

# WOLLF

Wound Management of Open Lower Limb Fractures

## UK WOLLF

-UK Wound management of Open Lower Limb Fractures-

*A Randomised Controlled Trial of standard wound management versus negative pressure wound therapy in the treatment of adult patients with an open fracture of the lower limb*

Protocol version 6.0

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## Table of contents

<b>TABLE OF CONTENTS .....</b>	<b>4</b>
<b>ABBREVIATIONS .....</b>	<b>5</b>
<b>1. CONTACT DETAILS .....</b>	<b>6</b>
<b>2. BACKGROUND .....</b>	<b>8</b>
2.2 GOOD CLINICAL PRACTICE .....	9
2.3 CONSORT .....	9
<b>3. TRIAL DESIGN .....</b>	<b>10</b>
3.1 TRIAL SUMMARY .....	10
3.2 NULL HYPOTHESIS .....	10
3.3 OBJECTIVES.....	10
3.4 OUTCOME MEASURES.....	11
3.5 SAMPLE SIZE .....	12
3.6 METHODOLOGY.....	13
3.6.1 Eligibility .....	13
3.6.2 Recruitment and consenting.....	14
3.6.3 Qualitative sub-study .....	15
3.6.4 Trial ID.....	16
3.6.5 Randomisation.....	16
3.6.6 Post randomisation withdrawals/exclusions.....	16
3.6.7 Blinding .....	17
3.7 TRIAL TREATMENTS .....	17
3.7.1 Treatment options .....	17
3.7.2 Rehabilitation.....	18
3.7.3 Follow-up.....	18
3.8 ADVERSE EVENT MANAGEMENT .....	18
3.8.1 Adverse event management.....	18
3.8.2 Risks and benefits .....	19
3.9 END OF TRIAL .....	19
<b>4. DATA MANAGEMENT .....</b>	<b>20</b>
4.1 STATISTICAL ANALYSIS .....	20
4.2 ECONOMIC EVALUATION .....	21
<b>5. TRIAL OVERSIGHT .....</b>	<b>23</b>
5.1 TRIAL SUPERVISION .....	23
5.2 QUALITY CONTROL .....	23
5.3 INSURANCE AND INDEMNITY ARRANGEMENTS .....	23
5.4 DISSEMINATION.....	23
5.5 PROJECT TIMETABLE AND MILESTONES.....	24
<b>6. TRIAL FLOW DIAGRAM.....</b>	<b>25</b>
<b>7. APPENDICES .....</b>	<b>26</b>
<b>8. REFERENCES .....</b>	<b>28</b>
<b>9. SUMMARY OF PROTOCOL AMENDMENTS .....</b>	<b>30</b>

## Abbreviations

AE – Adverse Event  
BNF – British National Formulary  
CEAC - Cost-Effectiveness Acceptability Curves  
CI – Chief Investigator  
CRF – Clinical Reporting Form  
CTU – Clinical Trials Unit  
DMC – Data Monitoring Committee  
DRI – Disability Rating Index  
EQ-5D - EuroQol  
HE – Health Economy/Economist  
HTA- Health Technology Assessment  
ICER – Incremental Cost Effectiveness ratio  
MAU - Multi-Attribute Utility  
MCID – Minimal Clinically Important Difference  
NPWT – Negative Pressure Wound Therapy  
NPWT-EP - International Expert Panel on NPWT  
PACS - Picture Archiving and Communications System  
PI – Principal Investigator  
PSS – Personal Social Services  
PSSRU - Personal Social Services Research Unit  
QA – Quality Assurance  
RCT- Randomised Controlled Trial  
REC – Research Ethics Committee  
RF – Research Fellow  
SAE – Serious Adverse Event  
SAP – Statistical Analysis Plan  
SD – Standard Deviation  
SF 12 – Short Form health survey 12  
TMG – Trial Management Group  
TSC – Trial Steering Committee  
QALY – Quality Adjusted Life Year  
WCTU – Warwick Clinical Trials Unit  
WOLLF – Wound management of Open Lower Limb Fractures

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## 2. Background

Fractures of the lower limb are extremely common injuries in both the civilian and military populations. Fortunately, the majority of these injuries are 'closed' i.e. the skin around the fracture is intact. In such cases, the risk of infection is low. However, if the fracture is 'open' such that the barrier provided by the skin is breached, then the broken bone is exposed to contamination from the environment.

In open fractures, the risk of infection is greatly increased.<sup>1</sup> Wounds associated with open fractures of the lower limb are graded by severity as part of routine clinical practice using the classification of Gustilo and Anderson<sup>2</sup>; grade 1 injuries are small wounds (a laceration less than 1cm), grade 2 involve larger wounds (laceration greater than 1cm) but without extensive soft-tissue damage, and grade 3 wounds have a laceration greater than 1cm with extensive soft-tissue damage. In addition, Gustilo and Anderson described a special type of grade 3 injury that involved damage to a major blood vessel that required surgical repair. The greater the extent of the injury to the soft-tissues around the broken bone, the greater the risk of infection.<sup>2</sup> In severe, high-energy fractures of the lower limb, infection rates of 27% are still reported, even in specialist trauma centres.<sup>3</sup>

If complications such as surgical site infection occur, treatment frequently continues for years after the open fracture. There is a huge health care cost associated with such injuries (US study: \$163,000 if the limb can be salvaged and \$500,000+ if amputation is required), and this is a fraction of the subsequent personal and societal cost.<sup>4</sup> In the UK civilian population, the risk of an open long-bone fracture is approximately 11.5 per 100,000 per year,<sup>5</sup> but this is much higher in the military population and the severity of the injuries frequently greater.<sup>6</sup>

The initial management of open fracture of the lower limb in the Emergency Department, involves the removal of gross contamination, the application of a sealed dressing and the administration of antibiotics, as described in the joint British Orthopaedic Association/British Association of Plastic Reconstructive and Aesthetic Surgeons publication 'standards for the management of open fractures of the lower limb'. ([http://www.boa.ac.uk/site/show\\_publications.aspx?id=59](http://www.boa.ac.uk/site/show_publications.aspx?id=59)). Some patients may be transferred immediately to a hospital with specialist facilities (Major Trauma Centre). However, the key component of the management is the surgical 'debridement' - removal of all contaminated tissue and washout of the open fracture in the operating theatre. Once the wound is clean, the fracture is usually immobilised with some form of internal or external fixation and a dressing is applied. **This proposal concerns the type of dressing that is applied to the wound at the end of the operation.**

Traditionally, a non-adhesive layer is applied to the exposed area. This is then covered with a sealed dressing or bandage to protect the open fracture from further contamination. The wound is covered in this way until a second look and further debridement is performed in the operating theatre, usually 48 hours after the initial injury. This method has been used throughout the NHS and in military practice for many years. However, any bleeding or ooze from the open fracture will collect under or on the dressings; this may be uncomfortable for the patient and may pose an infection risk.

Negative-pressure wound therapy (NPWT) is an alternative form of dressing which may be applied to open fractures. In this treatment, an 'open-cell', solid foam is laid onto the wound followed by a sealed dressing. A hole is made in the dressing overlying the foam and a sealed tube is used to connect the foam to a pump which creates a partial vacuum over the wound. This negative-pressure therapy removes blood and ooze from the area of the wound, may also remove any bacteria left in the wound and encourages the formation of

'granulation' (healing) tissue.<sup>7</sup> Recent laboratory studies have also suggested that NPWT may

stimulate the release of 'cytokines' that encourage new blood vessel formation. <sup>8</sup> However, NPWT is considerably more expensive than traditional wound dressings, both for the dressing itself and the associated machinery which generates the partial vacuum.

