ACB News

500th Birthday

It's Up to You Mate!

Christmas Crossword

EuroMedLab Poster

Deadline is 21st January!
Introducing HORIBA ABX Diagnostics

We’re rounding off our most successful year ever with a new name. For customers old and new we aim to support this with:

NEW ideas
NEW partnerships
NEW support structure

And what better place to announce this than the ACB News’ 500th issue - we look forward to working together in the future.

Haematology & Clinical Chemistry

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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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ACB News

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Front cover: The ACB News team: Sue Ojakowa, Louise Tilbrook, Jonathan Berg, Nikki Beeson, Ian Hanning and Peter Carpenter (Sophie Barnes could not make it!)

focus on the patient
at EuroMedLab Glasgow 2005

The 16th IFCC-PESCC European Congress of Clinical Chemistry and Laboratory Medicine
Focus 2005 – The Association of Clinical Biochemists National Meeting
8th - 12th May 2005 – SECC, Glasgow

www.glasgow2005.org

Email: euromedlab2005@meetingmakers.co.uk Tel: 0141 434 1500 Fax: 0141 434 1519

December 2004 • ACB News Issue 500 • 3
**Advance Notice: ACB Training Course 4**

**Devonshire Hall**  
**University of Leeds**  
**Monday 4th April - Friday 8th April 2005**

Principal topics:
- Immunoassay
- Haematological Disorders
- Biochemical Genetics
- Clinical Genetics
- Management Topics
- In addition, there will be an emphasis on biochemical calculations and case reports.
- Each day there will be small group activity in breakout sessions.
- Full social programme provided.

For further enquiries contact:  
Dr Mick Henderson, Department of Clinical Biochemistry, St James’s University Hospital, Beckett Street, Leeds LS9 7TF.  
Tel: 0113-2066861  
Email: mick.henderson@leedsth.nhs.uk

**Crossword Special Prizes**

We are very grateful to Mosby, publishers of William Marshall’s excellent book Clinical Chemistry, for donating so many copies as prizes for the monthly crossword. In November the following were deemed as lucky winners:

Nigel Brown, King’s College, London  
Chemical Pathology, Southampton General Hospital  
Eric Hindle, Blackburn  
David Bullock, NEQAS Birmingham  
Susan McLellan, Royal Free Hospital  
John Stevens

John Stevens has kindly asked that his prize is donated to the Chelsea and Westminster Hospital, Chemical Pathology Department. The book is dedicated to the memory of their Senior MLSO, Mike Bickel, a diabetic, who died unexpectedly in early Autumn.

Thanks to all the other entrants – sorry you cannot all receive a prize. However, if you send in a reply to the special Christmas Colley Crossword in this edition you are guaranteed a prize!
The UK’s leading supplier
of Laboratory Integration Solutions

We would like to wish all our customers
a very Merry Christmas and a Happy New Year

Congratulations ACB News on your 500th edition!
We wish you every success in the future.

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www.rochediagnostics.co.uk
Past Treasurer Visits ACB Office
Dr Colin Wilde and his wife Julie recently paid their first visit to the Tooley Street offices of the ACB. Colin is the retired head of the Doncaster laboratory and was the Association’s Treasurer for many years in the 1990s. He was also Treasurer of the 1996 International Clinical Chemistry meeting, the profits of which helped to secure the purchase of the office.

Dumfries Saddened at Untimely Death
ACB News is very sad to report the death of Dr John Paterson, Consultant Biochemist at Dumfries and Galloway Royal Infirmary. John died of colon cancer on November 3rd at the early age of 48 and leaves a wife, Janet, and three children, Ross, Sarah and Clare.

The Scientific Instrument Society
Many who spend a working life using scientific and technical instruments develop a fascination with the history of their development, the varied forms which they take and the role which they have played in the growth of science, medicine and technology. The Scientific Instrument Society exists to provide a forum for these interests. Based in the UK it has around 500 members world-wide. About a quarter of the members are academics drawn from University Departments of the History of Science or museum curators, and another quarter have commercial interests as dealers in antique instruments or as auctioneers. However, half its members are simply attracted to the various types of instruments and many of these are collectors. This is truly a ‘Learned Society’; it does not have a commercial interest and the members are united by the love of the subject.

The society has a programme of meetings with both invited speakers and contributions from members held in different places around the country. The only qualification for membership is an interest in the subject and the annual membership fee is £40. New members receive back copies of the Bulletin for the year in which they join.

Membership forms can be downloaded from the Society’s website at www.sis.org.uk or by post from: Scientific Instrument Society, 31 High Street, Stanford in the Vale, Faringdon, Oxon SN7 8LH.

EuroMedLab Poster Deadline & Roundtables
The deadline for poster abstracts to be received for the European meeting is 21st January 2005

Round Table discussion topics are now listed on the website

www.glasgow2005.org
ACB Southern Region Meeting

Hormones: Use or Abuse?

Friday 11th March 2005
Robens Suite, 29th Floor, Guy’s Tower, Guy’s Hospital, London
In Honour of the Retirement of Dr Mike Wheeler

Morning Session
10:00 Welcome and Introduction
10:05 Immunoassay: Past, Present and Future
10:45 Drugs and Sport
11:30 Use of Androgens in Sport: Analytical and Endocrinological Aspects
12.00 Automation in Laboratories

Afternoon Session
13:45 Interference in Immunoassay
14:25 UK NEQAS: Role in Maintaining Quality
15:05 Salivary Hormones: Application in Routine Practice
16:00 MHRA: Testing Tests
16:40 Endocrinology of Critical Illness
17:10 Concluding Remarks and Close
17:30 Southern Region AGM
18:30 Dinner

Cost of meeting: £15.00 (free for Grade A trainees/ temporarily retired members/ retired members)
Cost of 3 course evening meal: £30.
For further information please contact Professor R Swaminathan, Chemical Pathology, 5th Floor, North Wing, St Thomas’ Hospital, Lambeth Palace Road, London SE1 7EH.
Tel: 020-7188-1285. Fax: 020-7928-4226. E-mail: r.swaminathan@kcl.ac.uk
Turkey And Tinsel At Twenty-Three Thousand Feet

Steven McCann and four other non-professional climbers plan to eat their Christmas dinner on top of one of the world's highest mountains to raise money for a Manchester children's charity. The group will be scaling the awesome Aconcagua in Argentina, which at 22,841 feet (6962 metres) is the highest mountain in the world outside the Himalayas. With wind speeds of up to 100 mph, temperatures of -20°C and the risk of altitude sickness it is going to be a challenging climb. The ascent and descent should take around 15 days and the group are attempting to climb the mountain using the challenging Polish Glacier route. Although they have climbed other mountains, this is the group's highest challenge to date.

