RESEARCH SUBJECT INFORMATION CONSENT FORM
RANDOMIZATION PHASE

TITLE:	Multicenter Selective Lymphadenectomy Trial II (MSLT-II):A Phase III Multicenter Randomized Trial of Sentinel Lymphadenectomy and Complete Lymph Node Dissection versus Sentinel Lymphadenectomy Alone in Cutaneous Melanoma Patients with Molecular or Histopathological Evidence of Metastases in the Sentinel Node
PROTOCOL NO.:	MORD-LM/SL-CLND-1102 WIRB® Protocol #20050282
SPONSOR:	John Wayne Cancer Institute (JWCI) / National Cancer Institute (NCI)
INVESTIGATOR:	Richard Essner, MD 2200 Santa Monica Blvd. Santa Monica, California 90404 United States
SITE(S):	Providence Saint John's Health Center 2121 Santa Monica Boulevard Santa Monica, California 90404 United States
STUDY-RELATED PHONE NUMBER(S):	Richard Essner, MD (310) 829-8317 (24 hours)

NATURE OF THE STUDY

This is a research study. Research studies include only subjects who choose to take part. Please take your time to make your decision. This consent form may contain words that you do not understand. Please ask the study doctor or the study staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with your friends and family before making your decision.

You have been asked to volunteer for this research study because you have a form of cancer called melanoma, and your study doctor has found that cancer cells have spread to your lymph node(s). You might have already participated in the Screening Phase of this study.

The purpose of this consent form is to help you decide if you want to be in a research study.

PURPOSE OF THE STUDY

The overall purpose of the research is to find out if melanoma can be treated by removing only a few lymph nodes (called "sentinel nodes") from a lymph basin (called a "sentinel node dissection"), or if all lymph nodes in a lymph basin must be removed (called a "complete lymph node dissection"). That is what we will try to determine in this part of the study, the Random Assignment Phase.

We will compare subjects who receive sentinel node dissection only (but will be monitored through a test called ultrasound and through observation) with those who also receive a complete lymph node dissection. We will look at each group for ten years to see whether their melanoma spreads, whether they die from their melanoma, and other factors.

HOW MANY SUBJECTS WILL TAKE PART IN THE RANDOMIZATION PART OF THE STUDY?

About 1925 subjects will be participating in this phase of the study. At our site, we plan to enroll about 700 subjects.

PROCEDURES

If you agree to be a part of this study, you will be "randomly assigned" into one of two study treatment groups. The first group receives a complete lymph node dissection. The second group receives regular ultrasound tests of their lymph node basin and are followed by observation. Random assignment means that you are put into a group by chance. It is like flipping a coin, but it is done using a computer. Neither you nor the study doctor will be able to choose which study group you will be in. You will have an equal chance of being placed in either study group.

If you agree to take part in this study, the following procedures will be done as a part of the study:

Chest x-ray or a computerized tomography (CT) of the chest. A CT scan is a test that produces a picture of your body using radiation. You do not need one if you have had a chest x-ray in the last 60 days, or a CT of the chest in the last 90 days. This will help us be sure that your cancer has not spread.

You must have a complete medical history and physical exam if you have not had one within the past 60 days. If you took part in the Screening Phase, you only need a physical exam.

You must complete a Quality of Life Questionnaire (QOL) and a Medical Outcomes Study (MOS).

Your blood will be drawn. About 3 tablespoons, of blood will be drawn. This blood will be used to examine substances in your blood (antibodies, protein, and DNA [the chemical that makes up genes]) that may help us improve the way we detect cancer.

Node(s) removed during your lymph node discessction as well as your melanoma biopsy will be sent to the University of California, Los Angeles (UCLA) for further examination under a microscope.

You will be randomly assigned to one of the two study treatment groups.

1) You may be assigned to receive a complete lymph node dissection. If so, you will see your study doctor every four months for two years after assignment. Then it will be every six months for the next three years. Then it will be once a year for five more years. You will have a physical exam each time you see your study doctor. You will fill out a QOL and MOS 4 months and 12 months after your assignment and then annually thereafter until the end of the fifth year. You will also fill it out if your melanoma comes back, and three months after that. You will have radiology tests (x-rays, CTs, MRIs [use of a magnetic field to produce an image]) and blood tests for safety according to your study doctor's standard of care. You will also have blood drawn for research purposes at each visit.
2) You may be assigned to observation. If so, you will have all of the procedures noted above. Additionally, you will have a nodal ultrasound at every visit until the end of your fifth year.

