

ACB News

The Association of Clinical Biochemists • Issue 437 • 20th September 1999



**HbA1c
Standardisation**

**Young and Old
in Florence**

**Clinical
Comments on
Report Forms**

**Vituperative
Professor
Admonished**



About ACB News

The monthly magazine
for Clinical Science

The Editor is responsible for the final content. Views expressed are not necessarily those of the ACB.

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Front cover:

Professor Kumihiro Veda, Associate Editor of the Annals, gets Stephen Halloran to dress up at IFCC-WorldLab in Florence. Photography by Dr David Burnett.

Pathology
2000
BIRMINGHAM 15-17 MAY

For details of Pathology 2000 please contact the Congress office:

Tel: 01223-516103

Fax: 01223-500978

email: office@pathology2000.org

www.pathology2000.org

ACB Member Wins AVL Prize

At the recent 1999 International Congress of Clinical Chemistry in Florence, AVL Medical Instruments and the International Federation for Clinical Chemistry presented Dr Alireza Morovat from Addenbrooke's Hospital, Cambridge, with the prestigious 1999 IFCC-AVL Award and a cheque for US\$ 30,000 for his paper on: "Serum fructose-1,6-bisphosphatase and the early detection of liver damage".

Dr Morovat emerged as the winner in the final of the 1999 IFCC-AVL Award which was of a very high standard and which involved hundreds of young scientists from all over the world. Twenty-four national societies put forward their country's winner to participate in this international competition, from which ten finalists were selected. The IFCC, consisting of 70 countries, is the world's largest professional organisation for clinical chemistry. The full papers from all the finalists, together with selected abstracts from the other entrants, will be published later this year as the second edition of "Advances in Critical Care Testing". Professor Helmut List, Chairman and owner of AVL, the world's largest privately owned Austrian internal combustion engine R&D organisation and manufacturer of high-technology engine test and medical instrumentation, presented the award and cheque for US\$ 30,000 to Dr Morovat. ■



Professor Matt McQueen, Dr Alireza Morovat and Professor Helmut List

Sweat Test Performance

UKNEQAS Birmingham has recently reported to participants on the first survey of sweat testing in the UK. There are apparent performance problems and UKNEQAS is committed to a series of further surveys. If you are not registered but wish to participate, please contact UKNEQAS Birmingham as soon as possible at: PO Box 3909, Birmingham B152UE. Fax: 0121-414-1179. ■

All Set for Pathology 2000

The Pathology 2000 Invitation to Participate will be distributed in October 1999. This contains full details of the scientific and social events at the meeting together with abstract form to ensure your laboratory is well represented at this landmark meeting. An area of the Pathology 2000 web site has been developed to enable abstract submission using the web site and this should overcome difficulties with email submission. Indeed submission through the website is expected to be the preferred option. The Invitation to Participate will be distributed to all those who have expressed an interest in the meeting and are now on the contact database, which presently stands at over 12,000 names.

Peddle Power Gives Money for Bursaries

Fifteen laboratory staff completed a ride along the Grand Union Canal towpath between The Royal College of Pathologists offices in London and the International Convention Centre in Birmingham. This was a fun event which also raised money through personal sponsorship to contribute to a bursary fund for Pathology 2000. Euro/DPC and AVL acted as sponsors with event organisation. Indeed the sponsors participated to the full and at one point David Jacobs from DPC impressed other riders by launching himself and his mountain bike into the canal at 30 km/hour.

If you have an enquiry about any aspect of the Pathology 2000 meeting please contact the office at: Pathology 2000 Congress Office, PO Box 409, Cambridge CB1 4QD. Tel: 01223 515903. Fax: 01223 500978. Email: office@pathology2000.org ■



The final stop at Hatton Locks for the surviving London to Birmingham towpath cyclists

HbA1c Standardisation Meeting

Reported by Jonathan Middle, UKNEQAS

This meeting, the brainchild of Arthur Hall (Good Hope Hospital, Sutton Coldfield), was arranged for the Regional Audit Group to discuss issues surrounding HbA1c standardisation. It was generously supported by BioRad and Menarini Diagnostics and attendance was well over 40, mainly from the West Midlands.

MS for Reference

The first speaker, Dr Jonathan Middle (UK NEQAS, Birmingham), discussed the calibration and traceability issues that arise with HbA1c determinations. He avoided the word 'measurement' since routine methods cannot do this in the strict sense, due to their lack of recognised reference standards and inherent non-specificity for HbA1c. He contrasted the characteristics of true analytical assays with comparative ones, and showed how 'DCCT standardisation' is a misnomer. The DCCT was simply a clinical trial of intensive against conventional treatment in a highly unusual (in terms of normal clinical practice) subgroup of diabetics, and not a standardisation programme for HbA1c! The main HbA1c method used in the DCCT is not a true reference method (although this term is frequently used), but only a designated comparison method, and attempts by the US National Glycohemoglobin Standardisation Program (NGSP) to 'calibrate' HbA1c determinations to this method can at best only achieve a degree of comparability. True standardisation and traceability of measurement require a reference measurement system, exemplified by that being developed under the auspices of the IFCC. This employs purified glycated and non-glycated hexapeptides cleaved from the N-terminus, with capillary electrophoresis and electrospray mass spectrometry as reference methods. Jonathan concluded that although short term DCCT harmonisation of HbA1c measurements is necessary to enable the power of the clinical evidence bases to be exploited, this must be done in full knowledge of the limitations due to its non-scientific basis, so that eventual transfer to true measurements based on the IFCC system can be made. This must be carefully explained to clinicians by means of educational support, with continuous routine and reference method comparison data from EQA schemes.

