6654 FAQ
Study Visits – Protocol Compliance

After reviewing participant 0096, I discovered that the QP, Baseline Health Status Questionnaire was administered the day before the chest screen. Evidently the participant, who works at the hospital, decided at the last minut, when in the x-ray area, not to wait for the chest x-ray. The RA then scheduled him for the next day and did not administer the QP again. I will record this deviation in the chart. Anything else I can/should do at this point?

The fact that the participant completed the questionnaire a day before imaging is okay. Originally, the study planned for the QP to be completed at the time of screening. Logistically, that is not what is occurring at many sites and the study team has decided that this is okay. Some sites are having the participant complete the questionnaire at their enrollment visit or before. The main requirement is that the questionnaire be self-administered.

Would you happen to know which template letter I should use for an inadequate cxr?

The exam should be rescheduled and results sent based on a diagnostic exam. I would like to confirm that clinical reports will no longer be considered source documents. In turn, I trust this will mean that the clinical report will be independent and could be generated by any thoracic radiologist?

The clinical report will not be used as source document for the C2/DR. The clinical report is independent of the study and will not be reviewed at audit. The decision was made after consultation with Dr. Schnall (et al) due in part to the questions/comments made in San Diego.

Reporting of non-significant clinical findings within the study CRFs and clinical reports will vary and may not match exactly (requiring so is overly burdensome to the sites). Therefore determining correlation between these documents at audit is not feasible.

Could you possibly find out what “exposure value” means on the DR form. Our rad tech doesn't know what this is, but says all information has been sent in to you guys.

Exposure value: This is a 4-digit field that applies only to CR or DR technology.

The values vary by make and model, which must be separately recorded. If a digital system was used to acquire the image, record the exposure value.

This refers to the following: Fuji S-value, Kodak Exposure Index, Agfa Dose Monitoring Tool, Siemens’s Exposure Index, etc.

If the system doesn't display the exposure then you can't give it to us, we simply would like as many of the technical factors as possible.

One of our positive screens from last year went for a follow-up regular CT this week when she would have been due for her low-dose NLST later this month. Is there any way to rectify this so that she doesn't have to get another one?

My understanding was that the follow-up CT cannot be used for screening, and therefore, the screening exam must be performed in addition to the
high-resolution CT of the suspicious area. The screening CT must conform to the protocol requirements. It is for this reason that we encourage that follow-up CTs use the low dose protocol for nodules 4-10 mm diameter, reserving diagnostic CTs with other parameters or contrast for larger lesions in which biopsy, PET, or surgery are likely.

If a participant is randomized to CXR, and has an abnormality, which the PI wants followed-up with an immediate CT scan, if the scan clears up the abnormality, and the participant is to return to the screening process does he return to CXR screen for the next two years? Regardless of any/all follow-up participants always stay in their randomized arm to maintain the integrity of the study design. Follow-up will be a section of the final analysis.

In answer to your question about scanning the 450Lb. participant deemed too heavy for the scan table, Deb Harbison has consulted with Dr. Aberla and Ilana. In section 4.3 of the protocol titled Exclusion Criteria the last sentence states, “...those with physical conditions that would preclude high quality screening CT”. While this is not a direct reference to weight, excessive weight may cause failure of proper table incrementation and/or use of such high technique that the screening exam no longer qualifies as a ‘low dose’ exam.

We have a participant returning for annual screen, he has informed us that he has been diagnosed with CA, bone mets, but an unknown primary. We are still able to screen him, correct? He has had CT exams on his own in the past year and he is a CT screen for the trial. If the participant is willing, continue the annual screens and all other study activities. Lung Cancer and participant refusal are the only reasons a participant should not receive the annual screens. There may be individuals with other cancers that become so ill that they refuse the screens but we want to attempt to continue the screens and all other study activities.

I know (or think) the DR may change again. On the current version, I am not sure what should be going in for item #8 (mAs). It seems a repeat of #7 and #9 (time) and #10 (exposure value). We do not yet have the digital system so perhaps these items are referring to those issues.

Also, #11 - CXR Unit. The rad techs will know the differences between the parameters used for Q7-10. Q6-kVP should always be known. The reporting of Q7-10 is dependent on the CXR unit used (some display mAs, some display mA and time).

Additionally, exposure value is applicable only for CR and DR units, that said not all CR and/or DR units display this field. So in general, please ask the rad techs to record whichever fields among Q7-10 is possible/appropriate.

Each site will be asked to identify a number for each CXR unit (and provide the make/model for that unit#). The intention of Q11 is to record the site identified CXR unit #. Later, these fields will be reviewed by the physics team in context with the make/model of the CXR unit for QA purposes.

I got your message regarding the historical images arriving after the I8/I9 was completed. A second baseline I8/I9 should not be completed, instead this should be treated as a data correction. Pull the original I8/I9 from the study file and make corrections (per GCP) on the original.
data source as appropriate, include a brief note explaining the reason for the corrections (for example, historical images arrived after I8/I9 completed).
If per the corrected I8/I9, the review of historical images changes the screening result and/or recommendation (both on page 3) AND the screening letters have already been sent, then revised letters should be sent (per site norm) to the participant and physician of record. Additionally, a corrected IM form should be submitted to ACRIN documenting the change in screening letter, again include a brief note explaining the reason for the corrections.
This note is for auditing purposes, per GCP any data corrections that are not readily apparent should have an accompanying note explaining the correction.
If per the corrected I8/I9, the review of historical images did not change the screening result and/or recommendation then the letters and IM remain consistent with the I8/I9 and no additional action is warranted regarding the letters and IM.

Another question I have is how long are we supposed to keep images on the ACRIN computer? Can we delete them once we have sent them or are we supposed to hold them for a certain period?

The cases on your ACRIN computer should remain until you hear from us. Of course if you are having a hard drive space issue please contact us ASAP.
The review and confirmation of the DVD you are using to back up each case prior to sending is the trigger that cases can be removed.

I have been working on getting our images sent but just wanted to double check. Are we to send both sets? Jered does a Phillips D and Phillips B (which is the one our radiologist reads) we have been sending both is this correct?