NPWT has shown encouraging results in clinical trials related to diabetic foot wounds <sup>9</sup> and abdominal wounds<sup>10</sup>, but there is only one randomised trial comparing standard wound dressing with NPWT for patients with open fractures of the lower limb. <sup>11</sup> This trial demonstrated a reduction in the rate of wound infection in the group of patients treated with NPWT. However, the study had relatively small numbers (59 patients, 63 fractures), was single-centre, included only the most severe types of injury and was funded by a commercial company which produces a NPWT system. There are no similar trials registered on the international trials database.

Despite the limited supporting evidence, the current British Orthopaedic/British Association of Plastic Surgery guidelines (<http://www.boa.ac.uk/site/showpublications.aspx?id=59>), for the management of open fractures of the lower limb already include reference to the use of NPWT. A recent consensus paper, published by the International Expert Panel on NPWT (NPWT-EP) <sup>12</sup>, also recommended that NPWT "should be considered when primary closure is not possible" in the management of wounds associated with open fractures, but acknowledged that the evidence base to support this statement was very limited.

We believe that there is a pressing need to evaluate this relatively expensive technology. We therefore propose a multi-centre randomised clinical trial comparing negative-pressure wound therapy with standard dressings for patients with wounds associated with open fractures of the lower limb.

## **2.2 Good Clinical Practice**

The trial will be conducted in accordance with the Medical Research Council's Good Clinical Practice (MRC GCP) principles and guidelines, the Declaration of Helsinki, Warwick Clinical Trials Unit SOPs, relevant UK legislation and the Protocol. GCP-trained personnel will conduct the trial.

## **2.3 Consort**

The trial will be reported in line with the CONSORT statement

### 3. Trial design

#### 3.1 Trial summary

The proposed project is a two-phased study. Phase 1 (Feasibility phase) will assess the feasibility of running a large-scale multi-centre randomised controlled trial in this complicated area of trauma research. Phase 2 (Main phase) will consist of conducting the proposed randomised controlled trial in a minimum of 20 trauma centres across the UK.

##### Feasibility summary

The feasibility phase will take place in 5 centres over a period of 6 months. The trial will run as described below for the main trial, with the addition of a qualitative sub-study assessing patients' experience of giving consent for the trial and the acceptability of the trial procedures to patients and staff. Screening logs will be kept at each site to determine the number of patients assessed for eligibility and reasons for any exclusion. In addition, the number of eligible and recruited patients, and the number of patients who withdraw, will be recorded.

##### Main RCT summary

All adult patients presenting at the trial centres within 72 hours of sustaining an open fracture of the lower limb are potentially eligible to take part in the trial. Inclusion within the trial depends on the severity the wound associated with the fracture. Gustilo and Anderson Grade 2 and 3 injuries will be included.

A randomisation sequence, stratified by trial centre and Gustilo and Anderson grade, will be produced and administered by a secure web-based service. The random allocation will be to either standard wound management or negative pressure wound therapy.

The patients will have clinical follow-up in the local fracture clinic up to a minimum of 12 months as per standard NHS practice after this injury. Functional and quality of life outcome data will be collected using the DRI, SF12 and EQ-5D questionnaires at 3 months, 6 months, 9 months and 12 months post-operatively. These questionnaires will be administered centrally by a data administrator via post or telephone or they will be collected during routine clinic appointments by the local research associate. In addition, at the same time-points, information will be requested with regards to resource use and any late complications or surgical interventions related to their injury with specific note of continuing treatment for deep infection.

#### 3.2 Null hypothesis

There is no difference in the Disability Rating Index score (DRI) one year post-injury between adult patients for an open fracture to the lower limb treated with standard wound dressings versus negative pressure wound therapy before definitive wound closure.

#### 3.3 Objectives

This pragmatic randomised controlled trial will compare standard dressings with negative-pressure wound therapy in the treatment of wounds associated with open fractures of the lower limb.

The specific objectives for the feasibility phase of this study are:

*FEAS 1)* a qualitative assessment of patients' experience of sustaining a fracture of the lower limb, being enrolled in the study giving or declining consent for the trial and the acceptability of the trial procedures to patients and staff

*FEAS 2)* to determine the number of *eligible, recruited and withdrawn patients* in the 5 feasibility trauma centres over the course of 6 months. In addition, to determine if any of the trial patients

lack capacity to consent 6 weeks post injury.

At the end of the feasibility phase, the Trial Management Group will provide a report to the Trial Steering Committee. The report will show the actual rate of recruitment at the five centres involved in the feasibility phase compared with the target rate of recruitment (one patient per month per centre), in the context of the results of the qualitative study. If the patients are willing to give their consent and the rate of recruitment achieves the target rate by the end of the feasibility phase, we would anticipate proceeding to the main trial.

The primary objective for the full RCT is:

*MAIN 1)* To quantify and draw inferences on observed differences in the Disability Rating Index at 12 months after the open fracture.

The secondary objectives are:

*MAIN 2)* To quantify and draw inferences on patient-reported differences in 'deep infection' of the limb, in the 12 months after the open fracture. Photographs will be used to assess wound healing. Any infection that requires continuing medical intervention or has already led to amputation at or after the six week review will be considered a 'deep' infection.

*MAIN 3)* To quantify and draw inferences on observed differences in general quality of life (SF-12 and EQ-5D) in the 12 months after the open fracture.

*MAIN 4)* To determine the number and nature of further surgical interventions related to the injury, during the first 12 months after the open fracture.

*MAIN 5)* To investigate, using appropriate statistical and economic analysis methods, the resource use, and thereby the cost effectiveness, of negative pressure wound therapy versus standard dressing for wounds associated with open fractures of the lower limb.

### 3.4 Outcome measures

The primary outcome measure for this study is the **Disability Rating Index (DRI)** a self-administered, 12-item Visual Analogue Scale questionnaire assessing the patients' own rating of their disability.<sup>13</sup> This measure was chosen as it addresses "gross body movements" rather than specific joints or body segments. Therefore, it will facilitate the assessment of patients with different fractures of the lower limb.

The secondary outcome measures in this trial are:

**Deep Infection;** We will use the *Centers for Disease Control and Prevention* definition of a "deep surgical site infection": that is a wound infection involving the tissues deep to the skin that occurs in the first year following the injury.<sup>14</sup> Any infection that requires continuing medical intervention or has already led to amputation at or after the routine six-week outpatient appointment will be considered a deep infection.

We will use photographs of the wound at the 6-week clinical follow-up in order to provide an objective assessment of wound healing and infection. X-rays taken at 6 weeks and 12 months post-injury will be assessed for further indicators of infection - periosteal reaction/lysis at 6 weeks and chronic osteomyelitis at 12 months post-injury. The photographs and x-rays will be reviewed by two independent experienced assessors who are blind to the treatment allocation. In addition, patients will be asked to self-report on any further signs of infection and on any medical/surgical intervention related to infection associated with their open fracture, at each of the follow-up points.

**EuroQol EQ-5D;** The EuroQol EQ-5D is a validated measure of health-related quality of life, consisting of a five dimension health status classification system and a separate visual analogue scale. <sup>15</sup> Responses to the health status classification system will be converted into multi-attribute utility (MAU) scores using a published utility algorithm. <sup>16</sup> These MAU scores will be combined with survival data to generate QALY profiles for the purposes of the economic evaluation.

**SF-12;** The Short-Form 12 is a validated and widely-used health-related quality of life measure (21). Each permutation of response to the SF-12 will be converted into a MAU score using a published utility algorithm. <sup>17</sup> These data will be combined with survival data to generate QALY profiles for the purposes of the economic evaluation.

**Complications;** all complications and surgical interventions related to the open fracture will be recorded.

**Resource use** will be monitored for the economic analysis. Unit cost data will be obtained from national databases such as the BNF and PSSRU Costs of Health and Social Care (20). Where these are not available the unit cost will be estimated in consultation with the UHCW finance department. The cost consequences following discharge, including NHS costs and patients' out-of-pocket expenses will be recorded via a short questionnaire which will be administered at 3, 6, 9 and 12 months post surgery. Patient self-reported information on service use has been shown to be accurate in terms of the intensity of use of different services <sup>18</sup>.

