

## FAQ – Identifying and enrolling participants

### WHO IS ELIGIBLE - CASES?

#### – Patients with a new diagnosis of primary systemic vasculitis

**Patients suitable as cases** are over 18 years with a new presentation or an established diagnosis of:

1. Granulomatosis with polyangiitis (GPA) (formally Wegener's granulomatosis)
2. Microscopic polyangiitis (MPA)
3. Churg Strauss syndrome (CSS)
4. Polyarteritis nodosa (PAN)
5. Giant cell arteritis (GCA)
6. Takayasu arteritis (TAK)
7. Other less common vasculitis:  
Behcet's disease; cryoglobulinaemic vasculitis; Henoch-Schonelin purpura; isolated aortitis; primary cerebral vasculitis; single organ vasculitis; other small and large vessel vasculitis

### WHO IS ELIGIBLE – COMPARATOR GROUP?

#### – Patients with disease which mimics vasculitis

**Patients suitable for the comparator group** include patients presenting to secondary care with one of the following clinical presentations (for a full list please see page 26 of the CRF):

- Multi-system disease. Presentation of disease with at least 2 organs involved.
- Auto inflammatory Syndromes
- Pulmonary-renal syndrome. Defined as haemoptysis/pulmonary haemorrhage with acute renal impairment.
- Systemic lupus erythematosus
- Mixed Connective Tissue Disease/ Dermatomyositis
- Acute renal failure/ Acute Tubular Necrosis.
- Acute respiratory distress
- Chronic upper airways symptoms and signs and nasopharyngeal tumours
- Fever of unknown origin, raised inflammatory markers or unexplained weight loss.
- New onset hypertension
- New onset headache
- Jaw or tongue pain
- Sudden visual loss
- Limb claudication
- Aortic aneurysm
- Stroke
- Peripheral neuropathy (sensory or motor)
- Referred to secondary care with suspicion of vasculitis but confirmed not to have vasculitis.
- Infective Endocarditis
- Lymphoid malignancies e.g. Hodgkin's and Non-Hodgkin's lymphomas, Chronic Lymphocytic Leukaemia, Multiple Myeloma.

## Are patients with secondary vasculitis eligible?

Patients can be recruited to the study if there is vasculitis which is not thought to be primary vasculitis but secondary to another underlying cause.

*e.g. you may enrol a patient known to have RA for 10 years who develops vasculitis leg ulcers. Tick the secondary vasculitis box, then RA under section C.*

## What are some of the methods of IDENTIFYING PARTICIPANTS?

- Referrals from other specialties, e.g. renal, respiratory, neurology, ENT, ophthalmology
- Engage nurse specialists and junior doctors
- Use posters to advertise in other departments
- Attend multidisciplinary team meetings
- Use flyers on front of notes of potentially eligible patients to alert practitioners
- Talking at medical grand rounds and meetings
- Talking at vasculitis support groups
- Discuss participation with a relative/consultee where patients are incapacitated

## Should we keep a SCREENING LOG at our site?

We expect that sites will keep a screening log, but please follow local procedure. A template is available on the website. We do not require return of information recorded on screening logs as these are for site use only. They may however, be useful when returning the accrual reports.

## What is the format for the SCREENING ID?

The screening ID is for your local use. The screening ID is entered on the CRF, but is for local reference and not used to identify data. Please feel free to use the format you wish to identify patients screened. The local screening ID is usually allocated when screening patients. Not all patients screened will be eligible for the study. For instance, you may have a list of 10 patients screened with your local screen ID, but only 8 of them come into the study and only 8 are allocated a study patient ID in the form GBNORL0001.

## Should the patient ATTEND BASELINE and FOLLOW UP VISITS?

The baseline CRF form is completed by the investigator, the patient should be asked if they have or have not had each of the symptoms listed in the CRF in the lead up to diagnosis. Clinical judgement is needed; pre-existing symptoms related to co-morbidities, for example, long standing lower back pain, should not be included. The study investigator will also record information from the patient records including clinical signs, and results of investigations such as blood tests, and microbiology, radiology and pathology results where applicable.