The second speaker, Annette Thomas (Wales EQAS, Cardiff), supported many of Jonathan's points. With respect to NGSP

*Report of a
meeting held at
City Hospital
Birmingham on
15th July 1999*

'standardisation' she explained how the limits of acceptability which allowed for 'certified traceable' methods meant that numerical values could still differ by over 10%, although in the case of one commercial method, users who had 'calibrated to DCCT' did form a tighter group. Studies with lyophilised materials from pooled donations showed method-related differences in relationships with DCCT 'reference' values compared to fresh whole blood (indeed the NGSP literature states their system is only valid for whole blood). Annette also emphasised that samples from single donations of whole blood can show unusual characteristics due to the extent of acetylation or carbamylation in the sample, yielding between-method differences even for 'DCCT calibrated' methods.

Is HbA1c Dangerous to Patients?

The third speaker, Dr Steve Bain (Heartlands Hospital, Birmingham) gave a clinical viewpoint. He was critical of the restricted and unusual subject groups used in the DCCT, and highlighted the problems of hypoglycaemic episodes - these were greatly increased in the intensive therapy group - and the DCCT's quality of life questionnaire revealed no difference between the test groups. The clinician should be treating the patient with a stable but individual HbA1c level to the appropriate standard of control; both he and most patients were more concerned to avoid the risks of hypoglycaemia than other complications. Attempts to set and enforce national standards for diabetes care based on HbA1c could actually be dangerous for patients!

A lively discussion followed. The limitations of harmonisation rather than true standardisation were recognised, though the pressure for 'DCCT values' was urgent and IFCC standardisation might be too late. Method-related issues must not be neglected in any audits of diabetes care. Those attending from industry appreciated the opportunity to discuss the issues with laboratory scientists. ■

The ACB Take a Stand Abroad

By Hilary Crossweller and Jean Wardell

The ACB stand team arrived in Florence on the afternoon of Saturday, 5th June to find the city in the grip of a heat wave. Knowing we had very little time at our disposal, we deposited our luggage at our hotels and immediately made our way to the WorldLab '99 venue. This turned out to be an impressive exhibition and conference facility located within the fortress walls of Fortezza da Basso.

A report of the ACB official activities at IFCC-WorldLab 1999 Florence

Interesting and Inviting ...

Negotiating our way through the usual obstacle course of an exhibition set-up we found our 12 square metre shell stand in the second pavilion. There was no sign of the ACB's newly acquired portable exhibition stand and accompanying display material that had been shipped out in advance. Using our very limited knowledge of Italian and French we were able to track down our consignment to its temporary home in a large cavernous warehouse and arrange for it to be delivered to our stand space. After a bit of DIY and with the aid of our accompanying experienced engineers we assembled our so-called quick, simple and easy-to-erect stand. Finally, but the most important task of all, was to ensure that the stand looked as interesting and inviting as possible. The new eye-catching central graphics panel proved to be the focal point and helped cohere the surrounding display



Ian Barnes and James Hooper on the ACB stand

material. The laptops, which were to be used for demonstrating aspects of the Annals on the ACB Web site and the newly designed Computer-Aided Learning (CAL) product, were also fully tested in readiness for the opening of the exhibition on Monday morning

New CD-ROM Created Much Interest ...

Throughout the exhibition the ACB stand, which did not look out of place alongside those of major corporate exhibitors, attracted attention from delegates around the world. It also acted as a forum for ACB members to chat with colleagues from far and wide and provided us with the opportunity to meet in person some of our overseas members. On display were examples of all our publications including the Annals, ACB News, Venture Publications books and a demonstration version of the forthcoming CAL CD-ROM. Great interest was shown in the CAL CD-ROM and the ability to demonstrate it proved a major attraction.

Successful Italian Adventure

The ACB stand was undoubtedly a great success with sales of books and CD-ROMs and a good number of new membership applications taken. It reinforced the image of the ACB as the very active and successful professional Association it is. We hope the new portable exhibition stand will be widely used over the next few years thus continuing the development of a coherent policy of publicising the ACB - 'by their works shall you know them!'

Finally, our thanks go out to those many ACB volunteers who helped on the stand during the week but in particular to Stephen Halloran and David Burnett. We would also like to extend our gratitude to Roche UK who arranged for our stand and display material to be shipped to the exhibition in Florence and returned to the UK afterwards. ■



Ian Watson convening a workshop

Florence Red Carpet for WorldLab

By Richard Spooner and David Shapiro, Gartnavel General Hospital, Glasgow

Crashing my car on the evening before driving 450 miles to Gatwick or waiting for 90 minutes on the tarmac courtesy of my least favourite airline had me wondering what else could go wrong. David, already in Florence having used the once-weekly flight from Glasgow, was having his own problems as the frescos he had wanted to see were shrouded in scaffolding. However, stepping into a sweltering heat gave notice of the fabulous week to come.

We met up on the Sunday night at the opening mixer. This was held *alfresco* in the courtyard of the Fortezza da Basso, the old Medici citadel which doubles as Florence's conference centre. We were treated to a wonderful spectacle of trestle tables groaning under regional specialities and medieval entertainment culminating in a spectacular light and water show.

From Genome to Proteome

Monday brought the start of the scientific programme and a series of dazzling lectures which indicated that the amazing human genome project would be followed by an even more astonishing piece of work as functions are sought for the myriad of proteins uncovered by this work. Arthur Kornberg, the discoverer of DNA polymerase and an originator of the genetic revolution, gave the opening lecture: a masterly exposition, entirely without visual aids, from a man who is over 80 years old and still undertaking novel research.