**WallTR Scale;** This new patient-reported measure of recovery from lower limb injuries will be used in a subset of patients. This subset will be from 5 of the WOLLF sites: Morriston Hospital, Royal London Hospital, John Radcliffe Hospital, Frenchay Hospital and Royal Victoria Hospital.

We will use techniques common in long-term cohort studies to ensure minimum loss to follow-up, such as collection of multiple contact addresses and telephone numbers, mobile telephone numbers and email addresses. Considerable efforts will be made by the trial team to keep in touch with patients throughout the trial by means of newsletters etc.

TIME POINT	DATA COLLECTION
Baseline	DRI and SF-12 <i>pre-injury</i> , EQ-5D <i>pre-injury and contemporary</i> , routine radiographs of leg wound(s)
6 weeks	Complication records, radiographs, operative record, photograph of leg wound(s)
3 months	DRI, EQ-5D, SF-12 record of complications/rehabilitation or other interventions and economics questionnaire
6 months	DRI, EQ-5D, SF-12 record of complications/rehabilitation or other interventions and economics questionnaire
9 months	DRI, EQ-5D, SF-12 record of complications/rehabilitation or other interventions and economics questionnaire
12 months	DRI, EQ-5D, SF-12 record of complications/rehabilitation or other interventions and economics questionnaire, radiographs

**Table 1** Follow-up measures

### 3.5 Sample size

The minimum clinically important difference (MCID) for the primary outcome measure (DRI) is assumed to be 8 points <sup>13</sup>. The DRI is a 12 item, patient reported, functional outcome questionnaire that is transformed to a 100 point scale, where 0 represents normal function and 100 complete disability. At an individual patient level, a difference of 8 points represents the ability to climb stairs or run with 'some difficulty' versus with 'great

difficulty'. At a population level, 8 points represents the difference between a 'healthy patient' and a 'patient with a minor disability'.

The standard deviation (SD) of the DRI was estimated from a previous study involving fractures of the lower limb in a UK trauma setting, (Distal Tibia Fracture Trial: British Trauma Society 2011) to be approximately 20 points. Although the predicted disability at one year is anticipated to be closer to the lower end of the disability scale (approx. 30 points) than the middle, we are assuming that the distribution of DRI in the study populations to be approximately normal, which is consistent with assumptions made for other reported trials using DRI as the primary outcome measure. The Table below shows the total trial sample size with two-sided significance set at 5% for various scenarios of power and sample SD.

SD	Power	
	80%	90%
15	112	150
20	198	264
25	308	<b>412</b>

The bold figure of 412 patients represents a conservative scenario, based on a SD of 25 and 90% power to detect the selected MCID. However, a sample size of 308 patients would still provide 80% power. Allowing a margin of 10% loss during follow-up, including the small number of patients who die in the first year following their injury, this gives a figure of **460** patients in total. Therefore, 230 patients consented to each group will provide 90% power to detect a difference of 8 points in DRI at 12 months at the 5% level.

### 3.6 Methodology

#### 3.6.1 Eligibility

Patients will be eligible for this study if:

- They are aged 16 years or older
- Present to the trial hospital within 72 hours of injury
- Have an open fracture of the lower limb – graded as Gustilo and Anderson 2 or 3.

Patients will be included if they are transferred from another hospital to a trial centre within 72 hours of their injury. (A very small number of patients may present after 72 hours, but there is a possibility that any wound would already be infected with later presentations)

Patients will be excluded from participation in this study if:

- There are contra-indications to anaesthesia such that the patient is unable to have surgery
- There is evidence that the patient would be unable to adhere to trial procedures or complete questionnaires, such as permanent cognitive impairment. It is expected that for a very small proportion of patients this exclusion criterion will only be determined after randomisation has taken place. These patients will then be excluded from the study and no patient identifiable data will be retained.

Patients who sustain other injuries which may affect the primary outcome measure will have their injuries documented but will be included in the analysis.

### **3.6.2 Recruitment and consenting**

The feasibility phase of the study will specifically inform and test the recruitment rate for the main trial as well as assess the acceptability of the process of consent. Recruitment will take place in 5 trial centres over a period of 6 months for the feasibility phase. The expected rate of recruitment is based on recent audit data from two of the centres (Oxford and Coventry). In these centres, an average of 4 eligible patients are admitted with an open fracture to the lower limb every month. All centres involved in the trial will be Major Trauma Centres or Trauma Units with similar catchment areas as the five initial sites. During the main phase of the trial, trial site recruitment of the remaining sites will occur over a period of 8 months. Recruitment in these sites will take place over a period of 27 months to reach the target of a minimum of 460 patients.

Patients will be screened from the Emergency Department at the trial centres. All patients with an open fracture of the lower limb will be screened for eligibility by a research associate.

The nature of these injuries means that the great majority of patients will be operated on immediately or on the next available trauma operating list, depending on access to an appropriate operating theatre. A small number of patients are transferred between hospitals or wait for an operation and could potentially give consent prior to randomisation. These are the patients who may wait up to 72 hours before surgery.

Some patients may be unconscious, all will be distracted by the injury to their leg and its subsequent treatment all will have had large doses of opiates for pain relief, affecting their ability to process information. The great majority of patients will therefore lack capacity to make a decision about participation in a research project at this stage. In this emergency situation the focus will be on informing the patient and any next of kin about immediate clinical care. There will be limited time for the patient, if they had capacity, or their next of kin to review trial documentation and make an informed decision about whether they would wish to participate.

Conducting research in this 'emergency setting' is regulated by the *Mental Capacity Act 2005*. As patients are likely to lack capacity as described above, and because of the urgent nature of the treatment limiting access to and appropriate discussion with personal consultees, we propose to act in accordance with section 32, subsection 9b of the MCA following a process approved by the relevant research ethics committee. The patients who have surgery on the next available trauma operating theatre enter the study under presumed consent, We will not obtain consent prior to surgery but inform the patient and seek patient consent for continuation in the trial at the first appropriate time point in the post-operative period.

For those patients that are able to consent before their operation, namely those who have been transferred or are waiting up to 72hrs for their operation, will be approached by the research team for consent into the study.

A small number of the patients who have their surgery delayed, may still not have capacity e.g. those who are unconscious. If the clinical team in charge of that patients care do not think that the patient is able to provide clinical consent for their operation, then the research team will approach a consultee for agreement to randomisation. The patient themselves will be approached for consent as soon as the clinical team deem that they have regained capacity following their operation.

The treating surgeon will determine the final grade of the open fracture at the end of the debridement of the wound as per routine practice in the operating theatre, and then patients will automatically be enrolled into the study via the online randomisation system.

For those patients that did not consent prior to surgery, at the first appropriate time when the patient has regained capacity, the research associate will provide the patients with all of the study information. The patients will be given the opportunity to ask questions and discuss the study with their family and friends. They will then be asked to provide written consent for continuation in the study.

Throughout the whole study, screening logs will be kept at each site to determine the number of patients assessed for eligibility and reasons for any exclusion. Patients who decline to continue to take part during the feasibility phase will be given the opportunity to discuss/inform the research team of their reasoning behind their decision not to take part.

Any new information that arises during the trial that may affect participants' willingness to take part will be reviewed by the Trial Steering Committee; if necessary this will be communicated to all participants. A revised consent form will be completed if necessary.

### **3.6.3 Qualitative sub-study**

Within the feasibility study, a qualitative sub study will assess patient experience of having an open fracture of the lower limb, being enrolled in the study, giving or declining consent for the trial and the acceptability of the trial procedures.