Sponsoring YAT . . .
The expedition, which is being paid for by the climbers themselves, is in aid of Youth Adventure Tameside (YAT). YAT helps young people across the Northwest with learning difficulties, physical disabilities and those from disadvantaged backgrounds which through outdoor adventure activities aims to increase their personal development and self-esteem. The charity was selected, as it is a small, local charity where any money raised will make a large difference. As the cost of the trip is being met by the group all monies raised will go directly to YAT.

After the climb the group are planning on travelling to Buenos Aires to celebrate Hogmanay in Argentinean style.

If anyone wishes to sponsor Steven McCann please call him on 0161-861-0785 or 0790-373-9889.

Nominations for Association Awards for 2006

Nominations are invited for the three awards to be presented at the Focus 2006 Meeting in Brighton.

The ACB Foundation Award

The ACB Foundation Award is to acknowledge an outstanding contribution to clinical biochemistry by an Association member, who is normally resident in the British Isles. The recipient will deliver the Foundation Award Lecture, which will be of a specific nature, reflecting the state of the art in one area of clinical biochemistry.

Nominations may be made by any three members of the Association (excluding elected members of the Council) and should be submitted via a Regional Secretary.

The Thermo-Electron Award (formerly the Konelab Lecture)

The Thermo-Electron Award is given to honour a clinical scientist whose work has been of major importance to clinical biochemistry in practice, research or education, leading to improved international co-operation between workers in the speciality, particularly those within Europe. The Thermo-Electron Award comprises finance for the Thermo-Electron Lecture to be delivered at the National Meeting, and is usually awarded to a practising clinical biochemist from outside the UK.

Three members of the Association, but excluding certain ACB Officers, should make nominations.

The Roche Diagnostics Award

The Roche Diagnostics Award is used to finance the visit of an international lecturer to give the Roche Diagnostics Award Lecture at the National Meeting.

Any three members of the Association may make nominations.

Full details of the nominations procedure for each of the three awards can be found in the current ACB Members' Handbook.

Nominations should be sent, before 31st January 2005 to: Mr Gilbert Wieringa, National Meetings Committee Chair, Greater Manchester SHA, 7th Floor, Gateway House, Piccadilly Approach, Manchester M60 7LP.
Frontiers in Laboratory Medicine 2005
1st & 2nd February 2005
Austin Court, Birmingham City Centre

The third in the series of inspiring and challenging conferences and this year the following key topics will be addressed:

- The Laboratory and the Emergency Care Challenge, with speakers including the A&E Tsar, Sir George Alberti
- Direct Access Testing will include a study of how the USA is approaching consumer requests and will look at pilots in the UK

Other topics in the packed programme include:

- Patient Safety
- Informatics
- The Paperless Health System

Speaker master-classes give the opportunity for delegates to probe speakers further.

The Conference dinner will be at the Jam House Club, which has Jools Holland as the musical director.

Registration
NHS/Public Sector/Laboratory Professionals: £464.13 (£395.00 plus £69.13 VAT)
Commercial organisations: £581.63 (£495.00 plus £86.63 VAT)

For further details and to register please visit www.acb.uk.org or Tel: 0141-434-1500 asking for details of FILM 2005 to be sent to you
THIS IS WORSE THAN HARRY POTTER ........!!!
Deacon’s Challenge
No. 45 Answer

It is suspected that the glucose results obtained with a near patient testing (NPT) device on the ward are positively biased. One of the investigations into the problem involves analysing a series of blood specimens on both the NPT device (A) and an analyser in the laboratory which measures whole blood glucose (B), with the following results:

<table>
<thead>
<tr>
<th>Specimen</th>
<th>A (Blood glucose (mmol/L))</th>
<th>B (Blood glucose (mmol/L))</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.5</td>
<td>4.2</td>
</tr>
<tr>
<td>2</td>
<td>6.8</td>
<td>7.0</td>
</tr>
<tr>
<td>3</td>
<td>3.2</td>
<td>2.8</td>
</tr>
<tr>
<td>4</td>
<td>5.8</td>
<td>5.6</td>
</tr>
<tr>
<td>5</td>
<td>8.9</td>
<td>8.7</td>
</tr>
<tr>
<td>6</td>
<td>9.5</td>
<td>9.7</td>
</tr>
<tr>
<td>7</td>
<td>4.8</td>
<td>4.9</td>
</tr>
<tr>
<td>8</td>
<td>7.3</td>
<td>6.8</td>
</tr>
<tr>
<td>9</td>
<td>5.1</td>
<td>4.6</td>
</tr>
<tr>
<td>10</td>
<td>7.8</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Do these results support the suspicion of bias?

The variability of the results in groups A and B are due to differing glucose concentrations in the specimens and to the analytical variation between the instruments. Therefore a standard t-test comparing the means of both sets of results would be inappropriate for comparing the analytical performance of method B with method A. As the data are paired, i.e. the same samples were assayed by both instruments, a paired t-test can be used.