Yes please send both sets.. Actually the study protocol calls for a Phillips C as minimum requirements.

Who am I to send the full DVD's to?
If it is images for the study send them to Anthony Levering or Sharlene Snowdon.

We had a participant who's initial CXR we read as positive and she got a follow up CT which was negative. So what I did was put her follow up CT results with our CXR results and marked her as negative on our data base. this information we be collected via the F1 and DE

have a participant who may be unable to do her T1 visit in the scheduled time May-Aug but will be able to come in April is this OK since it would mean not doing it otherwise?
If the participant is unable to return during the specified time period, then yes, by all means, get her/him in when you can! Document this on a PR form and in the study file.
First, I want to know if ACRIN allows to give information to the participants by telephone.
Second, In case that we send information by mail only, how long time can we use in between the screening and the mailing.
Third, In case some people call us -after they receive the results by mail-, to know about what doctor we recommend to do the following, what do you suggest to answer?

Per protocol, for all cases a results letter must be sent within three weeks of the screening exam to both the participant and their physician of record. For positive screens either (a) phone call and result letter or (b) certified letter is required.
Participants with positive screens with no physician of record should have been offered a list of physicians at the time of study enrollment to choose from and documented on page 2 of the participant contact sheet.

Please refer to section 16.0 of the protocol for a description of the screening results procedures.

We apparently had a participant from Day 1 that was randomized to CXR and got a CT, What do we need to do??

I will fax you a protocol variation form to document the event described below, please fax to ACRIN headquarters once complete.

I have a couple of people that had a positive chest x-ray at their initial screening and had a follow-up CT that cleared them of any suspicious masses. I'm assuming that they are still able to return for their annual x-ray, but I was having trouble finding a definitive answer in the protocol.

if a participant is NOT diagnosed with lung CA they continue with the screening exams as scheduled as well as submit all the follow-up forms.

If a participant is diagnosed with a lung CA the screening exams no longer need to be done but we must do all the other follow-up forms.

The follow-ups are collected so that we may track the participants treatment, progress, utilization of medical resources, etc. If you review the chart in section 14.1 of the protocol it gives you an easy reference guide

I was wondering if the radiologists reading our cases can act as the treating physician if the participant has no primary care physician and order a follow-up test for the participant. i.e. participant has abnormal CXR and a diagnostic CT is recommended

I believe the NLST radiologist was considered the treating physician in the absence of a primary care physician, but am not certain.

Section 15.1, 16.1, and 16.3 provide details for following participants who require further testing due to screening and have no physician of record.

The protocol mandates that there be a physician to whom screening results be sent so that no participant's health care is compromised for lack of one responsible party overseeing their care.

All those exams that are negative we call the participant instead of mailing letters. However, on the IM form there is no place to note they were called so it looks like they have not been notified of their results. Is there some other place I should be noting this?

Per protocol, for all cases a results letter must be sent within three weeks of the screening exam to both the participant and their physician of record. For positive screens either (a) phone call and result letter or (b) certified letter is required.
Please refer to section 16.0 of the protocol for a description of the screening results procedures.

I have a question about protocol violation on the CT. I have someone that can lay completely flat on their back if it turns out to be a CT. The technician can still get the image but they would be turned and/or adjusted a bit.

They have spinal curvature. I need to know if this person should be considered ineligible. Curvature of the spine is not a factor that prohibits participation. A good CT tech can make adjustments and get good images. I have done it many times myself. As long as the entire chest is scanned and the MD can read the images satisfactorily then no problem. As long as they can get their arms up over their head, the shape of the chest cavity makes no difference.

I had someone bring in the reports of previous CXR and CT. There were no films. Would this be considered "historical images" to compare to? Previous reports are not comparable to historical images. Without the actual radiographic image the radiologist would not able to complete the I8/I9 as designed. Additionally, the radiologist should not review the previous imaging report prior to interpreting the screening study. The screening study should be read "cold," results and recommendations recorded, and then can review the previous report if s/he desires to do so (but again, no I8/I9 based on imaging reports only). You should probably retain the previous report in the case study file since the participant gave it to you, but are under no study obligation to do so.

I was just told by a co-worker that she thought we are supposed to be tracking each participant's education level because we have to report this to ACRIN. This question is answered on the DP form which gets entered on-line but we do not track it. Is this something new? You are correct that this is captured on the DP form and is not required to be tracked at the sites for ACRIN purposes. IRBs are sometimes interested in local race and educational recruitment reports but this is site specific.

I just had someone assigned to CXR but the tech. did a CT by mistake. I know I have to do a PR form and progress note. What else will I need to do. Will she have CT's the next 2 years? As you already indicated, please submit a PR form. The calendar has been revised to allow entry of a C2, I9 for the baseline screen. However, the participant will follow her original randomization year 1 and 2 (CXR).

I filed a PR form dated 2/6/04 for a participant B, R case #281, stating T1 visit not completed due to inability to contact participant. I have made contact with the participant and they are willing to come in for the T1. Can we schedule even though the PR was filed? They were due 10/25/03 for the visit. Yes, better late data than no data! When it comes time for T2, the participant should be scheduled as late in the T2 window as possible (T2=Jan 03). You should revise the previously submitted PR form, as a data correction, to document "screen not performed within protocol specified timeframe" versus "not performed."

The PR data correction should be submitted to ACRIN. I will go ahead and activate the T1 forms for this case based on this e-mail. The participant is currently at the 1.5 time point so please be sure to get the y1.5-F1 covering the entire time interval randomization through day of F1 completion.
I have been trying to get some death certificates on a few of our patients. Our state office charges $15 for them. Wendy mentioned that you can get a printout on the social security death index website. Is this sufficient or is it protocol driven that we get a copy of the certificate?

The Social Security Death Index can be used to find out if someone is dead but it does not provide the cause of death which is required by the death review process, additionally, this can take about 1-2 years to post. The National Death Index can be used as a last resort to obtain cause of death for those we know to be dead but there are fees associated with this also (one time application fee per study site, and an additional fee for each search). As with the SSI, the NDI information may take 1-2 years to be available.

