

## **INSTITUTION**

### **CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**TITLE OF THE STUDY:** Biological Response versus Clinical Efficacy of Desmopressin (DDAVP) IN von Willebrand's disease (VWD) type 1 and 2

An infusion trial with desmopressin (DDAVP) to evaluate if this drug is effective in correcting the defects of von Willebrand disease (VWD) .

#### INVESTIGATOR INFORMATION:

Dr. [Principal Investigator], MD, 24 hours phone [ \_\_\_\_\_ ]

Dr. [Sub-Investigator], MD, 24 hours phone [ \_\_\_\_\_ ]

I, (my child) \_\_\_\_\_, have been asked to participate in the research study under the direction of Dr [ Princ. Invest.] and the medical supervision of Dr. [Prim. Physician]. Other professional persons who work with them as study staff may assist or act for them.

#### PURPOSE:

I understand that I (my child) have/has inherited von Willebrand disease. I (my child) am missing or abnormal protein called von Willebrand factor (VWF), which is needed for my (my child's) blood to clot normally. My (my child's) blood takes longer than normal to clot and does not form a stable clot. This condition can result in serious complications from excessive bleeding. Sometimes, in order to help my (my child's) blood to clot, I (my child) have/has to take an intravenous infusion of desmopressin (DDAVP), a synthetic analogue of the antidiuretic hormone, which is able to release von Willebrand factor from the deposits contained in my vascular cells. However, the amount of von Willebrand factor released by my vascular cells might not be sufficient sometimes to stop bleeding or prevent hemorrhage during surgery. In this case, I (my child) must take an intravenous infusion of a blood product containing von Willebrand factor. I (my child) have (not)/ has (not) received an infusion of DDAVP and of a blood product for treatment of bleeding in the past. The purpose of this research study (PART 1) is to determine whether DDAVP is effective in correcting the abnormalities of persons with von Willebrand disease. DDAVP (MINIRIN-DDAVP) is a registered drug already in use for patients with mild hemophilia A and von Willebrand disease.

#### DURATION AND LOCATION

My (my child's) participation in this study will last for approximately 5 hours, as described below. The study will be conducted at the [ INSTITUTION ].

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## PROCEDURES

I have been told that during the course of this study, the following will occur:

If I (my child) participate in PART 1 (BIOLOGICAL RESPONSE):

I (my child) will have a physical examination by Dr [ Pr. Invest. ] prior to the study. The physical examination will also include baseline blood tests including Factor VIII activity, von Willebrand factor antigen and activity, a complete blood count, hepatitis studies and bleeding time. A bleeding time test is done by making a very small incision in my (my child's) arm, using a device called Simplate II. The technician will measure how long it takes to stop bleeding up to 30 minutes.

I (my child) will then have an infusion of DDAVP. The amount of DDAVP depends on my (my child's) body weight (0.3 µg/Kg). The DDAVP will be diluted in 50-100 ml of saline. An infusion means I (my child) will have a needle put into a vein in my (my child's) hand or arm and the DDAVP solution will be injected into my vein over about 30 minutes. Then the needle will be removed.

I understand that to find out how well DDAVP works, I (my child) will have to have more blood drawn at 0.5 hour, 1 hour, 2 hours and 4 hours after the infusion. About two teaspoons will need to be drawn each time for Factor VIII, Von Willebrand factor antigen and activity and blood counts. In addition, a bleeding time must be repeated at one hour, 2 and 4 hours.

If I (my child) participate in PART 2 (CLINICAL EFFICACY):

Since this study explores biological response versus clinical efficacy of DDAVP, I (my child) will be followed up for two years during each DDAVP infusion for bleeding or surgery. In these cases only FVIII:C and VWF:RCo (VWF:CB can be measured if VWF:RCo is not available) should be measured before and two hours after DDAVP injection (not BT or PFA) when I (my child) will stay in the hospital. In case of DDAVP therapy at home, I (my child) will describe symptoms to the hematologists when I (my child) will visit the Hemophilia Center.

I understand that all information related to my (my child's) conditions will be collected without revealing my (my child's) identity by the physicians attending the Hemophilia Centers. To determine the clinical effects of DDAVP, the physicians will use the same evaluation scale used for concentrates in other patients with congenital bleeding disorders. Excellent: No excessive bleeding; Good: Excess bleeding without need for VWF concentrate treatment; Poor: Excess bleeding with need for VWF concentrate treatment. The loss of blood during surgery will be evaluated directly by the surgeon and indirectly by the actual reduction of hemoglobin in my (my child's) body.

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## EXCLUSIONS

I (my child) should not participate in the study if:

1. I (my child) have/has taken any blood or blood product or DDAVP in the last seven days before the study date.
2. I (my child) am/is pregnant.
3. I (my child) have/has antibodies to Factor VIII or von Willebrand factor
4. I (my child) have/has taken medicines such as ibuprofen or aspirin or products which contain aspirin within ten days before the infusion date.
5. I (my child) have/has bleeding at the time of infusion
6. I (my child) have/has an infection with fever, chills, nausea.
7. I (my child) have/has an history of cardiovascular disease or epilepsy
8. I (my child) have/had had frequent reactions to blood products in the past.

## RISKS/DISCOMFORTS

I understand that there may be the following risks and discomforts associated with this study.

1. There may be reactions to the products itself such as rash, nausea, headache.
2. There may be pain, bruising or bleeding at the site of blood drawing.
3. Occasionally, but not usually, there is a very small scar which remains at the site of the bleeding time test

## BENEFITS

I have been told that the benefits of participating in this study may be:

1. A specific synthetic product for treatment of my (my child's) disease
2. No need for blood/plasma products for treatment of my (my child's) disease

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## OFFER TO ANSWER QUESTIONS

If I (my child) have/has any questions about this study, I (my child) may call Dr. [ Princ. Invest.] at [phone number]

## SIGNATURES

I understand my (my child's) rights as a research subject and I (my child) voluntary consent to participate in this study. I (my child) understand what the study is about and why it is being done. I (my child) will receive a signed copy of this consent form.

\_\_\_\_\_  
Signature of Research Subject

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date