LabMedNews

Association for Laboratory Medicine

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APRIL 2026

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Association for Laboratory Medicine

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Front cover: The New Library of Birmingham

MESSAGE FROM THE CEO

VICTORIA LOGAN
Chief Executive Officer

Over the past year, we've been doing some important behind-the-scenes work to review how the Association for Laboratory Medicine is governed. Our governance documents set out our purpose, how decisions are made, and how we stay accountable to you, our members.

It's been some time since we last took a full look at these documents, so this review has given us a valuable opportunity to modernise them and make sure they support where LabMed is heading. As part of this work, we've simplified and updated our Articles and Bye-laws, refreshed all our committee Terms of Reference, and ensured all directors have clear, up-to-date role descriptions. That clarity helps everyone focus on the same goals and work effectively together.

This work also sits alongside our wider rebrand and repositioning in recent years. It supports openness and transparency, and helps ensure LabMed remains accessible and relevant for members now and in the future.

We'll be asking you to vote on these changes at the AGM so if you'd like to find out more and ask questions, please join our members' governance Q&A webinar on Monday 27 April, 1.30-2.00pm, with our president, past president and company secretary.

Several major projects have also reached important milestones at the end of the first quarter of 2026. We have recently launched the redesigned Lab Tests Online UK website, one of the most widely used public resources explaining laboratory tests. The new design – developed following extensive user research – aims to make information clearer and easier for patients to navigate, particularly as more people access their results through the NHS App in England and other online systems.

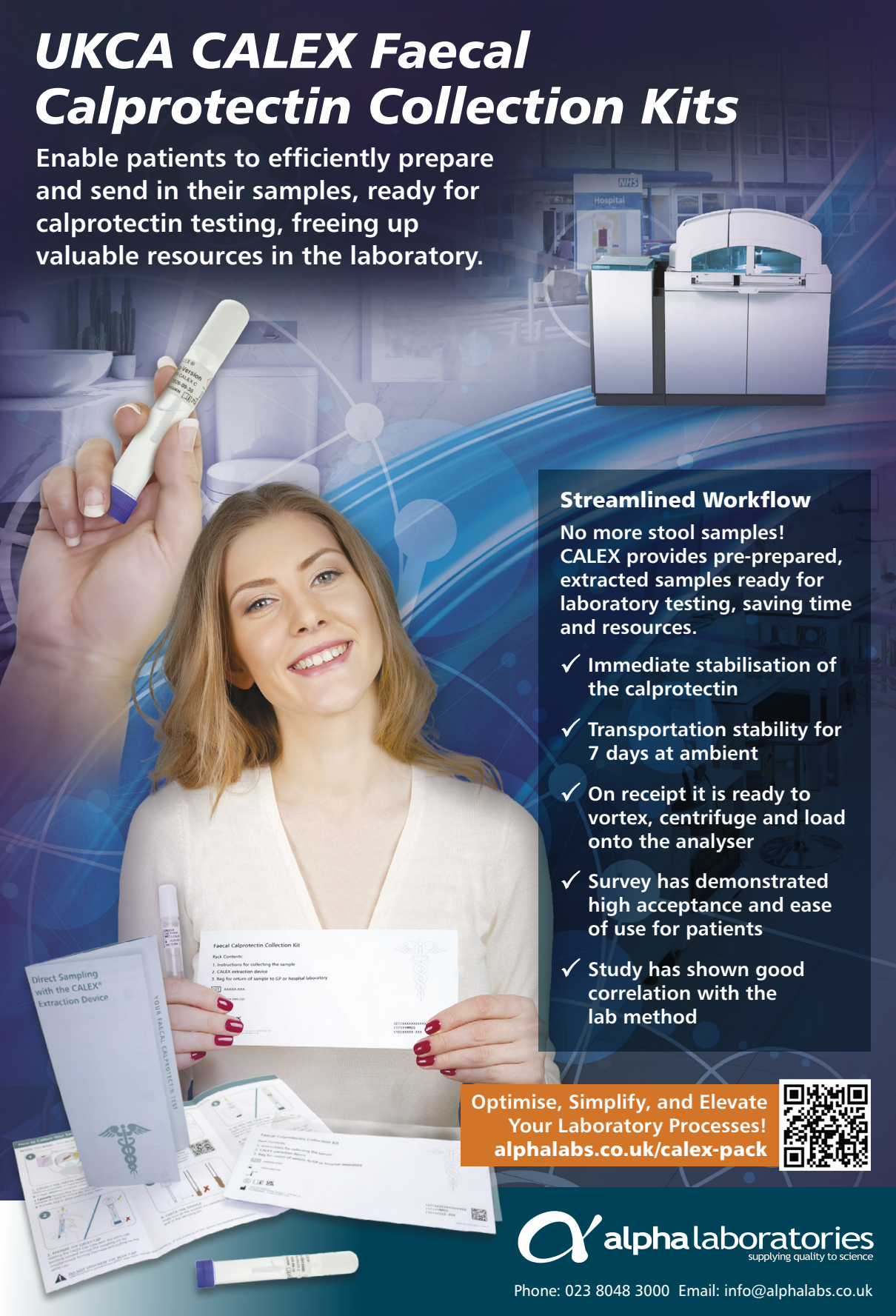
The Learning Academy was originally launched with grant funding from Health Education England; it expanded its range of online learning while we developed a sustainable model so it could remain part of our free member offer after the funding ended in March 2025. We are now migrating to a new platform that will support the Academy's long-term future and are launching it with an excellent new sustainability resource.

I've also been really pleased to see the LabMed team working closely with our Microbiology and Immunology Professional Committees to help strengthen engagement with colleagues across these specialties. We're delighted that the Immunology Training Day will take place at LabMedUK this year and early indications suggest that the new microbiology webinar series – open to all microbiology trainees – is proving very popular.

Finally, I'm very pleased that we are continuing to build our national events programme. This year's programme includes a focus on digital and patient-centred approaches to laboratory medicine, alongside courses in management and leadership, our residential course for trainees, and upcoming sessions on AI and informatics. Please do keep an eye on the website for further details.

UKCA CALEX Faecal Calprotectin Collection Kits

Enable patients to efficiently prepare and send in their samples, ready for calprotectin testing, freeing up valuable resources in the laboratory.



Streamlined Workflow

No more stool samples! CALEX provides pre-prepared, extracted samples ready for laboratory testing, saving time and resources.

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- ✓ Survey has demonstrated high acceptance and ease of use for patients
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LAB TESTS ONLINE UK LAUNCHES REDESIGNED WEBSITE

Lab Tests Online UK (LTO) has launched a newly redesigned website, marking an important milestone in the ongoing development of one of the UK's most widely used sources of information about laboratory tests, which is professionally peer reviewed and does not use AI generated content. The team is delighted to see the new site go live after a substantial period of research, design and development.

The rebuild follows a significant programme of user research and content review carried out by the LTO Board with digital agency William Joseph. We have also been fortunate to benefit from insights from an NIHR-funded study with the Universities of Bristol and Manchester into the accessibility of test results for patients. As a result, the site design has been informed by a strong understanding of how patients and members of the public use it, and how the information provided can be made clearer, more accessible and easier to navigate.

One of the most significant changes is a much simpler site architecture, designed to help users find the information they need quickly. Individual test pages have also been completely redesigned based on user feedback, with a clearer structure and more logical presentation of information for non-specialist readers.

The new site will initially go live with the existing content. However, LTO editor, Alan Deacon, is working closely with a team of reviewers to look at every page as it moves across to the new page template. A key strength of the site is that the information on each page is written by, validated and updated by a human expert with specialist knowledge in the relevant laboratory discipline. This work will continue over the coming months and the LTO team invites laboratory professionals from across the community to get involved and support this review process.

The redevelopment was made possible through a partnership between LabMed, the Institute of Biomedical Science and the Royal College of Pathologists who jointly supported the investment required to rebuild the site, as well as providing expertise through LTO Board members and reviewers.

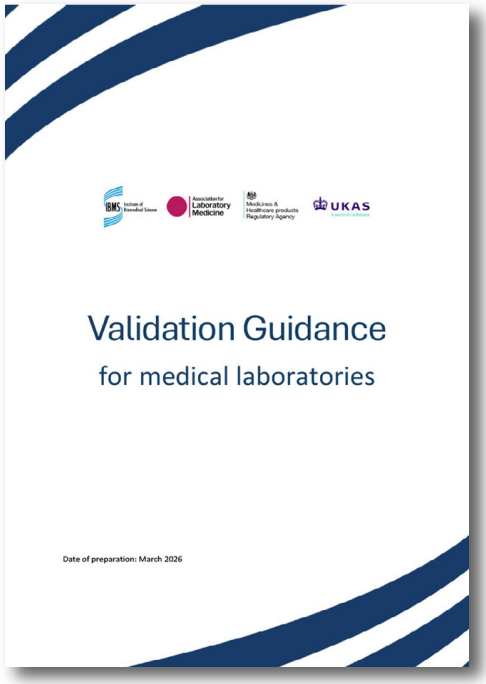
The new website provides a strong foundation for future development. As digital healthcare continues to expand, there are significant opportunities to further integrate Lab Tests Online more closely with NHS digital services, including the NHS App and GP systems, ensuring that patients have reliable, easy-to-understand information alongside their test results.

LabMed would also like to thank everyone on the LTO Board as well as Tracy Davis, who managed the project on behalf of LabMed.

To get involved please contact us at labtestsonlineuk@labmed.org.uk

VALIDATION GUIDANCE FOR MEDICAL LABORATORIES

The development of the new joint Validation Guidance for Medical Laboratories stems from initial discussion at LabMed's Patient Centric Sampling Conference in February 2025. The discussion identified a real need for guidance for laboratories on the validation of *in vitro* devices (IVDs) where this is not straightforward.



In practice, many laboratories encounter situations where an IVD or assay is used outside of the manufacturers' instructions for use (IFU), including modifications to sample types, workflows, or analytical parameters. Such use cases, which may be clinically justified, require robust, documented validation.

In addition, there is currently a lack of consistency around the use of external verification data to support the verification of point-of-care (POC) devices. This has been confirmed as acceptable providing that teams can demonstrate that the population and conditions used in the external verification are relevant to the intended use.

LabMed have worked in collaboration with the IBMS, UKAS and MHRA to produce this guidance for laboratories on how to provide the necessary validation of IVDs to ensure that the results generated are reliable, accurate and safe for patient use.

Access the guidance here.

LABMED TRADE UNION BACKS PUSH FOR FLEXIBLE WORKING AND FAIR PAY

LabMed is proud to be part of the coalition of NHS unions behind the Get Ahead on Flex campaign, calling for flexible working to become standard practice across the NHS – not a postcode lottery.

Alongside the other trade unions, we are clear that workforce pressures cannot be addressed without progress on both flexible working and fair pay.

Pay: part of the same conversation

The 2026-27 Agenda for Change pay award (around 3.3%) has been widely criticised as insufficient, with unions also calling for more meaningful dialogue on pay-setting processes. For the laboratory workforce, pay is closely tied to recruitment, retention and progression in highly specialised roles. From LabMed's perspective, pay and flexibility are inseparable.

We support:

- fair and transparent pay processes
- realistic, service-aware approaches to flexible working
- clearer career progression pathways

These issues directly affect workforce sustainability and the quality of patient care.

You can sign the joint union open letter here.

Flexible working: turning policy into practice

While NHS staff have the right to request flexible working from day one, access remains inconsistent between organisations.

The campaign calls for practical action, including:

- advertising flexible options in all roles
- setting clear targets for approvals
- improving transparency and manager training

For laboratory medicine, delivering flexibility within 24/7 services is complex – but essential to retaining skilled staff and supporting modern career expectations.

Looking ahead

There is now a clear opportunity to align workforce reform, pay and flexible working into a coherent strategy. LabMed will continue to work with partners across the union coalition to ensure policies translate into real, practical change for those working in laboratory medicine.