Knockout Mice

Thomas Caskey was also outstanding, discussing the opportunities which will arise from the imminent completion of the human genome. Sequences covering the entire genome will be available within a year. Several new, large and ambitious projects are already starting to analyse and apply the huge amount of new information. The Merck gene index, freely available to all, already contains most of the genes likely to be of interest in human disease. Single

nucleotide polymorphisms, which will be used as markers for gene variation, are being assigned and gene chips to assess variation in sequence and level of expression of genes are being developed. He emphasised that less than one third of genes have known functions, and there are many errors in the databases. To try to make sense of the data, a comprehensive set of mouse knockout models is being created, where each gene is knocked out individually to study phenotypes. Proteomics, the next step from genomics, will identify expressed proteins by 2D electrophoresis and mass spectrometry, and bioinformatics will use computer power to cluster proteins into pathways. The pharmaceutical industry is already trying to identify orphan members of known gene families and develop drugs to target them, and is using genetic information to improve drug safety



Richard Spooner helps to publicise the 2002 meeting in Kyoto, Japan

and to target drug to genetically responsive individuals - the new science of pharmacogenetics. Professor Caskey overran his time considerably, but nobody in the audience cared.

Another outstanding lecture was given by Professor John Burn from Newcastle on the application of genetic studies in the investigation of disease. His chatty style and wit made his talk crystal clear, as he ranged from discussion of the limitations of twin studies in the study of developmental defects, to his ongoing trials of dietary supplements to prevent bowel cancer in genetically susceptible families.

A Flavour of the Science

The standard of science and of presentation was generally very high. There were five simultaneous symposia and commercially sponsored workshops, and 400 posters to view each day.

In the automation symposium, Dr Felder described how the emphasis was shifting from the original large, inflexible, total automation systems to modular systems. He was also an enthusiast for NPT, predicting that high volume work will be carried out at clinics and onwards, with technicians monitoring performance remotely and doing the more exotic tests centrally. He claimed that this would be cheaper in the long run, but presented little evidence to support this.

Dr Souverijn from Leiden presented his experience with one of the few total automation systems in Europe. This performs 90% of the tests in his laboratory, but he has several other sections as well, employing a substantial number of staff, and it was difficult to see what the advantage in his approach



Ian Gunn gets more than he bargained for at the opening social event

was over a conventional large analyser.

The pioneer of automation, Professor Sasaki, presented a lifetime's experience of laboratory automation. He emphasised that his aim was to improve efficiency and reduce errors, not simply to reduce staff numbers. He showed videos illustrating the large number of changes his laboratory has gone through as the automation became more sophisticated.

The session on gene analysis was fascinating, showing how technology is rapidly developing to a stage where it will be available to all laboratories which are interested. Professor Larry Kricka described the increasing sophistication of miniature analysers on a chip. He is developing integrated analysers to carry out cell separation and PCR reactions, and showed a prototype point of care PCR analyser which can be held in the hand. Other possibilities included analysers to isolate bacteria according to their surface charge and 'talking test tubes' with a transponder attached which can signal a receiver to identify itself.

Italians Should Ban Mobile Phones from Meetings

WorldLab took on board a local initiative aimed at introducing school children to science. Under the acronym PUSH (Public Understanding of Science and Health) they took over the exhibition one afternoon. The initiative is to be applauded, but 60 excited youngsters outside a lecture venue easily becomes a distraction. However, it was nothing compared to the Italians on the phone inside the lecture. It soon became apparent that the Italians had developed a love affair with the mobile phone and there was no shame in receiving and answering calls in sessions. Unfortunately there were no referees here to admonish the guilty.

Younger UK Delegates Next Time Please!

There were a number of ACB members in Florence, some accompanied by MLSO colleagues. I don't know what the average age of the 4,000 plus delegates was, but there were large numbers of young people present from all over the world. However, the age profile of UK delegates was certainly not biased towards the young. In fact I began

to wonder if overseas trips are too coveted by senior staff to allow junior staff the opportunity to attend. It was difficult to gauge the UK poster contribution, but I suspect it was probably less than the number of committee meetings all these old men attended.

However, the meeting looked favourably on probably the second oldest and the youngest ACB member there. The ever young at heart Donald Moss received the IFCC Distinguished Clinical Chemistry Award for 40 years research into alkaline phosphatase and Alireza Morovat won the AVL Critical Care Award against strong international competition. Surely this has been a really emotional few months for Alireza who has just been made redundant on completion of his training.

The IFCC

The IFCC makes money from its conferences and the ACB contributes a per capita levy of 6 Swiss Francs. In Florence we were able to glean an insight into its workings. As speakers at an Educators meeting in the

IFCC Education and Management Division, we were able to meet and spar with international luminaries. It was a shame that there were four times as many speakers as participants. The concept of open committee meetings needed better advertising but is one the ACB might follow. It would be of interest to members to see the almost mythical Scientific Committee in the flesh! However, there is always a downside, and that is the time it takes to come to a decision. I attended the open meeting on standardisation of cardiac markers. Ten years after the introduction of mass CKMB and probably on the eve of it being put back on the shelf in favour of Troponin, we were given details on progress towards its standardisation. At the closing ceremony we were exhorted to continue our visits to the 'most beautiful cities in the world'. Kyoto, Prague and Rabat will hold the next three major IFCC conferences. The Japanese hosted the closing buffet with the centrepiece being the opening of the sake barrels. ■

WorldLab Offered a Huge Curriculum!

By Dr Bernie Croal, Grampian University Hospitals Trust

Florence, Italy, provided a marvellous venue for IFCC WorldLab - the 17th International Congress of Clinical Chemistry and Laboratory Medicine. Historically, Florence was the site of the ménage-à-trois between the Tuscans, the Romans and the Greeks, which led to the birth of the Renaissance. Indeed, Florence still bears the stretch marks with a fantastic array of architecture and art produced by the likes of Michelangelo, Botticelli, Brunelleschi and Donatello.

