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Quick View

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This will be my last address to you as President. It has been a most interesting and busy year. There have been times when I thought I bit off more than I could chew. With perseverance and lots of help from Janet Kingston, I can say I have learned much and hopefully represented you all well.

There are many things we have tried to accomplish but unfortunately these all take time. We are still working on the "rules"- this has turned out to be taking longer than I had anticipated. Professional Development Program (PDP) is proving to be a success with over a hundred completed so far. The rest of you will have to play "catch–up". Try filling out a form, you'll find you have more credits than you think. The Board of Director Manuals are all updated and on diskette. This will help to ease new members onto the Board and make them familiar with the responsibilities involved. We are also working on a better liaison with the students in both diploma and degree programs.

The plans for the Annual Provincial Scientific Convention (APSC) to be held in Fredericton, May 1-3, 2003 are in full swing with the Fredericton Academy. Get your costumes ready!! Mardi Gras Theme! Should be lots of fun. There are many excellent speakers lined up; also some French lectures are planned so make your plans now to attend.

There is a council of Presidents meeting coming up and one of the main concerns is the shortage of technologists across Canada and the hiring of Med Lab Assistants.

Congratulations to Bernadette Muise, our new President elect for 2003. I know she will do an excellent job. Give Janet Reid, our current President elect full support next year as she takes the reins. Thanks Janet and Colleen for all your help.

As you will probably be getting this during the Christmas season, I'd like to take this opportunity to wish you all a Blessed Christmas and Happy New Year.

Edna Smith
President,
NBSMLT

Great Job !

Congratulations to the following 2002 graduates who also were successful on the **CSMLS** certification examination in June 2002.

(The method of reporting CSMLS exam results ensures that the home province rather than the training province is notified first. As a result of this policy, the names of three successful students were inadvertently missed in the last issue of the Analyzer. My sincerest apologies for the error.)

Jennifer McMillan and Janet Reid

Angela Connors
Zoey Mossman
Michelle Young

Zoey Mossman was also the recipient of the Fisher Award. She has accepted employment at the Saint John Regional Hospital. We welcome her to the province and hope she will make it her home.

The award for "Outstanding Performance in Medical Laboratory Technology", donated by NBSMLT, was presented by Janet Reid, President-Elect, at the Fall Awards Ceremony November 1, 2002. Recipient of the award was Jennifer McMillan, second year student.

Newest NBSMLT PDP Recipients Congratulations !!

Nancy Savoie	Susan Findlater
Jean Little	Jacques Allard
Barbara Leclerc	Paula Steeves
Donna St.Pierre	Florence Duff
Suzanne Turcotte	Mohammed Athar

YOU DON'T WANT TO MISS THIS EVENT!!!

Start making plans for

APSC 2003

Unmasking the Future

May 1-3 Fredericton NB

Ramada Hotel (formerly Howard Johnson's)

Keynote Speaker - Brent Finnamore "Stress Smart"

high energy, solution focused, informative, and fun

Concurrent Scientific Sessions

Dr. Spencer Lee - West Nile Virus
Craig Ivany - Reorganization of CBS
Dr. David Crowe - Parasitology
Dr. T Haswell- Sentinel Node Biopsies
Margaret Flynn ART – pro-BNP
Dr. Allan MacDonald - Organ Donation
Dr. Penny Barnes – FNA of Breast
Dr. P. Neary - Hormones & Exercise
Dr. Denise Pugh-Cain - Breast Cancer
David Wilson - Hemophilia
Mike Keeney ART – Stem Cell Research
Dr. S. Hussain - CML

and many more!

Workshops

Eric Ching - Challenges in Transfusion Medicine
Phlebotomy with Dennis Ernst

Exhibitors' Night

Mardi gras - Banquet and Costume Party

NBSMLT AGM

Watch for program and registration form in the March Analyzer
For further information contact: Marty White, Microbiology, DECRH 452-5465

Costumes for rent on site!

Interpretation of Lupus Anticoagulants (LA)

Debbie Dennis, Coagulation Specialist; The Moncton Hospital

Lupus Anticoagulant was first discovered in a patient with Systemic Lupus Erythematosus (SLE), a chronic inflammatory disease of connective tissue, where it caused a prolongation of some coagulation tests. SLE, as we know, which affects skin, joints, kidneys, nervous system and mucous membranes. The disease occurs most frequently in young women. It's etiology in unclear and may occur acutely or present as a malaise over a period of years. The term *Lupus Anticoagulant* is an unfortunate misnomer as it is only found in a small percentage of patients with SLE and the term anticoagulant implies that these patients bleed. Patients with LA are in fact prone to thrombosis. The term anticoagulant was chosen simply because in patients with the condition, some coagulations tests were prolonged.