Want to get involved? Become a Trade Union representative

Our reps are practising clinical scientists who understand members' issues because they face them too. They are supported by an experienced network of regional and group officers (including microbiology, genetics and trainees) and by professional legal services with a proven track record up to Employment Tribunal level.

NOTICE OF ANNUAL GENERAL MEETING AND SPECIAL RESOLUTION

The Annual General Meeting of the Association for Laboratory Medicine will take place during UKMedLab26 at The Eastside Rooms, Birmingham from 2pm on Wednesday 10 June 2026.

A notice will be sent to all Members in advance, including the Annual Report, agenda, minutes from previous AGMs and notice of special resolution for the proposed changes to the governance documentation of the Association for Laboratory Medicine.

In accordance with current Articles 11, 12 and 14 and Bye-Laws 6.2 and 6.2, we give notice that all honorary officers and national members have expressed their wish to remain in their posts for the coming year, with the exception of the director of clinical practice and a national member who will reach the end of their respective terms of office at this AGM. These vacancies have been advertised widely to members but expressions of interest can still be submitted via Get involved. The respective appointees shall then be announced for approval at June's AGM.

This is a very exciting time for the organisation and we look forward to discussing our past, current and upcoming developments with our members. We hope to see you there!

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UPDATE ON CHANGES TO LABMED'S GOVERNING DOCUMENTS

BY SARAH GLOVER, LABMED COMPANY SECRETARY

Over the past year, a working group appointed by Council has reviewed LabMed's governance documents to ensure they are up-to-date, easier to understand and able to support the future needs of the organisation.

What has changed?

1. A single, modernised Articles of Association
We brought together our previous Articles of Association, Memorandum of Association and the General Meetings section of Table A Regulations into one updated Articles of Association.

- All key governance provisions and member rights are now in one place.
- As before, any future changes to the Articles will require member approval.
- Outdated language, duplication and inconsistencies have been removed.

2. Clear separation between Articles and Bye-laws
Some matters previously in the Bye-laws, such as voting rights and election processes, are now properly captured in the Articles and we have created one streamlined Bye-law document to set out procedural rules. These can be updated by Council when needed, without requiring a member vote, allowing greater flexibility.

3. Reflecting the change in trade union identity
Members voted at the AGM in June 2025 to stop using "Federation of Clinical Scientists" as the identity for our trade union activity.

- The Articles now place trade union activity clearly within the core purpose of LabMed.
- The National Committee of the trade union is now formally recognised as a standing committee of Council.
- All legacy trade union-only members continue to have full voting rights within the Association.

4. Combining previous Association and Federation rules
We previously had separate rules for the Association for Laboratory Medicine and the Federation of Clinical Scientists. These are now combined into a single, simpler rules framework.

5. Clarifying organisational purpose
We modernised and simplified the Association's objects to describe our role more clearly and provide future flexibility. This now explicitly includes trade union activity to support members' professional interests and working conditions, including representation and advocacy.

6. Strengthened governance structures
We formalised key governance arrangements, including:

- The role of the Nominations Committee, moving to an open application process for director appointments.
- New terms of reference for Council and all standing committees (Executive, Finance and Risk, Nominations and Remuneration).
- A new Scheme of Delegation clarifying responsibilities and decision-making authority across the organisation.

Why we made these changes

These updates ensure our governance remains transparent, modern and fit for purpose – making it easier for members to understand how LabMed operates, strengthening democratic accountability and giving us the flexibility and clarity needed to continue supporting the profession and workforce effectively.

LABMED MEMBERS' BRIEFING: GOVERNANCE CHANGES Q&A

MONDAY 27 APRIL 1.30PM–2.00PM

Join us for a member webinar with LabMed's president, past president and company secretary, where we'll walk through the recent updates to LabMed's governing documents, including the new Articles of Association.

Over the past year, Council appointed a working group to review and modernise LabMed's governance framework. This webinar will explain:

- How the Articles have been simplified and consolidated into a single, modern document.
- The separation of Articles and Bye-laws for clarity and flexibility.
- Updates reflecting the change in trade union identity and combined Association rules.
- Strengthened governance structures, including Council, committees and delegations.
- How these changes support transparency, accountability and the future of LabMed.

There will be a dedicated Q&A session, giving you the opportunity to ask questions directly to our leadership team.

Who should attend: All LabMed members who want to understand how these changes affect governance and the organisation's future direction.

Location: Online *(link to be provided upon registration)*

Don't miss this chance to hear directly from LabMed leadership and have your questions answered.

Register here.

HELP SHAPE SUSTAINABILITY IN LABORATORY MEDICINE

If you've been looking for a way to get more involved in sustainability – beyond conversations and into real influence – this new LabMed role offers exactly that.

We're inviting applications for a National member of Council (environmental sustainability), a position that puts you right at the centre of decision-making within LabMed while giving you the opportunity to shape how sustainability is approached across laboratory medicine.

This is more than a committee role. As part of Council, you'll contribute to the strategic direction of LabMed, gaining insight into how a national professional body operates and building experience that can support your own career development.

You'll also work closely with our Green Champions and wider network, connecting with colleagues who share an interest in sustainability and bringing ideas into practice – both within LabMed and across the profession.

For those interested in leadership, influence or developing a broader professional profile, this role offers:

- Experience of working at Council level and contributing to organisational strategy.
- A platform to influence sustainability in laboratory medicine nationally.
- Opportunities to collaborate with engaged and forward-thinking colleagues.
- The chance to turn ideas into tangible change.

Importantly, the time commitment is manageable, with a small number of short online meetings each year, making it realistic to take on alongside your existing role.

You don't need to be a sustainability expert – just someone with an interest in the area, a willingness to contribute, and the confidence to bring forward ideas.

If you've been thinking about getting more involved with LabMed, or taking a step into a more strategic role, this is a great place to start.

Find out more and apply here.

DON'T MISS OUT: LABMED EDUCATION BURSARIES CLOSE SOON

LabMed members have just a few weeks left to apply for one of the Association's education bursaries, designed to support professional development and help members access training, education and scientific events. The current application windows for the Regional educational bursaries and National education bursaries close on 30 April and 14 May respectively.

These bursaries help members take advantage of learning opportunities that enhance knowledge, skills and professional networks across laboratory medicine. Funding can be used to support attendance at courses, meetings or conferences that contribute to professional development and the advancement of laboratory practice.

Regional and national bursaries

LabMed offers both regional educational bursaries and a national education bursary, which can be used for the same types of educational activities, including conferences, training courses and scientific meetings.

Members should apply to their regional bursary scheme first before applying for the national education bursary. Regional bursaries are intended to support members within each LabMed region and help distribute funding opportunities across the membership. If regional funds are not available, members may then apply for the national scheme.

Both schemes reflect LabMed's commitment to supporting members throughout their careers and helping them access valuable educational and professional development opportunities.

Upcoming application windows in 2026

The current bursary round closes soon but members who are not ready to apply yet will have further opportunities later in the year. Two additional application windows will open in 2026:

- 3 June
- 19 August

Please plan ahead and consider how a bursary could support your learning and professional development over the coming months.

THE LEARNING ACADEMY GROWS WITH NEW CONTENT AND PLATFORM

The Laboratory Medicine Learning Academy is expanding with new content developed by LabMed members. Designed specifically for laboratory professionals, the Academy focuses on practical, relevant learning without the noise and clutter often found on larger platforms.

The Academy is also moving to a new platform, with improved navigation and more interactive courses. The site is fully mobile-friendly and users can track their progress through certification. A community space is also available to support peer interaction.

Launching soon, the Academy is designed to fit around busy schedules. With no deadlines or entry requirements, users can learn at their own pace. On launch, members will be notified on how to register/login.

New content

At launch, the Academy will feature a range of new training modules and self-guided learning opportunities.

Sustainability in clinical laboratories

Authors: Robert Shorten and Anna Sanders

This module explores the impact of the climate crisis on healthcare and clinical laboratories. It covers the climate emergency, the NHS response, effects on laboratory operations, diagnostic stewardship and possible interventions.

Point-of-care testing

Author: Rebecca Rawlinson

Focusing on the rapidly evolving field of near-patient or bedside testing, this module introduces the principles and practicalities of POCT. It covers common devices and

key considerations when choosing and implementing point-of-care testing services.

UKAS accreditation

Author: Heather Stoddart

This module explains the formal recognition that laboratories must achieve to demonstrate competence and reliability. It covers the UKAS accreditation application process, relevant standards for clinical laboratories and maintaining compliance.

Effective research

Authors: Phillip Monaghan and Helen Jopling

Aimed at supporting clinical research skills, this module highlights how research can enhance laboratory services and improve patient care. It covers formulating research questions, developing research skills, ethical considerations and tips for publishing results.

Coming later this year

The Academy will continue to address gaps in laboratory medicine training, with new resources planned throughout the year. Upcoming content includes training modules on professional development, laboratory skills and laboratory management; a digital relaunch of *Clinical Cases in Laboratory Medicine*; live training opportunities; and a range of additional resources.

Our resources are **created by our members for our members**. If you'd like to get involved, contact the digital learning officer at avi@labmed.org.uk or complete the Creating Digital Learning module available on the platform. Access to the Laboratory Medicine Learning Academy is included with your membership, start learning today.

A CONVERSATION WITH MAYUR PATEL

As Mayur Patel, consultant in chemical pathology/metabolic medicine at Oxford University Hospitals NHS Foundation Trust, comes to the end of his tenure as LabMed's director of clinical practice, we are now inviting applications for the role.

The position sits at the heart of LabMed's work to ensure that clinical expertise shapes guidelines, consultations and scientific outputs across laboratory medicine. During his time in the role, Mayur has helped represent the profession in national discussions and contributed to guidance affecting clinical practice across the UK.

We spoke to him about his experience and why you might consider applying.

Bringing a clinical perspective to LabMed's work

Mayur first became involved with the Clinical Practice Section as a trainee representative, which sparked his interest in the role.

"I applied for the director of clinical practice role as I had previously been the trainee representative for the Clinical Practice Section and enjoyed helping with the activities of the group."

The role provides an important clinical voice within LabMed's scientific and strategic work.

"This role adds a clinical steer to the decisions made by the Scientific Affairs and Clinical Practice Committee and the LabMed Executive Committee."

Influencing guidance and national discussions

One of the most rewarding aspects of the role is the opportunity to contribute directly to guidelines and national initiatives that shape clinical practice.

During his tenure, Mayur has represented LabMed in a range of activities.

"I have represented LabMed by contributing to various clinical and laboratory guidelines. This includes the NCEPOD blood sodium study and ongoing work with the Lp(a) Taskforce where the aim has been to get Lp(a) testing into the NICE lipid guidelines."

This work has taken him beyond the laboratory and into the policy sphere.

"This involved meeting MPs at a drop-in session held at Portcullis House which was a new and interesting experience."

He has also contributed to professional guidance in more specialised areas of laboratory medicine.

"I also represented LabMed in guidance on laboratory handling of insulin requests in the investigation of hypoglycaemia."

A varied role across the profession

The director of clinical practice contributes to a wide range of LabMed activities.

These include:

- contributing to **guideline development and consultation responses**
- endorsing **guidance produced by other professional societies**
- helping review **Research and Innovation grant proposals**
- judging **poster presentations at LabMedUK**
- contributing a clinical perspective to **LabMed committee discussions**

The role therefore provides a broad view of developments across laboratory medicine and the wider diagnostic landscape.

Building connections across laboratory medicine

For Mayur, one of the biggest benefits has been the opportunity to build networks and collaborate with colleagues across the profession.

"The role is very interesting as you can get involved in any aspect of clinical biochemistry. There is early visibility of clinical guidance written by other societies that are seeking endorsement from LabMed."

Working across committees and projects also helps build connections with leaders across the field.

"You are able to network at a national level and the best part is working with all of the enthusiastic committee members and the supporting team based at the LabMed Office."

In a profession where many colleagues work in relatively small teams, these connections can be particularly valuable.

