

# Canterbury DHB

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## District Health Board

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T e P o a r i H a u o r a ō W a i t a h a

### Meeting Minutes

**Subject:** Community Éclair Results Repository Biochemistry (Meeting 3)

**Location:** Seminar Room, Canterbury Health Laboratories

**Meeting Date** 07/08/2008

**Attending:**

|                       |                             |       |           |
|-----------------------|-----------------------------|-------|-----------|
| Peter George (PG)     | Medical Director            | CDHB  |           |
| Richard Mackay (RM)   | Chemical Pathologist        | CDHB  |           |
| Chris Florkowski (CF) | Chemical Pathologist        | CDHB  |           |
| Lesney Stuart (LS)    | Biochem Section Head        | CDHB  |           |
| Geoff Smith (GS)      | Chemical Pathologist        | SCL   |           |
| Max Reed (MR)         | Biochem / Haem Section Head | SCL   |           |
| Guy Mulligan (GM)     | Chemical Pathologist        | MLS   |           |
| Gordon Sutton (GSu)   | Biochem Section Head        | MLS   |           |
| John Moodie (JM)      | LIS Co-ordinator            | CDHB  |           |
| Robert Allan (RA)     | Medical Lab Scientist       | SCL   |           |
| John Livesey (JL)     | Scientific Officer, Endolab | CDHB  |           |
| John Sheard (JS)      | Biochem Section Head        | WCDHB | Apologies |
| Ruth Spearing (RS)    | Haematologist               | CDHB  | Apologies |

| Minute No | Minutes  | Action         |
|-----------|--|----------------|
| 1)        | <p><u>Welcome</u></p> <p>JM welcomed JL to the meeting to assist in the discussion around FSH and LH's.</p>  |                |
| 2)        | <p><u>Minutes / Actions of the last Meeting</u></p> <p><i>Action: Fasting Glucose: CF to look at the possibility of being able to add an appropriate report comment for GP's regarding the potential indications of glucose in the high 5.0 range and liaise with GS for a solution.</i></p> <p>GS noted that this still needs to be looked at.</p> <p><b>Action: GS and CF to discuss possible solutions.</b></p> <p><i>Action: Initiate comparison testing once a more definitive list is compiled.</i></p> <p>JM noted that this had completed and all actions regarding comparison testing will be discussed in detail later in the meeting.</p> <p><i>Action: JM to recheck the LOINC entry for Cholesterol / HDL ratio and email entry to attendees.</i></p> <p>JM confirmed that the entry had been sent by email to attendee back in May and that the only mention of the word ratio was in the keywords. If there were any other queries then contact JM.</p> | <b>GS / CF</b> |

*Action: JM to contact Sam Chan to see what options are available.*

*Action: JM to contact Cam Kyle to see what they do.*

JM confirmed that these actions were around the discussion of plasma vs. serum potassium's. JM confirmed that Sam Chan stated the turn around time for the initiation of new LOINC codes was 1-2 days. Sam's response had been circulated in June. In addition JM contacted David Bunkall in Auckland to ask what they do with regards to plasma vs. serum potassium's. David confirmed that they don't differentiate between plasma and serum in Auckland and when LOINC was first developed submissions were sent out went out and the issue of plasma vs. serum had been discussed and agreed. JM also noted that he had emailed Cam Kyle to ask what they do at DML. Cam's email response was circulated to attendees on the 06/08/08. JM also noted that there may be potential for us to look at using a locally agreed code to cumulate where possible. This suggestion would need to be looked at in more detail however to ensure it would work if deemed a suitable approach.

*Action: RM to send through the Paediatric reference ranges when complete.*

RM noted that a number of the paediatric ranges have been worked through and have been reviewed by the pathologists, others are still in progress.

***Action: RM to forward through agreed paediatric ranges to JM as they get completed.***

RM

*Action: JM to confirm the date calculation with the LIS team.*

JM has passed this on to Sandra for checking how the CHL LIS system deals with the date calculation for a person's age.

*Action: JM to consult with RC as to the capability of Éclair regarding the ability to limit Éclair access by region and to confirm that it is the testing, not requesting laboratory that will send the results into Éclair.*

JM noted that these questions will be passed on and looked at as more structure is put around the whole Éclair project. JM noted that there will be a trip to Auckland in the next few weeks where the processes around TestSafe will be looked at.

*Action: Contact GM and confirm the new TSH range for MLS.*

JM confirmed this had been actioned and the spreadsheet updated.

*Action: JM to confirm how many decimal places CHL are report Calcium*

JM confirmed with Phil Tough that CHL report the Calcium range to 1dp.

*Action: Confirm that the upper limit for Calcium is 2.55 for the LNIG and that it is not a transcription error in the collated spreadsheet.*

JM emailed attendees with confirmation of the Lower NI range.

