

Clinical Biochemistry News



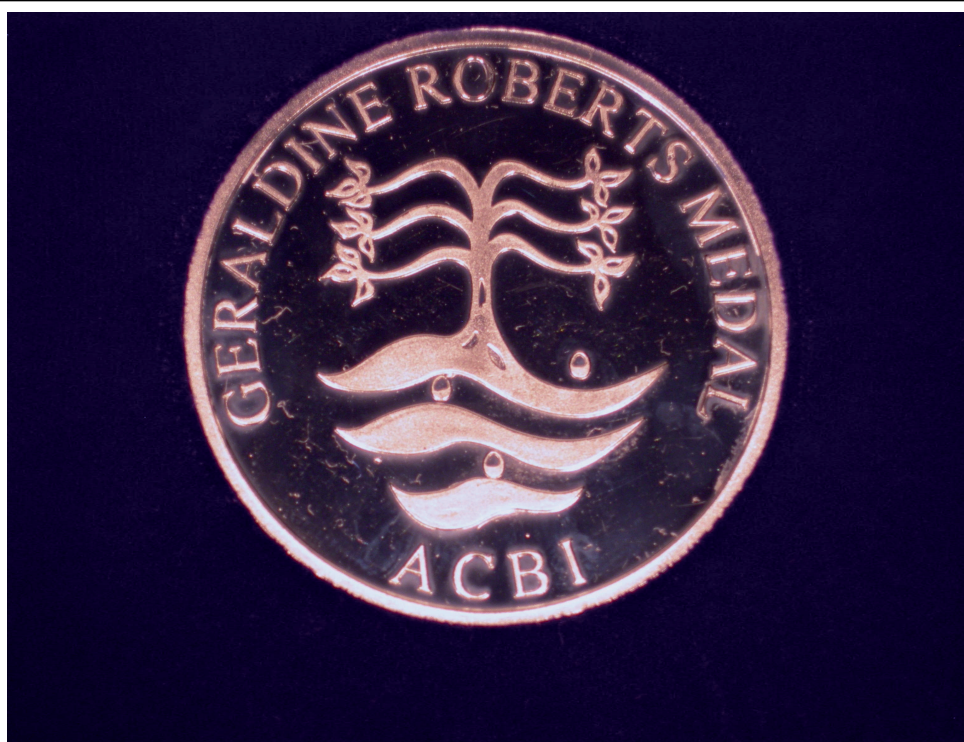
ACBI



ACB

October 2009

Newsletter of the Association of Clinical Biochemists in Ireland
and the Association of Clinical Biochemists (Republic of Ireland Region)



**The Geraldine Roberts Medal will once again be awarded for the
best scientific poster at the ACBI Annual Conference**

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From the President

Dr Alan Balfe

Well, after much delay, the “Teamwork Report” was officially released in Spring this year, and at last, it could be discussed openly without breaking confidences. I refer of course to the report entitled “Implementing a new system of service delivery for Laboratory Medicine Services”, commissioned by the HSE, and prepared by Teamwork Management Services. The report can be found on the HSE website and also on the ACBI website. It is indeed ironic that the word “teamwork” should appear on the title page of this report, as that was a concept notably lacking in the approach taken by the HSE towards laboratory professionals when this report was being produced in 2006, and continuing after it was delivered in May 2007.

In describing Teamwork Management Services’ remit, the report states “we were asked to prepare this report on an independent basis without formal engagement and consultation with the public, patients, staff and other stakeholders in laboratory medicine services”. Fair enough, perhaps: an independent, unbiased look at what we are doing in our laboratory service. It has a degree of plausibility. Bypass the vested interests with their biased views, and get a pure and clear analysis. It’s a pipedream of course. What you get is just a document coloured by an alternative set of biases. Still, no harm done. The report can be published, and a consultation process commenced, so that the document can stand or fall on its merits. Except that this didn’t happen - at least, not in an open and timely manner. The report was quietly released to some stakeholders soon after its delivery to the HSE. ACBI Council then sought a copy from the HSE, and received one with the stricture to treat it as confidential until its official launch, and with an embargo on onward circulation. We of course respected these conditions imposed on us. However, two years then passed before the official release of the report, while various comments on it appeared in the news media from time to time. In the meantime, it seems, the report was considered by the Government Cabinet Sub-Committee on Health, the Dept. of Health & Children, and the Board of the HSE, and we are told the recommendations in the report were approved. But, was there any sort of robust appraisal prior to this approval?