Calculate the difference (x) between each pair of results: \( x = A - B \)

<table>
<thead>
<tr>
<th>A (Blood glucose (mmol/L))</th>
<th>B (Blood glucose (mmol/L))</th>
<th>x</th>
<th>x^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5</td>
<td>4.2</td>
<td>0.3</td>
<td>0.09</td>
</tr>
<tr>
<td>6.8</td>
<td>7.0</td>
<td>-0.2</td>
<td>0.04</td>
</tr>
<tr>
<td>3.2</td>
<td>2.8</td>
<td>0.4</td>
<td>0.16</td>
</tr>
<tr>
<td>5.8</td>
<td>5.6</td>
<td>0.2</td>
<td>0.04</td>
</tr>
<tr>
<td>8.9</td>
<td>8.7</td>
<td>0.2</td>
<td>0.04</td>
</tr>
<tr>
<td>9.5</td>
<td>9.7</td>
<td>-0.2</td>
<td>0.04</td>
</tr>
<tr>
<td>4.8</td>
<td>4.9</td>
<td>-0.1</td>
<td>0.01</td>
</tr>
<tr>
<td>7.3</td>
<td>6.8</td>
<td>0.5</td>
<td>0.25</td>
</tr>
<tr>
<td>5.1</td>
<td>4.6</td>
<td>0.5</td>
<td>0.25</td>
</tr>
<tr>
<td>7.8</td>
<td>7.7</td>
<td>0.1</td>
<td>0.01</td>
</tr>
</tbody>
</table>

\( \sum x = 1.70 \quad \sum x^2 = 0.93 \)
If there is no bias then the differences between each pair of results \((x)\) would be very small and on average would be very close to zero. A paired t-test is used to compare the mean difference (i.e. the mean of \(x\)) with a hypothetical value of zero taking into account the standard error of the values of \(x\). The mean and standard error of the difference is calculated in the usual way:

\[
\text{Mean} = \sum \frac{x}{n} = 1.70 = 0.17 \text{ mmol/L}
\]

\[
\text{Variance} = \sum \frac{(x - \text{mean})^2}{n-1} = \frac{\sum x^2 - (\sum x)^2}{n-1}
\]

\[
= \frac{0.93 - 1.7^2}{9} = \frac{0.93 - 0.289}{9} = 0.0712
\]

i.e. assuming a Gaussian distribution the differences in results between the two instruments \((x)\) belong to a distribution in which the mean is 0.17 mmol/L and the variance is 0.0712.

\[
\text{Standard deviation of } x = \sqrt{\text{Variance}} = \sqrt{0.0712} = 0.267 \text{ mmol/L}
\]

\[
\text{Standard deviation of the mean (standard error)} = \frac{\text{Standard deviation}}{\sqrt{n}} = \frac{0.267}{\sqrt{10}} = \frac{0.267}{3.16} = 0.0845 \text{ mmol/L}
\]

\[
\text{Paired } t = \frac{\text{Mean} - 0}{\text{Standard error}} = \frac{0.17 - 0}{0.0845} = 2.01
\]

From a table of \(t\), the probability of obtaining a value for \(t\) of 2.01 for 9 degrees of freedom (i.e. \(n - 1\)) by chance if there is no significant difference between the methods is greater than 0.05 (since for 9 degrees of freedom tables give a \(p\) value of 0.05 when \(t = 2.262\)). Therefore the data show no significant difference in the results obtained with the two instruments and do not support the suspicion of bias.

**Exam tip:** Most modern pocket calculators allow the direct calculation of mean and standard deviation upon entering a series of individual values.

---

**Question 46**

A plasma contains 140 mmol/L of sodium and 95% water by volume. Neglecting sodium binding by plasma proteins, calculate the apparent plasma sodium concentration determined from measurements with an electrode system which responds to water sodium (a) in undiluted plasma, and (b) in plasma diluted 1 in 20 with water.
Season's Greetings to our clients and congratulations to ACB News on their 500th issue

When you partner with Beckman Coulter, a world leader in laboratory systems and process improvement, the innovation never stops. From automation, data management, flow cytometry and general chemistry, to haematology, disease management and immunodiagnostics, our resources for diagnostic testing are unequalled. Beckman Coulter gives you access to laboratory systems that simplify and automate every step of sample analysis. With Beckman Coulter, your laboratory can provide the tools clinicians require.

For more information, contact your Beckman Coulter representative today, visit us on the Web at www.beckmancoulter.com or email us at beckmancoulter_uk@beckmancoulter.com.
The Porphyria Interest Group meets at nine monthly intervals and is open to clinicians and scientists with a specialist interest in porphyria. The meeting is arranged by Orphan Europe and the aim of the group is to exchange views and present unusual cases for discussion. There are educational aspects to the meeting and representatives from the patient organisation British Porphyria Association (BPA) are invited to discuss issues raised by their members.

The last meeting was held at the British Society for Antimicrobial Chemotherapy in Birmingham on Tuesday 19th October 2004. The programme generally has the same format and the meeting began with questions from the representative from the BPA. The BPA are an invaluable link for patients with porphyria and are able to give support to them and their families.

Dr Mike Badminton (Cardiff) chaired the meeting and the first presentation was given by Professor Tim Cox (Cambridge) who gave us a fascinating insight into the problems associated with commissioning funding for rare diseases. The designation of an Orphan product is under the control of the Office of Orphan Products Development and has specific criteria related to its approval as an Orphan Drug. There are 242 licensed orphan drugs and with the approval the sponsor gains 10 years marketing exclusivity. In England the National Specialist Commissioning Advisory Group (NSCAG) remit is to advise Ministers on funding for commissioning of local patient services and to help patients gain access to uncommon services. However, as Professor Cox illustrated, there are still problems in patients gaining access to specialist medical treatment - so called postcode lottery - and there is an important role for patient organisations on this issue.

Andy Rennison (Wren Computing) demonstrated a database that is currently being used by a specialist porphyria centre for organising the information accumulated on patients and families identified as having porphyria. The database was particularly useful in enabling the genealogy of the family to be set up and for a timeline on dates when a patient has an acute attack of porphyria, together with results, referral letters and request forms. This database can be used in clinic meetings with the patient and is an invaluable tool for storing information about porphyria and links to other sites.

