could identify you as an individual such as name, address, date of birth, etc. By signing this Consent and Authorization Form, you give Beaumont permission to use and/or disclose (release) your health information related to this research. Your medical and billing records collected for the purpose of the study will remain confidential, but may be disclosed (released) or used by the following and/or their representatives:

- The investigators (study doctor/clinician, research staff)
- Beaumont and its' parent, Beaumont Health and affiliated hospitals
- The Food and Drug Administration
- Other governmental regulatory agencies (domestic and/or foreign)
- The study sponsor, AHRQ and agents of the sponsor involved in this study.
- Your health insurance company and/or group health plans and their intermediaries (companies contracted to process claims) may also have access to your medical and billing records of the study.
- Primary Care Physician

Optional Notification to the Primary Physician

The research doctor would like to inform your primary physician of your participation in the research study. If you agree, we will need you to give us the name of the primary physician to allow us to contact them.

☐ I do not have a Primary Physician
☐ You may contact my Primary Physician
☐ You may not contact my Primary Physician.

_____ _____
Participant's Initials Date

The purpose for this disclosure (release) or use is, for example, to assure compliance with the study protocol, to evaluate the effectiveness of the study, and/or to provide protection to you as a research study participant. The disclosure and use of your information will continue after your involvement in the study has ended. There is no expiration date for the use of your medical and billing records from the study. Any information about you disclosed to the parties identified above may be re-disclosed by them; however, such re-disclosure is not under the protections of this Consent and Authorization.

You will not be identified in any publication or other release of study results, data, and other information (such as in professional writings, at professional meetings, and in the study sponsor's product information, and/or advertising or other promotional materials).

If you decide to withdraw your authorization for the researchers to access and use your protected health information before the end of the study, you will be withdrawn from the research study. However, where the study relied on your Consent and Authorization for the time you participated in the study, your Consent and Authorization cannot be withdrawn, and the information already collected may still be used and disclosed as you previously authorized.

STOPPING STUDY PARTICIPATION

What if I decide to stop taking part in the study?

Taking part in this research study is completely voluntary. You may choose not to take part or to stop being in the study (withdraw) at any time without penalty or loss of benefits to which you are otherwise entitled, or without jeopardizing your medical care by your doctor at Beaumont. However, if you do not agree to sign this Consent and Authorization form, you will not be able to take part in this study.

If you decide to withdraw from the study you will need to notify the study doctor/clinician, in writing, of your decision to stop taking part in the study. This notice may be sent to Dr. Matthew Sims at William Beaumont Hospital – Research Institute, 3811 West 13 Mile Road/Suite 401, Royal Oak, MI 48073.

Your participation in this study may be stopped by the study doctor/clinician or study sponsor, without your consent, for any reason, which will be explained to you. Examples include:

- The study medication or procedures appear to be medically harmful to you.
- You fail to follow directions for participating in the study.
- It is discovered you do not meet the study requirements.
- The study is canceled.
- It is determined to be in your best interest (for example, your disease has progressed despite treatment).

As this is a placebo controlled or otherwise blinded study you may not review your research medical records during the course of the study, regardless of whether or not you continue in the study. If your study doctor/clinician stops your participation, or you decide not to continue, you may be asked to have a final study visit or examination, in order for you to be discontinued from the study in a safe and orderly manner. In addition, the type of treatment you are getting will not be able to be disclosed to you/your doctor until the study is completed.

CONTACTS

Who can answer my questions about the study?

You may talk to the study doctor/clinicians about any questions or concerns regarding your study participation, or you think you may have suffered a research-related injury. The doctor/clinician in charge of the study Dr. Sims may be reached at: 248-551-0027 to answer your questions. In an emergency after hours call 248-898-5000, ask the operator to page Dr. Sims or the physician covering him (24-hours). Your contact person is Marithel Sandoval-Yemmans, RN or Loni Lampkins CRC II. You may contact them at (248) 551-1556 or (248) 551-2151.

If you have questions regarding your rights as a research participant, or have problems, concerns, complaints, want information or would like to offer input, you may contact the Institutional Review Board Chairperson at (248) 551-0662. The Institutional Review Board is charged with the oversight of all human participant research conducted at Beaumont facilities.

STATEMENT OF VOLUNTARY PARTICIPATION

I have read the above, have asked questions and have received answers about this study to my satisfaction. I understand what I have read and willingly give my consent to participate in **SCREENING TO PROPHYLAX AGAINST *CLOSTRIDIUM DIFFICILE* INFECTION (StoP CDI).** I understand I will receive a signed copy of this document and will be promptly informed of any new findings regarding this study. I further authorize the use or disclosure of my health and personal information contained in records as described above.

_____
RESEARCH PARTICIPANT NAME (PLEASE PRINT)

_____ _____ _____
RESEARCH PARTICIPANT SIGNATURE DATE TIME

***WITNESS TO THE ENTIRE CONSENT PROCESS AND SIGNATURE ARE REQUIRED IF THE PARTICIPANT IS VISUALLY IMPAIRED, ILLITERATE OR NON-ENGLISH SPEAKING ONLY**

_____
WITNESS NAME (PLEASE PRINT)

_____ _____ _____
WITNESS SIGNATURE DATE TIME

AUTHORIZED CONSENT PROVIDER STATEMENT:

I have explained this study and have offered the study participant an opportunity for any further discussion or clarification.

_____ _____ _____
NAME (PLEASE PRINT) CREDENTIALS PHONE NUMBER

_____ _____ _____
SIGNATURE DATE TIME