

# Patient agreement to investigation or treatment

## Photodynamic Therapy (PDT)

**Authors:** The Dermatology Department

**Brief description:**

- Photodynamic therapy is a method of treating localised skin cancers or certain types of pre-cancerous lesions. The treatment consists of applying a special cream to the affected area and 3 hours later shining a pure red light on it. Both the light and the cream are harmless on their own and will not affect normal skin. Only when the two are combined will they treat the abnormal area of your skin.
- The treatment is usually repeated again after one week.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure. We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke’s website:  
<http://www.addenbrookes.org.uk/consent>
- Guidance for health professionals can be found on the Addenbrooke’s intranet site  
<http://nww.addenbrookes.nhs.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

**For staff use:**

Does the patient have any special requirements? (For example, requires an interpreter or other additional communication method)

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## Photodynamic Therapy

### Application of the cream (in the morning)

- Please inform the nurse prior to treatment if you have a peanut or soya allergy
- We will remove any crusting overlying the area to allow the cream to penetrate into the skin.
- We will then apply the special photosensitising cream to the lesion and surrounding area and place a dressing over the top. It is essential that you do not disturb or press on this dressing in case the cream becomes displaced or squeezed from the treatment area.
- We will give you a time to return to the clinic. The cream must be left in place for a minimum of three hours. The cream may be left for longer than three hours with no ill effect. During this time, you may stay at the hospital or may leave the hospital and return for your appointment. If you leave the hospital make sure you protect the area from very cold air or direct sunlight. You may eat and drink as normal.

### Illumination with the red light (three hours later in the late morning / early afternoon)

- When you return for the treatment we will remove the dressing and any excess cream. An ultraviolet light is then shone onto the area to determine whether the cream has been absorbed.
- You will then be asked to sit or lie down, whichever is more comfortable, as it is important that you do not move during the treatment.
- We will then shine a red light onto the affected area. You will be asked to wear a specially designed pair of goggles to protect your eyes from the red light.
- The exposure to red light treatment lasts for approximately 7-10 minutes. You might experience a tingling or burning feeling during the treatment. Please let us know as we can use a number of methods to help relieve any discomfort such as a fan or cooling water spray or even local anaesthetic if necessary. You may also find it helpful to bring your usual pain relief tablets (for example Paracetamol or Ibuprofen) with you to take 30 minutes prior to the treatment.
- After the treatment has been completed you may have a dressing applied to the area.

### What do I do when I return home?

- If a dressing has been applied please keep it in place for 48 hours. This is to protect the skin site and to avoid daylight getting to the treated area. After this time the dressing can be removed.
- Any discomfort usually settles within the first few hours. Occasionally it will last for up to 24 hours. Taking Paracetamol or Ibuprofen should help.
- After the first 24 hours, you can wash, bathe or shower as usual. Do not, however, rub the treated area, but gently dab it dry. It is best to avoid swimming until the area is fully healed. If the area is on the scalp cover with a hat or if on the body cover with clothing for approximately six weeks to reduce the risk of colour changes.

- After the dressing has been removed, the treated area will probably crust over. This is normal. Healing takes place under this crust. It is important that you do not disturb or pick at it because the crust will fall off naturally when the area underneath has healed, usually after a few weeks.
- In some cases, the treated area will appear pink, swell a little or ooze slightly. This is also normal and signifies a stronger treatment reaction. This will usually settle down within a day or so.
- The treatment will usually be given on two occasions one week apart.

### **Check-ups and results:**

- An appointment in outpatient clinic will be made for you approximately 12 weeks after the second treatment.
- If the skin is clear and there is no sign of any recurrence, we will check the area again in six months' time. If we find it is beginning to come back, we may give you further photodynamic therapy or an alternative treatment.

### **Intended benefits of the procedure**

- We have carefully considered all the other treatment options for your skin condition. There are many factors that we have to take into account. The most important benefits are:-
  - Healing is usually very rapid because there is only slight damage to the surrounding healthy cells.
  - Healing with photodynamic therapy is usually excellent, and the treatment can be repeated if necessary with no reduction in its efficiency.
  - The cosmetic result is usually very good.
  - Having this treatment does not prevent you from receiving any of the other treatment options in the future.

