Royal United Hospitals Bath NHS
NHS Foundation Trust

Department of Clinical Biochemistry
Royal United Hospital
Combe Park
Bath
BA1 3NG

Tel: 01225 824715

Moya.O'Doherty@nhs.net

October 2018

All GPs
All Practice Managers

Dear Colleague,

Clinical Biochemistry Service at the RUH: Update October 2018

I wanted to introduce myself. I am Dr Moya O'Doherty the new Consultant Chemical Pathologist in RUH, having recently taken over from Dr Andrew Taylor. I am keen to maintain and develop a clinical biochemistry service which supports primary care, especially as I once was a GP myself. We have expanded our clinical team and have a second Consultant Chemical Pathologist, Dr Paul Downie, starting in January 2019.

I am passionate about delivering a pathology service which is user and patient centred. With this in mind, this is the first in a series of regular updates for our primary care users to keep you informed of changes to the clinical biochemistry service. We also will be setting up a pathology/primary care interface group, developing our website to provide more clinical guidelines and we are available to come out to your surgery and provide educational sessions. Our aim is to support you and reduce the clinical uncertainty in diagnosis and management of patients across the breadth of medicine. Each week day there is a duty biochemist available from 9-5pm for clinical and biochemistry advice. For ease of use we have developed one direct telephone number as below.

From 19th November 2018 please telephone **01225 824050** or use **Consultant Connect** for Clinical Biochemistry advice.

This update includes information about AKI alerts, HbA1c and monitoring TFTs in pregnancy.

AKI alerts:
Following the National Patient Safety Alert in June 2014, a national algorithm standardising the definition of AKI has been agreed with the integration into laboratory reporting systems of an e-alert which notifies the requestor that the patient has AKI. Best practice guidelines are available to guide the response to these alerts and they form the basis of our AKI comments.

From November 2018, our reports will include guidance on interpretation of AKI alerts for primary care clinicians, as follows:

Stage 1

Rise in creatinine may indicate AKI stage 1.
Primary Care: Advise clinical review within 48-72h or sooner in the context of acute illness or comorbidities. Review risk factors, e.g. medications, infections, hypotension, hypovolaemia. See www.thinkkidneys.nhs.uk/aki/resources/primary-care

Stage 2
Rise in creatinine may indicate AKI stage 2.
Primary Care: Suggest urgent clinical review and repeat U&E to confirm. Causes include sepsis, hypotension, hypovolaemia, medications, obstruction or intrinsic renal disease. Consider need for admission if acutely unwell or hyperkalaemic. See www.thinkkidneys.nhs.uk/aki/resources/primary-care

Stage 3
Rise in creatinine may indicate AKI stage 3.
Primary Care: Consider urgent admission at this level. Causes include sepsis, hypotension, hypovolaemia, medications, obstruction or intrinsic renal disease. See www.thinkkidneys.nhs.uk/aki/resources/primary-care

We are aware that primary care clinicians are not always able to see the creatinine result at the same time as the AKI alert. We are currently exploring how we can resolve this issue with the company that provide our laboratory IT system and we will let you know the outcome of our discussions.

HbA1c in patients under children and young adults
We have noted that HbA1c is being used to diagnose diabetes in children and young adults. This is a serious clinical risk as a normal HbA1c may falsely reassure the clinician.

HbA1c is **NOT recommended** in the **diagnosis** of diabetes in the following patient groups:

- ALL children and young people
- Symptoms suggesting Type 1 diabetes (any age)
- Short duration diabetes of symptoms
- Patients at high risk of diabetes who are acutely ill
- Patients who have been taking medication that may cause rapid glucose rise for less than 2 months e.g. corticosteroids, antipsychotics
- Acute pancreatic damage/pancreatic surgery
- Pregnant women

WHO advise that these patients should have a fasting glucose measurement.

Please also remember that the HbA1c result can be altered by anything which affects the red blood cell lifespan, such as iron deficiency anaemia will increase HbA1c and haemolysis will decrease HbA1c. Other conditions and medications may affect HbA1c results; if any further information is required please contact the duty biochemist.

Pregnant and on thyroxine – please tell us

Please ensure that it is clear when you make a request for monitoring thyroxine replacement in pregnancy that the patient is pregnant, as this is key information for us to ensure that the interpretation you receive with the result is appropriate. TSH targets are slightly lower for pregnant women on thyroxine to ensure that the unborn child is adequately supplied with thyroxine in utero. The targets are given in an interpretative comment that is appended to the results: we understand from some GPs that this comment may not always be readily visible on your IT systems but it will be available and is integral to the whole report.

We welcome any feedback you may have on our service and are always happy to provide support with requesting the most appropriate tests.

Yours sincerely

Dr. Moya O'Doherty
Consultant Chemical Pathologist and Metabolic Medicine
Royal United Hospitals Bath NHS Foundation Trust
Combe Park, Bath, BA1 3NG

Dir Line: 01225 824715
Direct email: Moya.O'Doherty@nhs.net