The sample will include patients at two sites (Coventry and Oxford). This will include both standard wound care and negative pressure wound therapy. Semi structured interviews will be undertaken with up to 20 consecutive patients who provide informed consent for the interview during their hospital stay. Participants will be given information about the interview study and provide written consent. The interviews will be conversational in style<sup>19</sup> and focus on three areas i) the experience of open fracture of the lower limb ii) the impact and acceptability of the trial procedures and iii) the process of consent to a trial. Those who preferred not to take part in the trial will be asked to tell us about i) the experience of open fracture of the lower limb and ii) their thoughts and feelings about the trial. The key interview questions will be what is it like: to experience an open fracture; have an open wound and dressing/negative pressure wound therapy; to be part of a trial/prefer not to take part in a trial? These will be followed by prompts such as: tell me more about that; how did that affect you; how did you feel about that; what were you thinking at that point. The interviews will take place in hospital when the patients are well enough and feel able to take part. Where possible, they would take place in a private area on the ward, but at the bedside is likely due to the nature of the injury. Due attention will be paid to privacy and dignity and the interview will be stopped and reconvened if the patient feels uncomfortable or their privacy is compromised.

Interviews will be performed with both patients who agree to continue in the trial and those who decline to be further involved. The research team are aware that ethically patients do not have to provide a reason for their choice and should not be coerced in anyway. However in light of limited knowledge in this area the value of understanding what trauma patients' think and feel about research in this context would be substantial and would help to inform the recruitment process in the main trial. The researcher would take an exploratory, non-judgemental stance allowing the patient to tell their story. As interviews will take place with

participant refusers after they have withdrawn from the trial the interview cannot be construed as coercive in relation to the trial.

Two focus groups, 1 on each site, of up to 12 staff, will be undertaken with staff involved in the management of the trial or the management of patients in the trial. This will include surgeons, emergency department staff, theatre staff, ward staff and research staff. The participants will consider the factors that facilitate and inhibit the daily process of running the trial. This will include optimal timing and method to approach the patient with the participant information. Focus groups are a good way to access a range of views on a topic and provide opportunities for debate and challenge within the group.<sup>20</sup> Managing the dynamics of a group is important to ensure all participants have a chance to share their views and strong views are contained. Due attention will be paid to this through the use of basic ground rules and good facilitation of the group. The focus groups will take place in a quiet room away from interruptions. The interviews and focus groups will be digitally recorded and transcribed verbatim. Analysis will be line by line, identifying codes, building categories and themes, drawing on the work of Miles and Huberman.<sup>21</sup> NVivo9 a software package for qualitative data will be used to help with data management. The intention of the patient interviews is to understand how patients make sense of their treatment and to specifically address any issues related to their consent to participate. The focus groups will develop a greater understanding of the factors that facilitate and inhibit the process of the trial. The qualitative data will be used to provide depth of understanding of the process to augment the quantitative data.

#### **3.6.4 Trial ID**

When a patient enters the trial, sufficient non-identifiable details will be logged on a secure, encrypted, web-based system, provided by York Clinical Trials Unit. Basic information including the patient initials, date of birth, gender and eligibility checks will be entered. The patient will then receive a trial ID that will be used on all trial documentation.

#### **3.6.5 Randomisation**

The allocation sequence will be generated by an independent randomisation centre -York Clinical Trials Unit. Randomisation will be on a 1:1 basis, stratified by trial centre and Gustilo and Anderson grade – 2, 3, or 3 with vascular injury requiring surgical repair. Eligibility for the trial is based upon a wound of grade 2 or above, which will be established definitively at the end of the initial surgical debridement in the operating theatre as per routine clinical practice. Therefore, participants will be assigned to their treatment allocation at the end of the initial surgery but before the wound dressing is applied. All modern operating theatres include a computer with web-access, so a secure, 24-hour, web-based randomisation system will be used to generate the treatment allocation intra-operatively.

#### **3.6.6 Post randomisation withdrawals/exclusions**

Participants will be excluded in the post-randomisation phase if it is established that they would be unable to adhere to trial procedures or complete questionnaires eg permanent cognitive impairment.

Participants may decline to continue to take part in the trial at any time without prejudice. A decision to decline consent or withdraw will not affect the standard of care the patient receives.

Participants have three options for withdrawal;

- 1) Participants may withdraw from completing any further questionnaires but allow the trial team to still view and record anonymously any relevant hospital data that is recorded as part of normal standard of care; i.e x-rays and further surgery information.
- 2) Participants can withdraw wholly from the study but data obtained up until the point of withdrawal will be included in the final analysis of the study, thereafter no further data will be collected for that participant.
- 3) Participants can withdraw wholly from the study and data collected up until the point of withdrawal will not be included in the final analysis.

Once withdrawn, the patient will be advised to discuss their further care plan with their surgeon.

### **3.6.7 Blinding**

As the wound dressings are clearly visible, the patients cannot be blind to their treatment. In addition, the treating surgeons will also not be blind to the treatment, but will take no part in the post-operative assessment of the patients. The functional outcome data will be collected and entered onto the trial central database via postal questionnaire by a research assistant/data clerk in the trial central office.

In addition, we will use photographs of the wound at the 6-week clinical follow-up to provide an objective assessment of wound healing and infection. The photographs will be reviewed independently by two experienced assessors who are blind to the treatment allocation.

### **3.7 Trial treatments**

Patients with an open fracture of the lower limb usually have surgery on the next available trauma operating list. Some patients may be transferred to a Major Trauma Centre for definitive care – within the first 48 hours of injury – but will still have their initial surgery as soon as possible. All patients will receive a general or regional anesthetic. The wound associated with the fracture is ‘debrided’ (surgical decontamination and clean) in the operating theatre and the fracture is treated with either internal or external fixation. At the end of the initial operation, a dressing is applied to the wound. This trial will compare two types of wound dressing; standard dressing versus negative pressure wound therapy.

#### **3.7.1 Treatment options**

**Standard dressing.** The standard dressing for open fractures comprises a non-adhesive layer applied directly to the wound which is covered by a sealed dressing or bandage. The standard dressing does not use ‘negative pressure’. The exact details of the materials used will be left to the discretion of the treating surgeon as per their routine practice but the details of each dressing applied in the trial will be recorded.

**Negative-pressure wound therapy.** The NPWT dressing uses an ‘open-cell’, solid foam which is laid onto the wound followed by an adherent, sealed dressing. A hole is cut in the layer over the foam and a sealed tube is used to connect the foam to a pump which creates a partial vacuum over the wound. The basic features of the NPWT are universal, but the exact details of the dressing will be left to the discretion of the treating surgeon. Again, the details of the dressings used will be recorded in the trial documentation.

Both groups of patients will then follow the normal post-operative management of patients with an open fracture of the lower limb. This will usually involve a ‘second-look’ operation after 48 hours, where a further debridement is performed and the wound closed (with sutures or a soft-

tissue graft as necessary). Depending upon the specific injury and according to the treating surgeons' normal practice, the wound may be re-dressed again pending further surgery. Any further wound dressing will follow the allocated treatment until definitive closure/cover of the wound is achieved.

### **3.7.2 Rehabilitation**

The rehabilitation will be recorded but left entirely to the discretion of the treating surgeon, as the type of injury will vary between patients

### **3.7.3 Follow-up**

Baseline, standardised radiographs will be copied onto CD from the hospital PACs (archiving) system. Copies of the baseline clinical report forms (CRFs) and CD will be delivered to the trial co-ordinating centre.

The research associate will make a record of any early complications at the routine 6-week follow-up appointment and take a photograph of the wound. This data will be returned to the trial co-ordinating centre together with a copy of the routine 6-week follow-up radiograph. The number and timing of any subsequent follow-up appointments will be at the discretion of the treating surgeon.

