

Clinical Biochemistry News



October 2026

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

Join us in Dublin for the
48th Conference of the ACBI
November 6th and 7th, 2026

Sessions include

Chronic Disease Management
Point of Care Testing
Biomarkers in Chronic Kidney Disease
Clinical Biochemistry in Ukraine
AI in Laboratory Medicine
Assay Performance
Burnout and Balance



Registration / Programme
Details [here](#)

Inside

- | | |
|--|--|
| 2. Message from the President of the ACBI - Kelly Foley
Upcoming Meetings | 8. New Guidelines/Reviews/Federation and Journal links |
| 3. ACBI Members' Publications | 9. ACBI 48 Programme |
| 4. Review of LabMedUK26, Birmingham, UK | |



**Message from the President of the Association of
Clinical Biochemists in Ireland**
Kelly Foley

Welcome to the October edition of the newsletter.

I hope everyone had a wonderful summer and managed to enjoy some time to relax and recharge. It's hard to believe we are already into autumn and the final few months of the year.

We have an exciting period ahead, with our Annual Conference taking place in November. I would encourage you to book your place and join us for what promises to be a great programme, with plenty of opportunities to learn, share ideas and catch up with colleagues. We are also looking forward to showcasing the work and contributions of our members through the abstracts and presentations at this year's conference.

I would like to thank all our members for your continued support and involvement throughout the year. I look forward to seeing many of you at the conference and over the coming months.

Wishing you all a very positive start to the autumn.

Kelly Foley

President Association of Clinical Biochemists in Ireland

Upcoming Meetings

48th Annual ACBI Conference 6-7 November 2026, The Gibson Hotel, Dublin.

50th Annual Meeting of the Irish Endocrine Society 13-14 November 2026, Aula Maxima, University College Cork.

IFCC WorldLab 25-29 October 2026, New Delhi, India.

Lab Innovations 4-5 November 2026, NEC Birmingham, UK.

ESE Clinical Update on Obesity and Metabolism 2026 Online Meeting 12-14 October 2026; 16:00-18:00 each day.

Digital Health World Congress 23-24 November 2026, London, UK.

EUROMEDLAB 2027 Jointly organized by IFCC and EFLM in collaboration with LabMedUK27 16-20 May 2027, Excel London, UK

G-ARC Global Aging Research Conference 14-15 October. Online Meeting.

A Selection of Members' Recent Publications

Martin Healy

[Blood-Based Biomarkers Predict Cerebral Palsy and Cognitive Delay in Hypoxic-Ischemic Encephalopathy: A Secondary Analysis of the High-Dose Erythropoietin for Asphyxia and Encephalopathy Randomized Controlled Trial.](#)

Clifford D, **Vaughan CL**, **Costelloe SJ**, Walsh BH, Numis A, Juul SE, Murray DM. J Pediatr. 2026 Jul 1;297:115216. doi: 10.1016/j.jpeds.2026.115216. Online ahead of print.

[Plasma proteomics: considerations for preanalytical variability; a systematic review with narrative synthesis.](#)

Vaughan CL, Samjeed A, Murray DM, **Costelloe SJ**. Clin Chem Lab Med. 2026 Jun 8;64(10):2124-2140. doi: 10.1515/cclm-2026-0330. Print 2026 Sep 25.

[Drug-induced plasma discolouration mimicking icterus risks inappropriate withholding of critical lactate.](#)

Kerr B, Murphy A, Houstoun C, Tan J, Mykytiv V, **Costelloe SJ**. Pract Lab Med. 2026 Jun 3;50:e00543. doi: 10.1016/j.plabm.2026.e00543.

[Lipoprotein X: artifactual lipid derangement in type 3c diabetes with obstructive liver disease.](#)

Green D, Prem Kumar A, **Byrne B**, **Byrne E**, **Lee GR**, **O'Shea PM**. JCEM Case Rep. 2026 Aug 20;4(9):luag230. doi: 10.1210/jcemcr/luag230.

