



Pathology Newsletter

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NEW COLLECTION CENTRES

Did you know we now have collection centres open to the public at the Shepparton Private Hospital, Mivo Park Medical Centre in Cobram & Paul Wickham Pharmacy in Mooroopna?

Refer to the flyer attached for opening hours of all our centres.

(Note - The Waranga Campus collection centre is now managed by Waranga-Rushworth rather than GV Health Pathology).

BIOCHEMISTRY ANALYSER

We are in the last stages of correlations in the commissioning of our new Biochemistry analyser. This analyser replaces two other older instruments. The new analyser will primarily be used as a STAT analyser to improve the turnaround of results for the Emergency Department & other areas requiring this service. Other benefits are having a back-up analyser that performs essential tests during periods of maintenance & less down time due to loading of reagents. The final stages of the commissioning will be the releasing of new kits for HIV & Hepatitis C for the new analyser, which is expected to occur later this month.

DIRECTOR OF ANATOMICAL PATHOLOGY

We are very happy to announce that Dr. Hugh Turner (who has been a Consultant Anatomical Pathologist for us since 2007), has joined our 'in house' team as the Director of Anatomical Pathology from 1/12/08.

Hugh is an Anatomical Pathologist with extensive experience in Surgical Pathology & Cytopathology.

Previous experience includes work as a Renal Pathologist at Prince Henry's Hospital; Pathologist in Charge of Oncopathology & of Gastroenterology at Prince Henry's Hospital & subsequently at Western Hospital; Deputy Director of Pathology, Western Hospital (Footscray); Deputy Director of Anatomical Pathology, Western Hospital (Melbourne); Consultant Pathologist to Geelong Pathology & more recently (since 1998) as a Consultant Anatomical Pathologist to the Peter MacCallum Cancer Centre (Designated Sarcoma pathologist at Peter MacCallum Cancer Centre). Teaching experience includes involvement over many years with trainee medical laboratory scientists at RMIT & medical students at both Monash & Melbourne Universities.

On a personal level, Hugh is married to Robyn, with three grown-up daughters and three grandchildren. Hugh's main sporting interest is sailing. He is a member of the Port Melbourne Yacht Club & sails regularly (although he says often unsuccessfully) in a JB18 dinghy.

Should you wish to contact Hugh, he is available on 58322349, Monday to Thursday.

Dr Sam Rambaldo, our Director of Pathology is available on 58322345, Monday to Friday.



KEY PERSONNEL

Do you ever need to contact us but aren't sure who you should speak to? The following is a list of our key personnel with their relevant specialties, to assist you.

Director of Pathology	Sam Rambaldo	58322345
Director of Anatomical Pathology	Hugh Turner	58322349
Manager of Pathology Services	Jacinta Russell	58322355
Blood Bank Section Manager	Merilynn Cree	58322356
Haematology Section Manager	John Robert	58322352
Biochemistry Section Manager	Craig Baker	58322351
Microbiology Section Manager	Chris Barnard	58322350
Histology Section Manager	Rosie Crawford	58322353
Specimen Reception / Data Entry Manager	Lisa Hooper	58322344
Specimen Collection / Courier Manager	Carol Northey	58322344
Pathology IT Support Officer	Jeremy Fowler	58322369
General Enquiries / Office		58322344

LITHIUM & HbA1C TESTS

Lithium and HbA1C tests are now being performed at our Echuca laboratory. Urgent HBA1C's will be performed in Shepparton on our Point of Care instrument, while routine specimens are sent to our Echuca laboratory for processing.

LEUCODEPLETION OF RED CELLS & PLATELETS FOR TRANSFUSION

The implementation of pre-storage leucodepletion of 100% of red cells by ARCBS is now complete.

Why is this change occurring?

This change is occurring because ARCBS has now received funding from Government through the National Blood Authority (NBA) following the submission of a business case.

Leucodepletion of blood components has become the international standard of practice. In implementing this change, Australia will be aligning its practice with the many countries who have already adopted leucodepletion.

What are the benefits of leucodepletion?

Leucodepletion is the removal of white blood cells from a blood component.

The potential benefits of leucodepletion for patients include:

- Reduction in platelet refractoriness;
- Reduction in febrile non-haemolytic transfusion reactions;
- Reduction in CMV transmission risk;
- Improved chance of finding an organ transplant match if required;
- Reduction in storage lesion effect;
- Possible reduction in transfusion associated graft vs. host disease (TA-GVHD) risk;
- Possible reduction in transfusion related immunomodulatory effects, including cancer recurrence, mortality, non-transfusion transmitted infection; and
- Possible reduction in variant Creutzfeldt-Jakob Disease (vCJD) transmission risk.

Will the level of leucodepletion prevent my patient getting febrile non-haemolytic (FNH) reactions?

Pre-storage leucodepletion has been shown to reduce FNH transfusion reactions.

As one of the benefits of pre-storage leucodepleted blood components is a reduction in FNH transfusion reactions, fevers associated with the transfusion of such a component should be carefully assessed to exclude complications such as bacterial contamination.

Further information regarding this initiative, including a series of Frequently Asked Questions and Answers and a reminder poster about bedside filters, is available on the ARCBS clinical transfusion website,

www.transfusion.com.au.

B12 / FOLATE REQUESTS

Did you know that only three B12 / Folate tests are payable by Medicare in a 12 month period? Further requests attract an out of pocket expense for patients.