"Working in a laboratory setting can be isolating so being able to network and knowing who to ask is advantageous. We are fortunate to have so many experts and leaders in our field."

A manageable commitment alongside clinical work

A common question for potential applicants is how the role fits alongside a busy clinical career.

Mayur emphasises that the core time commitment is manageable.

"Around 30 hours is needed every year for the LabMed meetings which would include attending the Scientific Affairs and Clinical Practice committee meetings, Council and Executive meetings."

Additional activities can vary depending on the interests of the post-holder.

"Additional time will be required for contributing to committees outside LabMed which is around 15 hours a year, but this depends on the number of activities joined and the time commitment of the director."

Encouragement for potential applicants

For members considering applying, Mayur has a simple message: **don't hesitate.**

"Providing that a person is motivated this post should be suitable for most. The other committee members are incredibly supportive as there is a strong culture of collaboration and guidance."

Apply for director of clinical practice

LabMed is now inviting applications for the director of clinical practice position.

The role works closely with the director of scientific affairs and the Scientific Affairs and Clinical Practice Committee, helping ensure that the clinical voice of laboratory medicine is reflected in guidelines, scientific reviews, audits and consultations.

Members interested in shaping the future of clinical laboratory medicine are encouraged to apply. Further details about the role and how to apply are available on the LabMed website.

EUROMEDLAB 2027 UPDATE

EuroMedLab 2027 takes place at the Excel London from 16-20 May 2027. The event is the 27th Congress of Clinical Chemistry and Laboratory Medicine and LabMedUK27.

How EuroMedLab 2027 will be organised – and LabMed's Role

EuroMedLab 2027 will take place in London as a joint international congress led by the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC), the European Federation of Clinical Chemistry and Laboratory Medicine (EFLM) and the Association for Laboratory Medicine (LabMed).

Overall responsibility for delivering the Congress sits with the Congress Organising Committee (COC), which oversees the key decisions. Our president, Ian Godber, and Sarah Robinson, our director of conferences and events, will be part of this committee. The day-to-day planning and delivery is managed by a professional congress organiser called MZ Events who are based in Milan and have successfully delivered the event for a number of years.

The scientific programme is developed by the Scientific Programme Committee (SPC), operating under IFCC–EFLM guidelines. We have nominated Tim Lang to sit on this committee. The SPC is responsible for selecting topics, speakers and session formats, reviewing abstracts and ensuring coordination across workshops and satellite meetings.

Ideas are proposed to the SPC by the International Scientific Advisory Board (ISAB) that sits under this committee and is made up of members from the national associations in Europe. We have nominated Phil Monaghan to be part of this group. The final programme is subject to formal approval by the COC.

Three scientific symposia will be organised by LabMed within the main programme and we will be able to showcase our work in an exhibition booth. We are also able to propose satellite symposia that take place at the beginning or end but don't compete with the main programme.

BOOK NOW FOR UPCOMING EVENTS

LabMed members' briefing: Governance changes Q&A

27 April 2026, 1.30pm-2pm

Online

Over the past year, Council appointed a working group to review and modernise LabMed's governance framework. This webinar will explain how the Articles have been simplified and consolidated into a single, modern document plus the separation of Articles and Bye-laws for clarity and flexibility.

There will be a dedicated Q&A session, giving you the opportunity to ask questions directly to our leadership team.

Further details can be found here.

How to demonstrate competence in your equivalence portfolio

29 April 2026, 4pm-5pm

Online

Explore the processes of becoming HCPC-registered as a clinical scientist via equivalence routes with the Academy for Healthcare Science and the Association for Clinical Scientists, as well as the AHCS Higher Specialist Scientific equivalence route to become a consultant clinical scientist.

During the webinar, speakers will share their expertise on the process, common pitfalls, and hints and tips for success. Part of our microbiology webinars for trainees series.

Further details can be found here.

The digital landscape in laboratory medicine: current systems, future possibilities

30 April 2026, 10am-4pm

Horizon, Leeds

This one-day event will explore how laboratory IT systems work and how they can be utilised to support clinical decision-making, demand optimisation and safe, effective service delivery. The day will also showcase locally developed digital innovations and highlight the work of the LabMed AI and Informatics Specialist Interest Group.

Further details can be found here.

WELCOME TO SOME OF OUR LATEST COMMITTEE APPOINTEES

LabMed's committees and leadership groups are at the heart of everything the Association does – shaping scientific strategy, supporting members, developing professional education and ensuring the voice of laboratory medicine is heard nationally.

We are delighted to welcome several new colleagues into key roles across the Association. Each brings a wealth of experience, enthusiasm and fresh ideas that will help drive LabMed's work forward.

Director of publications and communications – Rav Sodi

Rav Sodi has been appointed as director of publications and communications, a role that oversees LabMed's publishing portfolio and communications activity, including *LabMed News, Annals of Clinical Biochemistry* and other digital content.

Rav is a consultant clinical biochemist at Broomfield Hospital, Mid and South Essex NHS Trust and an honorary senior fellow at Anglia Ruskin University in Cambridge. He undertook undergraduate studies in Canada and completed his postgraduate training and specialisation in clinical biochemistry in the UK.

Many LabMed members will already know Rav through his involvement with the Association's scientific work. He currently serves on the Scientific Committee and has long been active in laboratory medicine education and professional development.

Rav has extensive experience in teaching and digital learning and has published widely in the field of clinical biochemistry and laboratory medicine. He is a contributing author to several leading textbooks of the profession, including the *Tietz Textbook of Laboratory Medicine*. He has also developed a number of innovative e-learning platforms, and has contributed teaching to courses aligned with the European Federation of Laboratory Medicine syllabus.

His research interests focus on patient-centred diagnostics, particularly the opportunities presented by artificial intelligence, personalised genomics and home self-testing to improve disease diagnosis and monitoring.

In his new role, Rav will help shape how LabMed communicates its scientific work and engages with members and the wider profession.

Deputy director of scientific affairs – Chris Duff

Chris Duff joins LabMed as deputy director of scientific affairs, working alongside the director of scientific affairs to support the work of the Association's Scientific Affairs and Clinical Practice Committee and to help develop LabMed's scientific programme.

Chris is consultant clinical scientist in biochemistry at the North Midlands and Cheshire Pathology Service and has worked in laboratory medicine for around 15 years. He brings significant experience in clinical research and is particularly interested in helping colleagues build the skills and confidence to become more involved in research activity.

"I'm really excited about joining the LabMed team as deputy director of scientific affairs. I'm passionate about supporting colleagues in developing skills and experience in this area", he explains. "I also have an interest in digital healthcare, as well as patient-centric diagnostics – two areas that laboratory medicine is particularly well placed to embrace."

In the role, Chris will work with colleagues across LabMed to ensure that high-quality, evidence-based laboratory medicine remains central to healthcare and continues to influence clinical practice and policy.

Chair of the Trainees' Committee – Azul Zorzoli

The Trainees' Committee plays an important role in ensuring that trainee voices are represented across the Association's work – from education and events to professional policy and career development.

Taking on the role of chair is Azul Zorzoli, an HCPC-registered clinical scientist in microbiology and virology who is currently working towards HSST equivalency. Azul's training has taken her across several countries and disciplines, including biochemistry, immunology and microbiology in Argentina, the USA and Scotland. This broad international experience has shaped a strong interest in education, training and professional representation.

"I'm excited to begin my term as chair of the Trainees' Committee", Azul says. "I'm passionate about trainee development. In previous roles I've led educational initiatives, contributed to RCPath exam discussions and advocated for broader professional representation."

"During my term, I will focus on strengthening collaboration with other LabMed groups and advocating for trainees' interests. I look forward to meeting everyone, learning from your experiences and working together to support and empower our community."
You can hear more from Azul on pages 41-42.

These appointments reflect the strength and diversity of expertise within the LabMed community. We look forward to working with Rav, Chris and Azul in their new roles as they help shape the Association's work over the coming years.

STRENGTHENING PATIENT CENTRED PATHOLOGY AS A UKAS CLINICAL ASSESSOR

The publication of ISO 15189:2022 underscores a renewed emphasis on patient safety, clinical risk and the centrality of the patient pathway within medical laboratory services. For pathology disciplines, this shift reinforces the need for assessment teams that understand not only analytical processes but also the clinical context in which laboratory test results are generated and interpreted. To meet this need, UKAS is actively seeking clinical scientists and other laboratory personnel with a clinically-focused role, to join its network of technical/clinical assessors, recognising the critical contribution that clinically trained professionals bring to the assessment process.

ALYSON BRYANT

Healthcare accreditation specialist, United Kingdom Accreditation Service (UKAS)

A standard that goes beyond the bench

While ISO 15189 has always incorporated elements of clinical governance, the 2022 revision significantly strengthens expectations around:

- patient interaction and experience
- communication of clinical risk
- oversight of the full diagnostic pathway

These elements require assessors who can evaluate not just whether laboratory processes are technically compliant but whether they are clinically meaningful, safe and supportive of appropriate use of laboratory medicine.

Clinical scientists, with their roles spanning interpretation, validation, service development and multidisciplinary collaboration, are uniquely positioned to evaluate these dimensions. Their contribution ensures that accredited services meet not only the letter of the standard, but its clinical intent.

Why clinical assessors matter more than ever

High-quality pathology services depend on informed, context-aware assessment. Clinical assessors play a pivotal role in strengthening this by bringing insight into:

1. Appropriateness and optimisation of test requesting
Assessment of user engagement, clarity of requesting pathways, appropriateness of test repertoires and the avoidance of unnecessary or repeat sampling all benefit from clinical insight. Clinical scientists can evaluate whether services are aligned with current clinical practice and whether laboratories are effectively influencing diagnostic stewardship.

2. Clinical validity of assays and pathways
Clinical assessors play a key role in judging whether tests are validated and verified for their intended clinical populations. Decisions regarding reference ranges, sample types, assay selection and clinical performance characteristics require input from individuals familiar with diagnostic utility and clinical interpretation.

3. Identification and communication of clinically significant results
Setting safe and appropriate alert thresholds, ensuring suitable escalation processes and reviewing interpretive comments often requires clinical judgement. Clinical scientists bring context to these decisions, ensuring that laboratory processes genuinely support timely and informed patient care.

ISO 15189:2022 explicitly requires laboratories to safeguard patient wellbeing and rights. Clinical engagement – both within the laboratory and with wider clinical stakeholders – is essential to fulfilling these obligations and clinical assessors help ensure laboratories remain aligned with best practice.

A role that develops you as much as the system

Participation as a UKAS technical/clinical assessor offers a unique opportunity for clinical scientists to broaden their professional development. Assessors gain:

- a deeper, practical understanding of ISO 15189:2022
- exposure to diverse laboratory models and innovative practices
- enhanced ability to strengthen quality systems within their own organisations
- meaningful contributions to CPD (formally recognised by the RCPath), audit and leadership portfolios

Laboratories that support staff participation anecdotally report improvements in their own assessment outcomes. The knowledge gained through assessor activity often translates to fewer identified nonconformities, more robust internal governance, and stronger alignment with the expectations of ISO 15189:2022.

Flexible, supported and designed around you

UKAS provides comprehensive training for new assessors, including participation in the ISO 15189:2022 awareness course and supervised observation of assessments. Multiple contracting routes are available – voluntary, employer supported or paid assessor roles undertaken on non-working days – allowing participation to be tailored around clinical commitments.

In their words

“I became a UKAS assessor when my laboratory first began preparing for ISO 15189 accreditation. While the initial motivation was to strengthen our own compliance, I have continued in the role because it exposes me to a wide range of laboratory practices.

“Observing how other services approach similar challenges helps me remain open to new ideas and prevents the siloed thinking that can develop in busy clinical environments. The role has been invaluable for my ongoing professional development and supports maintenance of my CPD.”