With the publication of the report formal engagement with the professional representatives eventually began. Two committees were formed last April, with representatives of the various stakeholders invited to participate. These committees are the Laboratory Services Modernisation Group, and the Cold Laboratory Procurement/Technical Group, and their task is to plan and oversee the reform of the services. There was a lack of clarity initially, in that

on the one hand it was said that the task was to implement the recommendations of the report, and on the other, that the report was just one input informing the process, and that other inputs would also be considered. The latter has proven to be the case, and of course has to be so, because the report itself leaves various options open. The two groups are now working collaboratively, trying to discern the best way forward for Laboratory Medicine Services for Ireland, and ACBI representatives are members of both groups.

Underlying the reform process is the requirement to improve access by bringing services closer to the patient in the community, shifting the emphasis to the primary care setting as much as possible. The report provides useful information on the current scope of clinical laboratory services. It identifies several major deficiencies of the current disjointed system, much of which we have been aware of for years – inadequate IT systems with poor connectivity, inadequate phlebotomy and transport logistics, insufficient consolidation of analytical platforms and organisation within our laboratories, the need to reform work practices including extending the core hours of services, to list some examples. It advocates increased use of POCT in the primary care and community setting, as well as in the hospitals, and wants to develop the role of Laboratory Medicine staff as providers of expert advice.

Probably the most contentious proposal in the report is the suggestion to segregate work into what it terms “hot” labs and “cold” labs, with the “cold” labs handling non-urgent routine work from primary care and out-patients, with a fast turnaround. We know of course, that the analytical turn-around for this work currently is quite good – the problems are mainly due to deficiencies of access to phlebotomy, transport logistics and IT connectivity. We see great risks in this artificial separation of services, with potential to cause fragmentation rather than continuity of services. Elsewhere in this issue of the newsletter, you can read Ned Barrett’s excellent discussion on this topic. The report rather carelessly uses the term “international best practice” in relation to this concept, without showing any evidence to justify the use of this term. We know that this model is not without problems where it operates, and that other more integrated services are also common internationally, often within the same jurisdictions. Whereas opinion within the HSE seemed to favour the concept of stand-alone “cold” labs on a remote site, the report actually states that the “hot” and “cold” labs could be stand-alone or co-located, depending on how the national strategy is applied; and further, including academic labs and reference labs, it says “several perfectly reasonable

combinations of functions, co-locations and stand-alone solutions” are possible. The existing large hospital laboratories are already embedded in their local communities, and thus are well-placed to facilitate an integrated service.

We are at an important juncture in planning services for the future, and the future as we know begins now. Clear-thinking, and open minds will be critical to a successful outcome. Many other factors will be important, such as progress towards a unique patient identifier, development of a national catalogue of tests, harmonisation of reference ranges, demand management and progress on agreed testing protocols,

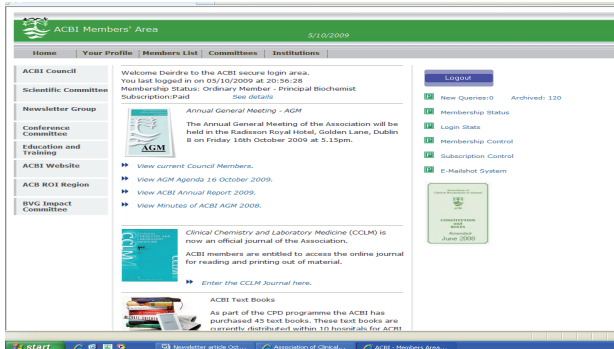
training and quality assurance of POCT in the community setting, to mention a few.

In finishing this discussion, I should say that we have had no response to date from the HSE on the implementation of another important report, issued by Comhairle na nOspidéal in December 2005 after detailed investigation and engagement with the stakeholders, on “Consultant Chemical Pathology / Top Grade Biochemist Services”.