Optional Storage of Blood, Tissue Samples and Medical Information:

The John Wayne Cancer Institute (JWCI) at Providence Saint John's Health Center would like to keep some of your excess blood or tissue and medical information. It is not needed for your care, nor is it needed for purposes of this research study. The blood or tissue would otherwise be discarded or disposed of. It may be used for additional future research studies involving melanoma or related to melanoma. If you agree, John Wayne Cancer Institute at Providence Saint John's Health Center will keep these samples in a specimen bank. The medical information will be kept in a database. John Wayne Cancer Institute at Providence Saint John's Health Center will be in charge of making sure your samples and any personal information are protected and kept confidential. John Wayne Cancer Institute at Providence Saint John's Health Center will give your samples a code to keep your identity private. The Western Institutional Review Board must approve the use of these samples and medical information for any future research. The research that may be done with your blood or tissue or medical information probably will not help you, and reports about research done with your blood or tissue or medical information will not be given to you or your study doctor. The research will not have an effect on your care, but may help others who have cancer or other diseases in the future. You will be asked in the Consent Section of this form to choose whether you will participate in this optional blood, tissue and medical information bank.

HOW LONG WILL I BE IN THE STUDY?

You will be in the Randomization Phase of the study for ten years.

RISKS AND DISCOMFORTS

While on the study, you are at risk for the following side effects. You should discuss these with the researcher and/or your regular doctor. There also may be other side effects that we cannot predict.

The nodal ultrasound has no known risks or side effects except occasional minor discomfort from pressure on the skin of the nodal basin during use of the ultrasound probe.

The complete node dissection may have risks and side effects. These include side effects immediately following the surgical procedure such as:

1. infection,
2. bleeding,
3. pain and discomfort at the site of surgical excision.

Side effects, other than at the surgery site might include:

1. pneumonia,
2. heart attack,
3. blood clots traveling to the lungs, which could lead to a longer stay in the hospital and rarely death.

Long term side effects consist of swelling or lymphedema of the legs or arm when the surgery involves the groin or the armpit.

The blood testing may have risks and side effects. These include:

1. Tenderness, pain, or bruising at the needle puncture of a vein site.
2. Rarely, infection, lightheadedness, or fainting.

There are risks associated with a loss of confidentiality of your health information and genetic and serum tumor marker testing results. The sponsor cannot be certain that your genetic test results could never be linked to you.

In addition, there may be other risks that are currently unknown.

Women who are pregnant or nursing a child may not take part in this study. Before entering the study, you and your study doctor must agree on the method of birth control you will use during the entire study. If you think that you have gotten pregnant during the study, you must tell your study doctor immediately. Pregnant women will be taken out of the study.

NEW INFORMATION

During the course of the study, we may find more information that could be important to you. This includes information that, once learned, may cause you to change your mind about continuing participation in this study. We will notify you as soon as possible if any information becomes available that might change your decision to be in this study. You may be asked to sign a revised consent form if this occurs.

BENEFITS

If you agree to take part in this study, there may or may not be direct medical benefit to you. The information learned from this study may benefit other patients with melanoma in the future. The

possible benefits of taking part in this study are the same as receiving a complete lymph node dissection without being in the study.

COSTS

You and your insurance company will be billed for the costs of procedures involved that are a part of standard care for a patient with melanoma, including surgery, the lymphatic mapping, and the pathologic examination of tissues. Your health insurance company may or may not pay for these charges.

There will not be a charge associated with investigational blood testing that is research-related.

Ask your study doctor to discuss the costs that will or will not be covered by the sponsor. This discussion should include the costs of treating possible side effects. Otherwise, you might have unexpected expenses from being in this study.

PAYMENT FOR PARTICIPATION

You will not be paid for your participation in this study

ALTERNATIVE TREATMENT

You do not have to participate in this study to receive treatment for your melanoma.

You may have a complete lymph node dissection even if you do not take part in the study. Please talk to your regular doctor about this and other options. Take the opportunity to ask questions.

CONFIDENTIALITY

Information from this study will be given to the sponsor. "Sponsor" includes any persons or companies which are contracted by the sponsor to have access to the research information during and after the study.