All patients will be reviewed at 12 months as per routine practice after this type of injury. Details of any late complications and copies of the 12-month radiographs will be sent to the trial co-ordinating centre.

The functional outcome data will be collected using questionnaires at 3, 6, 9 and 12 months post-operatively. In addition to the DRI, the patients will be asked to fill out the EuroQol and SF-12 questionnaires and a complications/further surgical interventions and health economics questionnaire. The 3, 6 and 9 months post-operative questionnaires will be sent to the patients through the post; a process done centrally by a data clerk at the Warwick Clinical Trials Unit. All of the outcome questionnaires can be completed over the phone if postal copies are not returned. Patients will be asked to complete their 12 months post-operative questionnaire during their routine follow-up appointment one year post operation.

## **3.8 Adverse event management**

### **3.8.1 Adverse event management**

Adverse events (AE) are defined as *any untoward medical occurrence in a clinical trial subject and which do not necessarily have a causal relationship with the treatment*. All AEs will be listed on the appropriate Case Report Form for routine return to the 'WOLLF' central office.

Serious adverse events are defined as *any untoward and unexpected medical occurrence that:*

1. *Results in death,*
2. *Is life-threatening*
3. *Requires hospitalisation or prolongation of existing inpatients' hospitalisation,*
4. *Results in persistent or significant disability or incapacity,*
5. *Is a congenital anomaly or birth defect*
6. *Any other important medical condition which, although not included in the above, may require medical or surgical intervention to prevent one of the outcomes listed.*

All serious adverse events (SAE) will be entered onto the Serious Adverse Event reporting form and faxed to dedicated fax at WMSCTU within 24 hours of the investigator becoming aware of them. Once received, causality and expectedness will be confirmed by the Chief Investigator.

SAEs that are deemed to be unexpected and related to the trial will be notified to the Research Ethics Committee (REC) within 15 days. All such events will be reported to the Trial Steering Committee and Data Monitoring Committee at their next meetings.

Some adverse events are expected as part of the surgical interventions, and do not need to be reported immediately to the Clinical Trials Unit, provided they are recorded in the 'Complications' section of the Case Report Forms and/or Patient Questionnaires. These events are: complications of anaesthesia or surgery (wound infection, bleeding or damage to adjacent structures such as nerves, tendons and blood vessels, delayed unions/non-unions, delayed wound healing, further surgery to remove/replace metalwork and thromboembolic events).

All participants experiencing SAEs will be followed-up as per protocol until the end of the trial.

All SAEs or SUSARs that occur between date of *consent* and *12 month follow-up point* will be reported.

### **3.8.2 Risks and benefits**

The risks associated with this study are predominantly the risks associated with the injury and the surgery: infection, bleeding and damage to the adjacent structures such as nerves, blood vessels and tendons. Participants in both groups will undergo surgery and will potentially be at risk from any/all of these complications. Allocation of the trial intervention will take place at the end of the initial surgery so that there is no difference between the groups in terms of surgical risk.

Both standard wound dressings and NPWT have been used widely in both the civilian and military settings and there are no specific risks associated with the use of either type of wound management - other than a potential reduction in the rate of wound complications which is the focus of this trial.

### **3.9 End of trial**

The end of the trial will be defined as the collection of 1-year outcome data from the last participant.

## 4. Data Management

The Case Report Forms will be designed by the trial coordinator in conjunction with the trial management team. All electronic patient-identifiable information will be held on a secure, password-protected database accessible only to essential personnel. Paper forms with patient-identifiable information will be held in secure, locked filing cabinets within a restricted area of Warwick Medical School. Patients will be identified by a code number only. Direct access to source data/documents will be required for trial-related monitoring. All paper and electronic data will be retained for at least five years after completion of the trial.

### 4.1 Statistical Analysis

#### Feasibility Study

At the end of the feasibility phase, the overall mean recruitment at the five selected centers for this phase of the study will be estimated (with a 95% confidence interval) and compared to the target rate of one patient per month per centre. The estimated recruitment rate and the overall rate of withdrawn patients in the feasibility phase will inform both the design and the decision to proceed to the main RCT.

#### Main RCT

Standard statistical summaries (e.g. medians and ranges or means and variances, dependent on the distribution of the outcome) and graphical plots showing correlations will be presented for the primary outcome measure and all secondary outcome measures. Baseline data will be summarized to check comparability between treatment arms, and to highlight any characteristic differences between those individuals in the study, those ineligible, and those eligible but withholding consent.

The main analysis will investigate differences in the primary outcome measure, the Disability Rating Index (DRI) score at one year after injury, between the two treatment groups (standard wound dressings and negative pressure wound therapy) on an intention-to-treat basis. In addition, early functional status will also be assessed and reported at 3, 6 and 9 months. Differences between groups will be assessed, based on a normal approximation for the DRI score at 12 months post-injury, and at interim occasions. Tests will be two-sided and considered to provide evidence for a significant difference if p-values are less than 0.05 (5% significance level).

The stratified randomization procedure should ensure a balance in Gustilo and Anderson grade and the recruiting centre between test treatments. Although generally we have no reason to expect that clustering effects will be important for this study, in reality the data will be hierarchical in nature, with patients naturally clustered into groups by recruiting centre. Therefore we will account for this by generalizing the conventional linear (fixed-effects) regression approach to a mixed-effects modelling approach; where patients are naturally grouped by recruiting centres (random-effects). This model will formally incorporate terms that allow for possible heterogeneity in responses for patients due to the recruiting centre, in addition to the fixed effects of the treatment groups, Gustilo and Anderson grade and other patient characteristics that may prove to be important moderators of the treatment effect such as age and gender.

It seems likely that some data may not be available due to voluntary withdrawal of patients, lack of completion of individual data items or general loss to follow-up. Where possible the reasons for data 'missingness' will be ascertained and reported. Although missing data is not expected to be a problem for this study, the nature and pattern of the missingness will be

carefully considered — including in particular whether data can be treated as missing completely at random (MCAR). If judged appropriate, missing data will be imputed, using the multiple imputation facilities available in R (<http://www.r-project.org/>). The resulting imputed datasets will be analyzed and reported, together with appropriate sensitivity analyses. Any imputation methods used for scores and other derived variables will be carefully considered and justified. Reasons for ineligibility, non-compliance, withdrawal or other protocol violations will be stated and any patterns summarized. More formal analysis, for example using logistic regression with 'protocol violation' as a response, may also be appropriate and aid interpretation. About 1-2% of patients are expected to die during follow-up, so this is unlikely to be a serious cause of bias. However, we will conduct a secondary analysis taking account of the competing risk of death, using methods described by Varadhan et al 2010.<sup>22</sup>

The main analyses will be conducted using specialist mixed-effects modelling functions available in the software package R (<http://www.r-project.org/>) where DRI data will be assumed to be normally distributed; possibly after appropriate variance-stabilising transformation. The primary focus will be the comparison of the two treatment groups of patients, and this will be reflected in the analysis which will be reported together with appropriate diagnostic plots that check the underlying model assumptions. Results will be presented as mean differences between the trial groups, with 95% confidence intervals.

Secondary analyses will be undertaken using the above strategy for approximately normally distributed outcome measures SF-12 and EQ5D. For dichotomous outcome variables, such as indicators of deep infection and other complications related to the trial interventions, mixed effects logistic regression analysis will be undertaken with results presented as odds ratios (and 95% confidence intervals) between the trial groups. Also, temporal patterns of any complications will be presented graphically and if appropriate a time-to-event analysis (Kaplan-Meier survival analysis) will be used to assess the overall risk and risk within individual classes of complications.

A detailed statistical analysis plan (SAP) will be agreed with the Data Monitoring Committee (DMC). Any subsequent amendments to this initial SAP will be clearly stated and justified. Interim analyses will be performed only where directed by the DMC. The routine statistical analysis will mainly be carried out using R (<http://www.r-project.org/>) and S-PLUS (<http://www.insightful.com/>). Results from this trial will also be compared with results from other trials.

