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Dear Colleagues

Feedback from the GP/Pathology Interface group

You may not know, but we have a very useful forum to discuss what you need in primary care from RUH Pathology and vice versa. As well as myself and the laboratory managers, we have GP's from BANES, Wiltshire and BEMS. A few items came up at the last meeting held in June that we felt would be important to disseminate. The following were some actions and an update on progress:

- Now that patients can view results there is a concern that some results could be harmful if viewed before a clinician has discussed the results with a patient. Dr Liz Hersch has advised:
  If there is a result of concern and you have not been able to contact the patient it may be better to avoid filing this result. This is a simple way to stop a result appearing in the app before a clinical conversation with the patient has occurred. The haematologists do try and contact patients directly who have significant new pathology but this is not always possible
- Could we de-couple urine and blood requests within a panel so that if urine sample is delayed being sent the entire request is not rejected and urine can be sent in at a later date. This has been implemented except where clearance needs to be measured and both are required.
- Could we review the need to file duplicate virology or microbiology reports. These samples are processed at NBT so how they are reported is down to them. However, we have brought this up at our contracts meeting with them and they will look into whether this can be changed.
- With declined samples, sometimes the reasons may be confusing or be a bit blunt. Now patients can access results it is important that these comments are correctly applied and a review of the language used was requested. The laboratory has already started a piece of work to review all comments with a view that patients can see them to ensure language is patient friendly and as part of this we will review declined samples.
- It was requested that PSA and TTG be put back onto the common test screen and this has been requested.
- A question was raised that within the PCOS profile testosterone is often unticked. I would firstly point out the PCOS profile is a grey bar below the other endocrine tests. We are going to colour these a different colour to make these profiles a bit more obvious. Previously testosterone could only be ticked once clinical details were added to a pop up box. I have removed this pop up box asking for clinical information to speed up the requesting process but in return can I ask that clinical details are added before accepting the request. Especially with endocrine or slightly unusual tests it is essential to have the clinical information.
- In the FBC panel a common complaint is that there are flagged results that a GP would not normally consider important. Jenny Page, Consultant Haematologist, gave a talk on this recently at the GP forum. She explained that most of these indices are required for producing the report and that there is not a way to hide them from view. However, we will be adding some guidance to the website that you can sign post patients to and also the mean platelet volume is being removed from view.

Keystone risk to results downloading

The software that feeds results into Emis/System one is coming to the end of its lifespan; we will be updating this in the current year. Recently there have been some errors leading to results not being released. We are not alerted automatically to when this occurs so if you have any concerns that this may be occurring please let the IT team know on ruh-tr.clinicalcomms@nhs.net

ICE Zebra printers

Thank you for your support implementing the new zebra printers, I know this is taking valuable time for surgeries. Using these printers is essential to us being able to read the sample barcodes on our new analysers and from next week the new state of the art track will go-live. The bar codes are essential to us being able to get the benefits of this track that will mean that results will be available to you quicker. It also allows us to remove unnecessary paper so is good for the environment.
There is an information pack supplied with the printers but again if you have any queries please contact ruh-tr.clinicalcomms@nhs.net

Assay changes

- **Ferritin**
  The new ferritin assay has a negative bias, this was flagged at the GP interface group and we noticed an increase in referrals for IDA. Therefore, I have discussed with gastroenterology, haematology and our network partners. We have decided to move to WHO guidance on ferritin interpretation 2020. This means:
  - Less than 15ug/L indicates absolute deficiency.
  - Between 15-30ug/L there still may be iron store depletion but the clinical presentation will determine the level of concern. We have added some guidance to comments.
  - Between 30-100ug/L if there is inflammation, CKD or malignancy ferritin may be raised as it is an acute phase protein so deficiency may still be present in these scenarios

  Like many tests ferritin is not interpreted using its reference range but rather thresholds set based on sensitivity and specificity. Iron deficiency anaemia requires clinical correlation and review of FBC and MCV.
  Non-anaemic iron deficiency can cause symptoms, for example fatigue or restless legs, so below 15ug/L, or potentially 30ug/L if high index of suspicion, OTC iron supplements may be an option even when anaemia is not present. There is useful guidance on NICE clinical knowledge summaries.

- **B12**
  The new B12 assay has a negative bias, although the previous assay had a positive bias so the new assay is correcting for that to a certain extent. The new decision thresholds are lower to accommodate for the shift. That said, it is clear many more patients have low B12 and in particular B12 100-180ng/L in the indeterminate range. All B12 assays are different and the difficulty in measuring functional B12 is well documented. A review of references ranges has been completed at another centre in the UK but this confirms our reference range. We are carrying out further studies and NICE guidance is due to be released so further guidance will be sent in due course.
  Again the clinical context is the most important factor with interpreting results. For those patients without neurological or haematological suggestion of low B12 who fall into the range 100-180ng/L, suggesting a review of their diet or OTC supplements and a follow up check in several months is often all that is required.

- **Insufficient samples**
  Lastly, some of the new assays need more sample volume to generate a result. We would always recommend filling the sample tube fully and of course with clotting (citrate) samples this is essential. Please be aware that if you are ordering multiple biochemistry tests you may need a second tube; as a general rule you should need one tube for chemistry and one tube for endocrine type tests.

- **Urine tubes and sample volume**
  We have received stock of the urine bottles so hopefully issues with supply of this will now settle. Where possible please revert to using the buff coloured vacuettes.
  Also please ensure urine tubes are only HALF-FILLED. The automated track is unable to place a cap on samples filled to the top so will reject samples.

If anyone would like something discussed at the GP interface group please let me know,

Many thanks for your support.

Dr. Moya O'Doherty
Clinical Director of Pathology