DiSCHARGE

Diagnostic Imaging Strategies for Patients with Stable Chest Pain and Intermediate Risk of Coronary Artery Disease: Comparative Effectiveness Research of Existing Technologies

Annual Meeting 2015

Friday, 13. February 2015, 08:30 – 12:40h

Participants:

P01: Marc Dewey (MD) (Coordinator), Adriane Napp (AN) (Project Manager),Robert Haase, Michael Laule, Jacqueline Müller-Nordhorn (JMN) (WP Leader), Nina Rieckmann (NR), Olaf Bender, Felix Frömel (FF), Corinna Meier-Windhorst (CMW), Florian Specht, Anja Bärrn, Lisa Timm, Paolo Ibes, Simon Drees, Sascha Priem, Viktoria Wieske, Christoph Katzer (CKa), Denise Sengül,
P02: Fabian Plank
P04: Vojtech Suchanek (VS) (PI CT), Cyril Stechvosky
P05: Klaus Kofoed (KK)(PI CT - WP Leader), Kirsten Thrysoe
P06: -
P07: -
P08: Pál Maurovich-Horvath (PMH)(PI CT), Mihaly Karoly , Csilla Celeng
P09: Peter Ball (PB)(PI CT), Michele Crawford Jefferson
P10: Jonathan Dodd (JD) (PI CT), Siobhan Quinlan, Ali Abdi
P11: Gildo Matta (GM), Maurizio Porcu (PI ICA)
P12: Marco Francone (MF) (PI CT), Iacopo Carbone
P13: Ligita Zvaigzne (LZ)(PI CT), Marina Berzina
P14: Gintare Sakalyte (GS) (PI ICA), Antanas Jankauskas (AJ) (PI CT)
P15: Ewa Zdunczyk
P16: Rita Faria
P17: Teodora Benedek (TB) (PI CT), Sebastian Condrea
P18: Nada Čemerlić Adjić (NCA) (PI ICA), Milovan Petrovic, Tatjana Miljkovic
P19: Jose Rodriguez Palomares (JRP) (PI CT), Filipa Valente
P22: Christian Delles (CD)(PI CT), Colin Berry, Katriona Brooksbank
P23: Gershan Davis (GD)(PI CT/ICA), Erica Thwaite
P24: Christine Kubiak (CK)(WP Leader), Christoph Schumacher (CS), Anke Strenge-Hesse (ASH)
P25: Koos Geleijns (KG)(WP Leader)
P26: Iñaki Gutiérrez-Ibarluzea (IGI)(WP Leader), Gaizka Benguria
P27: Vladimir Rogalewicz (VR)(WP Leader), Ivana Juřičková, Vojtěch Kamenský
P28: Peter Schlattmann (PS)(WP Leader), Mario Walther
P29: Antti Saraste, Heli Ylikoski
P30: Cezary Kepka (PI CT)
P31: represented through P17
P32: Radosav Vidakovic
P33: Inigo Sans Ortega
Clincal Site interested in participating: Ladislav Pavic (Croatia)
EAB: Harold Sox (HS)
DSMB: Danilo Fliser, Tim Friede

Nr.	Issues	Outcomes	
5.	**Welcome back** (Marc Dewey)		
	GS: difficult to get all the reports of patients , especially in rural areas VS: which information is considered to be a sufficient proof of MACE	MD: MACE definitions will be sent to sites so physicians and research nurses will know which information is most relevant. Minor events are not that crucial, but we need to know if there were myo-cardiac infarction, stroke, or cardiovascular death. Result documents are needed e.g. blood sample results, ECGs, CT and/or MRI of written reports for The Clinical Events Committee to identify MACE MD: Written in MACE definitions. No further imaging test is needed if e.g. stroke is symptomatic, but need to be assessed by physicians. Statement of family members are not sufficient. Asymptomatic stroke does not count.	
	ASH: Does the patient receive a document that he/she is part of a study? Maybe a small information that could be carried in wallet, e.g. in credit card format? Could contain information about web page and EU funding HS: Should contain information about patient's informed consent.	MD: a template of a credit card will be drafted and sent to sites, general information would include reference to DISCHARGE web page and EU funding. Additional information supplied by sites could be: Name of local site, local telephone number and contact data (e-mail address). Probably no patient name on card since it would be too expensive to personalise all cards. MD: Yes → This patient has provided informed consent that his/her physician is permitted to send clinical event data to local PI. Credit card printing should be done locally with local contact information.	
6.1	**Common Errors in Cardiac CT and how to avoid** (Anja Bärrn)		
	GM?: Concerning noisy images → no cut off of in scanner specific protocols (SSP), not possible to exclude patients with a high BMI Concerning iterative reconstruction (IR) → mandatory to send?	AB: according to 10-step guide, send both reconstructions if possible , will be highly appreciated MD: good to do and use all possibilities you have, especially in patients with high BMI. Sites with the same scanner should have two: first one for sites *with* IR, second one for sites *without* IR. Send both reconstructions for the phases that were used for reading the case. Review SSP if it works for your site.	