As the end of my term as President of ACBI approaches, I wish my successor Orla Maguire well and I know she can count on the support of the members in the years ahead.

When did you last log on?

Deirdre Deverell



Since the launch of the new website in January 2009 I'm sure many of you have been regular visitors to acbi.ie. The public pages contain up to date news, forthcoming events and reports of meetings, archives of newsletters and other material. There are some however who have not yet requested a password for the members' area and may not realise what they are missing!

Do you know that you have free access to the online journal Clinical Chemistry and Laboratory Medicine? Are you aware that there are 45 text books purchased for members and inter laboratory book loans can be facilitated online? Have you seen the notices published on the white board or do you have something of interest to share?

Also contained within the private area are details of all ACBI members and how to

contact them. Keep up to date with council members and when council meets. Know who your representatives on relevant committees are. Select a hospital to see what ACBI members are based there. Networking has never been so easy.

There are many web based utilities used by council members such as subscription control, internal web mail and document control. So not only is the website a mine of information it is also a management system using the ACBI members' database. Your 2010 subscriptions will be payable on line next January. There is a system for on line registration for scientific meetings and this will be expanded to allow online registration for ACBI annual conference in 2010.

The web has many useful links e.g. Lab Tests Online, IEQAS and IFCC. If you have any sites that you would recommend to other ACBI members please email me. I also am interested to get feedback about the website in terms of content and utility. The web is not a static page of information but a dynamic tool which members are encouraged to use to its full potential. Keep your ideas coming in; you know how to contact me through acbi.ie

An uncertain future for laboratory medicine?

By Dr Ned Barrett, Consultant Biochemist, Limerick Regional Hospital



Readers may be surprised to learn that the first scientist to suggest that changes in the composition of blood could be used as an aid in the diagnosis and management of disease was the Irish Chemist, Robert Boyle (pictured above). He was born in 1627 in Lismore, Co. Waterford, the youngest child of Richard Boyle, the Earl of Cork. He anticipated the complexity of interpreting changes in the concentration of substances in blood and he is often described as the 'Father of Chemistry'.

Laboratory medicine has come a long way since Robert Boyle's time. The Teamwork Management Services (UK) Report, commissioned by the Health Service Executive (HSE) in 2006, provides important information on the organisation of the clinical laboratory services in Ireland. The annual workload is 58 million tests, costing €328 million, employing 3000 staff and dispersed over 16 small, 21 medium and 9 large laboratories. The proportion of work originating from primary and community care settings is 32% overall, although this varies greatly by size of laboratory, as well as by laboratory discipline. The clinical laboratory services account for almost 5% of the acute hospitals (including cancer care) allocation for 2009 and 3% of the primary care allocation. Yet, laboratory results determine how a substantial proportion of this country's healthcare funding will be spent.

The 1970 Health Act included hospital laboratories as providers of outpatient services. This coincided with the introduction of the General Medical Service (GMS) Scheme. The laboratory medicine services have grown enormously over the past forty years. These increases have been driven by new consultant appointments; the commencement of new, enhanced

or expanded services; more complex treatment programmes; more intensive monitoring and management of long-term conditions; the growth in population and changing demographics; the growth in evidence-based practice and clinical audit; but especially by the strengthening and expansion of primary care services. When requested by a medical practitioner, laboratory medicine services are provided free of charge to all in the public health system, whether in the hospital, primary care practice, at home or in various other settings.

The healthcare of a great number of people has benefited from these developments. There is an estimate that, on any day, one in every nine of those patients attending for a consultation with their general practitioner has blood drawn for laboratory investigations. In the service that I am familiar with, the laboratory results for each episode of a patient's care, whether it be in the Emergency Department, an acute hospital ward, an outpatient clinic, the primary care practice or in a nursing home, are all integrated into the one patient record. This is not easy as the legacies of older structures linger on, but it matters greatly for good, safe patient care.

State-funded clinical laboratories are located in the acute hospitals and funded from the allocation for acute hospitals. The growth in laboratory medicine services provided to primary care by these laboratories has led to complaints from some in the acute hospital services, especially as budgets are squeezed. These attitudes often prevail when health services are organised, as it were, in silos or pillars and budgets are set accordingly and jealously guarded.