### **Who will perform my procedure?**

- The procedure will be performed by a Dermatology nurse on clinic 7.

### **Serious or frequently occurring risks**

There are no long-term side effects from this photodynamic therapy, but there are a few minor drawbacks:

- We need to leave the cream on for a minimum of three hours. Before treatment with the light can be given.
- You may experience discomfort during and after treatment.
- A persistent area of discoloration (usually light brown) is occasionally left at the treated area.
- There is a risk the lesion may recur following photodynamic therapy.

### **Information and support**

- If you have any questions or concerns you can contact the specialist nurses for advice. Tel. 01223 217391.



Addenbrooke's is smoke-free. You cannot smoke on site. For advice on quitting, contact your GP or the NHS smoking helpline free, 0800 169 0 169

Please ask if you require this information in other languages, large print or audio format: 01223 216032 or [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

Informacje te można otrzymać w innych językach, w wersji dużym drukiem lub audio. Zamówienia prosimy składać pod numerem: 01223 216032 lub wysyłając e-mail: [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Polish

Se precisar desta informação num outro idioma, em impressão de letras grandes ou formato áudio por favor telefone para o 01223 216032 ou envie uma mensagem para: [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Portuguese

Если вам требуется эта информация на другом языке, крупным шрифтом или в аудиоформате, пожалуйста, обращайтесь по телефону 01223 216032 или на вебсайт [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Russian

若你需要此信息的其他語言版本、大字體版或音頻格式，請致電 01223 216032 或發郵件到: [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Cantonese

Bu bilgiyi diger dillerde veya büyük baskılı ya da sesli formatta isterseniz lütfen su numaradan kontak kurun: 01223 216032 veya asagıdaki adrese e-posta gönderin:

[patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Turkish

এই তথ্য বাংলায়, বড় অক্ষরে বা অডিও টেপে পেতে চাইলে দয়া করে 01223 216032 নম্বরে ফোন করুন বা [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk) ঠিকানায় ই-মেইল করুন।

### Bengali

#### Document History

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Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 2QQ <a href="http://www.cuh.org.uk">www.cuh.org.uk</a>
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Consent form 1

# Patient agreement to investigation or treatment

<b>For staff use only:</b> <b>Surname:</b> <b>First names:</b> <b>Date of birth:</b> <b>Hospital no:</b> <b>Male/Female:</b> (Use hospital identification label)
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Responsible health professional/job title

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Special requirements.....  
 (For example other language/other communication method)

**Name of proposed procedure or course of treatment**

**Photodynamic Therapy** **Side (left/right).....**

**Statement of health professional**

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- How it will be performed
- The intended benefits of the procedure  
 Healing is usually very rapid, healing with photodynamic therapy is usually excellent, cosmetic result is usually very good and this treatment does not prevent you from receiving any of the other treatment options in the future
- Any serious or frequently occurring risks including those specific to the patient .....  
 Experience discomfort, persistent area of discoloration and lesion may recur
- Any extra procedures that might become necessary during the procedure

Blood transfusion  
 Other procedure (please specify) .....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following information leaflet has been provided: .....

**Health professional's signature** ..... **Date:** .....

Name (PRINT): ..... Job title: .....

Contact details (if patient wishes to discuss details later) .....

I have offered the patient information about the procedure but s/he has declined information.

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (eg Jehovah's Witness form)

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature ..... **Date:** .....

Name (PRINT): .....

Copy for patient

<b>For staff use only:</b>
<b>Surname:</b>
<b>First names:</b>
<b>Date of birth:</b>
<b>Hospital no:</b>
<b>Male/Female:</b>
<b>(Use hospital identification label)</b>

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please read the following:**

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

**I understand** that any tissue (including blood) removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below.** Yes No

**I agree** that tissue (including blood) not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** If you wish to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

**I agree** to the use of photography for the purpose of diagnosis and treatment.

**I agree** to anonymised photographs being used for medical teaching.

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:**..... Date: .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... Date: .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature Date: .....

Name (PRINT): ..... Job Title: .....