To meet our primary aim, the death review process requires ongoing collection of death certificates on all participants who expire. Subsequently, dependent upon the cause of death the case may be sent to the death review committee; for these cases, the medical records leading up to the death must be collected. More on the specifics of this process to come, we're still finalizing the process with LSS. In the meantime, we ask that you continue to collect death certificates on all deceased NLST participants. The death certificate does not need to be a "certified copy" so other options might be (1) obtain a copy from the family/spouse, I understand that this can be a sensitive matter; (2) some sites have gotten a copy from the funeral director; (3) you may be able to get a less expensive "non-certified" copy of the DC from the city/county office, this varies by state but it's worth a call to one of the city offices (you can find a list of offices w/ address and phone number on the RI Vital Records website). That said, in some states only the
 Spirometry

Catherine, AnnMarie is questioning whether or not is optional or mandatory to use the nose clips when conducting the baseline spirometry test. All of the ACRIN documentation notes use of nose clips. Is this mandatory for a good pft result? Or, is it optional? Do you know the answer?

Mandatory. We want to ensure that ALL the air from the participant goes through their mouth and into the SpiroPro unit to ensure a good PFT.

My question is, regarding today's participant, can she still be enrolled if she does not wish to stop using her inhalor? She had used Atrovent about 3 hours prior to spirometry (I did perform it & she had 3 ATS acceptable trials right off).

What do we do in a case where a participant cannot or does not wish to stop using their inhaler?

The participant does not have to STOP using the inhaler. If the participant does not want to wait until the effects wear off maybe it could be performed at the screening visit. In the event that spirometry is not performed again (without effect of Atrovent) please include a notation regarding the recent Atrovent use in the comments section of the PA.

Yes, I think coaching may be an issue.

When they start the test by pressing OK, coach patient:

ok, after the next breath, I want you to inhale quickly and full up your lungs all the way!!
Ok, now inhale...inhale...all the way... and...blast it out!
keep blowing..keep blowing..keep blowing..keep going....
and now...big breath back in! big...big...big!

When the test is complete, they can view the results and see the errors by pressing the information key (I think it is the key with an 'I')

Would be interested in knowing what error codes they are not meeting.
Can they fax me a few copies of the printouts?

323.467.1454

I have a question for you on the PA form. We had a participant that did the spirometry but she did so poorly it wouldn't measure it at all. Therefore there is not printout or results.
On the PA: for questions 8-13, should we answer "00"? I know some won't take 99. Complete a PR form documenting this event, no print-out then no PA form.
Q. I have an interested party for NLST, but he is currently involved in the Harvard Physicians Health Study. He is randomized to take vitamins A, E and selenium. The only screening that is done is an annual health questionnaire. Is he eligible?
According to the web site the study design includes cancer prevention (study information below) so the individual is, unfortunately, not eligible for our study. When designing the NLST trial, the decision was made to exclude any/all participants of other cancer prevention/screening trials in an attempt to limit "confounding variables" inherent in clinical trials.
The Physicians' Health Study-II aims to do just that. It is testing four of the most popular and promising agents--vitamin C, vitamin E, beta-carotene, and a multivitamin--for the primary prevention of cardiovascular disease, total cancer, and prostate cancer. It will also evaluate the effect of these agents on colon polyps and colon cancer, cataract, macular degeneration, and early cognitive decline. A detailed description of the rationale and design of PHS-II has been published: "Design of Physicians' Health Study II -- A Randomized Trial of Beta-Carotene, Vitamins E and C, and Multivitamins, in Prevention of Cancer, Cardiovascular Disease, and Eye Disease, ACRIN-NLST #6654 3-7-2003 and Review of Results of Completed Trials" by William Christen and colleagues in the February 2000 Annals of Epidemiology.

Q. We have a physician who is extremely interested in participating before he turns 75 by the 27th. However, he has quit smoking 15 years and 4 months ago.
Sorry, per protocol eligibility criteria the individual is ineligible. Eligibility overrides are sometimes given for treatment trials when the experimental course is the patient's best clinical option but for a screening trial there is no clinical reason to do so. In general they are bad practice since ineligible cases cannot be included in the final analysis.

Q. I just spoke with a gentleman who quite smoking cigarettes at least 15 years ago but has continued to smoke pipes and cigars. Does he qualify or is he ineligible?
Sorry-the study design does not include cigars or pipes. Ineligible.

Q. We have a potential participant for the lung trial who was a participant in the WHI but was only in an observational portion of the trial. She was not put on any diet or hormonal replacement, only questionnaires and had her BP taken. Her last appointment was in September of 2001 and hasn't been contacted since then. Should we exclude her for that reason?
Unfortunately, the individual is not eligible until WHI is closed. Even as a participant in the Observational Study of WHI the participant's health status is tracked, although this is not always apparent to the participant. When designing the NLST trial, the decision was made to exclude any/all participants of other cancer prevention/screening trials in an attempt to limit "confounding variables" inherent in clinical trials.

Q. Can you please provide me with a yes or no regarding eligibility for the following metallic objects which have come up with our initial screening. They are not specifically listed in the protocol so I would like something from ACRIN so I can include it in the notebook to document whether or not they are eligible. Do patients with the following qualify for the NLST trial?
stents
coronary shunt
bullet fragment (arm)
spinal surgery screws in back/neck
The question is designed to determine any individuals who have large metal objects in or around
the chest that would obscure anatomy or create artifacts (beam hardening artifacts) if they were
screened with CT. Acceptable metal objects would include: coronary artery bypass markers,
sternotomy sutures, metallic heart valves, vascular stents, angioplasty stents, or potentially small
amounts of shrapnel or bullet fragments. Each site, in consultation with PI, should use their best
clinical judgment for specific scenarios.
stents--Yes
coronary shunt--Yes
bullet fragment (arm)--Yes
spinal surgery screws in back/neck--depends on location of screws in back
Q. I have someone with oxygen for use at night, if needed. He is eligible otherwise. If he
does not use his oxygen the night before his appointment, can he still considered eligible to
enroll? (He has COPD.) Since home oxygen is an eliminator on the eligibility list I did not
know if he can be enrolled.
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Individuals on home oxygen supplementation, whether continuous or intermittent, are excluded.
The intent of Q14 is to exclude individuals with known lung conditions severe enough to require
prescribed oxygen use, as these individuals do not correspond with a true screening population.
Based on response to Q14 this individual is, unfortunately, ineligible.
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Question: a potential participant had TB 8 years ago and was treated with
INH. They've been clear ever since. Can they participate?