The Teamwork Management Services (UK) Report of May 2007 sets out a new system of service delivery for Laboratory Medicine in Ireland. It proposes many changes including the transfer of all primary care and community laboratory medicine services from the present laboratories in the acute hospitals to between one and three "cold laboratories". The report has been examined by the Government Cabinet Sub-Committee on Health, the Department of Health & Children and the Board of the HSE. It seems that its recommendations have been approved. Speculation and uncertainty centres on the funding and business arrangements for the one to three "cold laboratories" and the extent to which these will be state-funded or public-private partnerships or private commercial organisations.

The Teamwork Report was prepared in the year following the publication of the HSE's document *"Towards Better Health Care"* in December 2005. That publication described the then pivotal roles and responsibilities of the three healthcare silos / national service pillars: the National Hospitals Office pillar, The Primary, Community and Continuing Care pillar and the Population Health pillar.

So much has changed since 2006 and 2007 – the global economy, the public finances, the banking system, business confidence and more! In July 2008, long after Teamwork Management Services (UK) had completed its report on laboratory medicine services, the HSE radically changed the organisational model for health service delivery to the integrated service model, describing this model as *"our best chance of success"* and the case for its implementation as *"compelling"*. This will be the most significant change in how health services are delivered for several decades. These profound changes will, in the words of Professor Brendan Drumm (HSE CEO), enable patients to have *"a single point of entry to the health service. The services they need and the professionals who provide them should be well connected together; delays should be minimised whether patients and clients need one service or the advice of multiple health professionals"*.

The HSE is undertaking this reorganisation of health service delivery so as *"to meet increasingly complex health needs, which require health professionals to work differently to deliver a safe, quality service in the right setting"*. The nature of this reorganisation is epitomised in the First Report of the HSE's Diabetes Expert Advisory Group, published in 2008. The Report provides a blueprint for the development and delivery of integrated healthcare for people with diabetes in the years ahead. It stresses the need for redirection of resources and focus, for health professionals and organisations from primary, secondary and tertiary care to work together in a co-ordinated way, unconstrained by existing professional boundaries, so that clinically effective services can be provided in an equitable manner. The era of health service delivery silos or pillars is passing.

The Diabetes Expert Advisory Group's report is a framework that will guide how we manage many other chronic diseases and conditions. We know that chronic diseases cluster in individuals and that 80% of primary care consultations and 60% of hospital bed days relate to these chronic conditions. One third of men over sixty have two or more chronic

conditions. Laboratory medicine is closely involved in the management of many of these conditions such as kidney disease, cardiovascular disease and many endocrine conditions, but perhaps not more so than in diabetes. There, the condition is diagnosed by a laboratory measurement; another laboratory measurement plays a pivotal role in assessing the effectiveness of diabetes care and in identifying those at greater risk of developing the complications of diabetes. Laboratory medicine now has powerful investigations that function, as it were, like radar to predict the onset and the rate of progression of the complications of long-term diseases.

As the scope of integrated care extends beyond diabetes to more and more long-term conditions, the range of laboratory investigations required by primary care teams and by primary care doctors with special interests in long-term conditions at primary care network level will coincide with the range of laboratory medicine investigations delivered in the large acute hospitals. The artificial separation of laboratory services for primary care from those for secondary and tertiary care as envisaged in the Teamwork Management Services (UK) Report and the transfer of these services, with the entire transport infrastructure that that involves, to centres 100-150 km away, will be unlikely to enhance and facilitate the integration of care. It has the potential to reintroduce boundaries and chasms that have been characteristic of the silo model of healthcare delivery and organisation.

If each integrated care network serves a population in the range of 350,000 to 500,000, the number of regional laboratories required countrywide would be in the range of eight to twelve. It would not be sufficient that these laboratories were merely associated with or well disposed to or just supporting of integrated care – they would have to be intrinsic to it and be all that requires and obligates, including being unconstrained by existing organisational boundaries.