Take the next step

UKAS welcomes expressions of interest from clinical scientists across all pathology disciplines. For an informal discussion or to begin an application, please contact:

UKAS talent acquisition team – technicalresources@ukas.com
Al Bryant, Healthcare accreditation specialist – alyson.bryant@ukas.com

WELCOME TO OUR NEW MEMBERS

The Association is proud to introduce the following new members who have joined us since the last edition of *LabMed News*. Please extend a warm welcome to:

Blessing Adini, currently not working, Exeter

MeRita Adriani, Trainee clinical scientist, Queen Elizabeth University Hospital, Glasgow

Elena Cohen, Advanced biomedical scientist, Northern Care Alliance NHS Foundation Trust, Oldham

Kelly Foley, Principal biochemist, Cork University Hospital, Cork, Republic of Ireland

Filip Jinga, STP trainee clinical scientist, Charing Cross Hospital, London

Mala Mahto, Professor, AIIMS Patna, Patna, India

Fiona Nash, Clinical scientist, Lancashire Teaching Hospitals NHS Foundation Trust, Preston

Chinelo Nwoke, ST3 registrar, New Cross Hospital, Wolverhampton

Gill Richards, Clinical scientist, Royal Berkshire Hospital, Reading

Pavithra Samarakoon, International trainee, Oxford University Hospitals NHS Foundation Trust, Oxford

Lisa Taylor, Senior biomedical scientist and quality lead, West Suffolk NHS Foundation Trust, Bury St Edmunds

Students

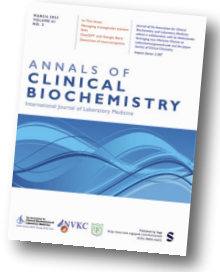
Muhammad Abdullah Ayaz, Medical laboratory technologist, Faisalabad Medical University, Faisalabad, Pakistan

Muhammad Haroon, MBBS student, Gujranwala Medical College, Gujranwala, Pakistan

Arasi Kasirajan, University of Strathclyde, Glasgow

Ahmad Raza, The University of Faisalabad, Faisalabad, Punjab, Pakistan

ANNALS OF CLINICAL BIOCHEMISTRY LATEST RESEARCH ARTICLES

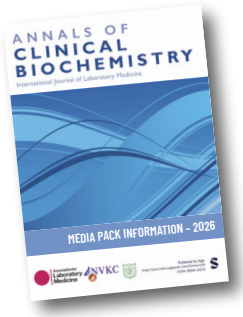


Check out these interesting new articles recommended for reading by the editors-in-chief of the *Annals of Clinical Biochemistry*:

Quantitative effects of bilirubin photoisomers on the measurement of direct bilirubin by the enzymatic bilirubin oxidase method
Nana Kawaguchi, Kosuke Koyano, Hirosuke Morita, Dk Nur Rosyiidah Apryll Czarina Pengiran Mohamad Fadly, Yuta Shinabe, Yuta Noguchi, Makoto Arioka, Yasuhiro Nakao, Miyo Ozaki, Shinji Nakamura, Sonoko Kondo, Yukihiko Konishi, Toru Kuboi, Hitoshi Okada, Saneyuki Yasuda, Susumu Itoh, Koji Murao and Takashi Kusaka

Real-life evaluation of an alert system to detect the risk of unreported dyskaelemia in haemolysed blood samples from a hospital emergency department
Valery Brunel, Julie Fettig, Luc Marie Joly, Guillaume Feugray, François Fraissinet and Helène Girot

Click here to submit your work to the *Annals of Clinical Biochemistry.*



ADVERTISING IN ANNALS OF CLINICAL BIOCHEMISTRY

Promote your brand to a highly engaged audience of laboratory medicine professionals – advertising is now available in both the *Annals of Clinical Biochemistry* online journal and our member-wide emails. To find out more, contact Jason Brown, Advertising Manager, at jason@labmed.org.uk

PUBLICATION DATES

LabMed News is published on the 15th of the month. To guarantee publication, please submit your article by the 15th of the preceding month (i.e. 15th May for the June 2026 issue) to: editor@labmed.org.uk We aim to be as flexible as possible and will try to accept articles up to the 1st of the month to be published if space allows. Otherwise they will be held over to the next issue. If we are aware that articles are imminent, this gives us more flexibility and we can reserve space in anticipation. If in doubt, please contact: Gina Frederick, lead editor, via the above e-mail.

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SUPPORTING TRAINEES ACROSS THE DISCIPLINES AT LABMEDUK AND BEYOND

Biochemistry and immunology trainees

LabMedUK26 continues to dedicate the first day of the conference to trainees with focused biochemistry and immunology training days. We are particularly pleased to welcome immunology trainees to the conference this year, creating new opportunities for collaboration and shared learning across disciplines.

Monday 8 June begins with a joint workshop on collaboration with other departments, bringing biochemistry and immunology trainees together to explore how laboratory services work across specialties and how effective partnership improves patient care. This is followed by a joint session on "not in the textbooks" topics, highlighting real-world challenges and insights that trainees may not encounter in formal training materials.

In the afternoon, the disciplines diverge into sessions tailored to their specific training needs. Biochemistry trainees will take part in an FRCPath Part 2 workshop, focusing on the objective structured practical examination (OSPE) and oral components of the exam, alongside a session exploring the value of UK NEQAS interpretative comments for participants. Immunology trainees will benefit from a mentoring session and an interactive discussion on FRCPath Part 1, offering practical guidance and peer learning.

Trainees attending the conference are also warmly invited to join the Welcome Evening on 8 June at The Botanist, Gas Street Basin, where delegates can connect informally with colleagues from across the profession. Events like this provide valuable networking opportunities and help trainees build relationships across specialties.

Microbiology trainees

For microbiology trainees we are trying something new this year. Following feedback from members, we are offering a series of free monthly webinars running from March to November 2026. Held on the last Wednesday of each month from 4-5 pm, the sessions are designed for trainees in infection specialties at all stages of training. Topics include guidance on FRCPath Part 1 and Part 2 examinations in microbiology and virology. The final webinar of the year will also give trainees the opportunity to present recent audits.

Together, these initiatives reflect LabMed's commitment to supporting trainees across the laboratory medicine disciplines and encouraging collaboration between specialties.

You can see all the 2026 webinars in our Events calendar.

LabMedUK26
Birmingham 8-10 June

HEAR THE LATEST FROM INDUSTRY AT LABMEDUK26

Industry sponsored workshops are a key part of the LabMedUK26 conference programme, giving delegates the chance to hear about the latest developments shaping laboratory medicine. These sessions offer valuable insights and practical updates that complement the scientific programme and are always popular with attendees. We're grateful to our sponsors for their support of the conference.

Tuesday 9 June – 12.00pm

BD

Small drop, big impact: launching the capillary blood sampling recommendations

Karen Perkins and Sophie Hepburn

Capillary sampling with back-to-laboratory analysis can enable the NHS strategic shift from hospital to community and treatment to prevention by providing a patient-centric alternative to traditional venepuncture.

The newly formed Patient-Centred Testing and Sampling (PaCTS) Group invite you to join them in launching the UK recommendations for capillary blood sampling. As the first published capillary sampling guidelines globally, this marks an important milestone in how laboratories can enable a shift to more patient-centric care.

Hear from Karen Perkins and Sophie Hepburn on ways to navigate this rapidly evolving field whilst keeping safety and quality paramount.

Binding Site

Multiple sclerosis: what it is and how it's diagnosed

Nehir Banaz, PhD – Medical science liaison

Multiple sclerosis (MS) is a chronic inflammatory demyelinating disease of the central nervous system affecting 2.9 million people worldwide. This presentation reviews MS disease courses and focuses on the 2024 revisions of the McDonald diagnostic criteria (Montalban *et al, Lancet Neurol* 2025). New topographical inclusion of the optic nerve and incorporation of paraclinical biomarkers (central vein sign, paramagnetic rim lesions and cerebrospinal fluid (CSF) positivity) enable earlier diagnosis. Notably, the κ free light chain index (≥6.1) is considered interchangeable with oligoclonal bands for defining positive CSF, providing alternatives for demonstrating dissemination in time.

SNIBE

Shifting UK chronic disease prevention forward: clinical practice and cooperation prospects of Chinese innovative solutions

Carol Chen, marketing and product manager

In the UK, there are over 15 million hypertensive patients. Chronic disease prevention and control urgently needs to shift from passive treatment to early screening and accurate identification, to reduce the burden on the medical system and improve patients' quality of life.

With the precise screening of secondary hypertension as the starting point, we will explain the breakthrough progress of Snibe's original technology in the detection of markers such as aldosterone and bring new perspectives and solutions for UK hypertension prevention and control through the practical experience of Chinese multi-center clinical studies; we will also focus on multiple chronic disease scenarios such as osteoporosis prediction and treatment monitoring, endocrine and metabolic system toxicity prediction during tumour treatment and the application practice of the GADA algorithm model aimed at hepatic cancer screening developed based on 30,000 samples from the Chinese hepatitis B population, sharing future innovative solutions for disease prevention and control from the perspective of an *in vitro* diagnostic enterprise.

Tuesday 9 June – 12.30pm

Roche

Beyond the launch: real-world performance and integration of the cobas® Mass Spec solution

For years, the potential of fully automated mass spectrometry has been a topic of anticipation. Following the 2025 launch of the cobas® Mass Spec solution, we are moving beyond theory to proven performance. This session reveals real-world metrics and firsthand insights from a UK early adopter on the installation, validation and the reality of transitioning complex mass spectrometry work flows onto an automated platform.

Biohit

To be confirmed

BIOHIT
Innovating for Health

Wednesday 10 June – 1.30pm

Abbott

Automating clinical diagnostic pathways with clinical decision support – outcomes from a CKD use case

Gemma Quinney, digital health consultant (Abbott), Anna Barton, principal clinical biochemist, Royal Cornwall Hospital

Abbott

AlinIQ Clinical Decision Support (CDS) automates diagnostic pathways by intelligently integrating evidence-based guidelines and laboratory medicine algorithms with patient data such as LIS and electronic health record systems (EHRs), to guide clinicians toward accurate diagnoses and appropriate testing. This digital tool enhances diagnostic accuracy, reduces errors and streamlines work flows by providing real-time recommendations.

In this 30-minute session, Abbott presents a description of what makes a strong candidate diagnostic pathway for application of AlinIQ CDS and our guest presenter, Anna Barton, principal clinical biochemist at Royal Cornwall Hospital, will share how AlinIQ CDS has helped to improve early diagnosis, screening and prevention of chronic kidney disease across Cornwall.

Siemens

Early identification and proactive prevention – the impact of diagnostics on patient liver pathways

James Dowd, scientific marketing manager, Northwest Europe

SIEMENS Healthineers

The NHS is shifting from treating illness to preventing it, with strong emphasis on obesity, cardiovascular disease and smoking. Early detection of chronic liver disease remains challenging, as routine tests provide limited insight into fibrosis risk. Using advanced biomarkers, risk scoring tools can improve triage, streamline referrals and ensure patients receive appropriate care sooner. This approach reduces late stage diagnoses and supports better outcomes.

Key takeaways:

- Prevention is now a core NHS priority, with ambitious population health targets.
- Advanced liver fibrosis diagnostics and digital tools can strengthen triage and care pathways.
- More efficient referral decisions can reduce late-stage diagnosis and support timely treatment.

SPOTLIGHT ON PLENARY SPEAKERS

FREDDIE FLYNN AWARD LECTURE

Tuesday 9 June, 1.45pm

Martin Myers MBE recently retired as consultant clinical biochemist and laboratory director at Lancashire Teaching Hospitals NHS Foundation Trust. During his time in Preston, he led a continuous programme of pathology redesign, improving clinical effectiveness, productivity and service delivery. He established and led the point-of-care testing (POCT) service for over 30 years, embedding POCT across the Central Lancashire health economy.

He has held several senior leadership roles, including clinical director of pathology, associate divisional medical director and lead scientist.