#### 4.2 Economic evaluation

An economic evaluation will be integrated into the trial design. The economic evaluation will be conducted from the recommended NHS and personal social services (PSS) perspective.<sup>22</sup> Data will be collected on the health and social service resources used in the treatment of each trial participant during the period between randomisation and 12 months post-randomisation. Trial data collection forms will record the duration of each form of hospital care, surgical procedures, adjunctive interventions, medication profiles, tests and procedures. Observational research may be required to detail additional staff and material inputs associated with clinical complications. At 3, 6, 9 and 12 months post-randomisation, trial participants will be asked to complete economic questionnaires profiling hospital (inpatient and outpatient) and community health and social care resource use and, for the purposes of sensitivity analysis, out-of-pocket expenditures and costs associated with lost productivity. Current UK unit costs will be applied to each resource item to value total resource use in each arm of the trial. *Per diem* costs for hospital care, delineated by level or intensity of care, will be calculated by the health economics researcher using data from detailed questionnaires completed by the local finance

departments, giving cost data and apportioning these to different categories of patient using a 'top-down' methodology. The unit costs of clinical events that are unique to this trial will be derived from the hospital accounts of the trial participating centres, although primary research that uses established accounting methods may also be required. The unit costs of community health and social services will largely be derived from national sources, although some calculations from first principles using established accounting methods may also be required.<sup>23</sup> Trial participants will be asked to complete the EuroQol EQ-5D<sup>15</sup> and SF-12<sup>24,26</sup> measures at 3, 6, 9 and 12 months post-randomisation. Responses to the EQ-5D and SF-12 will be converted into multi-attribute utility scores using established algorithms.<sup>16</sup>

An incremental cost-effectiveness analysis, expressed in terms of incremental cost per quality-adjusted life year (QALY) gained, will be performed. Results will be presented using incremental cost-effectiveness ratios (ICERs) and cost-effectiveness acceptability curves (CEACs) generated via non-parametric bootstrapping. This accommodates sampling (or stochastic) uncertainty and varying levels of willingness to pay for an additional QALY. Due to the known limitations of within-trial economic evaluations<sup>25</sup>, we will also construct a decision-analytical model to model beyond the parameters of the proposed trial the cost-effectiveness of negative pressure wound therapy in this clinical population. The model will be informed partly by data collected as part of the proposed trial, but also by data collected from other primary and secondary sources, including datasets held by the research team. Long term costs and health consequences will be discounted to present values using discount rates recommended for health technology appraisal in the United Kingdom.<sup>22</sup> A series of probabilistic sensitivity analyses will be undertaken to explore the implications of parameter uncertainty on the incremental cost-effectiveness ratios. Probabilistic sensitivity analyses will also explore the effects of extending the study perspective, target population, time horizon and decision context on the incremental cost-effectiveness ratios. In addition, cost-effectiveness acceptability curves will be constructed using the net benefits approach.

## 5. Trial Oversight

The day-to-day management of the trial will be the responsibility of the Trial Coordinator, based at Warwick CTU and supported by the CTU administrative staff. This will be overseen by the Trial Management Group, who will meet monthly to assess progress. It will also be the responsibility of the Trial coordinator to undertake training of the research associates at each of the trial centres. The trial statistician and health economist will be closely involved in setting up data capture systems, design of databases and clinical reporting forms. A Trial Steering Committee (TSC) and a Data Monitoring Committee (DMC) will be set up.

### 5.1 Trial Supervision

Day-to-day management of the trial will be overseen by a Trial Management Group.

A TSC -with an independent Chairman - and DMC will be set up.

The remit of the TSC is to:

- monitor and supervise the progress of the trial towards its interim and overall objectives
- review at regular intervals relevant information from other sources
- consider the recommendations of the DMC
- inform the funding body on the progress of the trial.

A DMC charter will be compiled detailing the members of the committee, their individual responsibilities and the overall responsibility of the DMC. The main roles of the DMC will be to review/approve the Statistical Analysis Plan (SAP), and to review trial progress, interim data and safety aspects of the study.

### 5.2 Quality control

We will institute a rigorous programme of quality control. The research fellow in conjunction with the trial coordinator will be responsible for ensuring adherence to the trial protocols at the trial sites. Quality assurance checks will be undertaken by Warwick CTU to ensure integrity of randomisation, study entry procedures and data collection. The Warwick CTU has a quality assurance manager who will monitor this trial by conducting regular (yearly or more if deemed necessary) inspections of the Trial Master File. Furthermore the processes of consent taking, randomisation, registration, provision of information and provision of treatment will be monitored. Written reports will be produced for the TSC, informing them if any corrective action is required.

### 5.3 Insurance and Indemnity Arrangements

Standard NHS cover for negligent harm is in place. There will be no cover for non-negligent harm.

### 5.4 Dissemination

The results of this trial will substantially inform clinical practice on the clinical and cost effectiveness of the treatment of these injuries. The results of this project will be disseminated through peer-reviewed journals, conference presentations, the National Library for Health and through local mechanisms at all participating centres.