History of TB is not an exclusion criteria. Although INH is considered a cytotoxic agent the
individual has been off the drug for years (correct?). This history does not exclude the individual
from participation in the NLST
A potential participant appears to be ineligible as he uses
home oxygen once a month. (He also happens to have COPD, uses a nebulizer 3
times perday). Could you clarify what continuous positive air pressure is?
Oxygen supplementation is an exclusion criteria. CPAP (continuous positive airway pressure)
is a treatment for sleep apnea syndromes and is not an exclusion criteria.

Question regarding eligibility.. A potential participant coughed up a small
amount of blood 2 months ago. This was an isolated event that she felt was
connected with recent throat surgery for polyps. Francine is unsure about her
eligibility. I actually think this event does not make her ineligible. What
does ACRIN think.

My understanding of question 17 is chronic or unexplained hemoptysis as indicative of lung
disease, i.e. advance lung ca. I would think this isolated incident and the relation to the
polyp surgery would allow this participant to be randomized.

Question 12 on the new form says other than in-situ transition cell cancers. Does this
mean all other in-situ cancer patients would qualify as far as this question is
concerned?
We have a subject we were going to enroll on Wednesday, but she answered
that question as having in-situ breast ca.
The E1 form should specifically state that in-situ carcinoma is not
an exclusion (with the exception of transition/bladder cell in-situ, which
acts like invasive cancer.) Therefore, a woman with prior history of breast
in-situ or cervical in-situ within the preceding five years (or EVER) is
eligible to participate.
I realize that we are to ask the patients to sign the medical record release and we have always had one available for patients to sign. There hasn't ever been an issue until today and I didn't realize that it was mandatory that they sign for inclusion in the study. On page 67 of the latest protocol there is a consent that must be signed for the participant to be on the study. If he doesn't sign the waiver he cannot be on the study.

We screened a patient today who said she is enrolled in what she thinks is called the Harvard Nurse's Health Study. According to the limited literature I was able to obtain, the study is not a cancer prevention or cancer screening trial so the individual is eligible to participate in NLST.

Melanoma in situ (MIS) is thought to represent a very early phase of melanoma. However, MIS is not commonly reported and SEER does not report 5-year survival or other outcomes for MIS. Therefore, I propose that we do consider MIS along with nonmelanoma skin cancer as exceptions to the cancer exclusion. In other words, we do NOT exclude potential participants from NLST because of a history of MIS.

I understood that
> we need a signed I8, or I9 on everyone regardless of whether Historical
> Images were looked at.
Correct, we need I8 or I9 for each case. If no historical images, the RA responds no to Q1 then signs and dates the form-no action required by the radiologist.

I spoke with a lady Saturday who qualifies except I believe is ineligible due to having a colon polyp removed this past summer. After removal of several polyps the physician told her one was an adenoma. She received no treatment nor was any more treatment recommended. Is she eligible or not? It is possible this may have been a benign neoplastic tissue-not considered cancer. It is hard for data management to resolve medical questions, please consult your site PI. You may or may not need additional information but the eligibility decision, considering the inclusion/exclusion criteria, is left to your site PI.

Just spoke with a lady who has a stereotactic clip in her left upper breast. This would not exclude her would it? In my opinion a breast stereotactic clip should be acceptable, however, please run this by your site PI. Ultimately the eligibility decisions that require a subjective and/or medical opinion are left with each site PI.

I just spoke with a lady who had a surgical pleurodesis with partial excision of the pleura for a spont. bleb x2 in the past. She has not had any of the lung removed but has had part of the pleura removed does she qualify? Patient is eligible based on the information provided. She has pleural procedure (and excision), not lung removal.
I just sent you another PR form for # 3630. She had a CT 15 months ago. I found it when I went to print results. I am anxious to see how they will handle these cases because she would be eligible in June. Until the next step is finalized with stat please continue to follow the participant/protocol as if eligible.

Subject 5438 requested a pregnancy test today. Prior to receiving the results of the pregnancy test, Gale randomized the subject. The pregnancy test came back positive on this 63yo, w/f. She declares that there is no possible way she could be pregnant; however, we cannot scan her under these conditions.

Please continue to follow the participant as an eligible case, based on the protocol inclusion/exclusion criteria the participant is eligible.

Eligibility is determined based on the inclusion/exclusion criteria at study entry, any subsequent event(including medical findings) which may or may not affect the participant's study involvement should be documented and may require an altered protocol course(protocol deviation) but does not change the eligibility status.

when the eligibility question asks if the person is on "home oxygen supplementation," what exactly does that mean?
Do they have to be on it 24/7 or using it occasionally, or on oxygen period...I need a little more detail. This person only uses it when they are coming down with a cold and usually only for 3-4 nights during that time...and it is 2 liters. this same person has had unexplained weight-loss of 32 lbs over the summer time and states that this is just lack of appetite. I would think this would probably exclude her, but wanted to make sure.

Individuals on home oxygen supplementation, whether continuous or intermittent, are excluded. The intent of Q14 is to exclude individuals with known lung conditions severe enough to require oxygen use, as these individuals do not correspond with a true screening population. Based on response to Q14 this individual is ineligible. Additionally, home oxygen requires a physician's order so I am suspicious of use "only when coming down with a cold." FYI—individuals on CPAP for sleep apnea are eligible.

Unexplained recent weight loss over 15 pounds. This would usually be left to the site PI to talk with the individual and determine eligibility.

