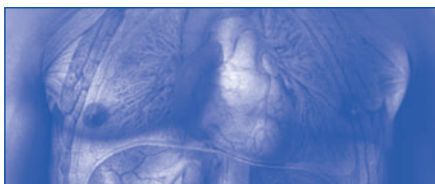


Newsletter.

May 2006



Lipid Update

Dr Charles Appleton

Pathologist in Charge - Biochemistry Department

The National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand have released a joint Position Statement on Lipid Management – 2005 to replace the NHFA 2001 Statement. The two differ in several aspects. A full copy can be downloaded or printed from www.heartfoundation.com.au on the Health & Lifestyle / Professional link. I shall summarise the current approach below.

Identify High Risk Individuals:

Patients at a higher absolute risk of a cardiovascular disease (CVD) event have the most to benefit from treatment. This group includes:

- Those with clinically evident existing vascular disease, diabetes mellitus, chronic kidney disease and familial hypercholesterolaemia.
- Aboriginal and Torres Strait Islander patients whose LDL cholesterol exceeds 2.5 mmol/L.
- Those whose absolute risk using the NZ CVD risk calculator exceeds 15%
- Those whose absolute risk using the NZ CVD risk calculator lies in the 10-15% range and who also have the metabolic syndrome or a first degree relative who developed CVD before the age of 60.

Targets:

- In high-risk patients with existing CHD, the recommended target LDL cholesterol (LDL-C) has been lowered to below 2.0 mmol/L.
- The HDL cholesterol (HDL-C) target remains above 1.0 mmol/L.
- The triglyceride target is now below 1.5 mmol/L.

How do we manage these patients?

- Lifestyle interventions must underpin lipid management in all patients.
- Lipid-modifying therapy is indicated for all patients in the high risk group (see above).
- Statin therapy is recommended for all patients with clinically evident vascular disease and should be commenced at the time of the first recognised event.

- Fibrates can be considered in combination with statins, particularly in those patients with the metabolic syndrome.
- Statin therapy should be considered for diabetics whose LDL cholesterol remains above 2.5 mmol/L after diabetic intervention.
- Fibrate therapy should be considered for diabetics whose triglycerides remain above 2.0 mmol/L after diabetic intervention.
- Statin therapy is always recommended for patients with familial hypercholesterolaemia.

Once at target, all high risk patients should have their lipid levels measured every 6-12 months.

Notes:

- Not all of the above patients will be eligible for PBS support.
- The NZ CVD risk calculator now plays a central role in guiding your patients' management. This is available in several popular medical practice software packages and can be downloaded from http://www.nps.org.au/resources/Health_Professional_Tools/nz_cardiovascular_risk_calculator.pdf as a soft copy or printed out as hard-copy for the patient to take with them as an aide-memoire. Alternatively copies can be requested through QML Pathology Medical Liaison.
- The serum total cholesterol now plays no role in lipid management other than in the calculation of the total HDL cholesterol ratio for use in the calculator. This ratio is included in each QML HDL cholesterol report.
- The full document includes discussion regarding lipid-lowering drug safety, patient compliance failure, disadvantaged groups, renal impairment, etc.
- **Medicare requires that for HDL cholesterol, LDL cholesterol, total/HDL cholesterol ratio etc to attract payment, the request form must include a specific HDL cholesterol request. On a request for "Lipid studies", "Lipids", etc, we can only perform and report total cholesterol and triglycerides.**

PBAC March 2003 Recommendation for amendments to the General Statement for lipid-lowering drugs prescribed as Pharmaceutical Benefits.

PATIENT CATEGORY	LIPID LEVEL FOR PBS SUBSIDY
Patients with one or more of the following: <ul style="list-style-type: none">■ existing coronary heart disease■ symptomatic cerebrovascular disease■ symptomatic peripheral vascular disease■ diabetes mellitus in patients aged 40 years or more	cholesterol > 4.0mmol/L
Other patients at high risk with one or more of the following: <ul style="list-style-type: none">■ diabetes mellitus in patients aged less than 40 years■ familial hypercholesterolaemia■ family history of coronary heart disease (first degree relative less than 60 years of age)■ hypertension	cholesterol > 6.5mmol/L or cholesterol > 5.5mmol/L and HDL < 1mmol/L
Patients with HDL < 1mmol/L	cholesterol > 6.5mmol/L
Patients not eligible under the above: <ul style="list-style-type: none">■ men 35 to 75 years of age■ post-menopausal women up to 75 years of age	cholesterol > 7.5mmol/L or triglyceride > 4mmol/L
Other patients not included in the above	cholesterol > 9mmol/L or triglyceride > 8mmol/L

