PhEAST – Frequently Asked Questions

Study Set Up:

Q: Can the PI for PhEAST be a non-medic?
A. Yes, for example a speech and language therapist, specialist nurse, as they can explain the benefit/risks of the intervention. It is advised to have a medic on the delegation log who can assist with SAEs.

Q: Are any additional blood samples for laboratory analysis required in PhEAST?
A: No additional blood tests are required. The results of blood tests performed as per standard of care relating to chest infections such as pneumonia will be collected.

Q: Do 'treaters' need to be GCP trained and have a Research CV?
A: Yes, staff members who are treating participants need to have their GCP, research CV and attend the SIV and face to face training.

Q: Do speech and language therapists who are only completing blinded bedside assessments need to be GCP trained?
A: No, as they are only completing their normal clinical role our sponsor has confirmed they do not need GCP training. However, they should attend the SIV and be signed on to the delegation log.

Q: Who is liable for the Phagenesis base station?
A: For the duration of the trial, sites will have their own base station under a loan agreement from the manufacturer, Phagenesis. In terms of the Loan agreement, the site is liable for any loss or damage arising out of or in connection with any negligence, misuse or mishandling of the device(s).

Q: What constitutes a recruit?
A: Once you have randomised a participant, this will count as a recruit. The catheter should be inserted, and treatment should begin as soon as possible after randomisation, if randomised to PES.

Q: What is the role of the SLT in this trial?
A: This varies by site. Eg. In Derby SLT are heavily involved in terms of helping with consenting and doing the treatment. In Nottingham the PI is SLT and research nurses do the treatment and assessment so depends on your research team.

Eligibility:

Q: Can we recruit participants who have COVID-19?

A: Yes, participants with COVID-19 can be recruited as long as they do not require more than 35% of oxygen. Researchers must follow their hospital policies and procedures with regards to PPE, and ensure the base station is adequately cleaned between participants.

Q: If a participant has a further stroke, can they remain in the trial?
A: Yes, please report this via the E-CRF.

Q: If a patient has already participated in the PhEAST trial, could they participate again if they had a recurrent stroke?
A: No - participants can only be enrolled into the PhEAST trial once, unless they withdraw consent and wish to participate again within the time frame (same stroke).

Q: If patients are receiving upper limb NMES, can they be recruited into the PhEAST trial?
A: Yes, NMES is only an exclusion when it is being used to treat dysphagia.

Q: Can participants who are awaiting VFS / FEES to assess swallow be entered into the trial?
A: If you are able to make a clinical diagnosis of dysphagia then yes. If you need to await VFS / FEES to get a diagnosis of dysphagia then please await the results of these before entering into the trial.

Q: What is the difference between a FOIS score of 2 and 3?
A: FOIS of 2 is up to and including 15 teaspoons of food / drink per day. FOIS 3 is still NG dependent, but above 15 teaspoons a day. Please see the trial manual for further guidance.

Q: Can we include patients who have purely oral dysphagia?
A: Yes.

Q: Can eligibility be confirmed by an SLT / research nurse?
A: Yes.

Q: Can we include patients who are experiencing total sensory loss?
A: Yes, these patients are great candidates to potentially receive PES.

Q: we use the water protocol a lot here, which would be recommending unlimited amounts of thin water but no other fluids. Do you know if this would count as level 3 on FOIS and therefore patients would be eligible for the study? Equally, on the DSRS would they score 0 under fluids?
A: Yes, there DSRS would be 0 for fluids, 4 for diet and 3 for supervision. Equally, they would score a 3 on the FOIS and therefore would be eligible for the trial.

Q: If a patient is downgraded from modified diet to NBM during their admission, do they have to be NBM for a certain amount of time prior to being enrolled into the trial?

A: No, no time frame here – as long as you think they are going to rapidly improve then they can be enrolled into the trial.

Q: Can patients be enrolled if they have a heart monitor (e.g. 'Zio patch')?
A: Yes. But pacemakers are an exclusion.

Q: Can patients be enrolled if their malignant MCA has been treated?
A: Yes. Do not enrol patients whilst they have an untreated malignant MCA – instead, wait for the patient to be stable following treatment (e.g. hemicraniectomy), and then enrol.

Q: Can a patient be enrolled if they have pre-morbid dysphagia that was caused by a previous stroke, and not caused by head and neck cancer, TBI, brain tumour etc?
A: No. The dysphagia in PhEAST must have been caused by their most recent stroke (index event).