NATA ACCREDITATION

Our Shepparton & Cobram laboratories have again been assessed by NATA (National Association of Testing Authorities) & successfully gained accreditation for the next three years. Our Echuca laboratory is scheduled to be assessed later this year.

DIAGNOSIS OF *C. DIFFICILE* ASSOCIATED DISEASE

Clostridium difficile is recognized as a significant cause of nosocomial diarrhea, with studies showing up to 25% of all inpatients develop *C. difficile* associated disease (CDAD). Patients over the age of 65 years, and/or patients on antibiotics/chemotherapy are the most at risk. There is potential for nosocomial diarrhea outbreaks if CDAD patients are not accurately identified to allow infection control measures to be started to minimize spread. Such incidents have had disastrous outcomes in the UK, USA and Canada. Previously our Microbiology department has used the Meridian Immunocard test to detect *C. difficile* toxins A and B from the faeces of infected patients. However, this kit is no longer available, and following a full review of options a new two step screen is being introduced.

The TechLab Quik Check GDH is the first step. GDH tests detect an antigen that is specific to *C. difficile*; however it will be positive for both non-pathogenic and pathogenic strains of the organism. This test has a negative predictive value of >98% meaning a negative result definitively rules out CDAD, and can do so within 30 minutes. GDH positive samples will then be tested for the presence of toxin using the TechLab Tox AB Quik Check. If toxin is detected this will confirm a pathogenic strain and likely CDAD. We are confident that the turnaround times will be the same as for the Meridian kit, and overall sensitivity and specificity should increase dramatically with this two step method.

In order to better target our *C. difficile* testing, our protocol has also been updated. All inpatients who have been admitted for 3 or more days will only be tested for CDAD, as diarrhea acquired after admission will not be caused by Salmonella, Campylobacter or parasite infection. This protocol is consistent with major hospital laboratories throughout Victoria, and should see us better identifying CDAD patients at GV Health. The laboratory will still perform a full culture all specimens from outpatients, patients admitted with diarrhea, and where the requesting clinician calls the laboratory to indicate that a full culture investigation is required.

If you have any queries regarding these changes, please don't hesitate to call and discuss them with Microbiology Section Manager, Chris Barnard on (03) 5832 2350.

REFERRED TEST CHARGES

The Alfred Hospital has advised us that testing for Free Light Chains will incur an out of pocket expense (currently \$55). As a result outpatients will be sent an account for this test.

Similarly, the Royal Children's Hospital is currently charging an extra \$150 per patient episode for Pneumococcal Specific Antibodies. Again, outpatients will be sent an account for this test. Partial reimbursement from Medicare may be available for these out of pocket expenses.

MEDICAL DIRECTOR

COMPATIBLE REQUEST FORMS

We have request forms available which are compatible with Medical Director, which include adhesive labels. If your surgery would like some, please call Lisa Hooper on 58322344

ANTENATAL & PERINATAL SAMPLE LABELING

In 2008 the National Pathology Accreditation Advisory Council (NPAAC) released a new document titled 'Requirements for Transfusion Laboratory Practice, First Edition 2008'. The standard for labeling of antenatal and perinatal samples now includes blood groups, antibody screens, and cord blood samples for blood group and direct antiglobulin tests. Labeling criteria that we have been applying to Group & Hold and Crossmatch samples, now applies to all Blood Bank samples i.e. all mauve top tubes. This means that the Specimen Collection Declaration must be completed in full, and that the samples must be labeled with:

Given name

Surname

DOB or UR No

Date and time of collection

Initials/Signature of the person collecting the sample

We will have an amnesty period of 3 months where all samples that don't meet these requirements will be processed, with results saved against the patient record and reports issued with a comment regarding the issue. After this period the samples will be processed, but the results will not be saved against the patient record and the report will include a comment to reflect this. This new criteria is a patient safety initiative and a requirement for our on-going accreditation. We appreciate your understanding as we implement this change.

URINE MYOGLOBIN TESTS

After an extensive review, we are no longer offering Urine Myoglobin testing (effective 9/2/09) and instead recommend that CK should be used as a guide to the release of myoglobin.

TEST ABBREVIATIONS

There are some Medicare Australia acceptable abbreviations for pathology tests such as FBE, LFTs, U & E and a few others. However, we sometimes receive requests for Autoimmune screen, Haemolysis screen and viral serology etc. Unfortunately these descriptions are too broad to satisfy requirements; the actual test must be named. If you are unsure what specific tests are available, please call the relevant Section Manager and they will be happy to assist you.

JAK-2 ENZYME

The JAK-2 enzyme variant is up to 95% reliable in the diagnosis of polycythaemia rubra vera (PRV) and has replaced all of the previous tests like blood volume measurements, NAP and even bone marrow examination. The test is also useful for the diagnosis of essential thrombocytosis (ET). Sample requirements are 1 ml of EDTA blood and test results take up to 3 weeks to return from the reference lab.

ON-LINE COLLECTION MANUAL

Our collection manual is now available via the internet & internal intranet, with details of individual specimen requirements listed alphabetically. The link to access the collection manual is <http://pathology.qvhealth.org.au/> The collection manual is being continually updated and feedback is welcome. To leave feedback, go to <http://www.qvhealth.org.au/AboutUsOurServices/DepartmentsServices/Pathology.aspx> and follow the link.