

# DASH trial

## Desmopressin for reversal of Antiplatelet drugs in Stroke due to Haemorrhage

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ISRCTN 67038373

### Day 2 follow-up form v1.0

Section A: Day 2 follow-up details			
A1	Date of data collection ( <i>dd-mmm-yyyy</i> )	D ____ / M ____ / Y ____	
A2	Weight on admission – actual value,	<input type="text"/> kilograms	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	or estimated weight if actual value not available	<input type="checkbox"/> <40 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60-69 <input type="checkbox"/> 70-79 <input type="checkbox"/> 80-89 <input type="checkbox"/> 90-99 <input type="checkbox"/> 100-109 <input type="checkbox"/> 110-119 <input type="checkbox"/> 120-129 <input type="checkbox"/> 130+ kilograms	
A3a	Did the participant suffer any side effects related to the study treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not known
A3b	If yes, what were they?	<input type="checkbox"/> Diarrhoea <input type="checkbox"/> Fever/pyrexia <input type="checkbox"/> Headache <input type="checkbox"/> Seizure/convulsions <input type="checkbox"/> Skin reaction <input type="checkbox"/> Thromboembolic event <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other	<input type="checkbox"/> Not applicable <input type="checkbox"/> Not known
A3c	If 'other', please describe	<input type="text"/>	<input type="checkbox"/> Not applicable <input type="checkbox"/> Not known
A4	Have there been any Serious Adverse Events (including SARs/SUSARs)?  <b>If 'yes', please complete a Serious Adverse Events form</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A5a	Was a Do Not Attempt Resuscitation Order put in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not known
A5b	If yes, date order was put in place?	D ____ / M ____ / Y ____	<input type="checkbox"/> Not applicable <input type="checkbox"/> Not known

### Haemodynamic measures (day 2)

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<b>Hospital number</b>	C	<b>Trial number</b>		<b>Sex</b>	<b>Investigator</b>	
<b>Date of collection</b>	d /m /y	<b>Initials</b>		<b>Date of birth</b>	d /m /y	<b>Signature</b>

		<i>Systolic / Diastolic</i>	
A6a	Blood pressure – reading 1	<input type="text"/> / <input type="text"/> mmHg	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
A6b	Blood pressure – reading 2	<input type="text"/> / <input type="text"/> mmHg	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
A6c	Heart rate – reading 1	<input type="text"/> bpm	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
A6d	Heart rate – reading 2	<input type="text"/> bpm	<input type="checkbox"/> Not done <input type="checkbox"/> Not known

<b>Section B: Blood tests (day 2)</b>			
B1	Sodium	<input type="text"/> mmol/L	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
B2	Potassium	<input type="text"/> mmol/L	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
B3	Urea	<input type="text"/> mmol/L	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
B4	Creatinine	<input type="text"/> µmol/L	<input type="checkbox"/> Not done <input type="checkbox"/> Not known

<b>Section C: Second CT scan (day 2)</b>			
C1	Was a second CT scan performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not known
C2	Date/time of second CT scan ( <i>dd-mmm-yyyy hh:mm 24hr</i> )	D ____ / M ____ / Y ____ H ____ : M ____	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
C3	Explanation if no scan performed or data missing	<input type="text"/>	<input type="checkbox"/> Not applicable

<b>Section D: Glasgow coma scale (day 2)</b>			
D1	Eye movement	<input type="checkbox"/> 1 - None <input type="checkbox"/> 2 - To pain <input type="checkbox"/> 3 - To speech <input type="checkbox"/> 4 - Spontaneous	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
D2	Motor response	<input type="checkbox"/> 1 - None <input type="checkbox"/> 2 - Extension <input type="checkbox"/> 3 - Flexor response <input type="checkbox"/> 4 - Withdrawal <input type="checkbox"/> 5 - Localises pain <input type="checkbox"/> 6 - Obeys commands	<input type="checkbox"/> Not done <input type="checkbox"/> Not known