Q: Can patients with subarachnoid haemorrhage (SAH) be enrolled?
A: No – these patients are not eligible for the trial.

Consent:

Q: Who can take consent?
A: Consent can be taken by NIHR CRN nurses/co-ordinators to recruit, all must be GCP-trained and on the delegation log. Written informed consent will be sought but a documented, witnessed mark or oral consent due to physical inability to sign is permitted.

Q: Can we use next of kin consent?
A: If a patient does not have capacity, you can attempt the consent of a consultee. Please use the correct paperwork for this. If the participant then regains capacity, you must attempt re-consent of the participant.

Q: Do we need to consent an informant even if the main trial participant has capacity?
A: Yes please, as the informants give us a different perspective on the participants' cognition. Please see the cognition sub-study WPD for more details on informant consent.

Treatment:

Q: Is the device for implementing the Pharyngeal Electrical Stimulation CE marked?
A. Yes. The device is being used for the purpose it was designed for, which allows for 3-6 days of stimulation.

Q: If the Phagenyx nasogastric catheter is pulled out, can it be replaced?
A: Yes, it should be replaced and treatment should continue as per protocol until the participant has received all 6 treatments. Treatment will be stopped early if the participant is ready for discharge.

Q: Can the trial catheters be used as standard NGTs?
A: Yes.

Q: Can you fit a bridle to the trial catheters?
A: Yes – size 12F.

Q: Do staff that insert catheters have to be GCP trained?
A: No, this can be anyone who is competent in inserting NGTs. Training is offered by the Phagenesis team for staff who insert catheters, although this is not mandatory. It is useful for a member of staff who has attended the Phagenesis training to be around at this time.

Q: Can the PI be a treater?
A: Yes.

Q: Is the trial catheter MRI compatible?
A: No. If a potential participant needs MRI to confirm a stroke, please wait until after they have had this done to recruit them into the PhEAST trial. If a participant needs an MRI scan whilst undergoing the treatment, the catheter will need removing and will not be replaced.

Q: Is the trial catheter CT compatible?
A: Yes – there is no evidence to suggest that the in-situ catheter is a contraindication to a CT scan.

Q: Who can deliver the PES treatment?
A: Anyone who has had the Phagenesis face to face training. This could be an SLT, research nurse or research coordinator.

Q: Can we treat two participants at the same time?
A: Yes, the catheters have special codes which when linked to the base station recognise which participant you are treating. Please follow your local policies and procedures with regards to cleaning the base station between participants.

Q: How soon after consent should we randomise, and how soon after randomisation should we treat (if randomised to PES)?
A: Please treat on the same day as randomisation, or the day after if unable to commence treatment that day. If a long gap is left between, then participants may return to oral food and drink, or deteriorate, and treatment will not happen. A protocol violation will be required for treatment that starts later than this.

Q: How do I know when the participant has reached their tolerability level before treatment?
A: We are looking for a body sign or twitch at which point the current is uncomfortable but not painful rather than a verbal response. It is important that the maximum current possible is supplied to the patient for maximum benefit. What we do know from previous trials if we undertreat then this method does not appear to work. So we suggest aim for as high current as possible and try not to ask 'how is it' or 'does it hurt?' and look for non-verbal responses instead.

When the base station calculates the treatment level, you can test this for 8 seconds prior to starting treatment.

Q: Can we run feed through the trial catheter whilst administering treatment?
A: No, please stop feed whilst administering treatment. It can remain connected to the stand though.

Q: Can we use the PES tubes to deliver medicine? Usage document states not to use with medicine?
A: As it is in the patient's best interest to be given medication during this trial whilst having PES it is ok. Sites should document that is off-label use and use the Phagenesis catheter as they would any other standard NG-tube. It is advised to make sure the medication is crushed really well and to flush the feeding tube afterwards to prevent any blockages.

Q: How many treatments are given in total?
A: 6 treatments are given in total, one a day, for six days. Please refer to the treatment schedule in the trial protocol or trial manual for more advice on treatment breaks.

Q: PES treatment must be given for 3 consecutive days before a break, however is it possible to take a second break during 'batch 2' treatments (i.e could we treat for three days, have a couple days off, treat once more, take another break and then resume)?
A: No, only one break is allowed, however this does not have to be after day 3. A MINIMUM of 3 consecutive treatments must be given. This means it is possible to administer 4 treatments and then have a break before the remaining 2 or even administer 5 before taking a break before the 6th and final treatment, but two breaks cannot occur.