Lupus Anticoagulants (LA) are immunoglobulins, usually IgG, but they can also be IgM, IgA or a mixture. LA's interfere with negatively charged phospholipid dependent tests, for example Activated Partial Thromboplastin Time (aPTT). Patients with a LA may have thrombotic episodes despite a prolonged aPTT. LA's are associated with recurrent pregnancy loss, pulmonary embolism, myocardial infarction, stroke, microvascular thrombi and arterial and venous thrombosis. Transient LA's can be a result of drug therapy. Drugs, which have been implicated in this phenomenon, are some antibiotics, phenothiazine, procainamide, quinine, chlorpromazine, hydralazine and phenytoin.

The mechanism by which LA's cause thrombosis is still poorly understood. Possibilities include;

- Alterations of the prostacyclin to thromboxane ratio
- Activations of platelets
- Interference of the antithrombin system
- Interaction with beta2GP1
- Up-regulation of endothelial tissue factor expression
- Inhibition of the Protein C system
- Interaction with annexins
- Reactions with platelet glycoproteins

LA's are found in 2-4 % of the general population as well as in:

Response to Autoimmune Disorders
Viral and bacterial infections
Malignancies
Acquired Immune Deficiency Syndrome
Cirrhosis
Multiple myeloma

At The Moncton Hospital LA's are diagnosed using a variety of tests. A patient will usually have an elevated aPTT with an aPTT reagent that is sensitive to Lupus Anticoagulant such as silica with synthetic phospholipid; while soy phosphatides with ellagic acid as an activator will be normal. The Dilute Russell's Viper Venom (DRVV) test involves the direct activation of Factor X in the test sample in the presence of calcium chloride. The test reagent is poor in phospholipid, making it sensitive to a Lupus Anticoagulant. To confirm the presence of the LA, phospholipid is added in excess and this will neutralize the LA and give a shorter clotting time than the DRVV. It is reported as a ratio of DRVV/DRVV Confirm.

In the Platelet Neutralization Procedure (PNP) three aPTT's are performed:

- aPTT Baseline designated by - PNP-B
- aPTT with added saline designated by - PNP-S
- aPTT with excess phospholipid (platelets) designated by - PNP-P

A positive PNP is determined by two criteria:

- PNP-S must be shorter than the baseline because the lupus is diluted by the saline and the clotting time is therefore shorter.
- PNP-P must be shorter than the PNP-S by **"X"** seconds. The excess phospholipid overwhelms the lupus and thus gives a shorter clotting time than the saline.

(Continued on page 5)

Interpretation of Lupus Anticoagulants (LA)

(Continued from page 4)

***Note*:** Each lab, for the reagent and instrument used in testing, must determine the value of **"X"**.

One of the most frustrating parts of any coagulation procedure set-up involves getting a proper platelet poor plasma sample. For valid coagulation test results, it has been found that you need to ensure platelet count <10 before freezing the sample for testing. In our institution we were already double spinning specimens for LA, but every person in the lab did a platelet count on a specimen before freezing to be sure they were not getting too close to the buffy coat when aspirating plasma. BEWARE of stat centrifuges with fixed heads for coagulation testing!!! Fixed heads cause the buffy coat to be slanted along the side of the tube. The platelets swirl back up into the sample when placed upright.

LA's are very heterogenous and although several different tests are performed they are not always positive. All too often some tests are positive and some are negative making a definitive diagnosis of LA very confusing.

Our lab decided to go back to basics, which included a re-evaluation of our fixed head centrifuge. We felt it necessary to do an in house study of the stat centrifuge to convince ourselves that there was indeed a problem with utilizing that centrifuge for coagulation testing. After 10 "in house" studies, it was determined that 30 % of specimens had a platelet count >10, 5 minutes after centrifuging in the stat centrifuge. We now use a stat centrifuge with swing out buckets.