As the HSE and its advisers work to discern the best system for the delivery of laboratory medicine services, I hope that they will give careful consideration to how laboratory medicine can be intrinsic to the integrated service and care model. The consequences of wrong or poor decisions on these matters will be long-lasting and costly and may not be easily reversed.

Dr. Ned Barrett

An abridged version of this article was published in Irish Medical News on 14th September 2009.

Report on IEQAS 2009

Hazel Graham IEQAS Quality Manager

The Annual Conference of the Irish External Quality Assessment Scheme (IEQAS) was held on Thursday October 1st in the Louis Fitzgerald Hotel, Dublin. Approximately 130 delegates attended the meeting, for which we have received very positive feedback regarding both content and facilities.

The IEQAS Chairman, Dr Ned Barrett welcomed the delegates before handing over to Mr Martin McDonald, Head of Workforce Planning and Professional Education, HSE who gave the opening address entitled "The Modernisation of Laboratory Medicine Services in Ireland: safeguarding quality during times of service reconfiguration". Ms Patricia Howley, Operations Manager of IEQAS, then presented a review of the scheme's performance over the last 12 months.

The theme for the remaining morning plenary sessions was Point of Care Testing (POCT) from a number of aspects: comparison of EQA between primary and secondary care (Ms Annette Thomas, WEQAS); new guidelines for primary care to be published shortly (Dr Judith Martin, IMB); a pilot study on pharmacy-based lipid

screening (Ms Aisling Reast, Irish Pharmacy Union); and finally a survey on hospital-based POCT (Ms Ruth O'Kelly).

The first presentation in the Clinical Chemistry workshop was from Dr Ned Barrett regarding preparations for implementing dual reporting (IFCC/DCCT) of HbA1c in Ireland on 1st July 2010. Dr Mark Lynch from Altnagelvin Tyrone County and Erne Hospital then spoke about the Northern Ireland Regional Audit Group in Clinical Chemistry. Ms Hazel Graham, IEQAS Quality Manager, reported the findings of two fresh serum surveys which were carried out by IEQAS.

Meanwhile at the parallel Haematology workshop, Dr Kanthi Perera, Midland Regional Hospital Tullamore, reviewed the Blood Cell Morphology slides distributed by IEQAS this year. Mr Gerry Judge from AMNCH presented a review of this year's Labquality Blood Transfusion schemes.

Both workshops ended with peer-presented case studies; this aspect was new for the IEQAS programme and was very well received.

ACBI News

The Scientific Committee of the ACBI have commissioned a booklet on fluids. Contributors to the booklet are Ruth O'Kelly, Peadar McGing, Jennifer Brady, Alan Balfe, Martin Healy, Ophelia Blake, Paula O'Shea, Dermot Canon and Mark Kilbane. Content was reviewed by Dr Yvonne O'Meara, Consultant Nephrologist, Mater Hospital. The booklet will be launched at ACBI 2009 and will be made available to ACBI members and other relevant groups. Future projects for the Scientific Committee will include revised editions of the ACBI Cardiac Marker, Tumour Marker and TDM booklets.

Mass Spectrometry Comes to St James's Hospital

Martin Healy



St. James's Hospital Biochemistry Department this year saw the arrival of an Applied Biosystems API 4000 Triple Quadrupole liquid chromatography tandem mass spectrometer. The St. James's lab is the first of its kind in the country to have acquired liquid chromatography mass spectrometry technology. These instruments have high sensitivity with low limits of detection and costs per test are low compared to other assay formats such as immunoassay. The API 4000 will be used initially to measure 25-hydroxyvitamin D, the nutritional marker of human vitamin

D status. The analyser is capable of resolving and quantifying vitamin D3, which is endogenously produced and vitamin D2 which is obtained solely through diet and supplements. Most current methods, particularly immunoassays, do not differentiate between the two forms and report total vitamin D concentrations only. Information regarding the efficacy and compliance of vitamin D2 supplementation is lost in these cases. In addition the API 4000 is capable of measuring 1,25-dihydroxyvitamin D, the hormonal form of the vitamin, produced in the kidneys. This can be especially important in patients with advanced renal disease where production of the hormone can be compromised. Additional assays which will be established on the mass spectrometer will include testosterone (particularly female testosterone), other steroids, and metanephrines. The list of other potential analytes is long and is limited only by capacity. We have been reporting 25-hydroxyvitamin D3 and D2 results assayed on the mass spectrometer since September.