We have a participant we have screened and she indicated that she is on novatron treatment for her MS. She said it is a chemotherapy treatment and her last visit for the treatment is in February. Is she OK to enroll? Laura, the eligibility criteria state "no individual within 6 months of receipt of a cytotoxic agent for any condition". "These persons will be eligible 6 months from receipt of last dose". Your PI may want to speak to Dr. Aberle about this being a chemotherapy treatment but it seems pretty specific.
I have an individual that had anterior tongue carcinoma in situ cancer three years ago. Is he ineligible or eligible?
Laura the protocol eligibility requirements state "treatment for melanoma or in situ or transitional cell CA of the bladder renders the participant ineligible. It also states "No treatment for or advisement by a physician of evidence of any cancer within the past 5 years with the exceptions of non-melanoma skin cancer and most in situ cancers." I think that makes him eligible. You may want an OK from your PI just to be certain.

One of the women that we enrolled this morning (Case #2584) mentioned at the very end of her visit that she was a PLCO participant. She answered "no" to question 15 on Form E1. She said that PLCO is over and she is only involved in follow-up from this point on. Unfortunately, as confirmed previously with both ACRIN and LSS study teams, this participant is ineligible. Please submit any data already collected (DP, SS, QP, etc.). Additionally, complete the attached PR form and submit to ACRIN HQ.

If a participant is found to have a lung cancer during the study (at baseline, for example) do we continue with their annual CXRs or CT scans? People entering the study must have no HX of Lung CA. If they have a lung CA that is undiagnosed/untreated up to the point of screening that is another matter. Section 12.1.4 and figure 4 clearly define the pathway for Lung Ca diagnosis at the time of screening or in follow-up.

I have someone who basically stopped smoking in 1984. (ie- ineligible) However, since then she has smoked a handful of times on special events/parties. Her very last cigarette was in 1994. The E1 asks "when was your last cigarette?" Technically it was 1994. Is that what I should go by, which would make her eligible? or 1984?

Technically, she meets the entry criterion she is eligible to participate. She smokes. Although we want to get folks with highest risk, she is eligible. If she wants to participate, you should enroll her.

We have randomized a participant by virtue of age. Participant will be eligible in 4 weeks, after 12-25-03, but has already been randomized (within the past 4 weeks I presume). The question was: shall we postpone her SCAN until after she comes of age? No. Eligibility relates to age at time of enrollment. Once enrolled, she should be scanned within the one month interval from time of randomization. Please complete a PR form regarding her enrollment despite ineligibility.

After enrollment if was discovered he has actually been on antibiotics. We waited 3 months and then had him return for all his tests. He came for his CT and was reconsented on 2-14-03. We've had a few people that this happened to. They signed their E1 that they had not been on antibiotics and then through conversation following enrollment, it was discovered that they had. We just bring them
back after the 12 weeks. Would we have to do a PR that they were not eligible at time of enrollment? They were eligible on their exam dates.

FYI - antibiotic use alone is not the qualifier for making the individual ineligible, the real qualifier is that the acute respiratory infection severe enough for the individual to be on antibiotics.

The purpose of the question is to delay eligibility (randomization) of individuals with recent acute respiratory conditions since this can confound the screening results. To avoid such “false [+]” screening results, eligibility determination should be postponed for 12 weeks from the time of the first dose of antibiotics.

Antibiotic use for a condition unrelated to a respiratory process (e.g. sinusitis) is not a reason to postpone eligibility.

To ensure proper documentation is satisfied a PR form should be completed to document that the participant was randomized as an ineligible participant.

Per your explanation, the participant provided an ‘no’ response on the E1 and antibiotic use was discovered later.

As long as this is documented in the case study file (comment on E1 or progress note, and PR form), showing due diligence, regulatory concerns relating to the randomization of ineligible participants are met.
Data Forms – Data Management

Q. I have a participant that the screening chest was ‘Limited CXR, but interpretable’. When I input the DR form, will this generate another DR form? Or do I wait and input the 2nd DR form when the participant comes back for their repeat CXR? Along with that, do I send out letters and complete an IM on the first reading or wait and do that with the repeat CXR reading? Please advise.

A. If it was determined to be interpretable there should not be a need for a repeat CXR. If the CXR needs to be repeated then "Non-diagnostic CXR, reschedule CXR" should be used. We collect only one baseline DR form=one baseline interpretation. The letters and IM should be based on the baseline result and recommendations, if the participant needs a repeat CXR for these to be made then wait for the repeat CXR. If this occurs outside the 3 week window simply note this in the chart and complete a PR form.

Q. I just spoke with a lady who had a surgical pleurodesis with partial excision of the pleura for a spont. bleb x2 in the past. She has not had any of the lung removed but has had part of the pleura removed does she qualify?

A. Patient is eligible based on the information provided. She has pleural procedure (and excision), not lung removal.

Q. We received historical images that change the original screening result and recommendations. The I8, IM have already been submitted and the screening letters sent to the participant and physician. What should we do now?

Ideally the I8/I9, IM, screening letters should not be sent until the historical images are reviewed; there is a 3-week window for this to occur. We realize the requesting site may not have any control of the availability of historical images. If the historical images arrive after the 3-week window, as in this case, use the original I8/I9, IM to record the new data (making any required data corrections just as you normally would). Submit the revised I8/I9, IM to ACRIN HQ. Record this incident on the PR form under Q1-Screening result changed based on delayed availability of historical images. Additionally, a revised letter will need to be generated. All of these documents should be retained in the case study file. The participant and the physician should be notified of the changed interpretation.

Q. I wanted to make sure I (and my PI) understood the recent discussion regarding the completion of the C2/DR abnormality, can you briefly explain this again.

C2: Slice location, anatomic location, dimensions, margins, and predominant attenuation should be reported only for code 51 abnormalities. Reporting data within these fields for abnormalities other than code 51s will result in a site query based on data validations. The text line adjacent to the reported abnormality field should be used only when reporting abnormality codes 63-65. This is a text field to allow you to report and specify an "other abnormality" that is not already specified in the chart. Reporting data within this field for abnormalities other than 63-65 will result in a site query based on data validations. These validations will be cross-referenced with the date of last week's operational call (01/30/2003), forms entered prior to 01/30/2003 will not be queried for this specific data validation error.