**Transplantations Criteria**

The afternoon session began with a summary of case reports from Professor Elias (Birmingham) on patients with erythropoietic protoporphyria (EPP) and acute intermittent porphyria (AIP) having successful bone marrow and liver transplantation respectively for their
disease. Professor Elias started the discussion about the criteria for transplantation in this patient group such as quality of life, frequency/severity of acute attacks in patients with AIP, end organ damage, drug dependence and the age of the patient. An increasing dilemma for surgeons in patients with AIP who have regular haem-arginate treatment is the difficulty of venous access when transplantation is considered as an option.

Dr Allan Deacon (Bedford) ended the round of presentations with a mathematical interpretation of biochemical data regarding the clinical role of measuring erythrocyte hydroxymethylbilane synthase (HMBS, PBG-deaminase). Dr Deacon highlighted that the measurement of HMBS is invalid in some clinical situations and there is overlap between normals and those patients with AIP. He calculated sensitivity and specificity based on a cut-off of 20 nmol uroporphyrin/ mL red cells/ h at 37°C (reference range: 20-42) and concluded that HMBS is best reserved for family studies and that there is no value in measuring HMBS in asymptomatic individuals.

The afternoon session finished with a series of clinical conundrums from the participants and lively discussion from colleagues in other porphyria specialist laboratories.
Pink Balloons and More . . .

Reported by Sadie Marsh, University Hospital, Birmingham

Being a resident of Birmingham, I did not stay on the University of Birmingham campus itself, but I gathered from the cheerful disposition of the trainees of Monday morning, that the ensuite accommodation provided was of an extremely high standard. Many of the female contingent were particularly delighted that the ACB training course had happened to coincide with a ‘Young Farmers’ conference, being held in the same halls of residence. Dinners provided on campus were said to be very good, with the exception of the caterers’ unusual take on vegetarian cuisine (prawns not being strictly vegetarian). Entertainment was provided on the first night in the form of a quiz.

As is typical on the first lecture day, the AV equipment did not want to play ball and the AV technician was nowhere to be seen. However, the show went on regardless in the form of Professor Lote, who talked us through ‘The Nephron’ with the aid of an overhead projector and various coloured pens. He was swiftly followed by Dr Bill Bartlett who, without the aid of his PowerPoint presentation, managed to steer us through the laboratory assessment of GFR.

Following coffee, and the restoration of audio-visual capabilities, the lectures proceeded with various aspects of renal biochemistry, concluded by an entertaining workshop on QA presented by Dr Jonathan Middle. The trainees’ meeting in the evening opened up discussions on HST posts in paediatric biochemistry and possible changes to the format of MRCPath examinations, with contributions from Dr Anne Green and Dr Trevor Gray, respectively.

The second day was composed of lectures on electrolytes, clinical cases and an accreditation workshop, presented by Dr David Burnett. The evening’s entertainment took the form of a trip to a local curry house to experience Birmingham’s infamous speciality dish - The Balti.

Pink Balloons and More . . .

Wednesday morning kicked off with lectures from Dr Alan Jones on acid-base homeostasis and assessment, and this was followed by clinical cases on the same subject. After lunch, Dr Peter Gosling, with the aid of an able assistant from the audience and a pink balloon, demonstrated 101 ways to mechanically ventilate a lung. This was followed by lectures on ‘Respiratory Chain Disorders’ by the ever enthusiastic Dr George Gray, and an introduction to the topic of screening by Dr Cathie Sturgeon. Coaches departed swiftly after the end of lectures to Tamworth Snowdome for an evening of tobogganing on real snow!
Thursday morning concentrated on antenatal and newborn screening. This was followed by a clinical case session on some usual and unusual causes of abnormal calcium levels, led by Dr David Kennedy. The afternoon concluded with workshops on aspects of health and safety and risk assessments.

Traditionally, the Thursday evening entertainment comprises a course dinner and the Birmingham training course did not disappoint, with a delicious three course meal held in the beautiful Highbury Hall, and that’s not to mention the free bar and even a front cover photo on ACB News!

For those who survived the consequences of the free bar, Friday morning took us through the clinical applications of DNA analysis and mass spectrometry, and ethical issues. The final session of the course was presented by Dr Allan Deacon. He did not, however, come to present his usual “Deacon’s Challenge”, but had instead conjured up a new ordeal for the trainees – MRCPath “Spot tests”! This was a great finish to the course for anyone with a competitive streak and a few brain cells remaining intact.

The consensus view was that the course was extremely enjoyable, with good accommodation, food, social events and a varied programme of lectures, workshops and clinical case discussions. Thanks go to the organising committee, comprising – Eddie Legg, David Andrews, Ruth Gallacher, Clare Ford, Julian Waldron and Annette Powell, for all the time and effort they put in.

Roll on the Leeds training course in April – see you all there!
The editorial policy on ACB News is to look forward and not back. However, this is the 500th edition of the magazine and this should be marked in some way. ACB News has provided an important communication link which has helped to promote the work of clinical chemistry and the Association both in the United Kingdom and abroad. Surprisingly there have been relatively few Editors of the magazine. Jonathan Berg, the current Editor, is starting work on his 200th edition and Joe O’Meara, his predecessor notched up 50 editions before. Deep in the mists of time Andre de Bats totalled even more editions and John Lines should be especially remembered both as the editor of 100 editions and for taking the magazine from a stapled series of A4 sheets to the professionally printed publication not far removed from what you see today.

Professional Input
ACB News has developed with the help of professionals with Mike Cartwright starting to print the magazine at Cambridge Library Press in 1975 and taking the publication with him when he bought Piggott Printers in Cambridge. Mike has gone on to print every edition of the magazine since then. Piggott Printers has printed many other items for the ACB and also provided us with much help in presenting a modern image of the Association to the outside world.
In a similar way Peter Carpenter at PRC Associates took over as the advertising agent and publisher in the late 1970s. Along with Sue Ojakowa, Peter has done a tremendous job of ensuring that our Corporate Members get the full benefits from the advertising potential of this keenly read and highly targeted medium. In response to this corporate support ACB News has managed to progress, as our correspondent last month pointed out, to that “red top” magazine that you see today!