Interferon β Bioactivity

IMPORTANT CHANGES TO REFERRED TEST

(Fact Sheet from the Institute of Clinical Pathology and Medical Research, Department of Immunology)

Summary

Multiple Sclerosis (MS) patients may fail to respond well to interferon β (IFN β) therapy for a number of reasons. A potential explanation for this is the development of neutralising antibodies to IFN β (NABs). These antibodies are thought to bind the drug and prevent its binding to target receptors. IFN β bioactivity is then lost and this can be measured using the IFN β response marker, MxA.

About the test

The test measures the increase in MxA mRNA transcription following IFN β injection. Failure to increase MxA levels after injection indicates the injected IFN β has no bioactivity. This loss of bioactivity has been shown to be due to NABs in the serum^{1,2}. MxA mRNA is measured and the patient is reported as a responder, where the MxA is upregulated more than 3 standard deviations above the mean of un-injected controls; or a non-responder, where the MxA levels are not different from un-injected controls. The maximal increase in MxA mRNA is 9 – 15 hours after injection, so patient blood needs to be collected then. The turnaround time for this test is usually two weeks.

Meaning of results

The development of NABs is a common phenomenon of IFN β -therapy for MS^{1,2}. The natural history and clinical significance of these antibodies warrants further study but their development offers a potential explanation for lack of clinical response to the drug. There are as yet no firm clinical guidelines in Australia as to the appropriate response should a lack of IFN β bioactivity be identified. However, such patients would warrant closer surveillance, repeated testing and consideration might be given to alternative management where a persistent lack of IFN β bioactivity is demonstrated.

Sample requirements

Samples should be collected 9 – 15 hours after treatment with IFN β . The sample is collected in a specialised tube to stabilise the mRNA (PAXgene™ Blood RNA tube) that **is not available through local pathology laboratories**. Patients will need to request a PAX tube from the WMI NAB service (details beside) in advance to take to their local pathology lab to have blood collected for the test.

Transport at room temperature ASAP. If delayed more than 24 hours, send frozen. Result expected in two weeks.

When to order

Testing for IFN β bioactivity may provide clinically useful information in any patient receiving IFN β , but particularly when relapses or MRI activity continues to be seen despite treatment.

IMPORTANT

Patients or Neurologists should request PAX tubes by phone or email to the address given.

Results

Please note that although sample collection tubes can now be sent directly to patients to take to their pathology labs, results will only be sent to the patient's physician to ensure appropriate response to the test result.

References

1. McKay F, Schibeci S, Heard R, Stewart G, Booth D, Analysis of neutralizing antibodies to therapeutic interferon-beta in multiple sclerosis patients: A comparison of three methods in a large Australasian cohort. *J Immunol Methods*. 2005 Dec 20
2. Pachner AR, Bertolotto A, Deisenhammer F, Measurement of MxA mRNA or protein as a biomarker of IFNbeta bioactivity: detection of antibody-mediated decreased bioactivity (ADB). *Neurology*. 2003 Nov 11;61 (9 Suppl 5): S24-6

Information

For more information please contact:

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At Home in Murarrie

Peter Freeleagus
State Manager

It may feel like we have spoken about nothing but the relocation of our Central Brisbane Laboratory since February last year. In light of this we are pleased to announce the relocation is complete and QML Pathology's Central Laboratory is now housed at Murarrie.

Firstly we would like to thank you for your patience and support during our relocation. On the eve of the move many of you extended words of encouragement which were very gratefully received by our staff. This has been a period of great change for our 80 year old organisation, however we are beginning to settle in and believe our staff together with our new facility gives us the capability to deliver a better service for doctors and patients in Queensland and northern New South Wales.

Once again, we extend our thanks for your understanding and ongoing support.



Changes in Cytopathology Imaging Technology at QML Pathology

In one of our recent newsletters we announced plans to implement a ThinPrep Imaging System at QML Pathology. We are pleased to announce this new system will begin processing samples on Monday 22 May.