Martin remains Co-Clinical Lead for the NHSE Getting it Right First Time (GIRFT) pathology programme, driving national improvements in quality, standardisation and patient outcomes. His work includes national reviews, analytical performance standards and linking laboratory performance to clinical impact through the Patient-Focussed Laboratory Medicine group.

He was awarded an MBE and the NHS Lifetime Achievement Award and has received international recognition for his contribution to healthcare science.

FOUNDATION AWARD LECTURE

Wednesday 10 June, 9.00am

Tim Wreghitt OBE has worked as a consultant clinical scientist in virology for over 50 years, witnessing major advances that have transformed diagnosis and patient care. Over this period, the field has evolved from reliance on serology and cell culture to rapid, highly sensitive molecular testing.

His lecture reflects on how these developments have improved outcomes, from early detection of infections to enabling timely antiviral treatment and strengthening infection control. Many viruses now routinely tested for – including HIV, hepatitis C and E, COVID-19 and norovirus – were unknown at the start of his career.

Tim also highlights the changing balance of techniques, noting both the benefits of molecular diagnostics and the loss of certain capabilities, such as detailed enterovirus typing once possible through cell culture.

Drawing on decades of experience, he offers a unique perspective on the evolution of clinical virology and its impact on modern healthcare.

LABMEDUK26 PROGRAMME: MONDAY 8 JUNE

Putting the patient at the heart of diagnostics

This new satellite workshop, led by Katy Heaney and Rav Sodi, focuses on integrating patient-centric principles into diagnostic testing – emphasising practical strategies and interactive learning on seeing patients as individuals throughout the diagnostic journey.

Biochemistry training day

A full day dedicated to biochemistry practice, including joint sessions with immunology and a focused FRCPath workshop on Part 2 OSPE and oral preparation.

9.00am	**Registration**
9.30am	**Collaboration with other departments workshop**
11.00am	**Coffee break**
11.15am	**Joint immunology and biochemistry 'not in the textbooks' session**
12.30pm	**Lunch break**
1.30pm	**FRCPath workshop – The FRCPath Part 2 Module 1 objective structured practical examination (OSPE) and Part 2 oral examination**
3.00pm	**Coffee break**
3.15pm	**The value of UK NEQAS interpretative comments for you, the participant**
4.30pm	**Closing remarks**

Immunology training day

Run in parallel to the biochemistry training day, with joint sessions and specialist activities including mentoring and focused laboratory topics.

9.00am	**Registration**
9.30am	**Collaboration with other departments workshop**
11.00am	**Coffee break**
11.15am	**Joint immunology and biochemistry 'not in the textbooks' session**
12.30pm	**Lunch break**
1.30pm	**Mentoring session**
2.45pm	**Coffee break**
3.00pm	**FRCPath part 1 interactive discussion**
4.30pm	**Closing remarks**

LABMEDUK26 PROGRAMME: TUESDAY 9 JUNE

8.00am **Arrival and registration**

9.00am **Welcome from the president**
Speaker: Ian Godber

9.15am **International Award Lecture**
From bench to pocket: nanobodies in point-of-care biosensor design
Speaker: Tahir Pillay

9.45am **Coffee break and exhibition**

10.15am **PARALLEL SESSIONS**
Delivering scientific strategy across the nations
This session will be formed by a panel of the chief scientific officers, chief scientific advisor and chief healthcare science officers from the four nations of the UK.
Panellists: Vicki Heath, Professor Dame Sue Hill, Catherine Ross, Ian Young

10.15am **The hunt for hidden paraproteins: unravelling their interference in biochemical diagnostics**
Chair: Alison Whitelegg

Can routine blood tests be used to develop a clinical risk prediction model to detect cases of multiple myeloma sooner
Speaker: Miguel Morales

Effect of paraproteins on bone metabolism investigations
Speaker: Nathan Lorde

IgM paraproteins: a "rare" interference in biochemical assays
Speaker: Nicola Pullan

11.45am **Lunch, exhibition and poster spotlight sessions**

12.45pm **Industry sponsored workshops**

1.45pm **Freddie Flynn Award Lecture**
Chairs: Ian Godber, Bernie Croal

Getting it right for the patient: patient-focussed laboratory medicine
Speaker: Martin Myers MBE

2.15pm **PARALLEL SESSIONS**
How good should we be? Setting analytical specification goals
Chair: Rav Sodi

Practical uses for analytical performance specifications: an example involving HbA1c
Speaker: Eric Kilpatrick

Improving the approach to cardiovascular risk assessment: performance of modern equations for LDL-cholesterol vs direct LDL-C assays
Speaker: Tahir Pillay

Poor serum B12 (total B12) method harmonisation and unwarranted variation in diagnostic cut-offs for the diagnosis of vitamin B12 deficiency
Speaker: Dominic Harrington

2.15pm **Advances in diagnostic neurology**
Chair: Melanie Hart

Clinical and laboratory diagnosis of Prion disease
Speaker: Tze How Mok

Translating Alzheimer's disease blood biomarkers into clinical practice
Speaker: Ashvini Keshavan

Using seed amplification assays to enhance diagnosis, prognosis and clinical trial design across the parkinsonian disorders
Speaker: Edwin Jabbari

3.45pm **Coffee break and exhibition**

4.05pm **PARALLEL SESSIONS**
Medal Award presentations
Chair: Katharine Hayden

4.05pm **Improving primary aldosteronism detection and classification in the UK**
Chair: Tejas Kalaria

Primary aldosteronism – 2026 update
Speaker: Mark Gurnell

Developing UK guidelines for biochemical investigation of primary aldosteronism
Speaker: Sophie Barnes

RASH-UK Workstream 1: Conn laboratories reduce variability in primary aldosteronism?
Speaker: Sarah Davies

LABMEDUK26 PROGRAMME: WEDNESDAY 10 JUNE

8.00am **Arrival and registration**

9.00am **Foundation Award Lecture**
Chair: Katharine Hayden

title to be confirmed
Speaker: Tim Wreghitt OBE

9.30am **PARALLEL SESSIONS**
Patient-centric diabetes care
Chair: Funmi Akinlade

POCT and HbA1c
Speaker: Emma English

Beyond HbA1c: Uuse of continuous glucose monitoring in diabetes care
Speaker: Parizad Avari

Continuous ketone monitoring in the management of diabetes
Speaker: Ketan Dhatariya

9.30am **Engineering the future of metabolic medicine**
Chair: Alana Burns

One kit, thirteen labs, twenty-six instruments: lessons in harmonisation from expanded newborn screening
Speaker: Rachel Carling

From drops to diagnosis: using dried blood spots for lysosomal enzyme activity
Speaker: Marianne Barr

The potential of metabolomic methods in inborn error of metabolism diagnosis: targeted, untargeted and functional
Speaker: Claire Hart

11am **Coffee break and exhibition**

11.30am **PARALLEL SESSIONS**
Interventions for obesity and the impact on laboratory medicine
Chair: Helen Ashby

Gut hormones from appetite regulation to obesity treatment
Speaker: John Wilding

Nutritional implication of metabolic bariatric surgery and glucagon-like peptide-1 (GLP-1) receptor agonist therapy
Speaker: Royce Vincent

Post-bariatric surgery hypoglycaemia and the lab investigations involved in diagnosis and treatment
Speaker: John Hazlehurst

11.30am	**Plastics, plastics everywhere: making a case for lab sustainability** Chair: Cerys March **Plastic fantastic . . . right?** Speaker: Lorna Jones **Sustainable pathology, diagnostics and clinical labs** Speaker: Martin Farley **Building sustainability into the everyday for healthcare professionals** Speaker: Lisa O'Fee
1pm	**Lunch, exhibition and poster spotlight sessions**
1.30pm	**Industry sponsored workshops**
2.00pm	**LabMed Annual General Meeting**
3.00pm	**Impact Award Lecture** **title to be confirmed** Speaker: to be confirmed
3.30pm	**Clinical Cases** Chair: Danielle Freedman
5.00pm	**Closing Ceremony and Awards**

PATIENT-CENTRED DIAGNOSTICS WORKSHOP: MONDAY 8 JUNE

9.30am **Introduction and the patient story**
What does "patient-centered diagnostics" mean to you?

The importance of a patient-first approach in the journey and experience of the patient.

A clinical case-based activity where participants are invited to consider the specific aspects affecting a particular case scenario. The anxieties, concerns, practicalities, contact points and barriers are dissected to arrive at the main challenges affecting a patient's healthcare journey.

11.00am **Break**

11.15am **Core principles of a patient-first approach**
In this presentation, the conceptual framework and principles of patient-centric diagnostics are outlined. The philosophical and psychological underpinnings are briefly discussed.

12.15pm **Lunch**

1.15pm **Mapping the patient testing journey**
In this group exercise, the patient testing journey is mapped to identify the key touchpoints in the pre-test, during test and post-test phases. Participants will learn to identify "pain points" and "moments of truth" at each stage. By sharing group maps and arriving at common themes, the areas where patient needs are often missed will be highlighted.

The role of different stakeholders: Laboratory personnel, clinicians, front desk, IT and administrative, senior leadership at local and national level will be delineated to show how all contribute to the patient-centered journey.

2.15pm **Practical strategies and tools**
Models for health-care improvement will be presented. At the core of this workshop is providing patients and clinicians alike with a clear road map to navigate the complexities of the healthcare system. Central to this is the appreciation of the importance of current and emerging technologies including artificial intelligence and machine learning.

3.00pm **Break**

3.15pm **Action planning – "your personal mission"**
Drawing upon the principles discussed throughout the workshop, individuals are given the opportunity to reflect on their personal mission and develop a personal action plan. Participants will be encouraged to note their commitment, visualise potential obstacles and the support needed to overcome these.

In this activity-based session, groups will be invited to brainstorm common barriers to patient-centricity in their settings. The aim for each group will be to develop one or two practical solutions or “small wins” for each identified barrier. They will then be encouraged to share these ideas with the wider group enabling the cross-pollination of ideas. The importance of change management principles will be highlighted: Gaining buy-in (from leadership and staff), piloting initiatives, measuring impact and celebrating successes.

4.15pm **Commitment, wrap-up, evaluation and closing**

We close the session by summarising the key takeaways.

Both individually and as a group, we will help you in your commitment to implement patient-first approach to service in your work and daily practice. Hopefully participants will appreciate that small changes collectively make a big difference.

SUPPORTING CARERS IN LABORATORY MEDICINE: A PERSONAL PERSPECTIVE

ALAN COURTNEY
Principal clinical scientist, Charing Cross Hospital; LabMed Union Rep and Staff Side Equality Officer

I'm a principal clinical scientist responsible for the Protein Service at North West London Pathology, part of Imperial College Healthcare NHS Trust. Outside of work I'm also a parent of three children aged 12, 10 and 2. My middle child, Milly, sadly has a rare progressive neuromuscular disease, related to a syndrome of conditions called Charcot Marie Tooth (CMT). She has an early onset presentation of an ultra-rare subtype of CMT with a prevalence of <1:1,000,000 (with less than 50 cases recorded in the literature) known as CMT4J. It is more akin to a lysosomal storage disease than other traditional types of CMT, caused by a recessive mutation in the FIG4 gene. FIG4 encodes a 907 amino acid phosphatase that maintains adequate concentrations of the lipid signalling molecule PI(3,5)P2, required for endosome and lysosome regulation and trafficking. Its dysfunction/absence leads to the accumulation of vacuoles specifically in Schwann and other neuronal cells that causes nerve cell damage and the progressive loss of myelin sheath. Interestingly, FIG4 defects may also be involved in other demyelinating conditions such as ALS (the most common type of MND) and MS.

CMT4J initially affects primarily distal axons causing muscle loss, poor balance, fatigue, pain/loss of sensation, poor circulation, reduced fine/gross motor skills and hand/foot deformities. As the condition progresses it involves the proximal nervous system with increasing global muscle loss and fatigue, scoliosis and eventually respiratory compromise and reduced lifespan. There is no treatment currently available, although there is a gene therapy trial about to begin in the USA, which we have put ourselves forward for. If we are unable to get onto the trial the alternative would mean, subject to FDA approval in one to two years, needing to raise in the region of $400,000 – $1,000,000 for the treatment: an intrathecal infusion of AAV9-based gene therapy vector that expresses the fully functional form of FIG4.