**Spanish Link**

ACB News has found a niche and while a publication of the ACB, editorial is clearly distinct from the ACB inner circle. This freedom has enlivened the pages of this magazine even to this very issue. Other organisations are quite rightly envious of the lively content and liberal spirit, though sometimes it has been suggested that ACB News presents a more enlightened view of what many still consider a rather conservative discipline.

More recently, ACB News has been available on the Internet as a PDF file and statistics for downloading are impressive, suggesting that electronic access is widening the readership in a way that could never have been achieved otherwise. Broadband internet access also means that Nikki, who has typeset the magazine since the 1980s, can continue to do so from her new home in Almeria, Spain.
Manage the Process - Control the Flow
I found reading the anonymous article “It’s not that Funny Mate . . .” in the October issue of ACB News fascinating. I must say I have experienced many of the problems described in the article personally. The only difference being that I am now a medically qualified Consultant in Clinical Biochemistry (Chemical Pathologist) of 18 years standing. The problems outlined are not unique to Clinical Scientists and apply to anybody taking up a senior position in any laboratory medicine specialty, whatever their background.

It may be illustrative to look at some of the problems described from a different perspective and it may help the readers to have the original article open beside them.

Leave CPA Out of It!

The first point set out by the author is that new and sometimes problematic Consultant Clinical Scientist posts are being created because CPA has made it a condition of accreditation. I would challenge this assumption. As an ex-CPA inspector, for which the reasons for the ex- would fill another article, I have inspected a number of laboratories with single-handed consultants - both scientific and medical. Without exception in my series of six such scenarios all have asked me to include a recommendation for the appointment of a senior colleague. Most, but not all, have wanted a colleague with a different background to themselves.

Often the CPA recommendation is the culmination of years of work advocating such an appointment. Very few trusts would employ such a senior person without the support of the department. It makes no sense to do so purely for a regulatory condition when cross-cover from another department would be much cheaper.

Different Views on the Workforce

The second point is that BMS staff are generally insecure, defensive, unwilling to share knowledge and implicitly have no insight into the failings of their service preferring to let their areas “fall into disarray” rather than cooperate with the newly appointed junior consultant who has “no authority to do anything about it.” Particular acrimony is reserved for those involved in IT and I would also challenge this.

Looked at from the perspective of the BMS with 20 years experience the newly appointed consultant may well appear overpaid, inexperienced, immature, always away at meetings, arrogant and disrespectful.
“The Olympus process management study identified areas where the introduction of new systems has greatly improved overall efficiency.”

Peter Thompson
General Manager
Biochemistry Laboratory
Aintree Hospital

“We know that we can justify the purchase by the fact that the system will pay for itself within three to five years”

Gary Barker
Head BMS
York Hospital

“Staff don’t have to spend large parts of the day producing work lists and hunting samples.”

Tony Dedman
Laboratory Manager
Lister and QE11 Hospitals

IN OUR EXPERIENCE
BIOMEDICAL SCIENTISTS TEND TO SAY EXACTLY WHAT THEY THINK

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Laboratory Manager
Clinical Biochemistry Dept.
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It is equally likely that the department is understaffed, that people will have voluntarily taken on extra responsibilities, mostly unpaid, and are feeling undervalued. They feel they have no time to train anybody else in what they are doing and may have little previous contact with senior staff if the single-handed HOD has been busy with external issues. It is also likely that under the current system there is so little redundancy of function that there is no prospect of covering absence.

**Creating a Team With Mutual Respect**

Let us assume for the moment however, that the author’s perspective on the workforce is correct. This would be symptomatic of a highly disaffected and dysfunctional team.

It is highly unlikely that the sort of line management authority requested by the author would be successful in resolving the problem. Before any specific reorganisation can occur the department has to think of itself as a team. One of the prime roles of any consultant is to forge and lead that team. This requires social interaction between the members and a feeling of mutual respect. Attitudes such as those expressed in the article would not help in this process. Once a modicum of trust exists specific areas can be addressed, but win-win solutions should be sought. I have found that during periods of stressful change within the laboratory, changes would only succeed if they could show a reduction in stress levels. This was often brought about by cooperation. It is critical to have frequent meetings at this stage in order for people to freely express their concerns. Once he/she has reached this stage of departmental development the newly appointed consultant will find he has all the authority he needs. The goal must be to treat the BMS staff the way the author feels the “medical fraternity” should treat him.
No Set Job Specification for Consultants

There follows a debate on the role of the Consultant Clinical Biochemist and the nature of the clarity with which this role should be spelt out in a service context.

I have attended a number of meetings on the role of both Chemical Pathologists and Clinical Scientists in the last year. The common theme is that everybody does the job differently. One of the great advantages of this job is the ability to develop your career in the way you want to with some flexibility. The last thing you need is a tight job description when you start. A structured discussion with your head of department who has more experience may give you a lead on how you want to develop. In a lot of laboratories result interpretation and clinical liaison is a key area and should not be undervalued. Most of your non-pathology medical consultants will judge you according to your competence and professional judgement in this field. Contacting them about a difficult diagnostic problem and offering them a solution will do a lot more for your reputation than a formal introduction.

As a Consultant Clinical Biochemist you now have the right to practice independently and to take individual responsibility for your actions. However badly you may think of your head of department he cannot stop you doing this. You should network furiously outside the laboratory in your first year to build your practice for future, this will be the powerbase you will need to advocate change within your department.

In the end the job is what you make it, the better you can co-operate with other people the wider the scope you will have.

Of course you will be expected to cover for the head of department absences and in the first year he/ she is going to need a lot of rest and recuperation after some years of single handed practice. Be kind and considerate and recognise this. Things should come into balance after a couple of years. The fact that he/ she is happy to leave the department in your hands should be taken as a compliment.

Fighting Those Fires . . .