The advent of benchtop mass spectrometry has made it feasible for hospital labs to embrace this technology. While the St. James's Hospital biochemistry lab is the first of its kind in the country to do so it will not be the last. Already other labs, such as the Mater Hospital, have expressed an interest (and have tendered for an instrument) and the next 5-10 years should see this technology well established in clinical biochemistry departments..



Labs Are Vital announces 15,000 Euro award for excellence in outcome research

Labs Are Vital and the European Federation of Clinical Chemistry (EFCC) have launched an Award for Excellence in Outcomes Research in Laboratory Medicine. This new award programme will recognise the clinical lab or laboratory professional in Europe whose published work best demonstrates improved clinical and/or economic outcomes through the utilisation of *in vitro* diagnostic tests. Judged by an independent panel of experts, the 15,000 Euro award, sponsored by Abbott, will be presented for the first time at the International Federation of Clinical Chemistry (IFCC)/WorldLab meeting in Berlin in 2011, and will be presented at an EFCC conference every two years thereafter.

Seventy percent of the objective information doctors use to make clinical decisions about their patients comes from data collected in the clinical lab — making outcome studies that evaluate the results of laboratory tests more important than ever. By conducting more outcomes research in clinical laboratories, labs will be better able to guide clinicians about the best and most accurate tests to perform for hundreds of different medical conditions. All entries must be published in English in a peer-reviewed medical, scientific or health economics journal, and must have been published or finally accepted for publication between 01 February 2009 and 01 February 2011. For further information and application details, please visit:

www.labsarevital.com <<http://www.labsarevital.com/>>

Miss CP (Connie) Glennon, BSc, MSc, MICI
Died 24 September 2009



Connie Glennon was born in Ballinasloe Co Galway. She attended university during the War years - a high thinking, low living student in Dominican Hall, St Stephen's Green just around the corner from lectures in Earlsfort Terrace. She qualified BSc (Hons) 1945 in Chemistry with Maths.

Connie moved straight into an MSc under Professor E J Conway (of Diffusion apparatus fame) on the Permeability of Cell Membranes to Electrolytes. That experience shaped her professionally, in the power of Mathematics and scrupulous analytical technique. She stayed on in the department for two and half years working for the Medical Research Council.

In July 1949 she took the post of Biochemist at the Mater Misericordiae Hospital, Dublin, under Prof Maurice Hickey, State Pathologist. There was no automated equipment. She worked with Mary Leydon when Dr Belle Farrell worked in a separate lab for the Professor of Medicine, Tim Counihan.

In 1956, she moved to Belfast to the Mater Infirmorum Hospital and took charge of biochemistry there. She dropped her family pet name (Stanza... from Constantia) and became Connie. She joined the fledgling (UK) Association of Clinical Biochemists in 1957 and attended summer courses in Clinical Chemistry at Glasgow University and in Birmingham. Connie was a keen

and strong golfer. Several times a week she took the bus from work up to Fort William Golf Club to play 18 holes or as long as light allowed. Four years after joining, the club made her Handicap Secretary. When she died their flag flew at half mast.

In 1965 twenty years after her first degree, Connie was promoted to Senior grade. The lab now took in biochemistry, haematology and blood transfusion. Her remit covered day to day lab activity, quality of results and training for all non-medical staff. She insisted that students develop and demonstrate good analytical technique. Jim Mulvenna, John Madden, Brian Cairns and Tim Wyatt saw her with respect first, then later with admiration and affection. She inspired her niece to take up Science. In Belfast in the 1970s and 1980s she made good friends and good conversation without gossip or politics. Margaret Telford, Selby Nesbitt, Mike Smye and Elly Duly remember her example.

She retired quietly in 1988.

Fourteen years later in 2002, she moved to Sandycove (Dublin) to live with her sister.

