IDENTIFYING CASES – some examples

NEW PRESENTATION

A new patient is admitted on January 1, 2012 under the general medical team with exacerbation of late onset asthma, acute renal impairment and mononeuritis multiplex and you are asked to review them that day on the ward or in clinic. The baseline form should be completed when you have a working diagnosis. The follow up form should be completed six months later (i.e. in June 2012.)

ESTABLISHED DIAGNOSIS

You have been referred a patient from the renal team for help with on-going management of immunosuppression therapy. The patient's diagnosis was first conclusively made by the renal team on March 1, 2011 and you review the case 12 months later on March 1, 2012. The CRF should be completed retrospectively using only relevant information collected up to the time of diagnosis (March 1, 2011). The six month follow up form should also be completed retrospectively using only information present up to September 1, 2011. For all subjects who are enrolled retrospectively, the investigator enrolling the patient to the trial must be reasonably satisfied that they have all relevant, correct and complete results, either from their own or the referring physician's records.

REFERRAL – outside 2 years

You have been referred a patient from another rheumatology colleague for a second opinion on management of on-going disease activity. The patient's diagnosis of GPA (Wegener's) was first conclusively made by your colleague on January 1, 2009 and you review them three years later on January 1, 2012. You have comprehensive medical records from the time of diagnosis. This patient is not eligible for enrolment into DCVAS.

CONSULTEE CONSENT

You are asked to review a new patient with MPA who is intubated on ITU with rapid progressive renal and lung involvement. The patient does not have the capacity to consent to participate in the study. After discussion with the admitting physician, you approach the patient's next of kin who gives consent on behalf of the patient on 1 March 2012 on the consultee consent form. You make arrangements to follow up the patient 6 months later on 1 September 2012. Unfortunately, the patient died on 3 April 2012. The date and cause of death is recorded in the follow up CRF.