Milly's disease has progressed to the extent that she is a full-time wheelchair user, with significant scoliosis. She also lost 95% of the function in her right arm and has limited use of her left but is still able to operate her electric wheelchair with a surprising level of competence. Our home was fully adapted last year: through floor lift, wet-room, ceiling hoists, hospital/adaptive bed, level access. Milly is also autistic (approximately 50% of children with CMT4J have a learning disability) and attends a specialist school, which comes with its own baggage and the requirement to be fully aware of what your legal entitlement to an education is (I have become somewhat of a legal advocate in my borough for other parents: we had to complain/appeal at least once at every stage, even to get access to a hoist at her school).

I remember during my initial training as a biochemist, doing a paediatric placement at GOSH. I never imagined that in the years to come that my daughter would be a patient there. No one ever plans on either becoming disabled or caring for a disabled child. Retrospectively, my previous lack of awareness of the disabled community and how society in general fails to interact with them on an equal footing does make me feel somewhat ashamed of myself. Milly recently described herself as *"I must be the most unluckiest girl ever".* Which, although hard to hear, we have tried to explain that we are still lucky to have what we do and we must try to make the best of everything.

Given the extent of my daughter's caring needs my wife no longer works, and it is

Alan and his family

increasingly hard to spend a significant amount of time away from home, particularly during the week. With a limited support network, I have adapted my hours at work, working compressed hours (Tuesday – Friday) with the flexibility to work from home where the service allows. Attending meetings can be a challenge and I avoid being away from home whenever possible. The option to attend meetings virtually is invaluable and I hope that this becomes more widespread across the organisation, particularly as my daughter's needs increase.

Life as a carer of a disabled relative can be particularly challenging and we need to ensure, as far as possible, that we are supported in the workplace. It is likely that caring for a disabled relative or someone with an illness will have an impact on most of us to some extent at some point in our lifetimes, with an estimated one in seven employees having some level of caring responsibility. With increasing lifespans and levels of chronic disease in the general population it is likely that this figure will increase.

The Employers for Carers (EFC) organisation provides a lot of useful and practical information including a tool kit which would be useful to bring into the workplace. They use the definition of a carer in the workplace as: *"Carers are employees with caring responsibilities that have an impact on their working lives. These employees are responsible for the care and support of ill, older or disabled family members, partners or friends who are unable to care for themselves."*

Many workplaces may have Carer's Networks, Support Networks or other Champions, but resources may be limited and caring is still an issue which people find hard to discuss and plan for in the workplace. As an employee, or a manager of an employee with caring responsibilities, it is best to try to be proactive, flexible, to think outside the box and be solution driven to support staff as far as possible. If possible, being open and honest is typically the best approach. Local policy should try to accommodate employees, but carers are a group that are not always at the forefront of EDI decision making. Employers do have a legal duty to support carers that includes requesting flexible working, unpaid/paid carer's leave and emergency time off as well as protection from discrimination under the Equality Act. Trade unions, such as the LabMed Trade Union, are also available to provide advice for members and I am happy to be contacted by members of the profession that may want any advice.

Useful sites

www.carersuk.org

www.employersforcarers.org

www.togetherforshortlives.org.uk

https://donate.curecmt4j.org/

https://labmed.org.uk/about-us/trade-union.html

WHAT MISTAKES REVEAL ABOUT EXCELLENCE AND SYSTEMS

AZUL ZORZOLI
Clinicial scientist, NHS Lothian

Since I have taken on the role of chair of the Trainees' Committee in November, I have had the opportunity to learn how the organisation works in practice. With a lot of support from the team, I have been navigating a busy schedule of meetings and learning about the work of other committees. For instance, I contributed to an award selection panel, participated in discussions about membership, and heard different viewpoints on the importance of visibility, education and rights of our workforce. What has stood out to me is the depth of coordinated, thoughtful work (previously unseen to me) taking place behind the scenes.

This month, I am reflecting on something that sits at the heart of what we do: the tension between the standards of excellence we as clinical scientists hold ourselves to and the rather humbling reality we all face on a daily basis. I have often considered these topics in hypothetical terms, almost as if they exist in a vacuum, but the reality is frequently more textured, and it rarely cooperates.

I recently started a new job in a different department. While incredibly interesting, it has been taking me some time to navigate the nuances of unfamiliar protocols. One day, trying to balance the competing demands at the end of a busy shift, I released a preliminary result without the confirmatory testing it required. It was a straightforward mistake; the type of thing that happens when you are tired, busy and running late.

The oversight was really frustrating at first, but it gave me a chance to think about what went wrong. I was rushing through the pile of tasks with the noble intention of leaving a tidy handover for my colleagues; a behaviour that ultimately made me more prone to errors. But my mistake also highlighted structural gaps. For instance, that our LIMS lacks embedded rules to warn the user about the release of preliminary results (luckily, we are moving to a new system soon!). Our work environment is

rarely as tidy as we would like it to be and that can also contribute to errors.

The most valuable lesson came from observing how my team, and the entire system, responds to mistakes. Instead of facing a culture of blame, I witnessed the value of clear processes. First, the unconfirmed result was quickly questioned by the end user, who is used to receiving the communication of sensitive results via phone. Then, our team lead quickly identified the problem and proceeded with remediation steps. In the end, I had some helpful conversations with my team. Their support helped me gain a clearer perspective and understand the steps to take when things don't go as planned.

My understanding of our systems has been enriched by this mistake. What I now see more clearly is that excellence emerges not from individual virtue, but from the conditions an organisation creates.

Those early committee meetings I attended were also hinting at this, showing that great leadership and coordinated work are more sustainable and make goals achievable, even in a messy reality. As chair of the Trainees' Committee, my responsibility is to contribute to those conditions and help bridge the gap between the standards we hold ourselves to and the reality we all navigate.

HIGHLIGHTS FROM THE BSI-CIPN CONFERENCE 2025

ELIZABETH RALPH
Principal clinical scientist,
Great Ormond Street Hospital

On Monday 1 and Tuesday 2 December 2025 immunologists from across the UK and beyond gathered in Liverpool for the BSI-CIPN Conference. Day one started with the keynote speaker, Mike Lenardo of Calico Life Sciences, who gave us an overview of the molecular analysis that led to the discovery of a number of inborn errors of immunity by his lab, including autoimmune lymphoproliferative syndrome (ALPS), X-linked immunodeficiency with magnesium defect, Epstein-Barr virus infection and neoplasia (XMEN), and more recently defects in the complement regulatory protein CD55 leading to complement hyperactivation, angiopathic thrombosis and protein-losing enteropathy or CHAPLE disease. He finished his talk with a whistle-stop tour of some of ways he is using AI in his everyday research – a glimpse of the future perhaps?

This was followed by a look towards the future of genetic testing for patients with severe presentation of infectious disease, with the next two sessions clinically focussed with a discussion of the current Hereditary Angioedema (HAE) treatment algorithm and a paediatric HLH MDT discussion. After lunch were a series of short talks from submitted abstracts, with highlights including a research assay presented by Grace Evans from UCL that is being used to investigate children with genetically undefined lymphopaenia, and has been of notable patient benefit where the diagnosis has been unclear, along with a talk by Mohammed Elmar Elhaj, University Hospital Birmingham, on the genetic and phenotypic examination of a cohort of adenosine deaminase 2 deficient (DADA2) patients.

The afternoon session covered the business of the BSI-CIPN including updates from the Clinical Guidelines Special Interest Group, QPIDS, and the launch of the BSI-CIPN Workforce report which examines the current issues and recruitment challenges across the country. The final session of the day was held jointly with the BSI Congress with the keynote delivered by Judi Allen, from the University of Manchester. It was a fascinating look at the often-neglected topic of helminth infections. The talk focussed on Th2 immune responses and the

balance between control of the infection and tissue repair, and the role that macrophages play in this. I learnt a lot about macrophages, a cell type that is generally overlooked. The day closed with the networking dinner and a chance to network and catch up with old friends and colleagues.

Day two then divided into a series of parallel sessions, split between a laboratory science session, the British Society for Allergy and Clinical Immunology (BSACI) session and a joint session with the BSI titled 'Challenging humans: infections, vaccines and allergens' the latter of which I chose to join.
The session started back with Mike Lenardo again, this time talking about a new genetic form of early onset inflammatory bowel disease and the role of CD8 TIGR regulatory T cells in this. This was followed by Mike Ehrensten from UCL highlighting personalised medicine approaches to treat patients with SLE by targeting B cells with monoclonal antibodies through trials (BEAT-lupus and STRATIFY), using biomarkers such as IgA2 anti-dsDNA antibodies. The next two talks in this session looked at pathogenic CD4+ T cells in autoimmune uveitis and innate immune pathways in the pathogenesis of rheumatoid arthritis.

After lunch the parallel session continued, with a dedicated nursing session, a joint session with the main congress looking at nucleic acid sensing by innate immune receptors, and another laboratory science session which I joined. Carol Stanley from UKNEQAS highlighted the new Digital ANA system and how this contributes to lab training and competence. This was followed by Beth Dancey on behalf of UKAS, looking at verification of immunology assays to ISO15189:2022 with some very useful take-home messages. There was much discussion generated by the final talk of the session from Dan Payne about the recent FRCPath Part 1 exams and areas of focus for the upcoming sittings.

The final session of the day, and of the BSI-CIPN, was again joint with the main congress, on an important topic – 'Is a cure possible to autoimmunity?', and it was a shame to miss this to catch a train home. The BSI-CIPN conference is one of the highlights of the conference calendar, bringing together medical, scientific and nursing staff, as well as research colleagues, through the joint sessions held with the main BSI Congress. I am already looking forward to the next, to be held in Glasgow 30 November – 1 December 2026.

MEETING REPORT

JCTLM MEMBERS' AND STAKEHOLDERS' MEETING AND WORKSHOP REPORT

SARAH DAVIES

Principal/HSST clinical scientist and EQA scheme manager; NEQAS (Birmingham Quality) – University Hospitals Birmingham NHS Foundation Trust

Birmingham Quality (a member of the UK NEQAS consortium) is a member organisation of the Joint Committee for Traceability in Laboratory Medicine (JCTLM). As such, I was delighted to represent Birmingham Quality at the biennial JCTLM Members' and Stakeholders' Meeting and Workshop in the Bureau International des Poids et Mesures (BIPM) in Paris between 1 and 2 December 2025. The topic of the meeting/workshop was 'Result harmonisation in medical laboratories: accomplishments and challenges'.

The meeting attracted a broad range of international delegates including international committees, industry, metrology organisations and External Quality Assessment (EQA) providers. Having recently (2025) been appointed to the JCTLM Database Review team for Non-Peptide Hormones, contributing to their 2025 review cycle, and as a new corresponding member of the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) Committee Traceability in Laboratory Medicine, I was excited by the programme. In addition, it was an excellent opportunity to connect with other professionals and organisations with an interest in traceability, many of whom we have ongoing collaborations with at Birmingham Quality.

Traceability helps to ensure comparability (equivalence) of results between laboratories. Laboratory professionals will be well aware of traceability requirements within the ISO 15198:2022 Standards. As such, I won't dwell on definitions and terminology, other than to say that there should be an unbroken traceability chain which links the methods being used in a laboratory via calibration and reference materials to hierarchically superior reference materials and reference measurement procedures within calibration laboratories. Being able to define the

measurand (analyte) of interest and characterise the uncertainty of measurement of a given method are required for traceability to be achieved. Maximal Allowable Measurement Uncertainty is an important concept for clinical laboratories at the end of the traceability chain to be aware of. Commutability of materials is crucial since bias can be introduced or mischaracterised if calibrator and EQA materials do not behave exactly like patient samples. This needs to be assessed down to the level of measurand (analyte) and method and can be impacted by analytical interferences.