The Conference took place in the magnificent "Fortezza da Basso" congress centre, which is a renovated sixteenth century fortress providing a mixture of 400 year old architecture with, thankfully, some modern touches such as air conditioning (31°C in the shade). Things kicked off on the Sunday evening with the opening ceremony which included a lecture on 'the achievements and perspectives in medical



One of the less conventional posters in Florence

biotechnologies' by Nobel Laureate Professor Arthur Kornberg, who managed to captivate the audience for 80 minutes without the use of slides. The opening ceremony concluded with the 'welcome' party where we were treated to a traditional Tuscan banquet and entertainment which culminated in a combined fireworks and dancing fountain display.

The scientific programme offered a variety of sessions covering a huge curriculum. Lunchtime roundtable sessions were very popular and allowed informal discussion led by an expert on a range of topics, although in some instances this discussion became quite heated. Five parallel symposia ran each morning and afternoon offering the choice of clinical, basic science or management-type presentations. This range of choice meant that there was almost always something for everyone. Poster sessions ran as usual each day with a total of 1,674 posters being presented. The posters were organised around common themes and so it was easy to congregate and discuss issues with participants with similar research interests. There were also several open sessions involving some of the official IFCC bodies such as the committee on standardisation of markers of cardiac damage, which allowed for an open exchange of information and ideas.

Radox was Exhibition Highlight

The huge scientific exhibition involved more than 140 individual exhibitors. These ranged from the familiar large multi-national diagnostic companies to some of the more obscure, less well known. In any case, the standard of exhibits was particularly high with many companies taking the opportunity to launch new equipment. For many the highlight was the demonstration of the new 'Evidence' analyser by Radox, which utilises bio-array technology and boasts the theoretical ability to perform up to 13,500 individual immunoassays per hour.

Several of the larger exhibitors also put on industry-sponsored workshops covering a variety of topical themes. These were for the most part an unbiased approach, and tended to involve



The Radox stand

presentations by some of the more prestigious scientists from around the world. As a result, such sessions were very popular with only standing room being available sometimes.

The official social programme was limited, which was understandable given the large number of participants. Nevertheless, there were countless opportunities to participate in some of the industry-sponsored evening events, with some of the big players entertaining up to five hundred people at a time. One of the more memorable evenings involved a 13th century monastery, a 10 course meal and a concert by 3 tenors.

Overall the IFCC WorldLab meeting presented a superb opportunity to attend and interact with a large number of clinical biochemists from around the world on both a scientific and social platform. The splendour and atmosphere of Florence clearly played its part in attracting participants from around the globe, while at the same time providing a wonderful distraction for those of us who found time to explore its artistic treasures. When a meeting such as IFCC WorldLab comes to Europe, it presents an ideal opportunity to present work and participate at the highest level. For those of us who took that opportunity, it was time and money well spent. ■

Comments on Biochemical Reports

By Dr William Marshall, King's College, London

Clinical biochemistry has a proud record in quality assurance, and CPA(UK) Ltd rightly requires that laboratories should be participating in appropriate external quality assurance schemes with regard to their analytical data, and that they have mechanisms in place for analysing the feedback from scheme organisers and responding to it.

Although every request received by the laboratory is akin to a referral for consultation, in practice, many reports do not require any additional input once the quality of the data has been verified in order to facilitate clinical decision-making; just as a competent physician should not need someone else to interpret a chest radiograph for him (especially since it should have been ordered to answer a specific question arising from the individual clinical circumstances), neither should he need help in interpreting standard (I cannot abide the term 'routine' in this context) biochemical data. But just as junior doctors may need help with chest radiographs, and even senior consultants with more sophisticated imaging modalities, so junior doctors and generalists may welcome help in the interpretation of even relatively simple biochemical data and senior consultants with test results that are outwith their own area of expertise.

Challand's Weekly Internet Challenge

Providing appropriate interpretative comments on reports is an important part of the work of clinical biochemists, both medical and non-medical. CPA(UK) Ltd recommends that the provision of such comments should be subject to audit. Internal audit is relatively easy to undertake: external audit, akin to external quality assurance, is more difficult. As the histopathologists are finding, such exercises are always artificial: the material used cannot be effectively disguised and is likely always to be treated differently from 'real' material.

Whilst recognising this difficulty, and appreciating that the role of external assessment of the quality of interpretative comments is more likely to be educational than true quality assurance, sporadic efforts have been made, usually on a regional basis, to survey practice and assess the quality of interpretative comments. 'Cases for Comment',¹ the weekly exercise run from the Royal Berkshire Hospital by Dr Gordon Challand, has harnessed the power of the Internet to provide a continuing, international exercise in quality assurance of interpretative reports. This is recognised by the Royal College of Pathologists' Continuing Professional Development scheme (to which, incidentally, non-members of the College who are not working in training grades may subscribe).

A Hugely Educational Process

In essence, each week a set of results is posted on the ACB's general discussion mailbase, together with a brief clinical scenario. Critically, this indicates the source of the request (e.g., general practitioner, junior house officer, etc.). Respondents are invited to indicate in two lines the comment they would write on the report or other

action they would take (e.g., telephoning the clinician, adding other tests, etc.). The responses are collated by Gordon and circulated to six experts (that blows my cover, but I can assure readers that the other five are experts), including clinical scientists and medical clinical biochemists, from teaching and non-teaching hospitals. These individuals then score the comments on a numerical scale (+2, +1, 0, -1, -2) according to how they judge their appropriateness. The range of comments and the mean scores are then published on the Internet (impressively, each cycle takes less than two weeks). Instances where the experts have disagreed (reassuringly few) are highlighted.

I find this is a hugely educational exercise but quite often I find myself wanting to award a score of -200 (at least) for what I consider to be an inappropriate comment. The exercise is anonymous to everybody except Gordon, and it is (perhaps fortunately) not possible to identify 'poor performers'. Should 'Cases for Comment' ever evolve into a UKNEQAS (and it would provide an ideal basis for that) it would have to be able to do this.