At follow up, data can be recorded from patient records and patients can be interviewed on the telephone if the clinician is satisfied the data is reliable and complete.

### What is the difference between the SCREENING DATE, the VISIT DATE and the ASSESSMENT DATE?

**The screening date is the date that you assess a patient's eligibility for the study.** This may be the same day that they are enrolled (give consent) or it may be earlier.

**The visit date is the study entry date.** This is the date you take informed consent, interview the patient and complete the baseline CRF.

The first visit date may be up to a maximum of two years after the date of diagnosis when collecting data retrospectively.

**The assessment date is the date your team first sees the patient for clinical assessment.** This may be before the screening and visit date.

### When should I record the BASELINE DATA?

The baseline data always refers to all relevant information from onset of symptoms up to the time of diagnosis.

The date of onset of symptoms may be some months before diagnosis and some time before first presentation.

*e.g. you may enrol a patient with a date of diagnosis two years ago, but the onset of symptoms arose earlier than this – they are still eligible as long as diagnosis was first made within two years.*

### When should I record the FOLLOW UP DATA?

Data should be recorded for **the time point closest to 6 months post diagnosis** (but not less than 2 weeks earlier). The date of follow up however, may be up to 8 or 9 months and can be flexible to fit in with varying healthcare systems and schedules.

### What is the TIME PERIOD for ELIGIBILITY?

**The date of diagnosis must not be greater than two years prior to the date the patient consents to participate in the study.** Patients can, however, have had symptoms for greater than 2 years.

*e.g. a patient would not be eligible if they were screened on 1<sup>st</sup> June 2012 and the date of diagnosis of vasculitis was on 1<sup>st</sup> March 2010. This is 3 months outside the two year time frame.*

On page 5 of the CRF you will be asked “Is this the first presentation for this illness” The answer to this question is always “Yes” because the data collected for this study relates to the **first presentation of vasculitis** and not a recurrent illness or flare.

### **When should I record the DATA POINTS for patients recruited retrospectively?**

**This will be identical to the time points used for patients with a new presentation.**

The baseline data will refer to all relevant information up to the time of diagnosis and follow up would be calculated from the time point closest to 6 months post diagnosis.

*e.g. A patient is enrolled in the study on 1 March 2012. A diagnosis of GPA was made on 1 January 2012. The baseline data is recorded with all relevant information up until 1 January 2012 and the follow up data would be recorded on 1 July 2012 or the nearest date post this where diagnosis has been confirmed.*

### **Can I complete the follow up data at the same time as I collect the baseline data?**

If a participant has had a diagnosis for 6 months or more, it is possible to collect data for both the baseline and follow up sections of the CRF at the same time.

*e.g. A patient with biopsy proven Giant Cell Arteritis(GCA) diagnosed in January 2011 is recruited to DCVAS at a routine clinic visit in September 2011. This patient has had a diagnosis for 8 months. It is possible then to have accurate and complete information for both the baseline and follow up visits which can be recorded at the same time.*

### **What should I record if the exact date is unknown?**

Please use dashes to indicate an unknown day of the month.

e.g. --/Jan/2012. Or --/--/2011.

## FAQ – Recording the VDI

### When is the VDI recorded? (see page 32 CRF)

The VDI is completed with reference to the date of diagnosis (i.e. 6 months post diagnosis). When completing for the retrospective patients this remains the same (e.g. diagnosis 30 June 2011 – VDI based on 30 Dec 2011). However, VDI would be completed with reference to patient's notes and items only recorded on the VDI form if they were present for 3 months or more at the time of follow up.

### Should I record VDI for patients in the comparative group?

VDI is a validated tool to collect clinical information about damage in vasculitis patients. It has never been validated as a research tool for collecting damage information on other groups of patients/ comparators. The DCVAS research study gives a unique opportunity to collect damage information within the existing research design and to begin to assess if the VDI tool may have a wider application.