Next we come to solving problems on your own and “firefighting”. You are a big boy or girl now with an MRCPath certificate to prove it. You are paid to solve problems and, equally importantly, to take responsibility for your decisions. In the first few months the staff will test you to see how you respond under fire, how far they can push you and they will collectively share their experiences. We have all gone through this and it is uncomfortable. My advice is don’t moan, don’t panic and ask advice when you need it. There is no shame in inexperience.

The main thesis of the article however is the question “Consultant equivalent or Consultant assistant?”

The answer to this question is quite clearly that “It’s up to you Mate”. The following advice applies to both scientists and medics.
There is no such thing as a medical fraternity. A good pathology department can work as a team if consultants are prepared to work together using the principles outlined under the section on BMS relationships. At worst the rivalries and interpersonal conflicts lead to a complete breakdown in communication and obstructive behaviour. Outside of pathology you are dealing with a mixed bunch of people who may have little in common. Some you will come to regard as friends and allies, with some you will have a purely professional relationship and some you are never going to get on with. It is no different than other walks of life.

As a junior consultant of either background you have no rights of acceptance, you will be judged on the qualities of professional judgement, individual commitment, mutual respect, friendliness, maturity and leadership, only one of which is examined by the MRCPath.

Finally, addressing the issue of a rotating head of department, nobody is going to offer a departmental headship to an untried junior consultant of any background until they have seen how they demonstrate the qualities outlined above. If the author, as a junior consultant, were to ask me if the HOD was rotational and held the attitudes outlined in the original article, I too might be looking at the ceiling!

As a final exercise, perhaps the reader might like to answer for themselves the question posed by the excellent cartoon at the end of the original article.

I find it impossible to check the results on this stupid computer system of yours....

Let's switch it on first eh?
Support all the way!

Merry Christmas and many congratulations to the ACB on its 500th issue

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focus on the patient

at EuroMedLab 2005

16th IFCC-FESCC European Congress
of Clinical Chemistry and Laboratory Medicine

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- Renal Tubular Disorders
- Current Issues in Intensive Care
- Hypertension
- Diagnosis and Management of Cancers
- Inherited Metabolic Diseases
- Biochemistry of Platelet Function
- Health Economics

Deadline for Poster Abstracts
21st January 2005
Christmas Crossword

Compiled by Dr Michael Colley, Great Western Hospital, Swindon

The grid is a mirror image left to right and also top to bottom.

The clues are arranged in alphabetical order of their solutions.

A prize for every correct solution.

Please fax or post your solution to the Editor to arrive no later than 10th January 2005.

Fax: 0121-765-4224

Clues

1. Sailor directed away (6)
2. Current team accumulate in a former fashion (6)
3. A cube for you, I hear. Goodbye (5)
4. Diary to alter a new way of working (6,3,6)
5. Wing made of a rare earth (3)
6. Initially networked in the US (3)
7. Let's hope this is not a complete failure before the end of this month (9,6)
8. Sailor without 17 (2)
9. Here we... wish you a Happy New Year (4,1,9)
10. He's fine (4)
11. Currency foreign to American State. Carried away by bull (6)
12. Used to have appeal. Get out (4)
13. Doomed to be short and obese (3)
14. Take away a square and you've still got one (6,9)
15. Male god or goddess? (4)
16. Short book in a thin layer (6)
17. In Scotland no element (2)
18. Call these three for a practical cat (5)
19. Smelly. Metal or rejected parts? (5)
20. Perfect brief costume sounds chaste but pointless after thirty-one (7)
21. Rock-crystal loses weight for wine (5)
22. Sounds like was one of eight. Not here (4)
23. Erase half deficiency disease. Add trace element to waterproof (9)
24. Fortune tellers cry “Erroneous!” but he looks to the future inside (6)
25. Peter Simple (5)
26. Standing order to such an extent (2)
27. Thirteen could be nastier (7)
28. Mixed up fish and fastened it with this? (5)
29. When Colin starts Bill comes first. What sauce! (7)
30. You sound as to replace the Spanish in dance with arachnid (9)
31. Six in test game with twenty (7)
32. Attila messed with tree to take off his headgear (6)
33. Chrysalis sheds its case and goes this way (2)
34. Welshman friend loses his head but is nonsensically sharp (6)
35. Zephyr takes account of help in preparing crossbow (6)
36. Cowardly short sailor takes public transport back to where our friends are all aboard (6,9)
We welcome the following into Membership of the Association:

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Seasons greetings from Randox
www.randox.com
HITF Report Kicks off Some In Vitro Action

Follow a year long initiative from Government and the Medical Device industry sector, the report from the Healthcare Industries Task Force (HITF) was launched on the 17th October. This report heralds the start of a programme of actions identified by HITF.

The HITF was established in October 2003 and has thus been a year long initiative, jointly chaired by Lord Warner, Under Secretary of State for Health, and Sir Christopher O’Donnell, Chief Executive of Smith & Nephew. The activities of the Task Force brought together Government and Industry leaders, including Clem Fitzgerald (Marketing Director of Randox Laboratories and Chairman of the British In Vitro Diagnostics Association (BIVDA) at the inception of HITF) to identify steps to develop, stimulate the growth and performance of the UK healthcare industry and maximise benefit to patients from the healthcare products it produces.

Background to HITF

Distinct from the Pharmaceutical Industry Competitiveness Task Force (PICTF) that went before it, HITF was supported by four working groups bringing together experts from the medical devices and healthcare industry that provides invaluable products and services to the NHS. The final report addresses issues to help maintain a high-quality, leading-edge supply to the NHS of critical items from diagnostic tests and equipment to surgical dressings and heart stents. It also recognizes the contribution of industry in providing education and training for the NHS as well as IT and maintenance services.