DR: Location of epicenter, dimensions, and margins should be reported only for code 51 abnormalities. Reporting data within these fields for abnormalities other than code 51s will result in a site query based on data validations. The text line adjacent to the reported abnormality field should be used only when reporting abnormality codes 63-65. This is a text field to allow you to report and specify an "other abnormality" that is not already specified in the chart. Reporting data within this field for abnormalities other than 63-65 will result in a site query based on data validations. These validations will be cross-referenced with the date of last week's operational call (01/30/2003), forms entered prior to 01/30/2003 will not be queried for this specific data validation error.
Q. Under #12 of the C2 form: If the abnormality is assigned #52 = micronodule < 4 mm, under dimension it will not let you enter anything less than 4 mm. This is backwards. It should only accept < 4 mm. Therefore we can not enter the C2's that have a #52 abnormality code.

CT slice location, anatomic location, dimensions, margins, and attenuation should be completed for code 51 abnormalities ONLY, hence the requirement of >=4 for longest dimension (of a code 51 nodule/mass). Additionally, the text line adjacent to the abnormality codes should be used only to report 63, 64, 65 abnormalities. Any other descriptive/clinical data should be reported in “Other observations/comments.”

Q. The code table on the IM does not match the code table on the C2/DR/I8/I9 forms, is this a mistake?

Since the IM is used for both study arms the code table for question 5 may not correspond directly to the C2/I9 or DR/I8, please read the code table and make sure you are reporting the correct result letter category. Due to the simplicity of this form you may find it easier to complete this form via the web without completing a paper version. If you choose to do so, print the electronic summary, sign/date, and place in the case study file (just as you would the paper form).

Q. Do we need an I8/I9 for every case?

Yes, either the I8 or I9 should be completed for every case. If historical images are not reviewed, answer 1-no to the first question then sign and date the form; no action is required of the radiologist. If historical images are not reviewed, again you may find it easier to complete the form via the web without completing a paper version. If you choose to do so, print the electronic summary, sign/date, and place in the case study file (just as you would the paper form).

Q. We made a few data entry errors, how do correct these?

Data corrections should be made following GCP guidelines:

If the error was made on the CRF--Indicate form revision (most data forms have a check box at top of page), cross through the incorrect information with a single line, record the revised information, and initial and date it. If the reason for the correction is not readily apparent from the study file include a note explaining the correction. Mail/fax the revised paper CRF to ACRIN Data Management.

If the error was a data entry error and the CRF is correct--Print the web electronic summary, make the correction as described above and mail/fax the revised electronic summary to ACRIN Data Management.

Q. I am a new RA, what are the C1 and C7?

The C1 and C7 refer to the CT and CXR prose reports. These are no longer required to be submitted to ACRIN and have been removed from the case calendars. The reports, if generated, are still required to be part of the case study file.

Q. Is it necessary to keep all of the new case registration e-mails and data form e-mails? I would like to delete them, but won't if there is a legitimate reason to keep them.

The electronic summaries are provided (1) as your confirmation that the data was downloaded to the ACRIN database, (2) as a QC tool--the summaries should be cross-referenced with the source document to check for data entry errors, and (3) data entry errors should be corrected by printing the electronic summaries and making corrections as you would on the CRF (per GCP). Obviously, you are not required to print the electronic summaries but they are to be saved and available for review at audit. The electronic summaries are part of the audit trail and may be needed if data entry errors are found.

Q. On the Smoking Status form (SS), #21 asks about smoking cessation. Our subject entered 99 as a response, but still had some responses for #23 and 24. It seems that when 99 is entered, the system immediately skips to #25, not allowing any previous responses to
be entered. Therefore, I'm unable to enter this data (#23 and 24) for our subject. This has been a recurring "issue." The skip patterns were included in the web programming to mirror the forms, any data responses within the skip patterns (due to participants not completing the form as intended) simply would not be captured. Ideally, the form should be reviewed for accuracy/completeness by the RA at the time of the registration visit so the participant has a chance to question/correct the form. However, we have continuously been asked about this and after yet further discussions it was decided to remove the skip patterns from the web module. The trade-off is the RA will need to data enter 99 for any/all blank data fields, even those within skip patterns. The programming revisions for the SS and DP are in the "queue" but are realistically a few weeks away. Until then, if you receive a form that has data responses within the skip patterns hold the form until we announce the programming revisions have been implemented. Hopefully, you will not encounter many of these. If you have any additional questions/comments please contact me, thanks.

Q. We have a couple of questions regarding the C2 and DR forms.
1.) On the C2 form: is there supposed to be a space that we specify which CT unit is used? We noticed there is a space for this on the DR form, but not the C2
2.) In the above referenced space on the DR form, there is only 1 space to designate which CXR unit is used. What goes here? Our units are specified by their make and model which is more than one character. 
1.) ACRIN obtains this information from the DICOM header of the digital CT images.
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2.) This is intended to map to the CXR certification form completed by the site physicist. The implementation of this procedure was delayed until a joint NLST (ACRIN and LSS) Physicist Committee made recommendations and approved the process. For now the tech can record the CXR unit used beside the data field. Since this process has not been implemented the data field is not a mandatory element on the web module and can be skipped (attached is the draft version of the CXR certification form intended for use).

Q. When we've been entering data online, we've been pulling the smoking history information from the E1, as it says in the table. However, during our internal audit we were matching the DP confirmations with the entire DP paper form. As you know, the same smoking history questions were asked on the DP and E1. And, participants were not consistent with their answers. So, we will need to make sure that we have given you all of the E1 data for smoking history, right?
Right. The smoking section of the DP forms dated prior to 10/25/2002 should be reconciled with the E1. Any data corrections made in response to this should be made on the DP CRF-paper form (consistent with ACRIN and GCP guidelines) and include a note referencing the E1 as the source for the data corrections (i.e., "data revisions per E1"). We realize this is additional work and appreciate your diligence.