Traceability is more than just an academic interest, as emphasised very eloquently by a patient representative. In addition to obvious patient safety risks associated with inconsistent results or differences in units, loss of trust, anxiety and confusion should not be underestimated. The transition from paediatric to adult medicine was a key point where the patient representative identified harmonisation failures. As laboratory services and care pathways are increasingly being delivered across organisational boundaries, the comparability of results is ever important.

Some challenging analytes were given dedicated time within the programme. These included: albumin (in serum and urine), bilirubin, chloride, digoxin, ferritin, immunosuppressants and transaminases. The role of EQA providers in achieving traceability was also a recurrent theme. Like us, some EQA providers are already taking their post market surveillance responsibilities seriously and doing work in relation to challenging measurands (analytes). As part of the laboratories ISO 15189:2022 accreditation when assessing EQA providers, key concepts to be considered from the meeting/workshop include traceability, commutability, target value assignment/validity, analytical performance specifications, selectivity (interference), clinical impact assessment and measurement uncertainty. High quality EQA material and sophisticated EQA scheme design is important, and when this is the case there is a wealth of data available in both routine EQA reports and specific commentaries and publications to help laboratories assess and verify traceability claims.

All that remains is to signpost the JCTLM Database (https://www.jctlmdb.org/) as a valuable resource to a broad range of stakeholders including laboratories, manufacturers and EQA providers. The JCTLM intend to produce more formal meeting documentation, and I await this with interest. Until then, I was left with a clear sense that as laboratory professionals we can no longer tolerate agreement with our method peers alone. We should be aware of method-related differences and characterise the clinical impact of these differences at key clinical decision points. This will need greater visibility on method information to clinicians, to patients and in literature publications. We also need to find a way to remove some of the barriers preventing transparent collaborations between the scientists invested in traceability.

OBITUARY

DAVID VALLANCE

1953-2026

David Vallance, formally consultant clinical biochemist at The Dudley Group of Hospitals, died in January after being diagnosed with prostate cancer five years ago. Even during these difficult times, David chose to get the most out of each day, spending quality time with his family.

David was born and brought up in Derbyshire, where he attended grammar school and was known for being good at everything; not just clever, but also an excellent sportsman. As a good all-rounder, David could have chosen any career, but his interest in biochemistry led him to study the subject at Manchester University and subsequently take up a post as a junior biochemist at Leicester Royal Infirmary in 1975. During his time in Leicester, David obtained his Diploma in Clinical Biochemistry (1982), Membership of the Royal College of Pathologists (1984), and Mastership in Clinical Biochemistry (1985), as were the professional qualifications at that time. It was in Leicester that David met his wife Michaela, a nurse, and where they began building their family life together.

He was already highly regarded, both personally and professionally, and it was during his time in Leicester that he came to know Professor Tony Winder. When Professor Winder later moved to the Royal Free Hospital in London, he invited David to join him as a principal grade biochemist and honorary lecturer. Accordingly, David took up the post in 1989, commuting during the week from Leicester to London, while weekends were devoted to being 'Dad' as Michaela worked weekend shifts. As was typical of him, he rarely spoke about himself and never mentioned the seven years of commuting, instead sharing fond memories of filling weekends with outdoor activities with his daughters. During this time, through clear hard work and commitment, he completed a PhD: 'Lipoproteins, apoprotein A-I containing particles and the development of atherosclerosis', built up a strong publication record and passed his Fellowship of the Royal College of Pathologists examination in 1994.

In 1996, David was again invited to apply for a principal post, this time in the

West Midlands; a move that would allow work and family life to be brought together throughout the week. His first consultant post was at Sandwell General Hospital in 2002, before moving to his final post in Dudley in 2004, where he remained until his retirement in 2017.

His great knowledge, wisdom and recognised calm approach to problem-solving led to his involvement in many regional and national committees. He was an expert member of the West Midlands Black Country Research Ethics Committee (2007-2017) and director and treasurer of the Association of Clinical Scientists (2013-2015). However, it was in training and education that he perhaps made his greatest impact, and for which he is most widely remembered professionally. David was regional tutor (2004-2012) and chair of the West Midlands Training Course Steering Committee (2008-2012) and was deeply committed to supporting others. His generosity was evident in the time and care he gave to developing colleagues and he was completely invested in helping others to succeed.

As West Midlands regional tutor, he went well beyond the remit of the role and was pivotal to the success of the University of Birmingham MSc in Clinical Biochemistry. He helped to set, proofread and mark examination papers, and contributed extensively through lecturing, coordinating and chairing training days. He also marked many dissertations, including one that was very memorable and others were avoiding because it included a significant cellular pathology component. In true David style, he demonstrated characteristic dedication to the task and read up on all relevant content so that he would not let the trainee down.

Having joined the Association in 1976, he was awarded Fellowship of the Association of Clinical Biochemists in 2017 in recognition of his outstanding contribution to the profession.

As a colleague, we can all talk of having received his kind and gentle wisdom; from encouragement and advice as a student or mentee, or his supportive calm presence on more personal matters such as receiving a life-changing diagnosis or having difficult times at home. We all enjoyed David's easy company (over a coffee or a pint), always interesting and varied conversations and a most excellent sense of humour.

Outside of work, he was a keen DIY enthusiast and vegetable grower, having grown much of his own food on his allotment for many years. He enjoyed music, playing the piano and going to the occasional gig with colleagues and remained active throughout his life – an excellent footballer in his youth and a keen mountain biker well into his 60s, often taking long rides in the Worcestershire Clent Hills and frequently speaking of his enjoyment of walks with his daughters.

He was a devoted family man, doting on his wife Michaela, his daughters Hannah and Alice, and his granddaughter Ellie. His Christian faith was very important to him and helped sustain him through the difficult years following his diagnosis. Quietly very clever, thoughtful and easy to be around, David's gentle character and a generosity of spirit touched all who knew him. He was a wonderful and inspiring human being and those who worked with him feel truly privileged to have known him.

Michaela wishes to express her gratitude for all the messages of condolence that she has received.

A. S., M. L., C. F., C. J., G. V.

THE DIGGLE MICROBIOLOGY CHALLENGE

These questions, set by Mathew Diggle, are designed with trainees in mind and will help with preparation for the microbiology part 1 FRCPath exam.

Question 52 from the February issue

In late summer 2025, a 72-year-old man from Rome (Lazio region), with a history of hypertension and type 2 diabetes, presents with three days of fever, malaise and myalgia, followed by acute confusion and right-sided weakness over 24 hours. He has not travelled outside Italy. On examination, his temperature is 38.9°C, GCS 12, with right upper limb weakness and neck stiffness. CT head is normal. CSF shows opening pressure 26 cmH_2O, WBC 180 × 10^6/L (90% lymphocytes), protein 1.1 g/L, glucose 3.0 mmol/L (serum 5.4 mmol/L). MRI shows T2 hyperintensities in the basal ganglia and thalami.

Which of the following is the most likely causative pathogen?

A) Listeria monocytogenes
B) Herpes simplex virus type 1
C) West Nile virus
D) *Neisseria meningitidis* serogroup B
E) Tick-borne encephalitis virus.

Answer

C) West Nile virus

Explanation of options

C) West Nile virus – correct

- West Nile virus is a flavivirus transmitted by Culex mosquitoes, now causing large seasonal outbreaks in southern and central Europe, including Italy, with particularly high case numbers and fatalities in 2025.
- It typically presents in older, comorbid patients with a febrile illness, progressing to neuroinvasive disease (meningoencephalitis, acute flaccid paralysis), and MRI may show basal ganglia and thalamic involvement; CSF often has a lymphocytic pleocytosis with mildly low glucose and raised protein, matching this case.

A) Listeria monocytogenes – incorrect

- Listeria causes meningoencephalitis, especially in the elderly and immunocompromised, but CSF often shows a neutrophilic pleocytosis and may be indistinguishable from other bacterial meningitides; brainstem (rhombencephalitis) signs and cranial neuropathies are more characteristic than focal basal ganglia lesions.
- There is no foodborne exposure history or brainstem signs, and the strong epidemiological link to summer arboviral activity in Italy makes Listeria less likely than West Nile virus.

B) Herpes simplex virus type 1 – incorrect

- HSV 1 classically causes sporadic encephalitis with fever, confusion, seizures and focal neurology, but MRI typically shows haemorrhagic involvement of the temporal lobes and limbic system rather than basal ganglia and thalami.

- CSF may be lymphocytic as here, but the combination of geography, season and imaging pattern is more typical of a mosquito-borne flavivirus such as West Nile virus.

D) Neisseria meningitidis serogroup B – incorrect

- Meningococcal disease usually presents with acute onset fever, headache, meningism and sometimes petechial rash, often with a neutrophilic CSF and markedly reduced glucose.
- Focal neurological deficits and basal ganglia MRI changes are less characteristic and there is no mention of rash or septic shock; in this epidemiological context a viral neuroinvasive infection is more likely.

E) Tick-borne encephalitis virus – incorrect

- Tick-borne encephalitis is a flavivirus endemic in parts of central and eastern Europe and transmitted by Ixodes ticks; it often has a biphasic illness and is more associated with rural, forest exposure and spring/early summer seasonality.
- Although it can cause encephalitis, including basal ganglia involvement, the strong, documented increase in mosquito-borne West Nile virus activity in Italy in 2025, with numerous neuroinvasive cases, makes West Nile virus the best single answer here.

Question 53

In early 2026, a 63-year-old man is admitted to an intensive care unit in London following emergency laparotomy for perforated sigmoid diverticulitis. He has a background of type 2 diabetes, obesity and chronic kidney disease. He spends 10 days in ICU, receiving piperacillin–tazobactam, and requires a femoral central venous catheter.

On day 11, he becomes febrile and hypotensive with rising inflammatory markers. Two sets of blood cultures are taken. At 24 hours, the aerobic bottle from one set flags positive; Gram stain shows yeast-like cells. MALDI-TOF MS on subculture gives an identification of *Candida auris* with a high confidence score.

Which of the following is the most appropriate initial antifungal management?

A) Liposomal amphotericin B monotherapy

B) Fluconazole monotherapy

C) Echinocandin (e.g. micafungin) as first-line therapy

D) Voriconazole monotherapy

E) No systemic antifungal; remove central line and repeat blood cultures only

The answer to this question will appear in the next issue of *LabMed News*.

DEACON'S CHALLENGE REVISITED

NO 42. ANSWER

The upper limit of the reference range for mercury excretion in urine in occupationally exposed workers is given as: 10 µg Hg/g creatinine.

Express this as nmol Hg/mmol creatinine (atomic weight mercury 200.6, molecular weight creatinine 113.1)

The general expression relating weights in mass units to SI units is:

$$\text{Weight (mol)} = \frac{\text{Weight (g)}}{\text{Atomic or Molecular weight}}$$

It is simplest to consider concentrations of mercury and creatinine in turn.

Mercury is expressed as µg and we wish to convert it to nmol. Division of mercury in µg by its atomic weight (200.6) will give mercury in µmol.

Since there are 1,000 nmol in each µmol, this value must be multiplied by 1,000. Therefore, for mercury:

$$\text{Mercury (nmol)} = \frac{\text{Mercury (µg)} \times 1{,}000}{200.6}$$

Creatinine is expressed as g/L and we wish to convert it to mmol. Division of creatinine in g by its molecular weight (113.1) will give creatinine in mol.