As of this date all ThinPrep slides will be scanned using the Imaging System and then reviewed by cytotechnologists using a specially integrated Review Microscope. If abnormal cells are identified the entire slide is re-screened. If no abnormal cells are identified, these slides are immediately archived and reported as negative. It is anticipated the new system will improve work-flow in the laboratory through increased screening productivity and improved diagnostic performance.

The cost of providing the new ThinPrep technology will increase to \$35.00 per test, which is not Medicare refundable. Please note that it is still necessary to prepare a conventional Pap Smear as all liquid based cytology remains an adjunctive technology in Australia.

For further information please don't hesitate to contact our Cytology Department on (07) 3121 4485.

Changes to "High-Risk" HPV testing

Please be advised there has been a recent amendment to Medicare Item No 69486: A test for high risk human papilloma virus (HPV).

Patients who are "already undergoing annual cytological review for the follow-up of a previously treated HSIL" are now eligible to claim on this item number when undergoing the test. Previously only patients who had received excisional or ablative treatment for high grade squamous intraepithelial lesions (HSIL) of the cervix within the last two years, or who within the last two years had had a positive HPV test after excisional or ablative treatment for HSIL of the cervix, were eligible for the rebate for this test.

This change will substantially increase the number of women who are eligible for a Medicare rebate on this test and potentially minimise the number of women requiring annual cytological review in the future.



Doctors' Notice Board

Dr Robert Purssey, Consultant Psychiatrist, would like to announce he has commenced private practice at New Farm Consulting Suites. He will be consulting on Tuesday, Wednesday and Thursday afternoons and all day Friday. Dr Purssey is experienced in general adult psychiatry including schizophrenia, bipolar disorder, perinatal, somatoform and substance disorders. His special interests are evidence based psychotherapy of anxiety, depression, bipolar and personality disorder.

For appointments or to discuss a referral, please call 3254 0639. Alternatively you may send queries by email to rpurssey@uq.edu.au, or via mobile message service on 3309 2268.

Dr Paul Koch, General Paediatrician, would like to announce he is commencing practice as of 29th May at the following address:

- 18 Gray Street, Ipswich

Dr Koch is a VMO at Ipswich General Hospital and has admitting rights to St Andrews Hospital, Ipswich. His areas of special interest are neonatology, infant health and respiratory paediatrics.

Dr Michael Busby, ENT Surgeon, is pleased to advise that he is commencing practice at –

- John Flynn Medical Centre, Suite 2B,
Sessional Suites
Inland Drive, Tugun

For appointments please telephone (07) 5598 9156

His interests include paediatric and adult ENT conditions, especially rhinology and head and neck surgery.

Dr David Sillar, Urological Surgeon, is pleased to advise he has commenced full time practice at the southern end of the Gold Coast. Dr Sillar will be operating at the John Flynn Hospital and Tweed/Murwillumbah Hospitals. His consulting rooms are located at:

- Suite 8, 38-44 Boyd Street
Tweed Heads
- Murwillumbah Specialist Medical Centre
Carinya Building, Cnr King & Commercial Rds
Murwillumbah

For appointments please phone (07) 5599 1395 or fax (07) 5599 1379.

COLLECTION CENTRE NEWS

For the convenience of our doctors and patients, we have listed the latest changes to QML Pathology's network of clinics:

NEW CLINIC

Mullumbimby **0400 221 435**

60 Stuart Street
Monday - Friday 8.30am - 1.00pm
2.00pm - 5.00pm

CLINIC CHANGES

Albany Creek **(07) 3325 0822**

Albany Market Place, 1/720 Albany Creek Road
Monday - Friday 8.00am - 1.15pm
1.45pm - 4.00pm

Loganholme **(07) 3801 1073**

Shailer Park Medical Centre, 70 Bryants Road
Monday - Friday 7.00am - 5.00pm

Thornlands **(07) 3821 4807**

Shop 3, 3-5 Cleveland-Redland Bay Road
Monday - Friday 8.00am - 12.30pm
1.30pm - 4.00pm

Tweed Heads West **(07) 5536 8796**

Shop 4, Kennedy Plaza Shopping Centre
97 Kennedy Drive
Monday - Friday 7.30am - 1.00pm

Wynnum **(07) 3396 9881**

6/86 Edith Street
Monday - Friday 7.00am - 12.30pm
1.00pm - 5.00pm
Saturday 7.00am - 11.00am

Please contact your local branch for further information.