The UK IVD industry was represented throughout the process by six BIVDA representatives to ensure that the value of diagnostics in healthcare would be clear in what is a wide and highly diverse industry sector. The work of the taskforce was split into four main areas to develop key output recommendations:

- Market access – The Market Access Working Group gave consideration to factors in the UK market for products from the healthcare industries and included David Horne (Managing Director, Bio-Stat Ltd) and Ian Pinn (UK General Manager, Beckman Coulter) representing BIVDA.
- Industrial base – The R&D and Industrial Base Working Group’s objective was to consider and make recommendations on how to strengthen the UK as an attractive location for R&D and manufacturing investment in the healthcare sector. Diagnostic input was provided by Dr Klaus Pollmann (Roche Diagnostics) and Doris-Ann Williams (Director General, BIVDA).
Corporate News Corporate News Corporate News Corporate News

- Regulatory issues – The Regulatory Issues Working Group looked into the regulatory environment for medical devices and public health in the UK, identifying issues which would benefit from joint working between Government and Industry, both currently and in light of forthcoming regulatory developments. George Zajicek (Business Development Director, Axis-Shield plc) with Doris-Ann Williams (Director General, BIVDA) were able to provide the diagnostic viewpoint for this group.

- International trade – The International and Export Business Working Group gave consideration to how Government, in conjunction with British Healthcare, can assist the healthcare manufacturing industry to improve its international trade performance with Clem Fitzgerald (Marketing Director of Randox Laboratories) participating in these discussions for BIVDA.

When announcing HITF at the end of 2003 Lord Warner, co-Chairman of HITF said, “The healthcare industry is important to this country, both in terms of developing products to support better healthcare in the NHS, and as an important economic sector. This Task Force will help us to get a better understanding of how Government and Industry can work together for mutual benefit. Great advances are being made in medical technology. I want to make sure we harness this expertise and maximise the benefits for the NHS, patients, industry and national economy.”

Doris-Ann Williams, Director General of BIVDA welcomes the publication of the final report saying that, “BIVDA now looks forward to seeing the key strategies developed by HITF and outlined in the report published today become tactical processes that will ensure tangible outcomes for patients in the long term.”

Professor Chris Price, President of the Association of Clinical Biochemists commented, “The HITF Report recognises a number of deficiencies in building on the NHS as a resource for innovation with the goal of improving patient care, which extend from agreeing priorities for research and development through to delays in technology transfer and slow implementation. The limitations extend far beyond the research community and therefore the messages in this report needs to be widely disseminated and acted upon in a concerted fashion. This is particularly true in the area of in vitro diagnostics.”

Professor Price added, “Thus there does need to be a greater focus on prioritising needs in order to stimulate confidence in the diagnostics industry and to invest the resources to satisfy these needs. There needs to be more work done on the effectiveness of diagnostic tests but taking a far more holistic view than is currently practised. This work then has to be more clearly communicated to policy makers and adopted in a more efficient way by those responsible for healthcare delivery. The current delays in technology transfer to its final destination - namely the patient - are to the detriment of all of the parties involved.”

David Horne, Managing Director of Bio-Stat Ltd, added, “Despite the very wide variety of companies and products represented in the
Market Access Working Group there was very close agreement on the common issues facing companies involved in marketing to the NHS. I see this launch meeting as only the beginning of the HITF dialogue and not an end product. There are many obstacles to overcome if our objectives as a group are to be achieved. A major objective should be the alignment of NHS purchasing systems to take into account benefits to patients and the NHS in general rather than just focusing on price of the product to the end user.

**Positive Impacts . . .**

Ian Pinn, UK General Manager of Beckman Coulter, remarked “Having been involved in HITF, with the Market Access Working Group, from the start of this project, I am impressed with the professional way it has been organised and the great interest shown from both within the IVD industry and Government. We have a great opportunity to show how in vitro diagnostics can have a positive affect on healthcare in the UK.”

George Zajicek, Business Development Director of Axis-Shield plc, said, “The Regulatory Issues Working Group examined the regulatory barriers to market access of innovative products and found much in common with the pharmaceutical industry in concern, inter alia, about the difficulty of conducting UK clinical trials and the availability of samples. I was gratified to see governmental eagerness to address all the issues of contention. The move towards diagnostics in primary care and ultimately self-testing carried out by the ‘worried well’ will bring new challenges which should be considered with the benefit of the individual uppermost, rather than on cost issues and NICE recommendations.”

The concluding message from Clem Fitzgerald echoed that of many of the participants, “The HITF has been a genuine attempt to identify how we can improve patients’ health and at the same time stimulate the devices industry to be an asset to the country. The HITF working groups have presented some 50 recommendations for consideration and the final report will support a spearhead of recommendations with a proposal for a strategy of implementation.

It is in the strategy for implementation that we now need to focus. HITF will only be of value if, through implementation, we identify an underlying standard by which we measure each decision and proposal. The whole in vitro diagnostics industry in Europe is convinced that we need to recognise value in terms of a strategy for the whole life of the patient. Short termism is the greatest handicap of our health system. If we use value rather than price to make informed decisions on health we will make decisions that in general cost less per patient. This is the real challenge for us all and we desperately need to embrace value-for-patient driven decisions. With this, the aspirations and infectious energy of the 200 participants in the HITF will come to something very special . . . a very modern health system that believes a stitch in time saves nine.”
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Super Size Me and The Fats of Life: The Obesity Epidemic

ACB South West and Wessex Scientific Meeting
Postgraduate Medical Centre
Derriford Hospital, Plymouth
Tuesday 22nd February 2005

10.00 - 10.30 Coffee and Registration
Welcome: Dr Ruth Ayling, Plymouth

10.30 - 11.10 EarlyBird, Insulin Resistance and the Metabolic Syndrome
Prof Terry Wilkin, Plymouth

11.10 - 11.50 Exaggerated Adrenarche: Linking Fetal Growth and Disease in Later Life
Dr John Gregory, Cardiff

11.50 - 12.30 Comparison of Assays for Measurement of Insulin Resistance by HOMA
Dr Sue Manley, Birmingham

12.30 - 13.30 Lunch

13.30 - 14.10 Should Bariatric Surgery be a First Line Treatment for Diabetes?
Dr John Pinkney, Liverpool