Based on the work Criteria for the Diagnosis of Lupus Anticoagulants: An Update 1995 by John, T. Brandt, Douglas A Triplett, Barbara Alving, Inge Sharrer; it has been shown that in order to make a diagnosis of LA, a sample should show each of the following criterion:

- Prolongation of at least one phospholipid dependent clotting test
- Evidence that the inhibitory activity is dependent on phospholipid. This may be achieved by addition or alteration of phospholipid, hexagonal phase phospholipid, platelets or platelet vesicles in the test system.
- Evidence of inhibitory activity shown by the effect of patient plasma on pooled normal plasma. (Mixing study)
- LA's must be carefully distinguished from other coagulopathies that may give similar lab results or may occur concurrently with LA's. If no Lupus is present, perform Factor assays (for example) if aPTT is increased.

Nine other recommendations were also made:

- Patient and normal plasma must have platelet counts < 10 x 10 9/l.
- Two or more screening tests should be negative before LA is ruled out.
- Inhibitory activity should be documented by the effect of patient plasma on pooled normal plasma.
- Confirmatory studies need to be performed to document the phospholipid dependence of the inhibitor.
- Confirmatory studies should be based on the method giving the abnormal screening test.
- Routine clotting tests, such as the PT and PTT should be performed to evaluate the possibility of other coagulation disorders.
- Solid phase studies such as anticardiolipin should not be considered a confirmatory test.
- Factor assays should be performed whenever there is a suspicion of a specific factor deficiency or inhibitor.
- The term "Lupus Anticoagulant" should be retained until the pathophysiology of these inhibitors is more fully delineated.

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Interpretation of Lupus Anticoagulants (LA)

(Continued from page 5)

Now we have only 3 possible interpretations:

1. **Presence of LA unlikely** if both aPTT and DRVV screening tests are negative.
2. **Presence of LA weak, moderate, or strong** if a screening test and its confirmatory and mixing study ALL based on the same method are abnormal. ie. aPTT + PNP (aPTT based) + aPTT mixing study are all positive
3. Still there are LA's that are positive with some tests and negative for others. These examples could have a positive screening test and positive confirmatory test but not based on the same test method. These are reported as **Presence of LA is questionable**.

With a **Questionable** result the report sent to the Physician will say :

"To positively identify a Lupus Anticoagulant, 3 criteria must be met:

Criterion 1&2 : A screening test **AND** it's corresponding confirmatory test must be abnormal

aPTT (screening test) & PNP (confirmatory for aPTT)

Or

DRVV (screening test) & DRVV Confirm (confirmatory for DRVV).

Criterion 3: The mixing study of the abnormal aPTT and/or the abnormal DRVV must show no correction upon mixing with normal plasma to within the patient normal reference range.

This patient did not meet all 3 criteria therefore a lupus anticoagulant cannot be positively identified based on lab testing alone."

Further notes:

Mixing studies must be done at both 1 hour and 2 hours because it has been demonstrated that between 8 and 30% of Lupus's are time dependent. One must also be aware of the effect of Heparin and Coumadin on coagulation tests when attempting to assess the possibility of Lupus Anticoagulants.

False positive in the aPTT will occur if the patient is on Heparin (Thrombin Time may help here. Thrombin Time will be positive in presence of Heparin)

False positive of the PNP will occur if the patient is on Heparin and possibly Coumadin.

False positive of the DRVV and DRVV Confirm will occur if the patient is on Coumadin.
(Ratio will probably be normal)

Note: The reagent we use for DRVV and DRVV Confirm contains polybrene, which will neutralize Heparin up to 1 U/ML. Other DRVV's may not contain Polybrene.

Mixing Studies – will usually correct indicating no Lupus.

I hope that this information will shed a little light on the fascinating world of Lupus Anticoagulant testing.

Thought for the day:

"Destiny is not necessarily what we get out of life, but rather, what we give."

Cary Grant

Editor's Note:

My heartfelt wish for you all is a joyous holiday season and productive New Year...

Another year draws to a close as you are reading this. The much awaited back-time is probably all spent…

I am continuing to learn "on the job" so to speak. Articles are not always easy to obtain. I know it seems like a lot extra when you've put in a full day with work and family but as always, any suggestions of things that might be of interest to the membership would be greatly appreciated. I would like to take this time to invite you to comment on the format, subject matter direction in which you would like to see your newsletter continue.