Q. I am slightly confused as to what information needs to be written on the PA forms and where the information is on the print-out from the SpiroPro. The SpiroPro automatically prints out the best trial info, correct? Then, column we use for the FVC and FEV measurements? Do we need to calculate the FEV% predicted or can we use the number on the print-out? And, last but not least, the FEV/FVC is that on the print-out also?
All PA required elements appear on the SpiroPro print-out:
9. FVC (L-BTPS) = FVC(1) Actual---middle column of print out
10. FVC %predicted = FVC(1) %Predicted----third column of print out
11. FEV1 = FEV1(1) Actual----middle column of print out
12. FEV %predicted = FEV1(1) %Predicted----third column of print out
13. FEV1/FVC = FEV1%FVC Actual----middle column expressed as percentage
Q. Does an I8/I9 historical image need to be filled out for every study? If the study is negative or only if there are positive findings and historical images are available? If there are no historical images to review?

An I8 or I9 need to be completed for every case. The C2 and DR are designed to capture the interpretation of the screening exam in isolation-prior to viewing any historical images. The I8 and I9 are designed to capture the interpretation of the screening exam after viewing historical images. This sequential process may or may not yield a different interpretation. If the case is negative there are trigger questions that let you skip most of the form. If there are no historical images, the RA can respond "No" to Q1 and sign/date-no action from radiologist is necessary.

Q. On the questionnaires, a lot of the time people don't answer a question or don't want to answer a question in which the answer should be a number. Since 99 is used for unknown/no response, do we still put in 99 for those that are blank? It will not let you continue if you do not enter in a #.

The RA should be reviewing these forms (SS, DP, QP) for completeness and accuracy during the visit, while the participant is available. Obviously we prefer actual responses, but if the participant does not want to answer the question then ask them to record 99. In the event blank fields are left on CRFs the RA should, at the time of web entry, enter 99 for the corresponding blank field. The ACRIN-NLST #6654 3-7-2003

RA should not alter the CRF by recording 99 on the paper form. The response 99 tells DM and stat the participant chose not to answer the question--whether the participant recorded 99 themselves or indicated so by leaving the field blank.

I was entering the DP into the web form and i had problems with question 5. I had to code one of the family member '98' which is does not apply, but the web would not accept a '98' Has this changed, or should I assume it was just a glitch in this particular case?

98 can only be answered for siblings, (brother, sister) or children. Parents can be 99 because the person may not know if the parents had CA. However everyone needs 2 parents so 98 'does not apply', would not apply.

I have a ques. when entering data on a pt. that another RA has enrolled and completed, should I log-in as myself and use the other RA's name in the space... form completed by? I think there is some confusion here because on the paper copy I'm asked for... staff submitting form signature and on line I'm asked for... staff completing form.

Based on the information provided below, you have your own password for access to the ACRIN web site.

As you are performing a data entry service from a form completed by the other RA, i.e. data obtained by the other RA, her name should appear in both instances. The other RA will be our point of contact in the instance that a data manager needs clarification of data submitted. That is the basis for a name on each form, as related to data management.

If you would like to keep a record of the fact that the person entering is different from the person who completed the "paper" form, then initial, date and note you were the input person of the data. This is not necessary for ACRIN purposes; however, if you feel it is necessary for purposes within your site, please feel free to do so.

We had trouble with the web this morning and with all the confusion we
didn't print out a patient registration confirmation on one of our patients. Is there some way of me getting a copy of it for the patient's chart?

ACRIN headquarters will automatically send a copy of the A0 and case labels for each case registered. Additionally, you should receive, via e-mail, an electronic summary of all registration and data forms submitted. These electronic summaries serve as your confirmation that the data was successfully submitted to ACRIN and can be used to QC the data entered (they can be printed, but you are not required to print each summary).

If a participant has an abnormal CXR for instance and we suggest an apical view, that clears up the abnormality, should they receive an abnormal letter followed by another letter stating that the apical view was negative? We are not sure if we should be sending follow up letters, presently we are calling the participants and the final report is being sent to the primary MD. The protocol does not address or require follow-up letters. Follow-up results can be communicated following normal procedures at your facility.

I am reviewing some PR forms that were sent in as a response to the forms due report. It is NOT necessary to do a PR if you receive notice on the Forms Due Report that a form has not been electronically submitted. All that needs to be done is to web enter the form as soon as possible. No extra paperwork is required.

when a participant is randomized to a CXR, has a follow-up CT scan, and returns to CXR for their annual screen, should the CT also be reviewed as a historical image? At year 1 any historical images available should be reviewed for completion of the I8/I9, this includes any interim diagnostic follow-up procedures.

We have 2 cases here where the mAs was not recorded at the time of CXR screening. One was about 2 months ago and we entered "000.00" into the web form, with a comment to explain. Yes, "00.00" and a notation on the CRF is appropriate if you do not have the mAs value.

have been entering data and on the SS form at the end it ask who completed the form. I have been putting my name because if we put the participants name then you have there full name not just initials. What is the correct way?

The person completing the form is the RA at the site. Even if the participant filled out all the information or even if you have a date entry/secretary type person who fills out the web form. The site RA is responsible for making sure the form is completed correctly prior to web entry so they are the person completing the forms.

What about on the C2 and DR form if the radiologist reads it one day and gets it back to me several days later. Do I put the date he completed it or the day I got it back and made sure everyone completed their part? the dates on the paper form for scan, read, and date form completed may be different from one another.
Are we supposed to print either a copy of the form as we submit it on the ACRIN data base or print the form when we get the confirmation it was Entered?
Should I start printing a copy either when we enter it or the confirmation then put it in the participants file?

If you are using paper forms as your original method of data collection you are not "required" to print either. The electronic summary serves as (1) your confirmation that the data was submitted and downloaded to the database and (2) a QC tool if you did not verify the web data prior to submission the electronic summary could be used to verify that the data entered indeed matches the source data (paper form). The electronic summary should be saved (e.g. hard drive case file) in the event web entry corrections need to be made, if this occurs you will need to print the electronic summary and submit the web data corrections to ACRIN HQs. If you are performing direct data entry (no paper form) then the web data is considered your original method of data collection and is required to be printed, signed (RA, rad-appropriately), dated, and retained in the case study file.