Q: Can you provide advice on how to keep the trial catheters in?
A: Please consider using a bridle or mitts (with correct DOLs in place) if you think a patient may pull them out.

Q: Will we get any support with treatments?
A: Yes, Phagenesis and our central SLT offer to remotely support your treatments, if your participant is randomsied to PES.

Q: If a participant needs botox injections for excessive saliva, do they need to wait a certain amount of time post PES treatment?
A: There are no known contraindications to this, but one of the know treatment effects is improved secretion management.

Q: If we take a weekend break, when we login to the base station on a Monday the device is not registering all treatments, what should we do?
A: Please ensure all treatments are logged in the E-CRF on a daily basis so you don't lose any data. If the treatment break has exceeded 48 hours then the base station will lose the previous treatment, but don't worry about this (and carry on as normal and give the remaining due treatments). If treatment

break has not exceeded 48 hours and you still have this issue please get in touch with the trial team.

Training:

Q: Will training be given for the Pharyngeal Electrical Stimulation device?
A. The company supplying the device (Phagenesis Ltd) will provide in-person training to each individual site at set-up. In addition, all trial detail can be found within the trial manual for reference. A member of the central co-ordinating centre at STU Nottingham will be dedicated to this trial and will be able to answer any queries.

Q: Will we have an SIV?
A: Yes, all sites have a virtual SIV, which takes approximately 1.5 hours. This is in addition to the face to face training you will receive from Phagenesis.

Q: How long does the Phagenesis device training take?

A: This takes approx. 1.5 – 2 hours

Q: Can we get additional staff trained up whilst the trial is ongoing?
A: Please submit any additional training needs to the clinical trial manager

Q: If I've received the Phagenesis device training, can I then go on to train other members of staff on the use of the device?
A: No, all device training must be delivered by the Phagenesis trainers.

Database:

Q: How do we print off SAE forms, so that the PI can countersign these?
A: There is an option on RedCap to download a PDF of the SAE form. This needs to be printed out each time you record an SAE and must always be countersigned by the trial PI. You can then save the paper copy in the site file.

Q:Where can I find the trial documents?
A:All trial documents for your site file can be found and downloaded at https://stroke.nottingham.ac.uk/pheast/docs/

Q:How do I get a new member of staff access to the online delegation log?
A:Please get the new member of staff to complete the trial training (review of the SIV slides / recording of the SIV). If they have any queries they can email the trial team. Once they have signed the SIV log, they need to send this to the trial team who can then invite them to the database where the online delegation log is stored.

Q: Do the cognition CRFs need to be filled in prior to randomisation?

A: Ideally yes, so that all CRFs are complete. However, if you are tight on time you can complete them after randomisation, but please do as soon as possible afterwards.

Q: How do I upload documents to the secure vault?
A: Access supporting site from the left hand side of Redcap, you can then upload documents for each participant. Please see the Document Upload WPD for more assistance on this. They must be uploaded within 24 hours of consent for the central trial team to review.

Q: PES tube has come up and coiled in throat on multiple occasions. Corrected on multiple occasions. Research team decided to remove Pes and replace with standard NG tube to feed as planned (so ward staff could manage the tube and not require trial staff). How are events such as this recorded as not full treatment given?
A: Once a participant is in the trial, all information is recorded. For events such as this all forms would still be required to be filled out including the 6 PES delivery forms – there is an option to record that treatment was not given and explain why. Each participant is allowed 2 PES tubes if required, so a second tube could be inserted if necessary.

Day-14 Follow Ups:

Q: Who can complete the day 14 follow ups?
A: A blinded SLT must complete a bedside assessment, the SLT can then go on to do the rest of the PhEAST follow up, or a blinded researcher can take over. Please refer to WPD 008 Blinding for a more detailed overview of blinding in the PhEAST trial.

Q: Does a blinded SLT have to do **everything** at day-14?

A: No, but it is vital the bedside swallowing assessment is completed by a blinded SLT. Other assessments (QoL, cognition, NIHSS, etc) can be completed by another member of the team.

Q: Can a VFS/FEES be solely used the primary outcome data?