Deadlines for submissions for the MLT Analyzer 2003:

Issue 1	**January 24/03**
Issue 2	**May 9/03**
Issue 3	**Aug. 1/03**
Issue 4	**Oct. 24/03**

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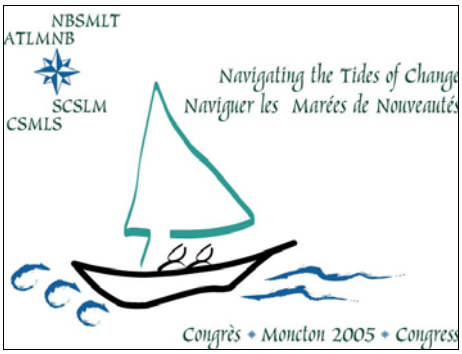
Congress 2005 Navigating the Tides of Change



It seemed like such a long way away when we began to talk about Congress in 2005; but time has a way of slipping away.

The committees have been very active in the preliminary stages but volunteers will still be needed.

- Ideas for speakers,
- topics you'd like to see presented…

Please feel free to send suggestions to the Scientific Chair, Congress 2005
Anne Robinson, The Moncton Hospital
Email : anrobins@sehcc.health.nb.ca

Upcoming Events you won't want to miss!!

May 1-3, 2003 APSC Fredericton NB
May 8-11, 2003 CSTM Halifax NS
June 7-11,2003 Congress 2003 Quebec City

The Draft Standards for Blood Bank will be posted to the Health Canada website November 15. Feedback from stakeholders is essential to the successful implementation of these standards which, it is hoped will result in better transfusion practice.

"The standards set out minimum safety requirements for acceptable performance. These requirements are in respect to: donor selection, blood collection, processing, testing, labelling, record keeping, look-back/traceback, recall and storage. It is expected that the implementation and use of the required safety norms will help establish and maintain safe practices and motivate all concerned parties to remain vigilant."

Source:http://www.hc-sc.gc.ca/hpfb-dgpsa/bgtd-dpbtg/04_blood_stds_e.html

Moncton Academy Report

On Saturday, October 26, the Moncton Academy of the NBSMLT held an Education day at The Moncton Hospital. Twenty-three technologists, including students from the BMLS program, attended.

The morning began with a presentation by Yves Grenier of Bayer, who demonstrated the *Rapidpoint* system for coagulation testing and blood gases as well as the *Rapidlink* software for quality control and monitoring. *Rapidlink* enables a supervisor to remotely monitor and control Bayer's Critical Care systems from a single central point. *Rapidpoint Coag* is a multitest analyzer used in monitoring anticoagulation therapy and determining a patient's coagulation status at the point-of-care. The system, which uses a simple, easy-to-use test card format, provides the full menu of point-of-care coagulation tests, including prothrombin time (PT), activated partial thromboplastin time (aPTT) and a next generation heparin management test. The *Rapidpoint* system delivers whole blood results in just 60 seconds for one test or a complete panel, with the most complete point-of-care menu available, pH, blood gas, electrolytes, glucose and hematocrit, all with the capability to be monitored remotely by the central laboratory. With the advent of point of care testing systems, technologists must become proactive in the role of quality assurance. In order for our patients to benefit from these machines, technologists must be involved in the maintenance and training.

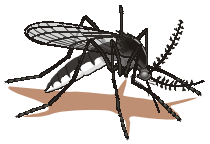
Debbie Dennis, Coagulation Specialist at The Moncton Hospital, discussed the interpretation of Lupus Anticoagulants and the new trend toward simplification of that interpretation. She shared with the group, methods currently employed at The Moncton Hospital, which allow for a more streamlined approach to what has, historically, been a time consuming and sometimes ambiguous diagnosis.

Gilberte Caissie provided a tour of the Molecular Biology process start to finish. Everyone came away with a greater understanding to the precision and pitfalls involved in this developing field.

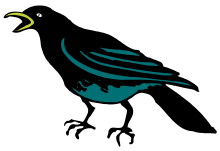
During mid morning, The Great Canadian Bagel and Atlantic Superstore generously provided the nutrition break. While technologists enjoyed the short break, Academy President Randi Hayes introduced the incoming Moncton Area Director, Sasha Wright, who begins her term January 1, 2003. Sasha circulated the Area directors report from the NBSMLT Board of Directors meeting in September. Randi thanked the students for their dedication in giving up their Saturday morning and the sponsors for providing the nutrition break.