Since there are 1,000 mmol in each mol, this value must be multiplied by 1000. Therefore, for creatinine:

$$\text{Creatinine (mmol)} = \frac{\text{Creatinine (g)} \times 1{,}000}{113.1}$$

These two expressions are combined in order to convert the mercury:creatinine ratio from µg/g to nmol/mmol:

$$\text{Mercury:creatinine (nmol/mmol)} = \frac{\text{Mercury (µg)} \times 1{,}000 \times 113.1}{\text{Creatinine (g)} \times 1{,}000 \times 200.6}$$

Note that since creatinine appears in the denominator its molecular weight appears in the numerator (since mercury concentration is divided by creatinine concentration). The 1,000s cancel and substituting the mercury creatinine ratio in µg/g gives:

$$\text{Mercury:creatinine (nmol/mmol)} = \frac{10 \times 113.1}{200.6} = \textbf{5.6 nmol/mmol (2 sig figs)}$$

For information, this question was recycled from when it was first used in 2005. The Health and Safety Executive (HSE) Health Guidance Value (HGV) for occupational exposure to inorganic mercury is now 20 µmol Hg per mol creatinine. As these questions are designed to develop calculation skills, the answer has been unchanged for those who had already attempted it with the originally quoted values!

Question 43

The older literature is full of enzyme data expressed in units other than international units per litre (U/L). For example , King-Armstrong (KA) units were used for many years to report alkaline phosphatase activity. One KA unit is the amount of enzyme in 100 mL of serum that will split 1 mg of phenol from phenylphosphate in one hour.

Convert 200 KA units to U/L.

The answer to this question will appear in the next issue of *LabMed News*.

SUSSEX CHALLENGES

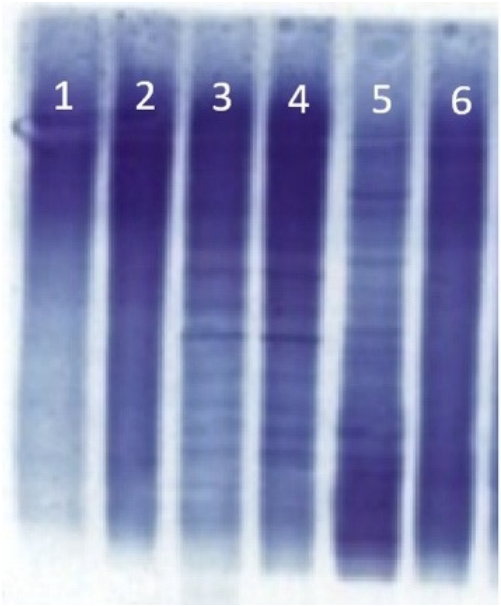
On the next few pages, you will find the latest Sussex Challenge and commentary. You may find that discussing as a group activity is beneficial.

Challenge 5

A male aged 33 years presents with progressive ascending lower limb weakness.

Analyte	Admission	Unit	Reference interval
Serum sodium	130	mmol/L	133-146
Serum potassium	3.9	mmol/L	3.5-5.3
Serum urea	4.9	mmol/L	2.5-7.8
Serum creatinine	72	umol/L	64-111
eGFR (CKD-Epi)	>90	mL/min/1.73 m^2	
Serum C-reactive protein	2.0	mg/L	<5
Serum total protein	70	g/L	60-80
Serum albumin	37	g/L	35-50
Serum globulin	33	g/L	20-35
Serum total bilirubin	10	umol/L	2-21
Serum alkaline phosphatase	98	U/L	20-150
Serum ALT	25	U/L	5-40
Serum LDH	177	U/L	125-220
Plasma glucose	4.8	mmol/L	3.0-11.1
Hb	145	g/L	130-170
WBC	6.6	10*9/L	4.0-10.0
PLT	267	10*9/L	150-410
RBC	4.7	10*12/L	4.5-5.5
HCT	0.44	L/L	0.4-0.5
MCV	96	fL	83-101
MCH	30.8	pg	27.0-32.0
MCHC	321	g/L	315-345
Neutrophils	3.8	10*9/L	2.0-7.0
Lymphocytes	1.7	10*9/L	1.0 -3.0
Monocytes	0.6	10*9/L	0.2-1.0
GM1 (IgM) Ab*	Negative		
GM1 (IgG) Ab*	Positive		
GQ1B Ab*	Negative		
CSF Glucose	3.2	mmol/L	2.0 - 4.5
CSF Total protein	4.7	g/L	0.1 - 0.5
CSF oligoclonal bands	See picture overleaf of iso-electric focussing of IgG bands		
CSF VGKC Ab*	<1	pmol/L	<69
CSF Red blood cells	<1	cells/mm3	<1
CSF White blood cells	2	cells/mm3	<5

*GM1 Ab = Ganglioside GM1 antibody; GQ1B Ab = Ganglioside GQ1B antibody; VGKC Ab = Voltage-gated potassium channel antibody



Iso-electric focussing of IgG bands.
From left to right:
1 Normal CSF
2 Normal serum
3 Inflammatory CSF
4 Inflammatory serum
5 This person's CSF
6 This person's serum

1. **What do you think are the key findings?**
2. **What do you think is the importance of 'paired samples' in fluid analysis?**
3. **What do you think are the important differences between the findings in 3 and 4 versus 5 and 6?**
4. **What causes of oligoclonal bands in CSF are you aware of?**
5. **What do you think is the laboratory role in the McDonald criteria for the diagnosis of multiple sclerosis (MS)?**

Commentary

1. What do you think are the key findings?

- Hyponatraemia
- Raised CSF protein concentration (normal CSF cell counts and glucose concentration)
- Positive serum GM1 (IgG) antibodies
- Oligoclonal IgG bands in CSF that are not present in the serum

2. What do you think is the importance of 'paired samples' in fluid analysis?

Normally, the CNS is a closed site and therefore CSF concentrations do not match those in serum directly for a range of analytes. For instance, the CSF glucose concentration is usually 60-70% of blood glucose. Therefore, if the concentration is lower than this, an intracerebral process consuming glucose can be suspected, e.g. malignancy or infection (but not viral). In searching for CSF oligoclonal bands, the aim is to determine if there is intrathecal immunoglobulin production as normally no bands should be present in the CSF that are not present in the serum.

3. What do you think are the important differences between the findings in 3 and versus 5 and 6?

In the IgG isoelectric focussing of samples 3 and 4, the bands are present is both the serum and CSF samples indicating that there is no intrathecal IgG production. However, in samples 5 and 6 there are bands in the CSF that are not present in serum indicating that there is intrathecal IgG production.

4. What causes of IgG oligoclonal bands in CSF are you aware of?

Causes of a CSF oligoclonal bands (not exhaustive) include:

- Multiple sclerosis, Guillain Barré syndrome
- Subacute sclerosing panencephalitis, Lyme disease, syphilis, herpes simplex encephalitis, HIV infection
- Neuromyelitis optica, systemic lupus erythematosus, Sjögren syndrome
- Subarachnoid haemorrhage
- Primary CNS lymphoma, meningeal carcinomatosis, multiple myeloma
- Neurosarcoidosis, Parry-Romberg syndrome

More rarely found in Alzheimer, cerebrovascular accident, idiopathic vertigo or seizures, amyotrophic lateral sclerosis, polyneuropathy or CNS glioma.

5. What do you think is the laboratory role in the McDonald criteria for the diagnosis of multiple sclerosis (MS)?

The recently revised McDonald criteria provide earlier diagnosis not only for typical MS but also for atypical presentations. Whilst there is an emphasis on clinical history and imaging criteria for demonstrating lesions in time and space, the criteria promote not only the use of oligoclonal banding of IgG in CSF but also newer tests such as free kappa light chains and serum neurofilament light chain (NfL) – although these are, currently, not widely available. The presence of oligoclonal bands in the CSF meets the 'dissemination in time' criterion for CNS lesions thus enabling quicker diagnosis rather than waiting for changes in MRI scans.

See: Dugue A. The 2024 Revised McDonald Criteria. *Neurol AMJ*. 2025: 2; 26-29

Comment:

The laboratory findings in this person together with the clinical history and examination indicated he had Guillain Barré syndrome. Anti-ganglioside antibodies and voltage gate potassium channel antibodies are associated with several immunologically mediated peripheral neuropathies, with GM1 (IgG) antibodies linked to Guillain-Barre syndrome.

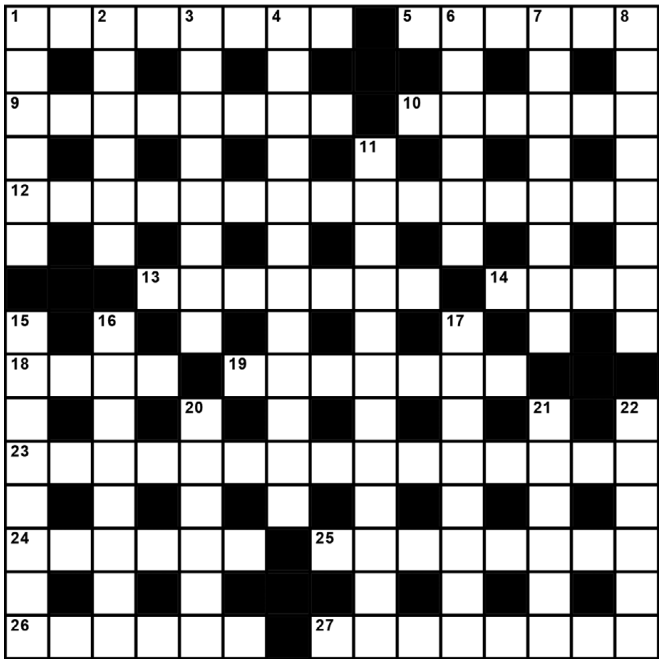
THE CROSSWORD BY RUGOSA

Across

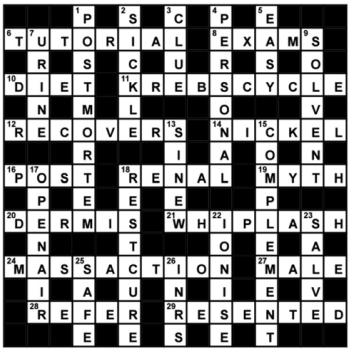
1 Post bearing thanks for shared organ (8)
5 Central element of 15 (6)
9 Silent nameless man concealing complaints (8)
10 Mass hysteria about ignoring Sharia practice (6)
12 Imply trainee emulate initial method of treatment for a cancer (8,7)
13 Hint from abnormal neutrophils: afflicted with a granulomatous infection (7)
14 Odd green tea cell structure (4)
18 Wary about being wrong (4)
19 Infuse? Reportedly hesitated after being more inclined (7)
23 Did public attack end this short-lived tax? (9,6)
24 Some are unequivocal – it must be an indicator (6)
25 Stricture about street noises (8)
26 Written intentionally: understand Scottish disgust (6)
27 The last 80% of complaints involved surgical procedures (8)

Down

1 Playmates injured but not yet for blood volume expander (6)
2 Gene variant in parallel evolution (6)
3 Inspect ship for makeup (8)
4 Later distribution option possible for this lab test (5,7)
6 Element of job centre coordinates information (6)
7 Perhaps phage not always an infectious agent (8)
8 Behaves violently, impacts catching young servant boy (8)
11 Complex summits involving enemy defence setup against foreign invaders (6,6)
15 Mathematical system suggests a cause of colic (8)
16 Redolent of getting married in Croatia (8)
17 Mid-evening hot meal involved alcohol (8)
20 Certain about first urinary tract stitch (6)
21 A fantastic singing temptress has got up (6)
22 Dispenses endless mixture for infection (6)



SOLUTION FOR FEBRUARY'S CROSSWORD



SUDOKU ... THIS MONTH'S PUZZLE

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E		Y				H		
	R				M		I	
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	H		E				R	
		I				M		T
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SOLUTION FOR FEBRUARY

H	S	Y	E	I	R	C	M	T
T	C	E	M	Y	S	H	I	R
R	M	I	C	H	T	E	S	Y
I	T	H	Y	M	C	S	R	E
E	R	M	S	T	I	Y	H	C
S	Y	C	R	E	H	I	T	M
C	E	R	I	S	M	T	Y	H
Y	H	S	T	R	E	M	C	I
M	I	T	H	C	Y	R	E	S

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