In her last decades she gave away her golf clubs but joined three separate bridge clubs where she was a respected, winning player. Connie was a lady without fuss. She took delight in a simple card from biochemists North and South sent to honour 50 years' membership of the ACB; enjoyed music in the National Concert Hall which she had experienced as the Exam Hall of UCD; tried out the Luas tram and took tea in the Shelbourne Hotel.

She was a pioneer, a dedicated worker during troubled times, and a true lady. RIP.

-Olwyn Lanigan

Upcoming Meetings

Applied Biosystems Seminar

Reaching New Heights: Advances in LC/MS/MS Solutions in Clinical Research and Organic Residue Testing

Venue: Crowne Plaza Hotel, Northwood, Santry Dublin 9.

Further information: Judy McCaffrey (+353 (0) 86 821 4878).

To Register: email judy.mccaffrey@lifetech.com

FiLM 2010 (Frontiers in Laboratory Medicine) Focusing on quality in lean times

Birmingham, UK

26-27 January 2010

Further information: film@meetingmakers.co.uk

British Renal Society

Manchester Central Convention Centre

17-20 May 2010

Website: www.britishrenal.org/events.shtml

Members' Publications

Duffy MJ, Sturgeon C, Lamerz R, Haglund C, Holubec VL, Klapdor R, Nicolini A, Topolcan O, Heinemann V. Tumor markers in pancreatic cancer: a European Group on Tumor Markers (EGTM) status report. *Ann Oncol.* 2009 Sep 8. [Epub ahead of print]

Collier G, Greenan MC, **Brady JJ**, **Murray B**, **Cunningham SK**. A study of the relationship between albuminuria, proteinuria and urinary reagent strips. *Ann Clin Biochem.* 2009 May;46(Pt 3):247-9.

Kavanagh-Wright L, **Smith TP**, Gibney J, McKenna TJ. Characterization of macroprolactin and assessment of markers of autoimmunity in macroprolactinaemic patients. *Clin Endocrinol (Oxf).* 2009 Apr;70(4):599-605.

O'Broin S, McCarthy N. Letter to the editor *Int J Lab Hematol.* 2009 Feb 25.

Murtagh G, Canniffe C, Mahgoub M, Blake L, **McCarroll N**, Crowley V, Bennett K, Silke B. Introduction of an NT-proBNP assay to an acute admission unit--a 2-year audit. *Eur J Intern Med.* 2009 Jan;20(1):58-62.

Hatunic M, **Stapleton M**, Hand E, DeLong C, Crowley VE, Nolan JJ. The Leu262Val polymorphism of presenilin associated rhomboid like protein (PARL) is associated with earlier onset of type 2 diabetes and increased urinary microalbumin creatinine ratio in an Irish case-control population. *Diabetes Res Clin Pract.* 2009 Mar;83(3):316-9.

Nugent C, Roche K, Wilson S, **Fitzgibbon M**, **Griffin D**, Nichaidhin N, Mulkerrin E. The effect of intramuscular vitamin D (cholecalciferol) on serum 25OH vitamin D levels in older female acute hospital admissions. *Ir J Med Sci.* 2009 Aug 28. [Epub ahead of print]

Nanda KS, Ryan EJ, Murray BF, **Brady JJ**, McKenna MJ, Nolan N, O'Farrelly C, Hegarty JE. Effect of chronic hepatitis C virus infection on bone disease in postmenopausal women. *Clin Gastroenterol Hepatol.* 2009 Aug;7(8):894-9.

Wallace I, **Cunningham S**, Lindsay J. The diagnosis and investigation of adrenal insufficiency in adults. *Ann Clin Biochem.* 2009 Sep;46(Pt 5):351-67. Epub 2009 Aug 12.



Online Information

Martin Healy

Chocolate

<http://www.fieldmuseum.org/Chocolate/history.html>

A recent article in the Journal of Cardiovascular Pharmacology (August 2009) brings good news. Chocolate, particularly the dark variety, can help delay the onset of heart disease. The downside is that only a half bar a week is needed. This website gives plenty of interesting facts on “the food of the gods”.