[Biomarkers for acute mild brain injury \(BAMBI\): optimising GFAP/UCH-L1 thresholds to support CT stewardship in a NICE-guided mild-traumatic-brain-injury cohort.](#)

O'Shea PM, Umana E, Broderick S, **Byrne E**, Samad NM, Nnamani C, Barrett S, O'Rourke M, Walsh I, Bolster F, Duddy J, **Lee GR**, O'Halloran PJ. Br J Neurosurg. 2026 Apr 29:1-10. doi: 10.1080/02688697.2026.2663478. Online ahead of print.

[Single-bacterial cell insights into mechanisms of](#)

[ceftriaxone resistance in Neisseria subflava.](#)

Zhang X, Cheng HS, Zhan X, Li X, Huang J, Liu H, Chua D, Wang G, Li X, Shi Y, Wang F, Xu Z, Qu J, Pethe K, Li G, Tan NS, **Mac Aogáin M**, Chotirmall SH, Li L. Nat Commun. 2026 Mar 27;17(1):4532. doi: 10.1038/s41467-026-68621-y.

[Human airway organoids for bacterial-host interaction studies: methods, insights and translational promise.](#)

Huang Y, Liao S, Chua D, Shi Y, Tan Y, **Mac Aogáin M**, Liu Y, Xu Z, Li L. Thorax. 2026 Aug 14;81(9):920-929. doi: 10.1136/thorax-2025-224030.

[Urinary alcohol and ethyl glucuronide as a screening tool for alcohol use in pregnancy: A multicenter prospective study.](#)

McCormick CA, Mealy G, **Donaghy C**, Gordon P, Dunn E, Carroll P, Rodriguez-Herrera A, Cusnaider CM, Ebbitt W, McCormick PA, McAuliffe FM. Acta Obstet Gynecol Scand. 2026 Apr;105(4):743-747. doi: 10.1111/aogs.70164. Epub 2026 Feb 17.

[Mapping pediatric cardiac troponin testing worldwide: results from the IFCC survey on emerging applications, standardization needs and access.](#)

Omosule CL, Lang T, **Geaghan SM**, Taneli F, Gupta A, Danckwardt S, Greaves R, Kohse KP, Wudy SA, Hartmann MF, Kyriakopoulou LG. Clin Chem Lab Med. 2026 Aug 4. doi: 10.1515/cclm-2026-0711. Online ahead of print.

[Laboratory medicine 2050: from testing to health intelligence network, a vision from the IFCC Emerging Technologies Division.](#)

Gruson D, Gouget B, Lee W, Thomas M, Mackay L, Kyriakopoulou L, Nichols JH, Yang HS, South A, Fux E, Stankovic S, **Geaghan S**, Kricka L, Paque M, Liu Y, Ebert S, Greaves R, Shah S. Clin Chem Lab Med. 2026 Jul 27. doi: 10.1515/cclm-2026-0903. Online ahead of print.

A welcome return to the UK thanks to the ACBI; Reflections on LabMedUK26 in Birmingham

Dr Janice Reeve, Principal Clinical Biochemist, University Hospital Galway,
Janice.reeve@hse.ie

Day One of the Meeting

The last time I attended 'ACB Focus' was 15 years ago in Harrogate. At the time, I was a trainee Clinical Scientist with NHS Grampian, based at Aberdeen Royal Infirmary (ARI). Later that same year I returned 'home', and in the years that followed both work and life evolved, priorities shifted, and time seemed to pass at remarkable speed. Fast forward to 2026, and I find myself based at University Hospital Galway (UHG), working as a Principal Clinical Biochemist. Thanks to an Association of Clinical Biochemists in Ireland (ACBI) bursary, I had the opportunity to return to the conference, now rebranded as 'LabMedUK26', held at The Eastside Rooms in Birmingham. I arrived with a degree of uncertainty about what to expect. With the Association for Laboratory Medicine (LabMed) having expanded its remit to include a wider range of specialties, I wondered whether the meeting would retain the same sense of focus and relevance that I remembered from years gone by.

Dr Ian Godber, president of LabMed, opened the meeting with his usual warmth and personality. Encouragement was given to delegates to visit the exhibition stands by providing them with a 'passport'. If all stands were visited and stamps received, delegates would be entered into a draw for attendance at a future LabMed meeting of their choosing.

