

# ADVERSE EVENT REPORTING

---

Kavita Patel

# Reporting Adverse Events

- The Adverse Event that is being reported must meet at least one of the following criteria below:
  1. Is likely related to study procedures (reasonable possibility or definitely), or
  2. Is serious, or
  3. Changes the function in the subject's affected arm
- If AE does not meet any of the three options, the AE form should not be filled out.

# Reporting Adverse Events

- Events existing prior to randomization should not be reported as AEs, unless there is a change in severity
- Pre-existing conditions that are discovered after randomization are not adverse events. These should be documented as medical history.

# Reporting Adverse Events

- Adverse Events are reported on Form 104
- Only 1 AE should be reported, per CRF
- Report AEs from end of week 1 visit to 30 day follow up visit
- Report the diagnosis, not the symptoms:  
Fever, cough, chest pain, crackles = pneumonia
- Death, surgery, intubation, etc. are not names of adverse events. They are outcomes of adverse events
- Avoid abbreviations/colloquialisms

# Reporting Adverse Events

Serious Adverse Events are:

- Fatal,
- Life-Threatening,
- Result in hospitalization
- Result in disability/congenital anomaly, or
- Require intervention to prevent permanent impairment or damage

# Reporting SAEs

SAEs require additional information

to be submitted on the AE CRF:

1. Detailed description of the event
2. Relevant tests/laboratory data
3. Relevant history and pre-existing conditions
4. Concomitant meds

# SAE Narrative

- Do not identify any subject, physician, or institution by name.
- Please provide a comprehensive SAE narrative:
  - ❖ "A [age] year old [male/female] presented on [mm/dd/yy] with \_\_\_\_\_ with initial NIHSS [score]. Patient was enrolled in TeleRehab, and randomized at \_\_\_\_\_ [mm/dd/yy]. On [mm/dd/yy], at \_\_\_\_\_ [days post treatment] the patient \_\_\_\_\_ [start of event, description of initial symptoms, course]. [Treatment course description in detail] \_\_\_\_\_. The patient developed \_\_\_\_\_ during hospitalization and was treated with \_\_\_\_\_. Patient was \_\_\_\_\_ [discharged/transferred/other course] on \_\_\_\_\_ [mm/dd/yy]. \_\_\_\_\_ [days] after discharge, the patient continued to decline cognitively. \_\_\_\_\_ [further description]"
- This example narrative can also be found in WebDCU → Toolbox → Project Documents → Data Collection Guidelines

# Data Entry Time Lines for AEs

- Non-serious AEs must be entered and **submitted** into WebDCU™ within 5 days of data collection.
- SAEs must be entered and **submitted** into WebDCU™ within **24 hours** of discovery