The information will also be given to the U.S. Food and Drug Administration (FDA). It may be given to governmental agencies in other countries. Medical records which identify you and the consent form signed by you will be looked at and/or copied for research or regulatory purposes by:

- the sponsor;

and may be looked at and/or copied for research or regulatory purposes by:

- the FDA;
- Department of Health and Human Services (DHHS) agencies;
- governmental agencies in other countries; and
- the Western Institutional Review Board® (WIRB®).

Absolute confidentiality cannot be guaranteed because of the need to give information to these parties. The results of this research study may be presented at meetings or in publications. Your identity will not be disclosed in those presentations.

COMPENSATION FOR INJURY

If you are injured as a result of research procedures, you will receive medical treatment at no cost. A research-related injury is any physical injury or illness caused by your participation in the study. Payments for such things as lost wages, expenses other than medical care, or pain and suffering is not routinely available. By signing this consent form, you will not give up any legal rights.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in this study is voluntary. You may decide not to participate or you may leave the study at any time for any reason. Your decision will not result in any penalty or loss of benefits to which you are entitled.

If you decide to stop participating in the study, we encourage you to talk to the study doctor and your regular doctor first.

The study doctor or the sponsor may stop your participation at any time without your consent. You may be asked to leave this study for several different reasons:

- If it is in your best interest.
- If your study doctor feels that staying in this study is harmful for you.
- If you don't keep appointments or follow study procedures.
- If the study sponsor or the U.S. Food and Drug Administration (FDA) decides to stop or cancel this study
- If you become pregnant, intend to become pregnant or are nursing a child during this study.
- You do not later consent to any future changes that may be made in the study plan.
- For any other reason.

SOURCE OF FUNDING FOR THE STUDY

The sponsor of the study, John Wayne Cancer Institute (JWCI), receives funding from the National Institutes of Health (NIH) for this study. Additionally, the study doctor will be compensated by the sponsor for procedures performed as a direct result of your participation in the study.

DISCLOSURE STATEMENT DUAL ROLE AS RESEARCHER/PHYSICIAN

Your health care provider may be a study doctor of this research study, and as a study doctor, is interested in both your clinical welfare and in the conduct of this study. Before entering this study or at any time during the research, you may ask for a second opinion about your care from another doctor who is in no way associated with this study. You are not under any obligation to participate in any research study offered by your doctor.

QUESTIONS

Contact Richard Essner, MD at (310) 829-8317 (24 hours) for any of the following reasons:

- if you have any questions about this study or your part in it,
- if you feel you have had a research-related injury, or
- if you have questions, concerns or complaints about the research.

If you have questions about your rights as a research subject or if you have questions, concerns or complaints about the research, you may contact:

Western Institutional Review Board® (WIRB®)
1019 39th Avenue SE Suite 120
Puyallup, Washington 98374-2115
Telephone: 1-800-562-4789 or 360-252-2500
E-mail: Help@wirb.com.

WIRB is a group of people who independently review research.

WIRB will not be able to answer some types of questions, such as questions about appointment times. You may contact WIRB if you cannot reach the research team or if you want to talk to someone else.

Do not sign this consent form unless you have had a chance to ask questions and have gotten satisfactory answers.

If you agree to be in this study, you will receive a copy of this signed and dated consent form as well as a copy of the "Experimental Subject's Bill of Rights".

CONSENT

I have read the information in this consent form (or it has been read to me).

I have had time and opportunity to ask any questions that I have about the study and this consent form, and all my questions have been answered. I agree to take part in this study.

Blood, Tissue and Health Information Bank
I have been told that I do not have to allow storage or future use of my blood, tissue or medical information to be a part of this study. My choices will not affect my medical care. My choices about having my blood samples, tissues samples and health information used in future studies are marked below:

Please read each sentence below and think about your choice. After reading each sentence, sign your initials next to "Yes" or "No". No matter what you decide to do, it will not affect your medical care. If you decide not to allow storage or future use of your blood or tissue or medical information, you can still be a part of this study.

1. Samples of my blood may be kept for future use in research to learn about, prevent, treat, or cure melanoma or conditions related to melanoma.

   _____Yes

   _____No

2. My left over tissue may be kept for future research about melanoma or conditions related to melanoma.

   _____Yes

   _____No

3. My medical information may be reviewed and followed to track my health status.

   _____Yes

   _____No

By signing this consent form, I have not given up any of my legal rights.