Award Lecture

The international award lecture, 'From bench to pocket: nanobodies in POC biosensor design', was delivered by Prof Tahir Pillay, Head of Department

of Chemical Pathology, University of Pretoria and National Health Laboratory Service in South Africa. Prof Pillay covered single-chain camelid antibodies ("nanobodies") as a breakthrough for point-of-care testing. At ~15 kDa, a tenth the size of conventional antibodies, they are highly stable (up to 60°C), expressible in *E. coli*, shippable at room temperature, and more easily engineered. Applications shown included lateral flow, electrochemical, and microfluidic immunoassays, with a COVID-19 nanobody test matching RT-PCR sensitivity. A glycated albumin POC assay was also demonstrated as an alternative to HbA1c, particularly relevant in regions where haemoglobinopathies limit HbA1c utility. A question from the floor sparked discussion on the lag period between discovery and routine testing. Manufacturers are always risk-averse and loathe to bring something new, and perhaps unproven, to market. This technology is in its infancy, but has huge potential to revolutionise immunoassay technology allowing for more varied, cheaper, equitable options.

Assay Interference from Paraproteins

From a choice of sessions, and despite Clinical Biochemistry in UHG not being the section processing serum protein electrophoresis (SPE), I attended 'The hunt for hidden paraproteins, unravelling their interference in biochemical diagnostics'. This session peaked my interest as; (1) in previous labs (ARI, St. Vincent's University Hospital), SPE was a 'Clinical Biochemistry' test, (2) in UHG, we review calculated globulin results and refer to our Immunology colleagues for SPE when

concerned, (3) I should be better versed in which routine assays are susceptible to paraprotein interference and (4) the parallel session involved discussion with the Chief Scientific Officers of the UK nations, so somewhat peripheral to the Republic of Ireland.

The session on paraproteins opened with Miguel Morales, Queen Alexandra Hospital. Miguel has spent 3 years developing and validating a clinical risk model for multiple myeloma (MM) using routine blood tests. Early diagnosis of MM remains elusive with delays to diagnosis worsening renal function, bone health and survival. The standard practice of ordering SPE and free light chain measurement is only followed through when MM is suspected. Many labs utilise calculated globulin (total protein minus albumin) as a crude screen for elevated immunoglobulin (Igs) and when combined with other clues, *e.g.* hypercalcaemia, reduced eGFR, anaemia and older age, may reflectively suggest adding SPE and Igs. The clinical logistic regression model generated at the Queen Alexandra builds on the idea of using existing lab data to systematically guide an action. Routine tests have potential to support earlier MM detection at minimal cost.

From the original 33 predictors included, the final logistic regression model, generated using R studio, employed eight routine lab predictors (ALP, eGFR, TP, albumin, WBC, MCV, MCHC, monocytes), together with age and gender. This achieved a C-statistic of 0.92 for early MM detection, with robust bootstrap validation. Limitations included reliance on patients already having SPE and no separation of light-chain-only myeloma.

Nathan Lorde *et al.* 'Paraprotein-induced spurious hypercalcaemia: diagnostic pitfalls in two cases', was published in the European Journal of Endocrinology in August 2025 and was a paper that I had read at the time. Nathan, from University Hospitals Birmingham, came to LabMedUK26 to present this work to us. Two cases were described.

The first was a 54-year-old male with known IgM kappa myeloma and hypercalcaemic. Despite work-up for paraprotein-induced hypercalcaemia there was no evidence on bone marrow biopsy. He was referred to the metabolic bone clinic with total calcium 2.85 mmol/L, total protein 100 g/L and a paraprotein of 33.7 g/L. Venous ionised calcium was 1.167 mmol/L (1.15-1.33), *i.e.* normal. The second patient was an 80-year-old female with CLL, an IgM lambda paraprotein and persistent hypercalcaemia despite treatment. She was referred to the metabolic bone clinic with total calcium 2.72 g/L and total protein 93 g/L. This patient had a low venous ionised calcium of 1.135 mmol/L on blood gas and was admitted for management of hypocalcaemia. Spurious hypercalcaemia with paraprotein is a known phenomenon with Abbott Architect Arsenazo II method. There is no routine way of testing or adjusting total calcium for paraproteins such that ionised calcium should be the go-to measure in this patient group. Interestingly, both patients also demonstrated spuriously elevated vitamin D likely due to non-specific antibody binding in the vitamin D assay. This suggests that vitamin D should be measured by LC-MS/MS in MM patients.