The next meeting will be held at Patterson's Restaurant in Sackville November 28th.

Seasons Greetings
from
The Moncton Academy



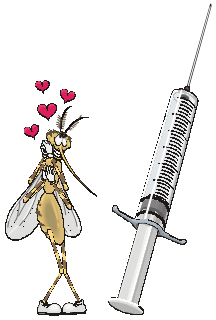
West Nile Virus (WNV)



The ”West Nile Virus” (WNV) was first described in Uganda in 1937. Since then there have been outbreaks of the disease in Africa, Western Asia, the Middle East and Europe but the first documented human case in North America only occurred in 1999. WNV is closely related to St. Louis encephalitis virus also found in the United States. The West Nile Virus is an arthropod borne virus belonging to the Japanese encephalitis complex of Flaviviridae. It is a small spherical virus approximately 50 nm in size. A lipid coat envelops the single stranded ribonucleic acid (RNA) virus. The genome encodes a polyprotein, which in turn forms three structural proteins, the capsid, membrane and envelope; as well as seven other non-structural proteins.

The West Nile Virus is primarily transmitted in birds through mosquito bites, with humans being only incidental hosts. Other incidental hosts may be horses, cats, squirrels and domestic rabbits. Although ticks infected with West Nile virus have been found in Asia and Africa, their role in the transmission and maintenance of the virus is uncertain. Mosquitoes become infected when they feed on infected birds. The virus may circulate in the blood of infected birds for a few days. The incubation period for the infection appears to be 2 –14 days after a bite from an infected mosquito. It must be remembered that even in an area where the virus is circulating, very few mosquitoes will become infected. One of the species of mosquitoes found to carry West Nile virus is the *Culex* species, which survive through the winter, or "overwinter," in the adult stage.

Only about 20% of infected people will develop any symptoms and it will generally be a mild disease characterized by flu-like symptoms; fever, muscle aches and headache. West Nile fever typically lasts only a few days and does not appear to cause any long-term health effects. Infection, with viremia lasting from one to two weeks, in healthy individuals, confers a protective immunity. In about 1% of those infected, the disease may progress to a more serious condition such as “West Nile encephalitis,” “West Nile meningitis” or “West Nile meningoencephalitis.” Frequently those who suffer the more severe form of the disease are immunosuppressed individuals who already are more susceptible to morbidity and mortality. West Nile virus multiplies in the person's blood system and crosses the blood-brain barrier to reach the brain. The virus interferes with normal central nervous system functioning and causes inflammation of brain tissue. Recently there has also been a poliomyelitis-like illness of asymmetrical acute flaccid paralysis as a result of viral infection reported. To date, there is no vaccination available for the encephalitis, but several companies are working toward that goal.



A recent investigation in the United States has identified transplanted organs as the source of WNV infection in four recipients of organs from a single donor. However, bites from mosquitoes carrying WNV remain, by far, the most common means of transmission of the disease. Investigations into possible transfusion mediated cases of WNV continue. The Centers for Disease Control (CDC), has received reports, from ten states, of patients confirmed with WNV infection diagnosed after receiving blood products within one month of illness onset. All patients lived in areas where there is active WNV activity present and so they may have been infected by mosquito bites.

To reduce the chance of infection, precautions to minimize exposure to mosquitoes are the first line of defense; use insect repellents containing DEET (N, N-diethyl-m-toluamide). The more DEET in a product, the longer it can protect you from mosquitoes. DEET does not kill mosquitoes it simply disrupts, for several hours, the ability of biting insects to detect the carbon dioxide given off by the person. DEET concentrations higher than 50% do not increase the length of protection. If you spray your clothing there is no need to spray the skin under the clothing. Consider staying indoors when the mosquitoes are more active, at dawn and dusk; and wear long sleeved clothing if possible. Keep screens in good repair to keep the mosquitoes outdoors. Reduce the number of mosquitoes around your home and property by ensuring the areas where standing wa-

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West Nile Virus (WNV)

(Continued from page 9)

ter can collect, such as; birdbaths, pet dishes, flower pots, rain barrels and gutters are kept clean and emptied frequently.

The West Nile Virus is a lipid enveloped virus and susceptible to conventional inactivation methods used in fractionation products. Other members of the flaviviridae, are known to be inactivated by the heat or solvent detergent treatments used in preparation of plasma derivative products. Transmission of the virus by coagulation Factor Concentrates, Intravenous Immune Globulin (IvIG) or Albumin is therefore unlikely.