'Bad' comments seem to fall into three areas. Some may relate to the relatively informal way the exercise is conducted and particularly the way the comments are presented to the experts. At present, the individual elements of comments are identified and presented to the experts for scoring: this simplifies the exercise and would make comparisons simpler but does mean that the overall comment is not being assessed. There may also be language problems: at the last count, there had been participants from 25 countries!

Comments One Shudders to Read

Occasionally, a participant may misunderstand or fail totally to appreciate the point of a case - equivalent to a blunder in analytical terms. None of us is immune to this, and it is important that we are continually reminded of the innate talent of all sentient beings occasionally to make a complete cock up.

But it is the third category that worries me, and Gordon. These are comments which either reveal shocking ignorance, or are so crass that one shudders to read them. To consider the latter first, I considered totally unacceptable a comment (on a request by a GP in a patient with diabetes and proteinuria) that they should 'check the blood pressure'. I would take considerable offence were I the GP. Likewise, 'analytical interference?' isn't helpful to the clinician: it's our responsibility to consider and investigate this possibility. 'Drug effect?' (abnormal LFTs in a patient with rheumatoid arthritis), without specifying what drug(s) in this context could be responsible, strikes me as singularly unhelpful. And I could go on. Are participants showing off? The instructions are to 'comment as you would on the report, not more than two lines please', but maybe some participants are commenting as they would to a laboratory during an 'unusual results' review session. But only maybe. The comments which reveal ignorance are a particular concern. Some are even dangerous. All of us have gaps in our knowledge but it is essential that we are aware of these gaps, and the limitations that they impose - or should impose - on our practice. Far better to say, 'I don't know' or, 'I'm not sure, but I know whom to ask/where to look it up' than to make a wild guess. It's easy to switch onto automatic pilot when scrutinising large numbers of reports, but we must never forget that every sample we analyse comes from an individual patient, whose well-being may be critically dependent not only on accurate analysis but also on the correct interpretation of the results.

Lets Build on this Successful Venture

So what I'm getting at is, is there some way that the educational value of 'Cases for Comment' - already considerable - can be improved? Should there be a mechanism for drawing participants' attention to poor performance, rather than assuming that they will notice it for themselves and take appropriate remedial action? Should there be a forum for discussing the appropriateness or otherwise of comments, so that we provide the essential added value to the analytical service but without alienating our colleagues by teaching them to suck eggs? In our individual hospitals, we are likely to (or should) know the GPs and hospital doctors who use our services. The College published guidelines on the provision of interpretative comments on clinical biochemistry reports;² did anyone notice? Local practice inevitably reflects local needs but is there a need for a forum to consider these matters on a national - or even international basis? Could this be ACB News? Perhaps our association could stop worrying about clinical scientists for a bit and take the lead in a matter of critical importance to clinical biochemistry - and incidentally set the standard for the other laboratory disciplines that deal mainly in numerical data.

This paper was largely stimulated by discussions on this topic over several years with Gordon Challand and I am grateful for his wise comments on an early draft.

-
- 1 Challand G S. Assessing the quality of comments on reports: a retrospective study. *Ann Clin Biochem* 1999; **36**: 316-322
 - 2 Guidelines for the provision of interpretative comments on biochemical reports. *Bull R Coll Path* 1998; **104**: 25



Letters

Readers speak out

Vituperative Professor Should Know Better

Professor Reynolds has written to the ACB News to deride the MRCP diploma (ACB News, July 1999, page 19). I read the letter with a mixture of dismay and annoyance. The whole tone of the letter smacks of someone who has either not been allowed to sit the exam because of insufficient clinical experience or who has tried to obtain the MRCP, failed and been left with simmering resentment.

I passed my physicians exams – I took several attempts and freely admit to being a ‘plodder’ rather than a ‘star’ – and I know that my ability to handle patients improved as a result of raising my standards for the exam and for my professional practice thereafter.

The vituperative content of the letter of Professor Reynolds is extremely discourteous to a sister College (Professor Reynolds is a member of the Royal College of Pathologists) and his thoughts should have remained private. That chap ought to know better.

J. D. Johnston

Consultant in Chemical Pathology

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SE10 9HE

Medical Devices Agency and Email

In response to Dr Jacob’s letter in your July edition, I would like to clarify the Medical Devices Agency’s policy on responding to all forms of communication.

We are quite happy, where possible, to reply to e-mail when the senders identify themselves and provide a full postal address. This allows us to keep appropriate records of our customers, enables a reply to be tailored to meet their needs and allows us to

send them anything that is not suitable for electronic transmission (we have many publications that are not yet available by e-mail)

The communication in question arrived with an e-mail address that was not recognisable as any particular individual or professional organisation. At the time of its arrival our position on the withdrawal of some blood glucose meters by the French authorities was not finalised. A response therefore needed to be considered with regard to whether the enquirer was a member of the public, or a healthcare professional.

We welcome e-mail correspondence, but please identify yourselves and your interest in a particular subject.

Sue Wilkin

Section Manager

Sterile, Surgical and In Vitro Diagnostic Devices

Medical Graduates, Qualifications and All That ...

I would like to respond to some of the points raised by Professor Reynolds about the qualifications required by medical graduates for training in clinical biochemistry.

I agree with Professor Reynolds (July ACB News) that the MRCP does not prove that one is more capable of practising clinical medicine than someone without, in the same way that the MRCPATH is no proof that one is a more capable clinical biochemist than one without. Passing exams is a mere demonstration that a candidate has achieved the minimum required standard as judged by a panel of examiners within a given setting, and does not come with any guarantee of competence in clinical practice.

I also agree that the MRCPATH is adequate for chemical pathologists to function in their current role, with some clinical commitments mainly for out-patients. But if the role of the chemical pathologist were to change in the future to a more clinical

role (like haematologists) to a chemical pathologist/metabolic physician with responsibility of care for outpatients and inpatients, then having an MRCP would be important. This is possible, as the need for diabetologists is likely to increase with the global incidence of diabetes expected to double by the year 2010. All this could simply be driven as a cost-saving exercise as a result of the expansion of the much required consultant grade, even if nothing else.