A striking case of a 38-year-old man misdiagnosed with AKI for over a year due to a falsely elevated creatinine on a Beckman analyser was presented by Nicola Pullan from Royal United Hospitals, Bath. A calculated globulin result of 38 g/L prompted a MM screen. The patient had an IgM kappa paraprotein, of 14 g/L. A bone marrow aspirate confirmed MGUS with a 1% chance of progression. Routine monitoring, 3 years on, revealed a dramatic increase in creatinine; confirmed in North Bristol. Multiple hospital appointments, blood tests and renal biopsies demonstrated stable disease with nothing on scans to explain renal dysfunction. Bloods measured in UCL (a different jurisdiction) one year later showed a normal creatinine and a somewhat unbelievable renal function recovery. Suspected analytical interference was only then

considered, and coincided with a change over in instrumentation from Roche to Beckman across Dr. Pullan's region in 2023. Interference was associated with assay dependent pH differences, resulting in paraprotein precipitation and increased absorbance readings (positive interference). An urgent audit identified a further four affected patients. Concerns were raised with Beckman and MHRA. Flagging of atypical reaction curves has since been implemented by Beckman on local instruments. There has been no response from the MHRA. Staff now visually check creatinine reaction curves for deviations from normal in patients known to have IgM paraproteins. A middleware rule was also implemented based on delta checks and commentary added to creatinine reports for IgM paraprotein patients. Users need to be aware of their assay limitations, if a result does not fit clinically, it requires investigation.

The Freddie Flynn Award

Martin Myers presented the Freddie Flynn Award Lecture on GIRFT & Patient-Focused Lab Medicine, a wide-ranging talk on reducing analytical variation across NHS labs. He spoke about initiatives to reduce unwarranted variation in GP requesting; stopping unnecessary testing, using intelligent/condition-based care sets, limiting expensive tests and stopping tests with limited or no clinical value. Dr Myers displayed the National AKI recommendations, published by GIRFT England after identifying significant variation in AKI reporting. Significant inter-lab variation was highlighted for B12, HbA1c, CA125, PSA, folate, calcium, and other assays. Such assay variation directly impacts NICE clinical cut-offs. The Patient Focused Laboratory Medicine (PFLM) group is working with NHSE and BIVDA to establish an escalation pathway. If an assay is not fit for purpose, it should be reported to MHRA through the yellow card system. Only in doing this can we reduce "failure demand."

Performance Goals for Laboratory Tests

I decided to attend the very practical 'How good should we be? Setting analytical specification goals for laboratory tests' over 'Advances in diagnostic neurology'. In the first talk, Eric Kilpatrick, Manchester University NHS Trust, put a call out to us to move away from blanket use of the single 2SD IQC rule. This is much favoured in labs across the UK and Ireland but ideally, we should be using analyte-specific performance specifications based on sigma metrics and perhaps CLIA 2025 total allowable bias criteria. This would better guide IQC frequency and IQC rule selection. Eric cited his paper, Kilpatrick ES, *Assay error detection when using common quality control targets across multiple instruments: An analysis using simulated and real-world data*. Ann Clin Bio, 2024;61(5):331-337, as a worthwhile read.

Prof Pillay returned to give a talk on the merits of modern-day LDL equations. He reminded us that reliable LDL reporting is not an academic exercise, but is essential for patient management. The Friedewald formula derived in 1972 has been widely adopted but in reality loses accuracy when triglycerides are ≥ 1.69 mmol/L (150 mg/dl). Modern LDL calculations, e.g. Sampson NIH2 and the extended Martin Hopkins equations, actively outperform direct LDL cholesterol assay, especially at the low end or in hypertriglyceridaemia. In large-scale, clinical chemistry validations, modern equations align almost perfectly with beta quantification; the gold standard method. Whilst the extended Martin Hopkins equation relies on a large 420-cell stratification of triglycerides and non-HDL, look up tables on the LIS are feasible and the equation works effectively up to triglyceride concentrations of 9 mmol/L. We (Clinical Biochemistry, UHG) have recently adopted the Sampson equation for LDL-C estimation.

