TDL Laboratory Guide 2019

Every year we review requesting patterns, frequency of use, new best practice, new methods, and include new and relevant assays into the test menu. We also try to incorporate the changes that have originated from feedback received over the past year. This helps us to keep profiles and test menus as up to date and relevant as possible. The developments in diagnostic pathology are very exciting and we hope this new guide captures some of the important trends.

Sample types and turnaround times have been updated throughout in the Laboratory Guide. There are around 1500 tests listed through the departments, by speciality, and through the accessible **A–Z test list**. For advice or information about any of the tests that are listed – and particularly if you cannot find the test you are looking for – please contact the laboratory on **020 7307 7373**, and if you need information and advice about Genetic testing please call **020 7307 7409**.

The **Tabs** will help you navigate to the various disciplines, and for sample takers, the inside back cover of the laboratory guide gives details of sample requirements, with coloured dots to match the colour of the BD vacutainer top (A B C F G H K).

REFERENCES TO NEW TESTS, CHANGES AND UPDATES ARE WITH EFFECT FROM 1ST JANUARY 2019

What is in your Pathology Pack?

- Laboratory Guide 2019
- New Tests, Changes and Updates 2019
- Sexual Health 2019
- Standard Terms and Conditions 2019
- **NEW** Sample Collection Guide 2019
- **NEW** Andrology Bookmark
- **NEW** Practice Packing Bag – Couriers
- **NEW** HPV and Gynae Cytology: Important Information

NEW Testing for ZIKA Virus in SEMEN (ZIKA RNA by PCR in Semen) page 77

The global risk assessment has not changed. Zika virus continues to spread geographically to areas where effective vectors are present. Zika virus is of particular concern in pregnant women and for couples who are planning to become pregnant.

How Zika spreads

- Through mosquito bites
- From a pregnant woman, even without symptoms, to her unborn child
- Through sex, and probably blood transfusion.

There is no vaccine – protection against bites is the only prevention at the moment. Symptoms of Zika are similar to other illnesses through mosquito bites (like dengue and chikungunya).

HFEA guidelines recommend that travellers returning from high or moderate risk areas should consider the following guidance to minimise the risk of Zika virus transmission:

- A female traveller, symptomatic or asymptomatic, should not try to conceive naturally, donate gametes or proceed with fertility treatment for 28 days
- A male traveller, symptomatic or asymptomatic should not try to conceive naturally, donate gametes or proceed with fertility treatment for 6 months
- The European Centre for Disease Prevention and Control (ECDC) outlines that men should not donate sperm for 6 months after sexual contact with a man who has been diagnosed with a Zika virus infection in the 6 months preceding the sexual contact, or after sexual contact with a women who has been diagnosed with a Zika virus infection in the 8 weeks preceding the sexual contact.
- Sperm donors who are known to have been infected with Zika virus should be deferred from donation for 6 months unless semen samples test negative for Zika virus RNA by NAAT. If sperm donation cannot be postponed, donors can be accepted if both serology (28 days after leaving the Zika affected area) and semen NAAT tests are negative.

When to test for reliable diagnosis of Zika Virus Infections

We expect antibodies to be present from 2 weeks after virus exposure. The most suitable method for the detection of Zika virus infection depends on the disease stage:

- RNA in blood up to 7 days
- RNA in urine for up to 14 days

After 7 days, serum Zika IgM antibody testing should be performed. Antibodies IgM develop during the first week of illness and can be detected up to 12 weeks.

All available information should be given when ordering a test for Zika virus infection including patient travel history, vaccination history, pregnancy intention/status and presence of symptoms.

Zika Virus testing is recommended for:

- Pregnant women with any possible exposure to Zika virus, with our without symptoms. Possible exposure to the virus is defined as:
  - Living in the area of active Zika virus transmission
  - Travelling to areas with active Zika virus transmission
  - Having sex without the use of condoms with a partner who lives in, or who has travelled to areas with active Zika virus transmission.
- Anyone who has recently experienced symptoms of Zika virus infection (fever, rash, joint pain, conjunctivitis) and lives in or has recently travelled to an area with active Zika Virus transmission.
- Anyone who has recently experienced symptoms of Zika virus infection (fever, rash, joint pain, conjunctivitis) and had sex without a condom with a partner who lived in or who recently travelled to an area with active Zika Virus transmission.