*Action: Chemical Pathologists to discuss the number of decimal places with regards to Calcium and Phosphate.*

This had not been discussed previously. PG initiated discussion at the meeting. **It was agreed that Calcium and Phosphate should both be reported to 1dp.**

*Action: Pathologist to discuss what other tests could be looked at as part of the comparability work stream.*

No formal discussion has taken place. PG noted that some of these potential analytes will be across different disciplines and some cross discipline discussion will need to occur.

JM noted that was the end of the actions and confirmed with the group the contents of the previous minutes were a true and accurate record. This was agreed.

3) Comparability Exercise.

LS co-ordinated the comparability exercise. JM posted the results on screen and each analyte was reviewed.

**It was agreed that all analytes tested would be comparable for the exercise of cumulating results in Éclair. Cholesterol, Triglyceride, HDL, LDL calc, GGT, TSH, FT4, FT3 and PSA.**

Notes:

HDL – it was shown that there were analyser differences in the results. And **it was agreed that this should be reported to 2dp.**

GGT – SCL use (International Federation of Clinical Chemistry) IFCC, CHL are currently half way between and GM noted that MLS need to standardise to IFCC.

TSH – GS noted that SCL's higher values fit well with RCPA.

FT4 – PG noted it looks like there is a Roche difference in the results.

PSA – It was noted how well the PSA results correlated across the laboratories.

4) Biochemistry Spreadsheet Review Continuation

JM noted that there was a Biochemistry TSG meeting at CHL yesterday and Anne Kempthorne from Taranaki noted that they would like to move towards the ARQAG ranges for LH and FSH. It was agreed that this would be a better forum to discuss this request.

5) LH / FSH

JL noted that the current Endocrinology Laboratory ranges were partly based on 200 normal's tested in 1998 and partly on Beckman Access references.

JL noted that he doesn't have any issue with the majority of the ARQAG recommendations there. The only points of contention were a) with regards to Male FSH, JL has noted a distinct upward trend and feels that Endolab data with the additional distinction for males greater than 40 is better. b) with regards to Post Menopausal our ranges are lower than ARQAG's and we encompass the total range.

PG pointed out that the objective would be to review the ARQAG ranges and if we didn't have any objections then we would also look to adopt these ranges.

It was agreed that the best way forward in the short term would be to run comparison testing for the LH and FSH to see how they compared.

It was also agreed that Prolactin (including macroprolactin samples), Oestradiol and Progesterone's should also undergo comparison testing.

It was noted that each laboratory will require approximately 0.5mL. JL noted that most of their samples are EDTA plasma and queried if this would be an issue.

A mix of plasma and serum samples to be circulated.



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| 9)  | <p><u>RED CELL FOLATE</u></p> <p>It was agreed that Red Cell Folates would be too different to cumulate.</p>   |    |
| 10) | <p><u>CREATININE KINASE (CK)</u></p> <p>It was agreed that creatinine kinase is likely to be comparable. It would be good to find out what ARQAG are doing and adopt is possible.</p> <p><b>Action: JM to find out what the ARQAG range is.</b></p>  | JM |
| 11) | <p><u>TOTAL AMYLASE</u></p> <p>It was agreed that the three laboratories would adopt the following for Total Amylase</p> <p>There would be no gender specific ranges and there would be no paediatric ranges. A single reference interval would be used.</p> <p>The range for Total Amylase: <span style="float: right;">&lt;100 U/L</span></p>  |    |
| 12) | <p><u>URINE AMYLASE</u></p> <p>It was agreed that the three laboratories would adopt the following for Urine Amylase</p> <p>There would be no gender specific ranges and there would be no paediatric ranges. A single reference interval would be used.</p> <p>The range for Urine Amylase: <span style="float: right;">&lt;35</span></p> <p>This needs to be reported as a ratio and not report the concentration.</p> |    |
| 13) | <p><u>MAGNESIUM</u></p> <p>It was agreed that the three laboratories would adopt the following for Magnesium.</p> <p>There would be no gender specific ranges. A single reference interval would be used.</p> <p>The range for Magnesium: <span style="float: right;">0.6 – 1.2 mmol/L</span></p> <p>It was agreed that it should be reported to 1dp.</p>  |    |
| 14) | <p><u>ANTIEPILEPTICS</u></p> <p>It was agreed that these need to be checked out individually. These ranges will include those for Valproate, Phenytoine, Carbamazapine, and Phenobarbitone.</p> <p>These need to be individually added to the spreadsheet if appropriate. Grant Moore should be invited to the next meeting.</p> <p><b>Action: JM to ensure Grant Moore is invited to the next meeting.</b></p>          | JM |



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