14.10 - 14.50 New Inherited Syndromes of Insulin Resistance
Dr Robert Semple, Cambridge

14.50 - 15.20 Tea

15.20 - 16.00 How the Gut Talks to the Brain
Dr Carel LeRoux, London

16.00 - 16.40 Fats for the Future

This meeting is CME & CPD accredited.
All laboratory staff are welcome to attend. Registration fee £15. Closing date: 9th February 2005.
Contact: Dr Roy Fisher, Department of Clinical Chemistry, Royal Cornwall Hospital, Truro TR1 3LJ.
Tel: 01872-252546. Email: roy.fisher@rcht.cornwall.nhs.uk
Letters

Readers speak out

**Autoclaving of Clinical Samples**

I don’t know whether anyone else has spotted it but there is an anomaly in the official advice given for clinical sample disposal in the guidance ‘TSE Agents: safe working and the prevention of infection’ June 2003.

Most of the samples handled in clinical biochemistry e.g. CSF, serum, urine etc taken from patients known or suspected of having a form of CJD, are classified by the guidelines as being low risk. The guidance then goes on to advise 1 of 2 things for these low risk samples, either they should be autoclaved prior to incineration (part 3 para 3.27) or that they can be disposed of by the routine methods used for disposal of clinical waste i.e. incineration (Annex C C.32).

I sent off a few emails seeking clarification about whether to autoclave or not to autoclave and have now received a reply from the ACDP Secretariat of the HSE which states that the TSE Working Group have reviewed the matter and have advised that low risk clinical material does not require autoclaving prior to disposal and incineration. The intention is to amend part 3 para 3.27 so that there is agreement with the advice given in Appendix C. So, it looks like we don’t have to worry about that one anymore.

**Catherine Shearing**
Principal Grade Clinical Scientist
Department of Clinical Biochemistry and Haematology
Western General Hospital
Crewe Road
Edinburgh EH4 2XU

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**Good Posts Around for ‘Matey’ . . . Not Often Vacated!**

I feel I must respond to ‘It’s Not That Funny Mate’. There may well be departments where medically qualified consultants treat their Clinical Scientist consultant colleagues as second class citizens, but that has not been my own experience.

Since being appointed as a Consultant Clinical Scientist I have been treated as an equal by all my medically qualified pathology colleagues, and I am currently serving my turn as Director of Pathology. There are good Consultant Clinical Scientist posts around but they don’t become vacant very often.

**Wendy Brown**
Department of Biochemistry
Harrogate District Hospital
Harrogate
HG2 7SX
We are looking for an enthusiastic Clinical Biochemist. We provide an analytical, interpretative and advisory service for the Highlands of Scotland whose population is around 200,000. The Department, which is fully CPA-accredited, is situated in Raigmore Hospital, a District General Hospital (approximately 600 beds) with a wide range of Departments including Paediatrics, Obstetrics, Oncology and Renal Medicine, and with links to Aberdeen University Medical School. The Department provides a service for patients in Raigmore Hospital and other hospitals, and for patients in the community via GPs and community nurses.

You will work with the Consultant Medical Biochemist (Head of Department) and will act as Deputy Head of Department. You should be a state-registered Clinical Scientist with MRCPath or equivalent and a broad knowledge of Clinical Biochemistry. Good communication and management skills are also required.

Inverness is a rapidly growing city with easy access to beautiful countryside and with a wide range of leisure activities available.

To discuss the post informally please contact Dr Douglas Robertson, Consultant Medical Biochemist, on Tel: 01463-704210.

Application Form and Job Description are available from the Personnel Department, Raigmore Hospital, Inverness IV2 3UJ. Tel: 01463-705159 (24 hour answerphone) or by e-mail on recruitment@raigmore.scot.nhs.uk or by visiting www.returntoscotland.com Please quote reference R/04/347.

Closing date for completed applications: Friday 17th January 2005.

‘Working with you to make Highland the healthy place to be’
EAST CHESHIRE NHS TRUST
MACCLESFIELD DISTRICT GENERAL HOSPITAL
EAST CHESHIRE NHS TRUST

Consultant Clinical Biochemist/
Consultant Clinical Pathologist

Applications are invited for this post which arises due to the impending retirement of the current post-holder. The present holder of the post is not medically qualified and as a result does not hold clinics. He is very active in providing advice on investigation and management within the limitations of his qualifications and has particular interests in Endocrine, Diabetes and Toxicology.

It is anticipated that any medically qualified appointee would seek to develop a clinical service within the areas of their specialised interest. The Trust would support these developments within the strategic planning framework. At the present time there is no preference as to the particular interests of applicants. The successful candidate would be expected to have at least an appropriate PhD, you will need to be a state-registered Clinical Scientist and have appropriate experience research in medical biochemistry. The possession of MRCPath or equivalent experience is preferable.

East Cheshire NHS Trust provides acute hospital care to a population of approximately 200,000 encompassing the towns of Macclesfield, Congleton, Knutsford and Holmes Chapel.

Macclesfield district is on the edge of the Derbyshire Peak District and covers approximately 220 square miles. It was the centre of the silk industry and is a town of charm and historic interest. There are first class shopping facilities locally and excellent schools are to be found nearby. There is a wide range of adjacent sports and leisure facilities. There is easy access to the motorway network and it is within 10 miles of Manchester International Airport. Manchester provides good facilities for both music and theatre, including the Halle Orchestra and the Royal Exchange Theatre Company. It is an ideal centre for touring the Peak District National Park.

We would like to talk to any interested individuals about their career aspirations and any interested parties are welcome to visit the department. If you wish to develop your career in a stimulating, challenging yet friendly environment then find out more about us by contacting: Dr A Williams on Tel: 01625-661820.

Job description/information pack and application form from: Medical Staffing, Macclesfield District General Hospital, Victoria Road, Macclesfield SK10 3BL. Tel: 01625-661234 or email: Sandra.Heaton@echeshire-tr.nwest.nhs.uk

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