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D3	Verbal response	<input type="checkbox"/> 1 - None <input type="checkbox"/> 2 - Incomprehensible <input type="checkbox"/> 3 - Inappropriate <input type="checkbox"/> 4 - Confused <input type="checkbox"/> 5 - Orientated	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
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Section E: NIHSS (day 2)			
E1a	Level of consciousness (LOC)	<input type="checkbox"/> 0 - Alert; keenly responsive <input type="checkbox"/> 1 - Not alert; but arousable by minor stimulation <input type="checkbox"/> 2 - Not alert; requires repeated stimulation <input type="checkbox"/> 3 - Responds only with reflex motor or totally unresponsive	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E1b	LOC questions (month and age)	<input type="checkbox"/> 0 - Answers both questions correctly <input type="checkbox"/> 1 - Answers one question correctly <input type="checkbox"/> 2 - Answers neither question correctly	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E1c	LOC commands (open and close eyes; grip and release hand)	<input type="checkbox"/> 0 - Performs both tasks correctly <input type="checkbox"/> 1 - Performs one task correctly <input type="checkbox"/> 2 - Performs neither task correctly	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E2	Best gaze (horizontal only, for isolated CN paresis score 1)	<input type="checkbox"/> 0 - Normal <input type="checkbox"/> 1 - Partial gaze palsy <input type="checkbox"/> 2 - Forced deviation	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E3	Visual	<input type="checkbox"/> 0 - No visual loss <input type="checkbox"/> 1 - Partial hemianopia <input type="checkbox"/> 2 - Complete hemianopia <input type="checkbox"/> 3 - Bilateral hemianopia	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E4	Facial palsy	<input type="checkbox"/> 0 - Normal symmetrical movements <input type="checkbox"/> 1 - Minor paralysis <input type="checkbox"/> 2 - Partial paralysis <input type="checkbox"/> 3 - Complete paralysis of one or both sides	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E5a	Motor arm - left	<input type="checkbox"/> 0 - No drift <input type="checkbox"/> 1 - Drift <input type="checkbox"/> 2 - Some effort against gravity <input type="checkbox"/> 3 - No effort against gravity <input type="checkbox"/> 4 - No movement	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	Explanation if untestable (e.g. amputation or joint fusion)	<input type="text"/>	
E5b	Motor arm - right	<input type="checkbox"/> 0 - No drift <input type="checkbox"/> 1 - Drift <input type="checkbox"/> 2 - Some effort against gravity <input type="checkbox"/> 3 - No effort against gravity <input type="checkbox"/> 4 - No movement	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	Explanation if untestable (e.g. amputation or joint fusion)	<input type="text"/>	
E6a	Motor leg - left	<input type="checkbox"/> 0 - No drift <input type="checkbox"/> 1 - Drift <input type="checkbox"/> 2 - Some effort against gravity <input type="checkbox"/> 3 - No effort against gravity	<input type="checkbox"/> Not done <input type="checkbox"/> Not known

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		<input type="checkbox"/> 4 - No movement	
	Explanation if untestable (e.g. amputation or joint fusion)	<input type="text"/>	
E6b	Motor leg - right	<input type="checkbox"/> 0 - No drift <input type="checkbox"/> 1 - Drift <input type="checkbox"/> 2 - Some effort against gravity <input type="checkbox"/> 3 - No effort against gravity <input type="checkbox"/> 4 - No movement	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	Explanation if untestable (e.g. amputation or joint fusion)	<input type="text"/>	
E7	Limb ataxia	<input type="checkbox"/> 0 - Absent <input type="checkbox"/> 1 - Present in one limb <input type="checkbox"/> 2 - Present in two limbs	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	Explanation if untestable (e.g. amputation or joint fusion)	<input type="text"/>	
E8	Sensory	<input type="checkbox"/> 0 - Normal <input type="checkbox"/> 1 - Mild-to-moderate sensory loss <input type="checkbox"/> 2 - Severe to total sensory loss	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E9	Best language	<input type="checkbox"/> 0 - No aphasia <input type="checkbox"/> 1 - Mild-to-moderate aphasia <input type="checkbox"/> 2 - Severe aphasia <input type="checkbox"/> 3 - Mute, global aphasia	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
E10	Dysarthria	<input type="checkbox"/> 0 - Normal <input type="checkbox"/> 1 - Mild-to-moderate dysarthria <input type="checkbox"/> 2 - Severe dysarthria	<input type="checkbox"/> Not done <input type="checkbox"/> Not known
	Explanation if untestable (e.g. intubated or other physical barrier)	<input type="text"/>	
E11	Extinction and inattention	<input type="checkbox"/> 0 - No abnormality <input type="checkbox"/> 1 - Visual, tactile, auditory, spatial, or personal inattention <input type="checkbox"/> 2 - Profound hemi-inattention or extinction to more than one modality	<input type="checkbox"/> Not done <input type="checkbox"/> Not known

Are any values missing due to tests not done (or measures not taken), or because data are unknown and every effort has been made to find the data – i.e. 'Not done' / 'Not known'?	<input type="radio"/> Yes <input type="radio"/> No
Comments  If any values are missing, please provide a full explanation	<input type="text"/>

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