I think what the Professor probably meant by 'clinical medicine' (not being one I wouldn't know) was 'general medicine', and not all the specialities in medicine at large. It would not be possible for most of us (certainly non-professorial material) to have MRCOG, FRCS, MRCP and MCSE, and these are indeed unnecessary if one is to work effectively as a chemical pathologist/metabolic physician.

Finally, the MRCP might well deter candidates from entering clinical biochemistry, but not for the reasons mentioned by Professor Reynolds. Only

graduates, who are capable of passing two exams as well as having the enthusiasm, would even consider entering the profession. Hence this is unlikely to attract mediocrities, rather the contrary.

Haematologists would certainly not agree that they attract mediocrities just because they have to pass two exams. Just as the role of the clinical pathologist from a multidisciplinary one has evolved, and likely to evolve even further in future, it seems only logical and desirable that the qualifications required are commensurate with the duties and responsibilities to adapt to the changing times.

Dr Sudha Bulusu

Department of Chemical Pathology
Newham General Hospital
Glen Road
Plaistow
London
E13 8RU

Colin Selby

Nottingham City Hospital

In Tom Sawyer, Tom and his friends ran away to Jackson Island; they were thought by their parents to be drowned. When they secretly crept back to witness their own funeral, they were so overcome by all the nice things that people said about them, that they came out of hiding. One of our problems is that we never say to people the nice things we think about them while they are still with us. We only say them when it is too late, and to each other. To everyone who knew him Colin was a very special person.

He left school at 16, and worked for four or five years as a milkman. He studied in the evenings at Arnold & Carlton College, and after a couple of other brief jobs, he joined the Department of Clinical Chemistry at the City Hospital, Nottingham, as a junior laboratory technician. He was to work there initially as an MLSO then as a Principal Biochemist for almost forty years.

A Dedicated Laboratory Enthusiast

Quite early on in his career, Colin developed a keen interest in immunoassay, and built up a laboratory service that was the mainstay of clinical endocrinology in Nottingham for 20 years. His interests ranged far and wide, but he will be remembered for his work with SHBG; the NEQAS scheme which he set up and ran until his death was thought excellent by all. His research interests in SHBG and other areas led to numerous publications and presentations at scientific meetings. His recent review article on 'Interferences in Immunoassay' is an example of his unique understanding of his chosen area of research. He was a regular presenter at Focus and NEQAS meetings, and had spoken at many international venues. In addition he worked tirelessly for various national committees.

Outstanding Biochemist and Generous Man

His enthusiasm was appreciated by generations of staff who came through the Clinical Chemistry Department at Nottingham City Hospital. Many medical students owe their high marks in their projects to Colin's supervision. Trainee biochemists and MLSOs will always be in Colin's debt. His eye for detail and his willingness to devote so much of his own time for others benefit, will be greatly missed by all his colleagues. Above all else we will miss his friendship and humour.

But he was more than just an outstanding and dedicated biochemist: he was a warm, sociable and generous man. Colin's patience, generosity and kindness were uppermost at all times. We all extend to his mother, to his wife Lynda, his children Andrew, Jane and Robert, and to his young grandchildren, our heartfelt sorrow at their loss. It is such a tragedy that for someone who was so appreciative of life in general, his own was to prove so much shorter than it should have been. ■



Colin Selby by his poster in Florence

WJJ & NL

Glasgow Area Hospital Biochemists Club

By **Elliot Simpson**, Monklands Hospital, Lanarkshire

On Tuesday the 4th October 1949, 14 biochemists met at Glasgow Royal Infirmary to discuss the desirability of occasional meetings to discuss common interests. This led to the formation of the Glasgow Area Hospital Biochemists' Club which was the first such group to be formed in the UK. The Club held sixteen meetings and at its last, held on Wednesday 27th May 1953, the motion to dissolve the Club was accepted and followed immediately by the Inaugural Meeting of the Scotland and Northern Ireland Region of the ACB.

Topics discussed at these meetings included:

9th November 1949

The use of milliequivalents instead of mg/100 mL for values of certain electrolytes in blood

These were early steps towards SI Units

8th February 1950

A demonstration of methods of identifying urinary porphyrins

17th May 1950

Estimation of lipase did not yield any useful information which could not be obtained by determining amylase

7th February 1951

Report of subcommittee on laboratory safety precautions

A group of four had been set up at the October 1950 meeting because of a serious laboratory accident. A set of rules for all members of laboratory staff and, although these drew attention to risks associated with various solvents, it did not prevent the fire which seriously damaged the laboratory at Glasgow Royal Infirmary on 21st August 1951 and which had been the result of an ether spillage.

7th November 1951

Dr E B Hendry discussed potassium metabolism with special reference to loss of potassium from cells. - - It has been widely believed that all cell membranes are impermeable to cations. This is not really true - - potassium in plasma falls when cases of diabetic acidosis are treated with insulin. This suggests that potassium passes into the body cells, particularly into muscle and it appears that potassium is a factor in carbohydrate metabolism.

25th March 1953

Mr Kenny described the E.E.L. flame photometer and its uses. Dr Anderson and Dr Eaton gave accounts of the results they have so far obtained, and attempted to assess the utility of the flame photometer in problems of electrolyte balance.

When the fourth meeting of this Club was held in 1950, the travelling instructions indicated the Victoria Infirmary may be reached by No. 24 tram to Langside terminus or Nos. 5 or 11 tram to Battlefield. When it visited one of the Edinburgh hospitals, a carriage was reserved on the train for, according to the notice on it's window, "the Comical Chemists".

In June 1952, Eaton and colleagues helped organise a Royal Institute of Chemistry training course; a fore-runner of the ACB Training Courses.