Fictional Medicine

http://www.forbes.com/2007/09/19/tv-health-missteps-forbeslife-cx_avd_0919health.html?feed=rss_forbeslife_health

TV has produced the whole gamut of medical practitioners from saintly Dr Kildare to mean and nasty House. What has become clear is that a lot of people, in the USA at least, take the medicine portrayed in these shows as gospel. The above article in Forbes frets over this. Click on the ‘In Pictures’ link for specific inaccuracies.

Free statistics site

<http://www.danielsoper.com/statcalc/>

A fairly comprehensive list of calculators for critical values, confidence intervals, effect sizes, regression, power etc.

Science as culture

<http://www.lablit.com/about>

Attempt to engage our right brain. Essays, fiction, reviews, poetry all on science based themes.

Journal



Watch

Article: Adit A Ginde et al. Prospective Study of Serum 25-Hydroxyvitamin D Level, Cardiovascular Disease Mortality, and All-Cause Mortality in Older U.S. Adults. J Am Geriatr Soc 2009;57(9);1595-1603.

Found that older adults with insufficient concentrations of vitamin D die from heart disease at greater rates than those with adequate concentrations of the vitamin. All cause mortality also increased.

Article: Johan Rung et al. Genetic variant near *IRS1* is associated with type 2 diabetes, insulin resistance and hyperinsulinemia. Nature Genetics 2009 September 6 [epub].

New genetic variant associated with type 2 diabetes, insulin resistance, and hyperinsulinemia identified. Located adjacent to the insulin-receptor substrate 1 gene (*IRS1*). Presence of variant leads to 40% reduction in *IRS1* protein resulting in increased insulin resistance.

Industry News

Abbott announced in August it has entered into an agreement with **Pfizer Inc** to develop a molecular diagnostic test intended to screen non-small cell lung cancer (NSCLC) tumours for the presence of gene rearrangements. Pfizer has developed an oral therapeutic agent that selectively targets cancer-causing genes implicated in the progress of many cancers. In order to receive Pfizer's new therapy, a particular genetic translocation known to be found in NSCLC tumours and a wide variety of other cancers, but not in normal cells, must be present. The agreement stipulates that Abbott will develop a companion diagnostic test which will determine a patient's genetic status and will be used in patient selection for future clinical trials of the Pfizer therapy.

July saw the announcement that **Johnson & Johnson** would pay \$1 billion for a stake in **Elan Corp**. J & J, said to be the world's biggest healthcare company, will own 18.4 percent of Elan. J&J is specifically acquiring the rights to Elan's stake (in partnership with **Wyeth**) in an Alzheimer's disease treatment portfolio. A new company will be created to develop these drugs, of which Elan will own 49.9%. Completion of the acquisition was announced in September.

Roche Diagnostics announced the introduction of the Roche Cardiac 200 in July, a lateral flow immunoassay testing system aimed at the POCT market. Using whole blood it provides quantitative results for a panel of cardiac markers with a turnaround time of 10-19 minutes.

Beckman Coulter completed the acquisition of **Olympus Corporation's** lab-based diagnostics business in August at a cost of approximately \$780 million.

Thermo Fisher Scientific has agreed to acquire **B.R.A.H.M.S** for €330 million. The flagship product of B.R.A.H.M.S is procalcitonin, a marker for the early diagnosis of sepsis.



COFFEE:

.....Caffeine
.....H₂O
.....Proteins
.....Hunic acid
.....Chlorogenic acid
.....Lipids
.....Aliphatic acids
.....Amino acids
.....Minerals
.....Vitamins A, B, C, D, E, K
.....Sucrose *2 lumps*

Before we talk diagnostics let's talk about you

And not just you, your laboratory and your business. We want to know what works, what doesn't, and what could work better – not only in terms of workload and throughput, but the ins and outs of your specific situation. We want to know what you need today, and what you might need tomorrow. Because once we know

these things, we can help you find the perfect solution. Perhaps it's our belief in communication that has helped us become the UK and Ireland's leading supplier of In Vitro diagnostics technology. If you'd like to discuss the ways in which Roche can help, we will gladly arrange to come and meet you. Just let us know how you take your coffee.

Hard Data. Human Touch

www.roche-diagnostics.co.uk



We Innovate Healthcare