A: No. The primary outcome, DSRS, should always be a blinded bedside assessment of swallowing from the SLT. Results of a VFS/FEES can be known by the blinded SLT, prior to completing the bedside assessment. VFS/FEES data is collected during day-14, but performing a VFS/FEES is not a mandatory trial procedure.

Q: If a participant is discharged or sent to another hospital prior to day 14 follow up, how do we go about completing it?
A: If discharged home, please telephone and complete as much of the follow up with the NoK or participant over the phone. If discharged to another hospital, please see if you can call the team there, again to get as much information as possible.

Q: How do we complete a bedside assessment if a recent VFS / FEES has indicated that upgrades should be managed using VFS / FEES as opposed to at the bedside, for example due to silent aspiration?
A: This is quite common in stroke where there is silent aspiration etc - we don't often refer for a repeat VF so soon and often not at all - the ward SLTs tend to make judgements based on the VFS and how they manage the patient going forwards. It can make doing the follow-up bedside assessments more challenging especially if it is needed to be done quite soon after a VFS. Usually when a patient has a VFS/ FEES, they won't get a bedside assessment straight away, depending on the recs of course, but usually a recommendation is made and then the patient has those recs for a few days at the very least (especially if they are quite severe)
For PhEAST, the situation could come up (and has come up) where a patient had a VFS the day before the day 14 and then they need a bedside assessment for day 14 blinded assessment - this scenario would not be usual/ typical
They would have access to the VFS/ FEES information as this was carried out as usual care and it will be at the back of the bed, etc. The VFS or FEES will influence that bedside assessment and what the SLT does and it could mean they don't do a lot to change the recs at all (e.g. they may just check the recs) - especially if silent aspiration was seen on VFS/ FEES, etc

Q: How do we perform the GCS on participants suffering with aphasia?
A: Verbal response should be scored as per the aphasia (e.g a 2 if incomprehensible sounds) – the trial team will look at all 3 aspects of the GCS separately when analysing.

Q: If a participant passes away, do I need to record an SAE?
A: If they pass away prior to day 90, then yes, and this should be reported within 24 hours of knowledge of the event. We collect all fatal SAEs up until day 90.

Baseline Data:

Q: How do we know what stroke syndrome the participant has?
A: The deficits of each syndrome are explained in the brackets of the answers (e.g.TACS, weakness and/or numbness + dysphasia and/or neglect + hemianopia). Please choose the most relevant to the participant.

Q: If a patient is unable to answer some of the EAT-10 questions, how do we proceed to randomisation?
A: You can click the ‘M’ symbol next to the question, and report as not done / not known.

Serious Adverse Event Reporting:

Q: If a participant passes away and we complete the discharge / death form, do we still need to report a Serious Adverse Event?
A: Yes, all fatal SAEs are recorded and must be reported up until day 90.

Q: If the PI has signed the SAE form on redcap, do we also need to get a wet ink signature from them, and upload the form to the secure vault?
A: No, if the PI has reviewed and signed the form on redcap there is no need to do this.

Blinding

Q: If a participant has a VFS / FEES just before the day 14 follow up, can the blinded SLT know the outcome of them?
A: Yes, an unblinded SLT should give the blinded SLT a handover of the results. Please refer to the blinding WPD for more advice on blinding.

Q: Do the cognition forms need to be completed by a blinded researcher?
A: Ideally yes, but if unable to please complete unblinded, and write a comment at the bottom of the CRF to state it was done unblinded. The DSRS and associated SLT scales must be completed by a blinded SLT and researcher.

Q: What do I do if I become unblinded?
A: If you become inadvertently unblinded, see if there is another blinded member of staff who can do the follow up. If not, you can record on the CRF that you became unblinded, and how this happened.

Best Practice Tips:

Best practice tip:
When consenting a participant, please ensure you inform them that if they are randomised to receive PES, that they will need their standard NG tube replacing with a Phagenyx catheter, and that this will need replacing again with a standard NG tube at day 13 (if they are still requiring feeding).

Best practice tip:
If unsure of the FOIS score when working out eligibility, please consult the trial manual which gives detailed advice on how to score minimum amount and consistent amount trials.

Best practice tip:
Attempt recruitment into PhEAST as early as possible, so that participants are not discharged or moved to another hospital before the 14 day follow up.

Best practice tip:
The SLT team and research team should work together to screen and identify any potential participants.

Best practice tip:
Get ward nurses and doctors involved in the trial, they can be trained up to administer the treatment which can help with weekend cover, and even help to identify potential participants!