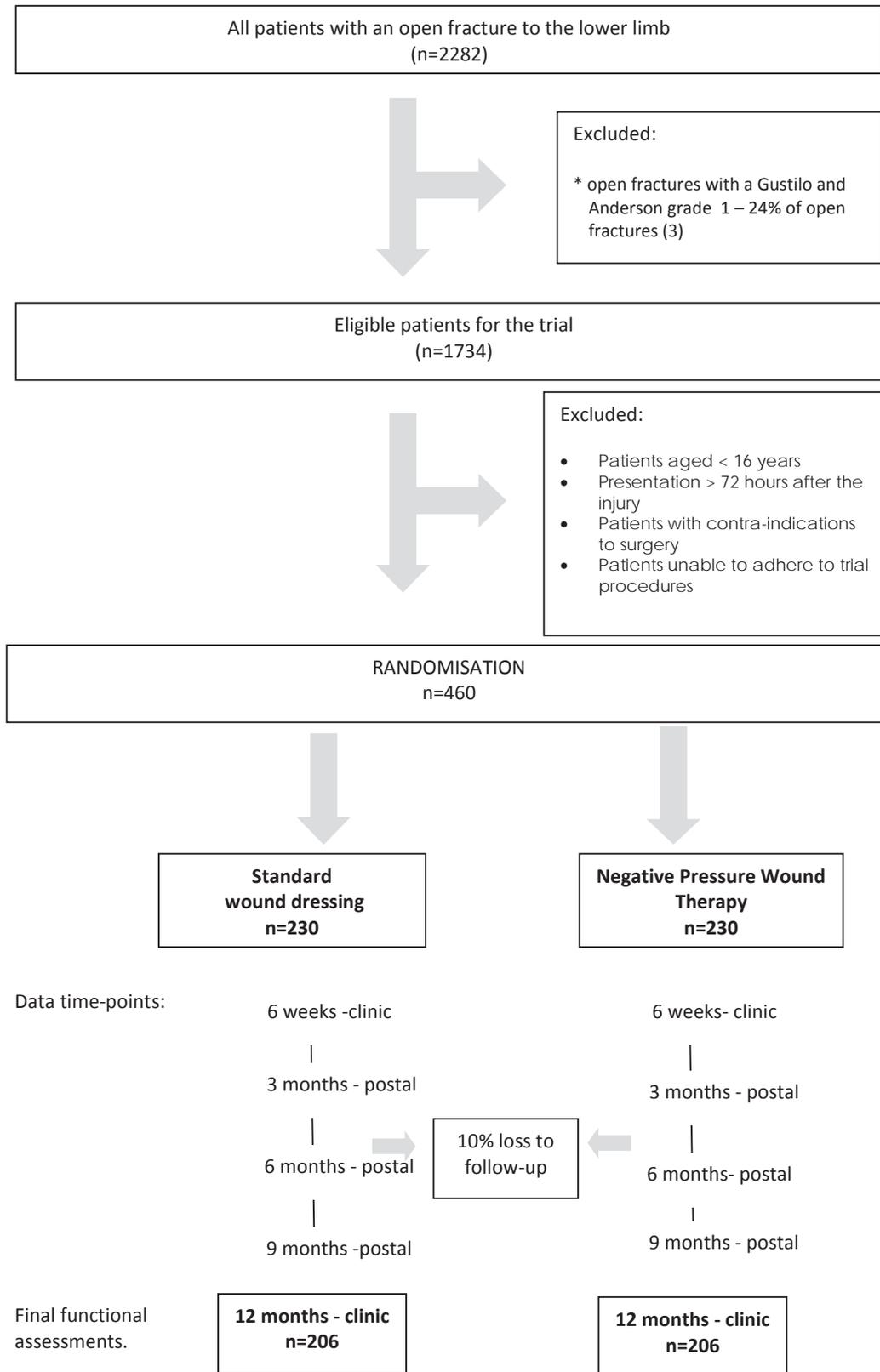
## 5.5 Project Timetable and Milestones

This is a 5 year study starting in April 2012. The planned trial timetable is shown below, with key milestones indicated and the responsible parties identified:

Month	By date	Activity	Milestone	Responsibility
<b>-6-0</b>		Ethic submission	MREC approval	CI/RF
		Set-up main contract	Signed contract	CI/RF
<b>0-6</b>	April 12	Start Trial		
	May 12	Recruit trial manager	Trial manager in post	TMG
	July 12	Compose TSC/DMC	1 <sup>st</sup> TSC meeting	CI/TC
	Aug 12	Complete CRF's/set up database		CI/Stat/TC
	Aug 12	Set-up sub-contracts		
	Sep 12	Site initiation 5 feasibility centres		
<b>7-12</b>	Oct 12	Start recruitment lead centre		CI/TC
	Oct 12	Start recruitment feasibility centres		CI/TC
	Mar 13	End of 6-months feasibility recruitment	Complete feasibility recruitment	
<b>13-15</b>	May 13	Analysis feasibility		TMG
	June 13	Report feasibility via TSC		TSC
<b>16-23</b>	July 13	Start enrolment of main trial sites		TC
	Oct 13	Start 12/12 follow-up assessments at feasibility sites		
	Feb 14	Complete site initiations	All site recruitment	PI/TC
<b>24-42</b>	July 14	End of 6-months all site recruitment		
	Aug 14	Data review first 230 patients (50% total)		DMEC via TSC to HTA
	Feb 14	Start 12/12 follow-up assessments at main trial sites		TC
	Sept 15	End recruitment	460 patients recruited	TMG
<b>43-54</b>	Sept 16	Complete 12/12 follow-up all sites		
<b>55-60</b>	Sept 16	Data review		TC/STAT
	Dec 16	Statistical analysis		STAT
	Dec 16	Health economics analysis		HE
	Jan 17		Final TSC meeting	TSC
	Feb 17	Final report HTA		TMG

*CI Chief Investigator, RF Research Fellow, STAT Statistician, HE health economist, TMG Trial management group, TC Trial coordinator, TSC trial steering committee, DMEC Data monitoring and Ethics Committee*

### 6. Trial flow diagram



## 7. Appendices

### WOLLF Preliminary Report-qualitative element

#### Sample

8 patients have so far been interviewed, 6 from Coventry and 2 from Oxford, two had injuries to one limb the rest had multiple injuries. One patient approached preferred not to be interviewed as he felt it would be too upsetting to talk. 7 digital recordings have been transcribed. No patients have been interviewed who choose not to take part in the trial.

Figure 1 Showing gender and age of sample

Site	Gender	Age	Treatment
UCH	Female	24	SD
UCH	Male	50	SD/NWPT
UCH	Male	40	NWPT
UCH	Male	32	NWPT
UCH	Male	42	SD
JRH	Male	69	SD
UCH	Male	52	SD/NWPT
JRH	Male	30	NWPT

The patients are in a vulnerable and fragile state, all but one were very comfortable talking although it was clear that they were easily worn out and needed a rest after I had visited. One of the patients was seen early in his recovery as he was due to be transferred out, although happy to chat he had very poor memory and could say very little about his experience. In addition he had no memory of the trial even though the papers were on his side table. When prompted he did recall a discussion but indicated that it was not his major concern at this time. The interviews varied from 25 minutes to 72 minutes. There were two main questions: what has it been like for you since your injury?; what has it been like being in the Wollf trial?; followed by appropriate prompts.

The aim is to interview up to 20 patients and undertake two focus groups with UCH and JRH staff to identify process issues that may help with recruitment.

#### Context in relation to experience

A preliminary analysis suggests that three key themes are present in their experience of injury, bodywork, emotional work and knowing. These themes will change and develop with further interviews and analysis.

#### Body work

The group is under severe duress and suffering extreme degrees of trauma that impact on their ability to undertake normal daily activities and require a high level of dependence on others. They find it shocking that sitting up in bed requires so much effort and describe transferring into a wheelchair as absolutely exhausting. Their loss of strength makes them feel extremely fragile. In addition to this they feel mentally fragile, unable to retain thoughts for long, unable to read or cope with many visitors. In the early days of their hospitalisation they are often scared or terrified of having more pain, for example a) pain caused by moving 'I hated being rolled, I was absolutely terrified of being rolled...any kind of sitting up or anything was excruciating' b) 'this phantom pain business, it is constant 24 hours a day, it's just like a gnawing sort of pain, and every so often it is like someone has hit your arm with a spade'. They have strategies that they develop for coping with their changed bodies such as 'pacing' themselves, 'thinking it through' before undertaking any activity, controlling interactions to minimise effort and conserve energy.

#### Emotional Work

The emotional hit of major trauma is stark. Many of the participants describe thinking they were going to die or others telling them they thought they would die. This has an impact on their stories, as being alive is a bonus and other challenges are often placed within this context.

There was a deep level of gratitude for the surgeons who saved them, or 'kept my leg attached to me'. This level of gratitude is linked to the trust they have in their surgical team and how they make sense of this study. (I trust them to do the right thing for me). Emotionally the participants were incredibly vulnerable, needing family members present around the clock, scared that 'she wouldn't find me attractive', 'at the end of the day my family need me I have got to be strong', 'its taken its toll on the wife, its upset the kids', 'I put on a brave face', 'I was like a big girl's blouse because I didn't have the wife there or anybody there, just two strangers and I felt lonely and vulnerable and basically my life is in their hands', 'everybody else is just grieving really badly' and several participants cried at some point in the interview. Often body parts were ignored as missing already or referred to as if they were independent from the body suggesting some degree of disassociation. Real shock and distress was expressed from seeing their wounds and skin grafts for example 'it was off (the dressing) and I thought oh my God they obviously have to cut my leg off because it just looked horrendous'. They were reassured by staff calling their wound 'beautiful', 'brilliant', by taking photographs to show others their fantastic handiwork but still sought reassurance from the researcher that it looked good and was healing well.