When we screen people if they have old films available at another facility I mark yes on Historical images Available but then if they have a negative screen the radiologist does not need them so we do not get them. Should we then change that to a 1 because if you enter yes when entering the form on the web part B will come up and we have nothing to enter? So should we just change the yes to a no if we do not use the historical images?
Correct, if historical images were not reviewed Q1=1 no

I have all the forms due completed except the DP and SS form on case #7866. Our problem is he will not return them. He was a person who we signed up while screening another and gave him those forms to complete and return. Should I fill out the General Communication Memo form you sent and fax it to you?
Yes, complete a GCM stating just this, we will then suppress the forms on the calendar so that they do not keep showing up on the report. If at some point the participant returns the forms, call or e-mail us and we will re-activate the forms for web entry.

he list that ACRIN sent to Kim and I has some items that have a category mismatch for the correct age.
Do I make the changes on the hard copy of the computer generated AO form and initial them and then fax them to you along with an individual Z1 explanation for each case?
You can fill in the Z1 electronically or print it and fill it in and fax it. Then you can send a copy of all the corrected forms via fax or mail.

When I screened him he told me he had Cirrhosis of the liver then when I went in to retrieve his X-ray results it looks as though they are working him up for and he has liver cancer. I assume he is ineligible correct?
Since the cancer diagnosis came after randomization the participant is eligible for NLST. Since the participant has already signed consent and been randomized the participant and study activities should be followed per protocol. The cancer diagnosis should be reported on the F1 due 1/26/2004.

I marked I sent a letter to the physician but I did not because the participant never filled out a contact information sheet and after multiple attempts we filled out a General Communication Memo and sent it in on 9/2/2003. I need to correct the IM which form do I need to fill out?

Some complete the web IM only versus completing the IM CRF, please review both data correction scenarios:
If the IM data was originally documented on the paper CRF, the data revisions should be recorded on the original paper CRF following GCP guidelines. The revised CRF should be faxed to ACRIN HQ, please make sure to check the box at the top of CRF identifying it as a revised form.
If the IM data was originally documented via the web, the data revisions will need to be documented on a paper CRF. Please complete a paper CRF and include a note, near the revision box, that the CRF is a revision for a web entered form. The revised CRF should be retained in the study file with the web IM for proper data documentation. All original and revised data must be retained in the study file. Fax the revision to ACRIN HQ.

When randomized the birth date was entered correctly but when the screener picked an age group they entered 2 instead of 3. What should I do about that one?

If the age group is OK and only the birthdate is wrong just fax the corrected A0. If the age group is wrong we need a PR form sent and also the corrected A0.

If Dr. Mullan does a comparison to old films and we have already submitted the I8 or I9 and he fills out a completely new one do we fax that to you and then keep both in the file? Correct the I8/I9 you already have and send that to me. That way we will know it is revised. Please check the revision box on the form.

I am entering C2 form on case 1529, and for the question 12, after it goes through the area to complete for code 51 nodules or masses only, I have trouble trying to enter the nodules which size is-as described-, less than 4 mm diameter.

In this case there are three different nodules which size is 3 mm diameter each one. So I don’t know if this area was designed only for nodules equal or over 4 mm diameter, and it will not accept 3. Can you tell me what to do in this case?

By definition and as the chart indicates, code 51 is for nodules/masses =>4mm so longest diameter requires a value =>4, there is no validation on longest perpendicular diameter. Any nodule/mass = 3mm must be coded 52 and diameter dimensions are not recorded. As was confirmed during our conference call last week the chart should be used as originally intended, location, dimensions, margins, attenuation reportable ONLY for code 51. Other clinical data should be reported in Part D, other observations.
SS questionnaire, question #11 Which cigarette of the day did you hate to give up the most? My participant states the one he would hate to give up the most is after a meal, that answer is not listed. How should this question be answered. He put in a 9 and wrote in "After a meal".

If the person filling out the SS form can not find an appropriate number among the selections they may answer 99 no response/unknown. There is a comment section at the end of the form that may be used to explain the response.

On the forms, a lot of the time people don't answer a question or don't want to answer a question in which the answer should be a number. Since 99 is used for unknown/no response, do we still put in 99 for those that are blank? It will not let you continue if you do not enter in a #.

Obviously we prefer actual responses, but if the participant does not want to answer the question then ask them to record 99. In the event blank fields are left on CRFs the RA should, at the time of web entry, enter 99 for the corresponding blank field. The RA should not alter the CRF by recording 99 on the paper form. The response 99 tells DM and stat the participant chose not to answer the question--whether the participant recorded 99 themselves or indicated so by leaving the field blank.
Audit – AE

We have had our first death but I am not sure how to report it.

Could you tell me if the audit requires us to print out all of the web confirmations we get by email for all of the forms?
No you do not have to print out all the web confirmations on all the forms, but we recommend you store them in a file (several sites are using a zip file due to the large number) so if necessary you are able to print a confirmation.
For example, a participant case record selected for audit is missing a form, the confirmation would serve as validation of the actual data entry and the date of the entry.

What if some E1’s or questionnaires did not get signed by the subject? I recall on conf call they said we don’t have to bring the subject back in but just making sure-
No, you don’t have to bring them back, but you should make an effort to call and verify via phone conversation that these were indeed their responses.
This should be done the same day if possible, as dates in this instance are very important.
In the guidelines the E1 must be signed and dated by the participant.
This is for eligibility to participate in the trial. We will be looking at this form for the signature and date it was signed, as these are areas that impact the C2 and DR forms.

Do you know if the radiology technologists who are working within the study “must” be registered with the ARRT or registry eligible?
I have some new rad. techs. who are willing to take part in the NLST study but not all of them have taken their boards yet, even though they have their KY licences. Section 17.1.2 of the protocol details the required qualifications of the radiology technologist; must...‘be certified by the ARRT or by a state regulatory agency.’

Is it necessary to keep all of the new case registration e-mails and data form e-mails?
I would like to delete them, but won’t if there is a legitimate reason to keep them.
The electronic summaries are provided (1) as your confirmation that the data was downloaded to the ACRIN database, (2) as a QC tool--the summaries should be cross-referenced with the source document to check for data entry errors, and (3) data entry errors should be corrected by printing the electronic summaries and making corrections as you would on the CRF (per GCP). you are not required to print the electronic summaries but they are to be saved and available for review at audit. The electronic summaries are part of the audit trail.