**We therefore request that the VDI form be completed on all participants in DCVAS.**

Apply the same rules as patients with vasculitis, - symptoms which have been present and have lasted 3 months or more since diagnosis of the comparator disease can be included as "damage" at the six month follow up.

### What ITEMS should I record on the VDI form?

*Example 1:* In January 2011 a patient presented with a six week history of mouth and genital ulceration and a diagnosis of Behcet's disease is made by the rheumatologist. He was recruited onto the DCVAS study in early March 2012, where the symptoms of genital and mouth ulceration are recorded at baseline. His 6 month follow up is calculated as July 2012. When completing the VDI, it is necessary to ask about presence and duration of symptoms recorded at the first visit. The mouth ulcers persisted for 5 months until the end of May 2012 and count as damage, but the genital ulcers healed within 9 weeks and as such do not count as damage.

*Example 2:* A patient was referred by her GP to the renal team for urgent assessment, with high blood pressure, fever, blood and protein in the urine and a creatinine of 400umol/litre. She had a renal biopsy which showed a focal segmental necrotizing glomerulonephritis with multiple crescents. She was commenced on plasma exchange and immunosuppression. She was recruited to DCVAS study while on the renal ward for this first presentation. All of the presenting symptoms were recorded. Her six month follow up is due, and discussion should take place regarding all of the initial symptoms. She has made a good recovery, with no fever, blood or protein in the urine. Her most recent creatinine is 180umol per litre. Her blood pressure is well controlled on antihypertensive medication. Only the blood pressure counts for VDI as none of the other symptoms lasted longer than 3 months. *Note: even though her creatinine is elevated, it does not represent a) GFR<50%; b) proteinuria > 0.5g/24hrs; or c) end stage disease.*

*Example 3 (comparator patient):* An 82 year old man develops a hospital acquired infection during an inpatient stay for excision of a meningioma in January 2011. He is treated with Nitrofurantoin. He is reviewed by the respiratory team in May 2011 for a dry cough and severe shortness of breath on exertion. A chest x ray at this time is suggestive of an interstitial lung disease. He has doves and pigeons around his home and regularly uses compost. Immunological antibody tests show a weak positive p -ANCA and MPO. He is recruited to the DCVAS trial as a control as vasculitis was a possibility in the differential disease. At his 6 month follow up in November 2011, he has a CT scan which shows a resolving organising pneumonia thought to be secondary to Nitrofurantoin. He has no cough but remains breathless on exertion, with abnormal lung function tests.

To complete VDI for this patient consider his presenting symptoms of shortness of breath and cough, abnormal lung function and their duration. The cough has gone and lasted 2 months, but the shortness of breath is present 6 months later. Score chronic breathlessness and abnormal lung function.

## **When should the stroke CRF be completed?**

The Stroke CRF should be completed when a patient presents with stroke or TIA. The electronic version will automatically open up the Stroke CRF when *item 18. Stroke* is selected on page 2 of the CRF or *transient ischemic attack (TIA)* or *cerebrovascular accident* are selected on page 16 (Section 10 neurology).

## **Should I also record other clinical information in the main CRF?**

The main CRF should be completed as usual for patients presenting with stroke. There will be items of relevance to stroke in both CRFs. For example cardio embolism may be recorded in the other section of the cardiovascular section of the main CRF.

## **How should I record information when a patient has more than one event?**

In a patient with several different TIAs please define the main event as follows:

1. The event that was associated with the most severe neurological deficit;
2. The event (even if transient) associated with documented brain lesion;
3. If events are of equal severity and no brain lesion is present the investigator should choose the most recent event (closest to visit 1).

## **How should I calculate the inpatient stay in the stroke management section?**

Where patients have had several TIAs and strokes and different admissions, inpatient length of stay should reflect the total length of stay due to stroke (for instance a patient may have to be readmitted to complete endovascular treatments, etc.). Only record hospital admissions and not admission to a rehabilitation unit.