Haematology rather than Clinical Biochemistry manage serum total vitamin B₁₂ testing in UHG. Dominic Harrington of the Viapath Group reminded us that humans require Vitamin B₁₂ for methionine synthase and methylmalonyl CoA mutase functioning. Vitamin B₁₂ deficiency has variable clinical consequences with vague, non-specific symptoms; interestingly, anaemia does not manifest in about 20% of cases. Each year, approximately 22 million vitamin B₁₂ tests are performed in the NHS. There are major inter-platform variations such that cut-offs used in NICE guideline (NG239), 'Vitamin B₁₂ deficiency in over 16s: diagnosis and management' (<180 ng/L = deficiency; 180-350 ng/L = indeterminate, >350 ng/L = deficiency unlikely) are hugely compromised. Active vitamin B₁₂ (holotranscobalamin) and methylmalonic acid (MMA) are considered superior markers; new, automated and more affordable versions of these assays would change the landscape of Vitamin B₁₂ testing.

Hyperaldosteronism

For the last session of day one, I attended 'Improving primary Aldosteronism and classification in the UK'. Prof Mark Gurnell, University of Cambridge, remarked that it was an exciting time for Primary Aldosteronism (PA). PA is not rare as we have previously been taught, rather it is the most common cause of primary hypertension (HTN), conservatively estimated at 5% but as high as 25% of patients with refractory HTN. PA is not binary as biochemical cut-offs might imply; not everyone will meet conventional aldosterone:renin ratio (ARR) cut-offs. Despite this diagnostic difficulty, it is important to distinguish

HTN from PA-induced HTN as the latter will have worse outcomes; high aldosterone is toxic and results in poorer renal and cardiovascular function. There are many shortfalls in current management. We are heavily reliant on adrenal vein sampling (AVS) yet we have limited access to high quality services; typically the failure rate is 50%. Functional imaging with ¹¹C-metomidate and ¹⁸F-CETO PET-CT is showing promise (MATCH Trial). Adrenal-sparing thermal ablation is being explored in the FABULAS and WAVE trials. It is important to diagnose PA as interventions, and potential new pipeline medications, may be available to patients.

Sophie Barnes, Consultant Clinical Scientist at North West London Pathology and Lead of the Renin and Aldosterone Standardisation and Harmonisation (RASH) group spoke about the new British best practice guideline for screening and detection of PA for non-specialists. Release of this document unfortunately coincided with the new 2025 Endocrine Society clinical practice guideline for PA. Sophie remarked that the British guideline does not contradict the European one. Medications that impact on ARR interpretations, with emphasis on drug combinations, are elaborated on in the RASH document.

Following a brief stop at the hotel to prepare for the conference dinner at Birmingham's historic Council House, an educational and eventful first day came to a fitting close. The programme was packed with informative presentations and stimulating discussions, while the breaks between sessions offered a welcome opportunity to reconnect with many colleagues from my time in both the UK and Dublin.

Editor's note: Day 2 report will appear in the November edition of the Newsletter



Some of the Irish contingency at the conference dinner, Birmingham Council House, 9th June 2026. L to R: Prof Graham Lee (MMUH), Niamh O'Connor (MMUH), Dr Janice Reeve (UHG), Wendy Groenendijk (SVUH), Dr Micheal O'Meara (TUH).

New Guidelines

Martin Healy

Cardiovascular-Kidney-Metabolic Syndrome

2026 AHA/ACC/ADA/ASN Guideline for the Prevention, Detection, Evaluation, and Management of Cardiovascular-Kidney-Metabolic Syndrome: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines.

Ndumele CE, Rodriguez F, Dixon DL et al. J Am Coll Cardiol. 2026 Jun 9;87(22S):e1889-e2007. doi: 10.1016/j.jacc.2026.03.056.

Comprehensive guidelines for treating CKM syndrome with an integrated approach rather than treating each disease entity individually.