There is no current screening test available for the WNV. A WNV test which would meet the stringent requirements for implementation in a blood donor screening process would need to be nucleic acid based. At present, the donor selection process includes questions about the donor's general health, as well as a physical examination by a Registered Nurse; with instructions for the donor to contact the Canadian Blood Services (CBS) centre if they begin to feel unwell in the days immediately following the donation. The donation would then be removed from inventory. The CBS is coordinating with provincial public health agencies to determine if individuals with suspected or confirmed cases of WNV have been blood donors. Even in an area where the WNV is epidemic, the risk of transmission is estimated at 2 in 10,000 donations. Any possibly contaminated product is immediately removed from inventory. The risk of acquiring WNV infection due to transfusion is believed to be very low but investigations continue. In any medical situation the benefits of transfusion or transplantation must be weighed against the possible risks and the appropriate decision reached.

References:

Transfusion 2002;42:1019-1026

Update:
Investigations of West Nile Virus Infections in Recipients of Organ Transplantation and Blood Transfusion MMWR 2002;51:833-6.

Update:
Investigations of West Nile Virus Infections in Recipients of Organ Transplantation and Blood Transfusion - Michigan 2002
MMWR 2002:51:879

http://www.cdc.gov/od/oc/media/wnupdate.htm

www.cdc.gov/ncidod/dvbid/westnile/index.htm

http://www.hc-sc.gc.ca/english/diseases/west_nile.html

http://www.hc-sc.gc.ca/pphb-dgspsp/wnv-vwn/index.html

http://aabb.org/Pressroom/In_the_News/wnwnv100302.htm

For further information on reducing the local mosquito population go to: The Information Sheet entitled *Effective Control of Mosquitos Around Your Home* on the Pest Management Regulatory Agency website at: www.hc-sc.gc.ca/pmra-arla.

Blood Bank Humour

Three vampires walk into a bar. The waitress comes up to them and asks what they'll have…
The first vampire says (Transylvanian accent inferred) *"I'll have a glass of O Positive."*
The second vampire says, *"I'll have a glass of AB Negative."*
The third vampire says, *"I'm the designated driver. I'll just have a glass of plasma."*

The waitress turns to the bartender and yells *"Gimme two bloods and one blood lite!"*

NBSMLT Board of Directors 2003

Randy Thornhill, Saint John; Colleen Moran, Miramichi; Sasha Wright, Moncton; Edna Smith, Past President; Janet Reid, President 2003; Marty White, Fredericton
Germaine Savoie; North Shore; Bernadette Muise, President -elect; Janelle Levesque, Edmundston; Janet Kingston, Executive Director
Missing from this photograph: Lay Representative Richard Lafleur

WISHING YOU ALL THE BEST IN THE HOLIDAY SEASON AND THROUGHOUT 2003

AT THIS FESTIVE TIME OF YEAR LET US NOT FORGET THOSE WHO ARE LESS FORTUNATE THAN OURSELVES. MAY THIS HOLIDAY SEASON BE LONG REMEMBERED FOR THE WARMTH WE DISPLAY TO ALL OUR FELLOW BEINGS.

"Seasons Greetings and all the best for 2003 from your CSMLS Bilingual Director. These last eight years volunteering for our Profession here in New Brunswick, both at the Provincial and the National level, have been so worthwhile and I hope and encourage that you will all do something in the coming year. You will find it so personally rewarding."

Susan Atkinson, Bilingual Director CSMLS

For those who haven't already heard, a $6 dues increase was approved at the CSMLS AGM in May, 2002.

All Regional Payroll Departments were notified of the increase in early June, 2002. If your dues are deducted from your pay, you have probably noticed a slight increase in the amount deducted.

2003 fees are $226 and include:
CSMLS dues $ 128
NBSMLT dues $ 90
Liability insurance $8

Deadline for receipt of fees is January 31, 2003. Otherwise, a $50 late fee will be charged.

Please note that annual liability insurance coverage for members expires on December 31st of each year, so to ensure coverage, it is recommended that dues be received on or before December 31, 2002.

If you have questions, please do not hesitate to call the Society office at 506-455-9540

Janet L. Kingston
NBSMLT Registrar

2003 - Conseil d'administration

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