At the February 1950 meeting it was decided to defray such minor expenses as occurred in connection with the Club by a levy of one shilling (5p) per member as required. This was sufficient to cover such expenses for two years (when a balance of 3.5d (1.5p) was declared. The proposed membership fee for the ACB was two guineas, of which five shillings per member would be sent to the Regions. The membership fee for eligible members of the Club for the first (part) year was fifteen shillings (75p). ■

ACBI '99

Stakis Hotel

Dublin

Ireland

29th-30th October 1999

22nd Annual Conference of The Association of Clinical Biochemists in Ireland

Friday 29th October

Guidelines in Clinical Biochemistry: Application of Evidence Based Medicine

- Evidence Based Laboratory Medicine: an Overview
Dr Danielle Freedman, Luton
- Towards a Consensus in Diagnosing Acute Coronary Syndromes
Professor Fred Apple, Minneapolis
- Therapeutic Drug Monitoring
Mr Mike Hallworth, Shrewsbury
- Strategies for the Optimal Use of Thyroid Function Tests
Professor Michael Cullen, Dublin

Saturday 30th October

Bone Biochemistry

- Metabolic Bone Disease, Markers and Fracture Risk
Dr Rosemarie Freaney, Dublin
- Chemistry of Bone Markers
Professor Juha Risteli, Oulu, Finland
- Genetic Markers of Bone Disease
Professor Stuart Ralston, Aberdeen

Applications of Information Technology in Laboratory Medicine

- Bioinformatics: from Genome Data to Protein Structure and Function
Dr Geoff Barton, Cambridge
- Decision Support Linked to Laboratory Information Systems
Dr Gerard Boran, Dublin
- Intranet in Medical Laboratories
Mr Des Kenny, Dublin

Posters on all aspects of clinical biochemistry will be welcomed.

For further details please contact: Ms Orla Maguire, Department of Clinical Biochemistry, St Vincent's Hospital, Elm Park, Dublin 4, Ireland.
Tel: +353-1-2094550. Fax: +353-1-2691285.
Email: omaguire@svherc.ucd.ie

Point of Care Testing: Into the Millennium

Westwood Hall Hotel and Conference Centre

Leeds

Wednesday, 29th September 1999

The last meeting at Westwood Hall was very successful in settling a number of POCT issues, particularly related to EQA. There was also an insight into the development of new technologies and remote control systems.

However, the problem of setting standards of performance is still an issue and at the forthcoming meeting we will have speakers who will be speaking from both the laboratory and the clinical perspective about setting appropriate standards of performance for POCT systems.

Also, as we approach the new millennium, there are several new developments emerging, particularly in the area of data integration, and there will be a session at the meeting which will be dedicated to looking at the new systems.

Main Sessions:

- IT and Data Integration
- Clinical Performance

Registration details available on the ACB website and from: Mrs Win Barney, Old Medical School, Thoresby Place, Leeds LS2 9JT. Tel: 0113-233-5677. Fax: 0113-233-5672. Email: WINB@pathology.leeds.ac.uk

Clinical Biochemistry: Past, Present and Future

Birmingham Children's Hospital

Birmingham

Thursday 2nd December 1999

West Midlands Association of Clinical Biochemists
50th Anniversary Meeting

Programme

- | | |
|---------------|--|
| 12.30 - 14.00 | Registration, Posters and Finger Buffet |
| 14.00 - 14.15 | Chairman's Introduction
Dr David Worthington |
| 14.15 - 15.00 | The Growth Curve of Paediatric Clinical Biochemistry
Dr A Green |

- 15.00 - 15.45 Testing at the Point of Care
Professor C P Price
- 15.45 - 16.15 Tea and Poster Display
- 16.15 - 17.00 Diabetes and Clinical Biochemistry;
A Symbiotic Relationship
Dr Malcolm Natrass
- 17.00 - 17.45 An American Perspective on the Direction
of Clinical Chemistry
Dr Peter Wilding
- 19.00 - 19.45 Reception at the Royal Angus Hotel
- 19.45 - late Dinner

- A Novel Treatment for Patients with
Fatty Acid Oxidation Defects
Dr S J Heap, Sheffield
- The Effect Of Test Strip Batch On Blood
Glucose Meter Measurement
Dr E S Kilpatrick, Hull
- Determination of Nitric Oxide Metabolites
in Human Serum
Dr J M Monaghan, Leicester
- Raised Alkaline Phosphatase: Barking up
the Wrong Forest?
Dr M E Westwood, Leeds
- 15:30 Tea
- 15:50 Presentation of Geoffrey Walker Award

Calcium Homeostasis and The Geoffrey Walker Award

Postgraduate Centre
Nottingham City Hospital
Nottingham
7th October 1999
Yorkshire Trent ACB

10:00 - 10:30 Registration and Coffee

Morning Chair: Dr Nigel Lawson, Nottingham

10:30 - 11:10 Clinical Diagnosis and Management of
Hypocalcaemia
Professor D J Hosking, Nottingham

11:10 - 11:50 Hypercalcaemia
Dr W D Fraser, Liverpool

11:50 - 12:30 Vitamin D
Prof E B Mawer, Manchester

12:30 - 13:30 Lunch

Afternoon Chair: Dr Howard Worth, King's Mill

13:30

Dr W J Jeffcoate

14:00 - 15:30 Geoffrey Walker Award (an award for
Yorkshire Trent members aged 35 or
under)

Development of an Immunoassay for
Arginine Vasopressin (AVP)

Mr G A Armstrong, Leeds

Molecular Diagnosis of Metachromatic
Leukodystrophy

Dr E Halligan, Leicester

Accreditation by the Royal College of Pathologists applied
for.