	KK: For many research protocols the requirement in radiation dose are restricted, whereas in DISCHARGE there are no limits in order to obtain good image quality in patients with in high BMI and/or high heart rate in order to have no non-diagnostic images → higher doses should be reported to IRB?	KG: effective dose is defined for standard size patient, but not for obese patients. Should not be limited by any IRB MD: in case of any difficulties, MD will give support call High BMI not in SSP → could/should be added	
6.2	**Follow-up Strategies** (Viktoria Wieske)		
	KK: There will be patients lost at follow-up. There should be a part in the CRF to ensure that the sites can state the effort to get the patient.	VW: we are working on this question and should be a decision by end of next week MD: Open for proposals to this part and how to get track of the patients. Drop out should be similar in both groups. The with PS developed aim is a drop out of 5% annually VW: proposal from Charité → overall process for follow-up would be scheduled two month.	
	Q: Is there a follow-up routine? Should preferred way of contact be asked? In other studies patients were lost to follow-up, because they did not answer letters or e-mail. Could there be a phone call?	MD: procedure of follow-up not fixed, letter and e-mail are preferred as patients have to answer questionnaires. But phone calls should be an option as well. In local file the following data of the patient should be stored: name, address, e-mail address, telephone number of a)patient, b) at least one relative and c) two doctors (e.g. general practitioner and specialist)	
	HS: Follow-up is a good indicator whether to trust the study or not. FU should be monitored meticulously. What is the procedure? Will there be reminder e-mails in the eCRF? Completed cases important for authorship, not just high recruitment rate.	FF: not legal to save names or addresses in the eCRF due to GCP, therefore external data base is necessary. But system reminder/alerts could be set in the eCRF.	
6.2a)	**The eCRF: Practical Teaching** (Felix Frömel)		
	VR: It is not allowed at our hospital to enter real data like names and birthdays into the PC due to data safety issues.	FF: The data is needed to generate the patient identification form. Data will not be stored in any software or server. Question addresses general safety issues. There is a secured internet connection to the server protected by a firewall.	

		MD: This is for monitoring, no information will be saved on the computer. Patient is connected with an acronym. Charité has only the acronym, the connection to the patient has to be done by site by using the local source data.	
	MW: What happens when browser is accidently shut down?	FF: If information is not saved will be lost. If server connection is lost the current from open will be locked for an hour	
	JR: what happens if patient is randomised but not part of the trial because of drop out? Which forms have to be filled?	MD: Only screening log needs and result of ICA need to be filled.	
6.3	**Monitoring Strategies** (Corinna Meier-Windhorst)		
	TF: Stresses importance of low drop-out rate and low follow-up loss rate as well as source verification of MACE. These are essential; if there any doubts on the endpoint main result of the trial could be questioned. Maybe good to ensure a minimum standard. MD: is concerned about high error rate threshold for intensified monitoring	CMW: It is a flow process, it is possible to adapt thresholds, 25% error rate can be changed. DF: focus on primary outcomes in monitoring	
	TF: How is monitoring organised?	CK: ECRIN is European Clinical Infrastructure Network with resources in every country, it will organize coordination using the networks in the different countries. Usually there will be a monitor who is close to investigation site. Process of selecting the different monitors in the different countries is ongoing.	
	ASH: More visits at site should be considered.	CMW stated that four visits will be mandatory for each site. Most of the monitoring will be done remotely. If a higher frequency of mistakes is detected, the on-site monitoring will be intensified.	
	DF: Monitoring should also focus on MACE	Monitoring outcomes will be divided into different priority groups. MACE is in the highest priority and will be monitored 100%. Mistakes in the highest priority group will directly increase the site contact and the on-site monitoring. The 25% mistake border is not in place for the group of highest priority items.	
	GS: time window of two days for reporting is too short	CMW stated that the two days time window will be in place for every step of the visit plan, not for the whole patient. (e.g. eCRFs for the CT/ICA	