### **Knowing**

An element of knowing was how the participants developed an understanding of their injured bodies and how to make them work. Self determination and trust in the nurses and physios were often important to this process e.g 'I am the only one who can get me out of this situation so I just have to trust in the nurses'. It was greatly appreciated when staff spent time finding out about the participants knowledge of themselves and used that as part of the care e.g 'They wanted to know what was best and what I wanted which made me feel like they were doing the best for me'. The degree of information participants required varied depending on their current state and how much information they could cope with at any one time. Some participants would have liked more, others preferred to wait until they were told e.g 'what you imagine is usually worse so it is nice to have a picture of my leg, that is not going to look that bad'. Working out the future and having some understanding of what that entailed was important for all participants. Other patients on the ward and support personnel bought in by the team provided really good experiential knowledge that allowed participants to imagine a future or at least the next step e.g. 'I had a chat with this guy for about an hour and it was the most inspiring conversation and you could understand how life just continues one-handed, you don't really need two'. Major lifestyle changes such as stopping smoking to save a leg were also made in the early stages of care e.g. 'I have had this leg for 40 years and I have become quite attached to it', '...I want to hang onto it a bit longer'. There were also examples where participants were saddened that staff did not know them well enough and opportunities for good care were missed.

### **The trial**

In general the participants so far felt that the trial was a minor aspect of their current circumstances (in light of the major nature of their trauma and impact on their life) and they were happy to help in light of the serious life and limb saving treatment that had been provided. They felt that answering a few questions was a small price to pay if it helped care improve in the long term. So gratitude expressed in terms of 'giving something back' and 'improving care' was important to them.

Mostly the understanding of wound care and principles of trial design was minimal. Two participants due to the nature of their work understood randomisation and negative pressure wound therapy (NWPT). Two people had very little memory of the trial and the rest felt they had been given the best option for them. This is in keeping with other studies which suggest some participants make sense of trials after the event by assuming they get the best care tailored to their requirements, a therapeutic misconception identified by Locock & Smith (2011). Often during the course of recovery participants said they were exposed to interactions with staff and family that suggested the NWPT was the preferred choice.

Asking for consent after randomisation (during surgery) was felt to be the only possible time as they were 'out of it' before surgery. None of those interviewed had any problems with this approach e.g '...you realise that somebody had to make a decision on your behalf and it was

reversible. If I had said I don't like that they would have taken it off and they would just have put a bandage on...'.

Understanding the nature of the two interventions and possible differences was hazy and often participants said they would not have known the difference so they trusted a surgeon to do what they think is best e.g. 'Like I said I just entrust them to take care of my wounds and get it healing and get it going and bring me out the other side, as long as that happens I'm happy regardless of how they do it'. Those that had standard dressings were concerned about cleanliness and pleased with the care and concern staff demonstrated when regularly changing their dressings e.g. 'They're so thorough and yet so gentle with it that I don't feel anything and yet I know that it's really clean, completely clean'.

Participants who had the NWPT were generally happy with it. There was one example of pain on removal and also problems making it air tight. In general they liked the fact that it was a 'new 'technology', that you knew it was working as the dressing would sink down and you could see the fluid coming out. In some ways they felt they had special treatment which they found reassuring e.g. 'I thought there is another piece of clever technology'. Two participants had experienced both dressings and were really glad they had the NWPT, one did not like having a wound sitting in goo or the smell when the dressing was changed e.g. 'Rather than bandages soaking up all the goo that was coming off to see it being mechanically extracted for me was, as an engineer, more reassuring than just being stood there. I wouldn't like to think that my leg could be lying in a puddle of goo when it could be freshly vacuumed, so in a way I found that reassuring'. The second participant had NWPT after his second surgery and preferred it as it did not require changing so often as his foot was extremely painful, was less tight and he could see it working. Another participant, a medical practitioner, had the standard dressing and said he would have been happier if he had been randomised to the NWPT as this was a better treatment although he understood the rationale for the study.

A question was added regarding filling in the EQ5D twice for pre and post injury. No one could remember any problem with this aspect of the study.

Follow up, most people are happy with paper follow up. Emails would be OK too if easy to fill in. Several people realised they would need help filling the forms in due to their injuries. Texts did not seem to be a key way of communicating for this group so far.

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LT 9Jan2013

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## 9. Summary of Protocol Amendments

Amendment Number: 1

Date of Amendment: 19/04/2012

Date of Approval: 11/05/2012

Summary of changes:

Added ethics approval details and ISRCTN registration number.

Changed the start date due to a delay in signing the main contract.

Updated the TSC and DMC members.

Changed all references to the SF-36 to the SF-12.

Version 1.0 of the protocol stated that no identifiable details would be kept of patients who are post randomisation exclusions, however as part of the qualitative sub study during the pilot phase we propose to interview some patients who decline consent to ask about their experience of being randomised and approached to take part in the study. Therefore we need to keep some of these details.

Amendment Number: 2

Date of Amendment: 08/11/2012

Date of Approval: 23/11/2012

Summary of changes:

Created a letter for both the patient and next of kin to aid the process of informing them they had been randomised into the study but then found to be ineligible either due to their age, their injury being too old or they are unable to adhere to trial procedures and complete postal questionnaire and so are being withdrawn and do not need to consent to the follow up.

Amendment Number: 3

Date of Amendment: 07/03/2013

Date of Approval: 05/04/2013

Summary of changes:

Changed consent procedure. Patients who have surgery on the next available trauma operating theatre continue to enter the study under presumed consent but those that are able to consent before their operation, namely those who have been transferred or are waiting up to 72hrs for their operation, will be approached by the research team for consent into the study. If the clinical team in charge of that patients care do not think that the patient is able to provide clinical consent for their operation, then the research team will approach a consultee for agreement to randomisation. The patient themselves will be approached for consent as soon as the clinical team deem that they have regained capacity following their operation.

Amendment Number: 4

Date of Amendment: 23/07/2013

Date of Approval: 20/08/2013

Summary of changes:

Changed primary data collection procedure. In the original protocol, all post-operative data was obtained via postal questionnaires, with collection over the phone or during routine follow-up clinics as back up. In the revised protocol, the data for the primary outcome point (12 months post-operative) will be collected during routine follow-up clinics, with postal/phone as back-up.

Examples of text messages to prompt patients to return questionnaires were provided.

The names of the TSC and new trial coordinator were updated in the protocol.

Amendment Number: 5

Date of Amendment: 22/04/2014

Summary of Changes:

Additional of withdrawal option to allow patients to be withdrawn from questionnaires but to remain in the trial for hospital data collection. Addition of 'Hospital Data Only' consent form in

line with this change. Also change to procedure to allow copies of patient consent forms to be sent to WOLLF office at Warwick CTU.

Amendment Number: 6

Date of Amendment: 08/2014

Summary of Changes:

Additional secondary outcome measures incorporated into Case Report Forms and patient questionnaires, and data sharing agreement established with Prof. Ian Pallister's research team at Morriston Hospital Swansea.

Patient Information Sheet updated to clarify that consent forms will be sent from site to Warwick CTU for monitoring purposes. Consent forms also changed to reflect this.

E-mail version of follow-up questionnaires implemented for patients who have not responded to postal questionnaires.

## Appendix 1

### Additional Secondary Outcome Measure in 5 Participating Sites

The following set of questions are from the WaLLTR scale and will be added to WOLLF data collection at each time point. This additional data will only be collected for 5 of the participating sites: Morriston Hospital, John Radcliffe Hospital, Royal London Hospital, Frenchay Hospital and Royal Victoria Hospital.

**Please answer the following according to how you feel today.**

**How strongly do you agree or disagree with the following statements** (Please tick one option for each question)

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. I live in fear that I will get another injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am very reliant on others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I earn less now because of my injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am unable to walk around the shops due to my injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have aches in my leg all during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I am pleased with my recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have avoided large groups of people/social gatherings as a result of my injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I tend to wear clothing to hide my injured leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am happy to participate in all the things I used to do before the injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have no significant pain in my leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In your own words, can you describe how you feel today?

During an average week of **7 days**, on how many days do you use the following mobility aids (please choose the mobility aid which is used for the majority of the day)?

Stick

---

Crutches/2 sticks

---

Zimmer frame

---

Wheelchair

---

Did you suffer other injuries (not to your legs) which are impacting on your recovery?

Yes No