The meeting is kindly sponsored by IDS Ltd and EG&G
Wallac and is free for ACB members. Non-members pay
£10 (includes lunch). Please make cheques payable to
Yorkshire-Trent ACB.

To register contact: Steve Goodall, Clinical Biochemistry
& Immunology, Leeds General Infirmary, Leeds, LS1 3EX.
Tel: 0113-392-3691. Fax: 0113-233-5672.

Email: stevego@pathology.leeds.ac.uk

Accreditation . . . Quality in the Spotlight

Antwerp

Belgium

11th-12th October 1999

For more details please contact: Dr Henk M J Goldschmidt,
Managing Director CKCHL, St Elisabeth Hospital,
Hilvarenbeekseweg 60, 5022 GC, Tilburg, The
Netherlands. Tel: +31-13-539-26-93.

Fax: +31-13-535-23-90. Email:

H.M.J.Goldschmidt@ckchl-mb.nl

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The Association of
Clinical Biochemists



MILLENNIUM
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of MEDICINE

CLINICAL BIOCHEMIST GRADE B

Directorate of Pathology

£25,885 - £27,988 p.a. (spine points 17 - 19)

Plymouth

Applications are invited for this newly created position based within Derriford Combined Laboratory at Derriford Hospital. Plymouth Hospitals NHS Trust is one of the largest providers of acute care in England and the Laboratory provides biochemistry, haematology and immunology services for a comprehensive range of clinical specialities.

You will join the Biochemistry section at a time of substantial upgrading and expansion, and will play a pivotal role in the provision and development of the service. Broad experience in the field of clinical biochemistry will be expected, and you should hold either the DipRCPath or MRCPPath. Particular experience in any of the following areas would be welcomed; laboratory computing, near patient testing, trace metals or toxicology.

For further information please contact Dr Michael Murphy, Consultant Chemical Pathologist on 01752 792417.

An application form and further details can be obtained from Sharon Bailey on 01752 792638, quoting reference CL-24.

The closing date for completed application forms is 4 October 1999.

Plymouth Hospitals NHS Trust is an equal opportunities employer and is actively working towards a smoke-free working environment. The Trust operates a Green Commuter Strategy.



UCL HOSPITALS NHS TRUST DIRECTORATE OF PATHOLOGY DEPARTMENT OF CHEMICAL PATHOLOGY

Clinical Biochemist Grade B

(Scale 8-10) £20,419-£21,902 pa (inc of IW)

Applications are invited for the above post within the Chemical Pathology department of this prestigious London Teaching Hospital. A comprehensive diagnostic service is offered to the various hospitals within UCLH Trust and to local general practitioners. The department is also an SAS centre for urine steroid profiling and acts as a referral site for a number of other specialist services.

The postholder will be expected to contribute to all aspects of service delivery but will also have some scientific responsibility for a defined section of the department.

Applicants should have recently completed, or be close to completing, an approved Grade A training scheme in clinical biochemistry. They will be expected to pursue a programme of Higher Specialist Training in preparation for the MRCPPath Part I examination and for which appropriate support will be provided.

For further information or to arrange an informal visit please contact Mr Colin Samuells, Consultant Biochemist/Head of Department on 0171-504-9205.

For application details please contact the Personnel Department on 0171-837-3611 Ext 3125/8715 quoting reference no PNT/0331.

Closing date: Friday 8th October 1999.

**NOTTINGHAM CITY HOSPITAL (TEACHING) NHS TRUST
DEPARTMENT OF CLINICAL CHEMISTRY**

Two Posts

The Clinical Chemistry Department of Nottingham City Hospital NHS Trust is inviting applications for vacant Principal Biochemist and Senior Biochemist posts.

Ref H:68 Principal Biochemist/Clinical Scientist Grade B

Starting salary between Clinical Scientist B points 17-22, dependent upon the qualifications and experience of the successful candidate.

The successful candidate will be expected to specialise in the areas of Endocrinology, Tumour Markers and Antenatal Screening, and should already have an established background in one or more of these areas. The Clinical Chemistry Department enjoys an excellent reputation for specialised endocrine testing. Ideally, the candidate should also hold DipRCPath or MRCPath and a PhD.

Ref H:69 Senior Biochemist/Clinical Scientist Grade B

Starting salary between Clinical Scientist B points 8-16, dependent upon the qualifications and experience of the successful candidate.

The successful candidate will be expected to develop specialist skills, and take responsibility for one of the Department's Sections, and will be given training to obtain DipRCPath or MRCPath if not already held. He/she will be expected to hold a higher degree (e.g. PhD) and to have already undertaken training in a recognised department.

**EPSOM AND ST HELIER NHS TRUST
ST HELIER HOSPITAL, WRYTHE LANE, CARSHALTON, SURREY SM5 1AA**

Clinical Scientist (Full Time) Grade B

**Salary £23,310-£28,066 per annum (inclusive)
Starting salary commensurate with qualifications and experience**

Job Ref: BW111

Applications are invited for this full time post in the Department of Immunology. The department provides a full range of immunological investigations using a variety of techniques that includes FACS analysis, ELISA, cell culture, PCR and immunofluorescence.

This is a training post with some service commitment and the successful applicant will be expected to participate in medium term service development and enhancement, R&D, clinical audit and the training of BMS staff.

The successful applicant will be encouraged to pursue higher professional qualifications, e.g. MRCPath.

For more information please contact Dr Amolak Bansal, Consultant Immunologist on 0181-296-2085.

For a job description and application form please contact the Human Resources Department on 01426-915501 (local charge). Please ensure that you quote the appropriate job reference number.

Closing date for applications: 11th October 1999.

To advertise your vacancy contact:

**Dr Simon Olpin, Neonatal Screening Laboratory, Pathology Block,
Sheffield Children's Hospital, Western Bank, Sheffield S10 2TH
Tel: 0114-271-7267**

Deadline: 26th of the month prior to the month of publication

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