REVIVED-BCIS2
Newsletter
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REVIVED

News

May was another great month for REVIVED with 13 patients recruited from 11 sites. This is a record for both number of patients recruited and for the number of sites recruiting in a month. Special congratulations go to the teams at Royal Free and Sunderland who both recruited their first patients this month. Successful site visits were held at Wycombe on 6th May and Basingstoke on 22nd May bringing our total number of open sites to 24.

Michelle Anderson, research nurse at Leeds kindly described the identification and screening methods for their first five patients which have been turned into an article on page 2. Since then Leeds have randomised a further two patients and are now established as a leading site on REVIVED.

LUCKY NUMBER

In May the 88th patient was recruited by St Thomas' Hospital. Well done to Sophie Jones, Natalia Briceno and the rest of the St Thomas' team.

This month's lucky number is 100

Whichever site recruits the 100th patient over the course of June will win a box of chocolates.

Amendment 8 approval

We are pleased to tell you that amendment 8 was approved on 19th May.

The main changes are as follows:

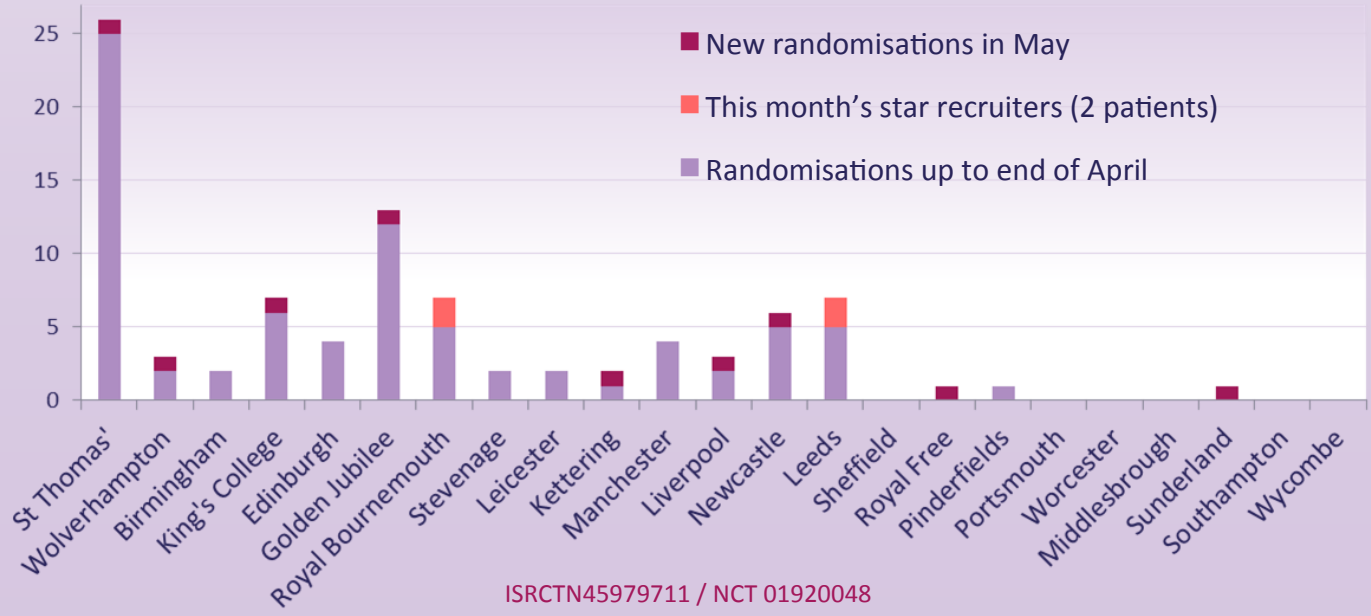
- The 30 day limit to complete PCI after randomisation has been removed.
- Qualifying ejection fraction can now be assessed by MRI or echo up to 1 year prior to randomisation

For more information, please contact Rebecca Matthews (rebecca.matthews@lshtm.ac.uk)

Site Progress Summary

91 patients recruited—13 patients in May

Sites currently screening (23) arranged in order of site initiation:



Identifying patients at Leeds General Infirmary

Patients at Leeds have come from a range of sources, none have proved more effective than any other for me so far. I screen MRI reports once a week, MRI referrals folder once a week, wards daily, cardio base and cath lab lists daily. I attend every PCI and cardiac surgery MDT and go to the heart failure clinics each week.

All identified patients are either referred directly to me or Prof Greenwood, who then passes on all their details to me. Once any patient is identified the journey really is the same;

1) I make up a screening folder for each patient. These contain a checklist that sits in the front with all the required eligibility elements and tests listed.
2) I then screen each patient through electronic sources to identify what tests they have had and what they may need doing.
3) Once I have got a patient to the point where they have had the angiogram, echo and viability study I arrange a meeting with Prof Greenwood. Usually Dr Blaxill, who deals with a lot of our complex PCIs, will also attend. After this meeting I know whether the patient meets all the initial inclusion criteria.
4) I then provisionally book the PCI slot, or slots if a staged procedure is planned.
5) Whether the patient is an inpatient or outpatient depends how we then see them to discuss REVIVED. **Inpatients** – Prof Greenwood and I see them together on the ward and introduce REVIVED and follow up with the patient up to the point of consent. **Outpatients** - I identify which consultant they are under medically and Prof Greenwood and I go and speak to them first about the trial and make sure they are happy for us to approach the patient. The first meeting with the patient will usually coincide with a clinical outpatient appointment so they are reviewed medically first. I will then join and discuss the trial with the consultant and patient and if they are happy to consider it I give a more detailed explanation. They are then given time to consider things.
6) I then keep in contact with them over the phone and if they are keen I then bring them back once more to the CRF to see Prof Greenwood and myself and this is usually when we take consent. I will have already pre-booked the PCI slots so can then give the patients the date and time of the procedure if randomised to PCI.

Written by Michelle Anderson, Research Nurse at Leeds General Infirmary April 2015

Randomised patients

Patient 1 was identified through MRI and was identified as having viable dysfunctional myocardium with a significantly impaired LV function.
Patient 2 was also identified through MRI as having a significantly impaired LV and viable dysfunctional myocardium.
Patient 3 was identified by myself through general screening of our medical wards (I do this every day). Admitted with a new presentation of heart failure and MI.
I identified **Patient 4** through screening the angiogram lists this patient had three vessel disease.
I identified **Patient 5** through a PCI MDT with our interventionalists. I make sure that Professor Greenwood (Leeds PI) or I are in attendance at these.

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