An ICU Sedation Study

https://www.ed.ac.uk/usher/edinburgh-clinical-trials/our-studies/ukcrc-studies/a2b

@A2BTrial

FAQs – May 2019

Q: Are patients that use nocturnal CPAP for obstructive sleep apnoea eligible for the Trial (Exclusion 7 Home ventilation)? A: Yes, the use of nocturnal CPAP for obstructive sleep apnoea is not an exclusion

Q: What happens if the patient has been discharged from the Trial ICU, but is readmitted within 48 hours of extubation – should they be re-started on the intervention?

A: Yes, you should be collecting data on the patient for 48 hours after extubation anyway, so if they are re-admitted to the Trial ICU and re-intubated, then the intervention should be re-started, just as if they had never left the ICU.

Q: Can we recruit a patient who has been readmitted to the ICU and if we do, when does their time of ICU mechanical ventilation start?

A: You can recruit a patient who has been re-admitted to the ICU provided they haven't previously been enrolled on the A2B Trial (exclusion 17). The start of their ICU ventilation will relate to the new ICU admission, so the previous ICU mechanical ventilation can be disregarded.

Q: Can we use our own unit guidance for weaning clonidine or dexmedetomidine for patients on the Trial?

A: Although there is some general advice about weaning on the Trial flowcharts, as long as your unit guidance doesn't contradict this, you can use your own unit's weaning guidance e.g. provided it doesn't delay extubation. Remember clonidine and dexmedetomidine are relatively free from respiratory depressive effects, so can be safely continued post-extubation.

Q: Where can I find the flowchart about Adverse Event Reporting that you showed at the SIV?

A: A copy of the A2B Safety Reporting flowchart is included in your ISF- section 5.1. This may help you to decide whether you need to report AEs.

Q: Should patients with meningitis or encephalitis be excluded from A2B under exclusion 1 (Acute brain injury)?

A: No, patients with meningitis or encephalitis should not be excluded on this basis

Q: When filling the baseline EQ-5D form with the NOK; as we can't tell what the score out of 100 would be for the last question ('health today' score), would you like us to ask what the most recent score prior to admission might be?

A: Yes, please ask what their normal score would have been prior to ICU admission, for both the proxy EQ-5D and the recalled EQ-5D at 30 days.

Q: Our unit uses different concentrations of clonidine and dexmedetomidine than those stipulated by the A2B Trial protocol and our pumps are programmed with these concentrations. What do you advise?

A: If your unit uses a different concentration of clonidine or dexmedetomidine, then perhaps you can arrange to have a pump or pumps programmed for e.g. "A2B Dex" or "A2B Clonidine" (some units are considering changing their practice to come into line with the ICS concentrations used in the trial:www.ics.ac.uk/ICS/guidelines-and-standards.aspx)

Q: What do we do about the SOFA score when the patient has been randomised after less than 24 hrs in ICU

A: If the patient has been in ICU for less than 24 hours, use whatever results are available (e.g. from other hospital wards, A&E, ambulance service etc.). If less than 24 hours of urine output is recorded, estimate the daily output from what is available e.g. if 250ml has been recorded over 12 hours, estimate output as 500ml/day. Remember to use the values that give the WORST score for SOFA.

Q: Although we aren't doing the sub-study it is still on the consent form – is there a different one, or do you just ask them not to fill it in?

A: Just put N on eCRF and either N or N/A on the (only) paper form

Q: We don't do APTT ratios – do we just leave the question blank?

A: Your Lab may report APTT Ratio as APTR (if so, this is what we want) or they may just report APTT, in which case we could use this to calculate APTR (if your Lab only reports APTT get in touch and we'll agree a denominator to use to derive the ratio).

Q: APACHE score based on results from the first 24 hours in ICU – do you literally take that 24 hours from admission even if this makes the end time post randomisation?

A: Yes, even if this includes post randomisation time, please use results from the first 24 hours in ICU. This will mean that if you are to extract the APACHE II (severity) score from ICNARC's Case Mix Programme, or from SICSAG's WardWatcher database, then you can use the score from the database

Q: What if we can't get an APACHE II (severity) score from the CMP/WardWatcher? Do you have a tool to work this out?

A: Yes, an A2B APACHE II worksheet is available for you to use for patients who don't have a score on the CMP/WardWatcher.

Q: How long do we collect daily data forms? If a patient was extubated for more than 48hrs and then re-intubated should we be collecting daily data?

A: No, after the day when you can determine that the patient has reached primary outcome (i.e. after the day when the patient reaches 48 hours of self-ventilation) then we don't need you to collect daily data for any further days. So, for example, if your patient were extubated during Day 3, we'd ask you to continue collecting daily data for Days 3, 4 and 5 (in case the patient failed to remain self-ventilating), but if on Day 5 (48 hours of continuous spontaneous breathing later), you can determine that the primary outcome was met, you wouldn't then need to collect daily data from Day 6 onwards..

Q: Does a regular prescription for chlordiazepoxide count as rescue medication on the daily data form (it can have quite an effect on their agitation)?

A: It's at the discretion of your clinical team to interpret what they call rescue medication. So if a drug is given that they consider 'rescue medication given for agitation', please record this. If the drug was started for another reason e.g. given as *prophylaxis* for alcohol withdrawal (i.e. if there hadn't actually been any agitation when it was prescribed), then this might not be considered medication.

Q: If a patient is restarted on usual medication like olanzapine, then I presume that doesn't count as rescue medication?

A: If patients are restarted on *pre-existing* medications, e.g. olanzapine, then this would not count as rescue medication given for agitation.

Q: Do I have to fill in paper versions of the daily data collection forms or can I just input data directly into the eCRF database?

A: You can enter data directly onto the eCRF if you like. The paper forms are provided in case you find it easier to use them. If you do use them, please retain them for monitoring purposes, along with the Shift Forms completed by the bedside nurses.

Q: Our pharmacy allows clonidine to be run with other sedatives, can we run other sedatives with A2B Clonidine or might this lead to clonidine in the line being bloused if other drugs were bloused (blousing 2B clonidine or dexmedetomidine is not allowed)?

A: Wherever possible run the A2B trial drug separately**. Remember that either A2B clonidine or dexmedetomidine can be given via a peripheral line**. However, If you have very restricted access, we advise that you follow usual critical care guidelines, i.e. never run A2B Clonidine or Dexmedetomidine with vasopressors /inotropes and wherever possible run with other sedation/opioid. You are welcome to contact the Trials Office about individual A2B patients.

Q: Do we need to have a Trial prescription to release the trial drugs from pharmacy?

A: No, the Trial drugs can be taken from stock in the ICU, just as if they were being prescribed for non-Trial purposes. However, your pharmacy may need to amend your ICU stock levels, to ensure that there is always sufficient stock in the ICU, in case patients are randomised to clonidine or dexmedetomidine as part of the Trial.