(Please date your own signature at the time of signing)

_____
Printed Subject Name

_____ _____
Signature of Subject Date

_____
Printed Name of Person Conducting Informed Consent Discussion

_____ _____
Signature of Person Conducting Informed Consent Discussion Date

_____
Printed Name of Investigator

_____ _____
Signature of Investigator Date
(if different from above)

---------- **Use the following only if applicable** ----------

If this consent form is read to the subject because the subject is unable to read the form, an impartial witness not affiliated with the research or investigator must be present for the consent and sign the following statement:

I confirm that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the subject. The subject freely consented to be in the research study.

_____
Printed Name of Impartial Witness

_____ _____
Signature of Impartial Witness Date

Note: This signature block cannot be used for translations into another language. A translated consent form is necessary for enrolling subjects who do not speak English.

CONFIDENTIALITY AND AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

Your study doctor will try to keep your personal information confidential, but he/she cannot guarantee absolute confidentiality. This section provides information on how your personal information will be used and disclosed if you take part in this study. If you choose to sign this consent form, you will authorize these uses and disclosures of your information. If you choose not to give your authorization, you will not be able to participate in the study.

Medical Information that will be Created if You Take Part in the Study

The medical information that will be collected from you if you take part in the study includes the following:

- Your medical history, including information contained in your medical records related to your treatment for melanoma;
- Information obtained from the screening tests and scans that are performed to determine whether you are eligible to be in the study;
- Information obtained during the course of the study as you receive study treatment (including photographs and the results of any tests or scans performed);

- Follow-up information on your medical condition that the study staff may ask you for after the study is completed.

This medical information may identify you by name, address, telephone number, social security number, health plan number, study number, medical record number, date of birth, dates of various medical procedures, or other identifying information.

Use and Disclosure of Your Medical Information

If you sign this consent form, your study doctor will be authorized to use the information described above to carry out the research purposes of the study. Your study doctor will also be authorized to disclose the information described above to the following entities involved in the study:

- John Wayne Cancer Institute at Providence Saint John's Health Center research staff or agent
- Staff or agents of the sponsor
- The U.S. Food and Drug Administration (FDA)
- U.S. National Cancer Institute (NCI)
- The National Institutes of Health (NIH)
- Governmental agencies in other countries
- Western Institutional Review Board® (WIRB®)

Your personal information may also be released to another entity if required by law.

Once your information is disclosed to the entities described above, there is a potential that your information may be re-disclosed and will no longer be protected by federal privacy regulations. The laws of your state may provide further protection. You will not be identified by name in any research reports or publications resulting from this study.

Your Right to Inspect and/or Copy Your Medical information

Once the study is completed, you have a right to inspect and/or obtain a copy of the medical information that was created during your participation in the study and is held by your study doctor. The study will be complete when the data collected from the entire study has been analyzed and the results of the entire study have been submitted to the regulatory authorities, such as the FDA, or made publicly available. While the research is in progress, your access to your medical information will be temporarily suspended. You will be able to access this information by contacting your study doctor as soon as the research is completed.

Term of Your Authorization

This permission will be good until December 31, 2050. If you sign this consent form, you authorize the use and disclosure of your information for the purpose of the research study at any time in the future.

Revoking Your Authorization

You may revoke your authorization at any time by sending a written request to Richard Essner, MD at 2200 Santa Monica Boulevard, Santa Monica, CA 90404. If you revoke your authorization, your study doctor will stop collecting information from you, and will stop using and disclosing your information for the purposes of the research study. If you have already begun taking part in the study, however, some medical information about you may have already been used or disclosed as described above. You will not be able to revoke your authorization as to information that the study personnel have already gathered for purposes of the research study. For example, your study doctor may need to continue using or disclosing information obtained before you revoked your authorization in order to preserve the scientific integrity of the study.

Authorization:

I have been given the information about the use and disclosure of my health information for this research study. My questions have been answered.

I authorize the use and disclosure of my health information to the parties listed in the authorization section of this consent for the purposes described above.

_____
Printed Name of Subject

_____ _____
Signature of Subject Date

_____
Printed Name of Person Conducting
Informed Consent Discussion

Signature of Person Conducting Informed Consent Discussion

Date

Printed Name of Investigator

Signature of Investigator (if different from above)

Date

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment, or who is requested to consent on behalf of another, has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be used.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs, or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or other procedures involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time, and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of a signed and dated written consent form when one is required.

10. 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.

Signature of Subject	Date
Signature of Witness	Date