Type 2 Diabetes Management

American Association of Clinical Endocrinology Consensus Statement: Algorithm for Management of Adults With Type 2 Diabetes - 2026 Update.

Samson SL, Vellanki P, Blonde L, Hirsch IB, Hoang TD, Isaacs SD, Izuora KE, Low Wang CC et al. Endocr Pract. 2026 Apr;32(4):473-518. doi: 10.1016/j.eprac.2026.01.006.

Guidance on the diagnosis of adult pre-diabetes and type 2 diabetes. Personalised medical approach recommended. Algorithms provided to aid in diagnoses.

Coeliac disease guidelines

The 2026 British Society of Gastroenterology

guidelines on the diagnosis and management of adult coeliac disease.

Penny HA, Shiha MG, Raju SA et al. Gut. 2026 Jul 12;gutjnl-2025-337747. doi: 10.1136/gutjnl-2025-337747.

Updated guidelines on strategies for diagnosing and managing coeliac disease. Importance of serological testing emphasised.

Reviews

Martin Healy

Caffeine and Cardiovascular Disease: A Scientific Statement From the American Heart Association.

Marcus GM, Hu FB, van Dam RM, Cornelis MC, Dewland TA, Kang J, Larsson SC, Page RL 2nd, Parekh N; American Heart Association Council on Lifestyle and Cardiometabolic Health; Council on Clinical Cardiology; Stroke Council. Circulation. 2026 Sep;154(9):e345-e355. doi: 10.1161/CIR.0000000000001454.

Caffeine and Cardiovascular Health: What the Science Says.

Rubin R. JAMA. 2026 Sep 18. doi: 10.1001/jama.2026.16716.

The AHA paper gives an informative overview of caffeine in its various manifestations including details of its metabolism and biochemical interactions. The consensus is that moderate intake of unadulterated coffee can have positive effects on heart health. Energy drinks and shots etc, because of the very high caffeine content, not so much. The JAMA piece is a summary of the findings.

Federation / Journal Links

EuroLab News: The current edition of the EFLM Newsletter, July/August 2026.

Clinical Chemistry: September 2026, available to EFLM Academy members.

IFCC eNews: September 2026.

eJIFCC: Latest IFCC journal issue, 37(2) April 2026.

Unified definition of integrated diagnostics: a position statement of the EFLM: This report challenges the silo mentality of many professions and outlines the benefits that a more integrated approach between disciplines such as pathology, radiology, genomics and laboratory medicine would benefit society. This approach is already being provided in some jurisdictions e.g., the **Rapid Diagnostic Centres** in the UK, which significantly speeds up the diagnosis of cancer.

CCLM: 64(10) 2026. A paper and an editorial examines the heterogeneity of eGFR reporting linked to the use of different formulae and what this means for accurate staging of kidney disease. Open access.

Programme for the 48th Annual ACBI Conference - Friday 6th and Saturday 7th November 2026
Gibson Hotel, Dublin D01 X2P2