		examination need to be completely entered two days after the examination.)	
	CB: Process of communication of AE and SAE	AEs need to be reported in the eCRF. SAEs need to be reported within 48 hours after the time point the site knows about the event. The reporting needs to be done in the eCRF and additionally via FAX to the KKS.	
	JD: Timeframe from communication of monitoring visit to the visit	The monitors will contact the site and discuss about the next date. The frame from the notification to the visit can be 2-4 weeks.	
6.4	**Dissemination Policy** (Jonathan Dodd)		
	CK: Is the Dissemination Committee (DC) in charge of giving access to the raw anonymised data after end of the study?	MD: DC with the overview of all planned analyses would be the best to address this question. JD: refers to the Dissemination Policy draft	
	KK: DISCHARGE should be registered at clinicaltrial.gov, otherwise the New England Journal of Medicine will reject it.	MD: Registration is in progress, delays are expected due to amount of secondary outcomes, which should be entered prospectively.	
	HS: Are there requirements for data sharing imposed by the European Union?	AN: Since DISCHARGE is funded by public money, there is a right for the public to have the data available. It is also mandatory to share the data to use ECRIN. MD: Data will be released at an appropriate time, but only the data that is necessary at this time in order not to avoid the opportunity to publish any secondary outcomes. CK: This is important to ensure quality and transparency	
	HS: Is it planned to post the complete study protocol and revisions on the webpage?	MD: The study protocol will be on clinicaltrials.gov with the main method paper as well as several additional method papers, e.g. on CT. If a journal requests, data it will be released for the reviewers, but it is the current opinion of the DC not to not to provide complete data with IPD data with the publication on the website. The person who agreed to write a paper should take responsibility, which will be taken away after six month if no progress has been made.	
		MD: DC discussed organisation of authorship on secondary and tertiary outcomes.	

		→ A person having an idea will be connected to the proposal in the secondary outcome paper and should be responsible for the proposed paper. → Tertiary outcomes will give the clinical sites the opportunity to present results in an oral or poster presentations on a national level, e. g. at national conferences. It will not be allowed to publish the material on websites or in journals before all secondary outcomes affected. The presentation should not be in an item from the secondary outcomes in order not to obstruct the entire path of publishing for that outcome. There will be a two week deadline to inform the DC before submission deadline for an abstract.	
	HS: Journals do not want to publish what is in the headlines of national papers. Recommendation would be not to talk to reporters.	MD: It will be a part of the dissemination policy that talking to reporters is forbidden unless the DC and coordinator know about the effort and until after the main paper is published.	
6.5	**Finances: Update** (Adriane Napp)		
	No further questions		
6.5a)	**Committees** (Marc Dewey)		
		MD: Antanas Jankauskas was added to the DC by the Consortium, already approved by the Steering Committee (SC). Matthias Gutberlet and Ligita Zvaigne were added as regional site representatives to the SC by the Consortium.	
6.6	**Image Data Upload to Core-Lab: Practical Training** (Alissa Neill, AG Mednet)		
	KK: Will a firewall be a problem?	AMN: The AG Mednet IT department can contact local IT department and a solution will be found.	
	DO: Is a special software needed to run the program?	AMN: Java 8 is supported, below that there is a little reduced functionality; with an Internet Explorer 9 and lower. Macs are no problem.	
		AN: There will be some online training provided by AG Mednet. Groups have to be formed	

		AMN: There are different kinds of training like centre training and trial admin training which can be used with account access data. Slides will be provided as well. AG Mednet can be contacted any time as there is a 24/7 support.	
	MD: What is the process of storing program? Can it be stored directly in CT and/or MR scanner? In the cathlab? Has DICOM to be put on a CD first?	AMN: Wherever desktop agent lives would be a great spot. MD: It might be difficult to store program directly on the imaging machines since these are very well protected. The advantage of having images on CD is the second back up in addition to the local RIS/PACS and allows easy source data verification.	
7.	**Farewell and Announcement of Meeting Date and Place 2016**		
	<u>The next annual meeting will take place from February 17 – 19, 2016</u> <u>At the site with the highest and cleanest recruitment in DISCHARGE</u>		