Day 1

8:30 - 09:00	Arrival and Registration
09:00 - 09:10	Opening Remarks Dr Lucille Kavanagh, Principal Clinical Biochemist, Mater Misericordiae University Hospital, Dublin - Chairperson, Conference Organising Committee 2026.
09:10 - 09:25	President's Address Ms Kelly Foley, ACBI President - Principal Clinical Biochemist, Cork University Hospital.
Session 1	Chronic Disease Management Chair – Ms Karen Heverin, Principal Clinical Biochemist, Galway University Hospital.
9:30 - 10:00	Evolving Chronic Disease Management: from framework to future impact Dr Maria O'Brien - General Manager Enhanced Community Care Programme Chronic Disease.
10:00 - 10:30	POCT to support CDM in the community Dr Claire McRory, Operational Lead CDM Service, HSE and Ms Francesca Patton, Chief Medical Scientist, LUH, Donegal.
10:30 - 11:00	Biomarkers in Chronic Kidney Disease Dr Sarah Moran - Consultant Nephrologist, Cork University Hospital.
11:00 - 11:40	Tea/Coffee and poster viewing
Session 2	Routine Services - When Routine Matters Most Chair: Dr Paula O'Shea, Consultant Clinical Biochemist, MMUH and Our Lady's Hospital, Navan.
11:40 - 12:10	Unlocking the Power of Laboratory Data for Precision Population Health Professor Austin Stack - Consultant Nephrologist at University Hospital Limerick.
12:10- 12:40	Keeping Routine Going: Laboratory Services in Ukraine Under Challenging Conditions Professor Nataliia Kozpas, Department of Clinical Laboratory Diagnostic, Danylo Halytskji Lviv National Medical University, Ukraine.
12:40 - 13:10	Oral presentations 3x 10 min Oral presentations from selected abstracts.
13.10 - 14:15	Lunch Lunch and poster viewing.
14:15 - 14:30	Premium Event Partner Showcase
Session 3	Artificial Intelligence in Laboratory Medicine Chair: Dr. Micheál Mac Aogáin, Senior Clinical Biochemist, St James's Hospital; Clinical Senior Lecturer, Trinity College Dublin.
14:30-15:00	Artificial Intelligence in Clinical Biochemistry: Current Applications and Future Directions Dr. Stephen R. Master. Associate Professor of Pathology and Laboratory Medicine at the Children's Hospital of Philadelphia University of Pennsylvania Perelman School of Medicine.
15:00-15:30	Governance of AI in Healthcare: opportunities and challenges of AI in clinical practice Ms Erin Daly - Operations Manager, Pillar Centre for Transformative Health, Mater Misericordiae University Hospital.
15:30-16:00	Tea/Coffee and poster viewing

- Session 4** **Analytical performance challenges - detection and mitigation strategies**
Chair: Mr Carl Talbot, Principal Clinical Biochemist, The Coombe Hospital, Dublin.
- 16:00-16:30 **The Good, the Bad and the Unacceptable: Managing Assay Performance**
Dr Rachel Marrington, Deputy Director and Consultant Clinical Scientist at Birmingham Quality (UK NEQAS), University Hospitals Birmingham NHS Foundation Trust.
- 16:30-17:00 **Laboratory testing with confidence: when to replace, repress or reframe an assay**
Dr Rav Sodi. Consultant Clinical Biochemist at Broomfield Hospital, Mid & South Essex NHS Trust.

Drinks reception from 18:30

Day 2

- Session 5** **Biochemistry Beyond the Laboratory: Patient Access in the digital age**
Chair: Dr Jennifer Brady, Consultant Clinical Biochemist, Children's Health Ireland.
- 09:15-09:45 **Direct to Consumer Testing - Biochemistry outside the Laboratory**
Dr Matthias Orth, Medical Director of the Institute for Laboratory Medicine at Marienhospital Stuttgart, Germany.
- 9:45-10:15 **Patient Access to Results**
Professor Maria Hagglund, Uppsala MedTech Science & Innovation Centre, Uppsala University, Sweden.
- 10:15-10:45 **Irish Perspective on Patient Access to Results**
Mr Stephen McMahon, Director of the Irish Patients' Association (IPA).
- 10:45-11:15 **Tea/Coffee and Poster viewing**
- Session 6** **The Head and The Heart, Burnout and Balance**
Chair: Dr Heloise Tarrant, Principal Clinical Biochemist, St. Vincent's University Hospital, Dublin.
- 11:15-11:45 **Oral presentations**
3 x 10 min oral presentations from selected abstracts.
- 11:45-12:15 **The use of NTproBNP in Cardiovascular Disease in Primary Care**
Dr Eamonn O'Shea, General Practitioner, Claddagh Medical Centre & Cardiovascular Lead, Irish College of General Practitioners (ICGP).
- 12:15-12:45 **Burn Out and Balance and the Modern Laboratory Workforce**
Professor Brendan Kelly, Consultant Psychiatrist, Tallaght University Hospital, Dublin.
- 12:45-12:55 **Medals and Awards Presentation**
ACBI President - Ms Kelly Foley, Principal Clinical Biochemist, Cork University Hospital.
- 12:55-13:00 **Meeting Closing Address**
ACBI President - Ms Kelly Foley, Principal Clinical Biochemist, Cork University Hospital.

Lunch to go