	TEST	CODE	SAMPLE REQUIREMENTS	TAT
	Zika Abs IgM and IgG – Antibody detection from 7 days	ZKAB	B	5 days
	Zika RT PCR – Window of detection from 1-7 days from onset of symptoms	ZIKA	B	5-7 days
	Zika RT PCR – Window of detection from 1-14 days from onset of symptoms	ZIKU	RU	5-7 days
NEW	**Zika RNA by PCR in Semen**	ZIKS	Semen	2-3 days

Collection Instruction for ZIKA RNA by PCR in SEMEN

- 2 x **Consecutive** semen samples required. Sperm quality/fertility is not being assessed so the fertility window does not apply.
- Small fresh volume (1ml) of semen needed in standard universal container.
- Do not send samples on Fridays or the weekend (TDL London) or between Thursday or the weekend (TDL Manchester).
- Please notify Referrals (020 7307 7380) that semen is being sent to the laboratory for Zika Virus by PCR.
- Each sample will be reported individually as Detected/Not Detected.
- Travel history is not needed. Patients may be symptomatic or asymptomatic.

NEW: Reflex testing for Macrolide Resistance in all cases of positive Mycoplasma Genitalium

page 61

BASHH recommendations:

- Test for M.gen in all males with non-gonococcal urethritis
- Test for M.gen infection in all individuals with signs and symptoms suggestion of pelvic inflammatory disease
- Test current sexual partners of persons infected with M.gen
- First Void urine is the specimen of choice in males
- Vaginal swabs are specimen of choice in females
- **M.gen positive specimens should be tested for macrolide resistance mediating mutations**
- All patients should attend for test of cure 5 weeks (and no sooner than 3 weeks) after the start of treatment to ensure microbiological cure.
- M.gen can be requested as a single PCR test or with CT/GC – or in any other combination of STI screening options.

MYCOPLASMA BY PCR
(Urine, Swab, Thin Prep, Semen)

Mycoplasma genitalium
Macrolide Resistance Test (M.gen)*

TAT 2 DAYS

**If Mgen is positive, reflex testing for macrolide resistance will be carried out, using the same sample*

MGEN

FCRU OR PCR Swab OR TPV

MYCOPLASMA/UREAPLASMA BY PCR
(Urine, Swab, Thin Prep, Semen)

Mycoplasma genitalium
Macrolide Resistance Test (M.gen)*
Ureaplasma urealyticum/parvum

TAT 2 DAYS

**If Mgen is positive, reflex testing for macrolide resistance will be carried out, using the same sample*

MUPC

FCRU OR PCR Swab OR TPV

7 STI PROFILE BY PCR
(7 PCR TESTS FROM 1 SAMPLE)

Chlamydia trachomatis
N. Gonorrhoea
Mycoplasma genitalium
Macrolide Resistance Test (M.gen)*
Ureaplasma
Trichomonas vaginalis
Gardnerella vaginalis
Herpes Simplex I/II

TAT 2 DAYS

All tests can be requested individually

**If Mgen is positive, reflex testing for macrolide resistance will be carried out, using the same sample*

DL12

FCRU OR PCR Swab OR TPV OR Semen

UPDATE: Group B Streptococcus (GBS) Guidelines page 38

An estimated one in five pregnant women around the world carry Group B Streptococcus (GBS) bacteria which is a major, yet preventable, cause of maternal and infant ill health globally.

Current GBS prevention focuses on giving antibiotics to women in labour, aiming to reduce disease in infants at delivery. At least 60 countries have a policy for antibiotic use in pregnancy to prevent newborn GBS disease. Of those, 35 have a policy to test all pregnant women to see if they carry GBS, and the remaining 25 countries identify women with clinical risk factors. However, implementation of these policies does vary around the world. At this time there is no policy to test for GBS in the UK, but all pregnant women should be provided with patient information about HPV.

GBS is carried by up to a third of adults, usually with no symptoms. In women, GBS can live harmlessly in the digestive system or lower vaginal tract, from where it can be passed to the unborn baby through the amniotic fluid or to newborns during labour. If untreated, GBS can cause serious infections, such as meningitis and septicaemia, which may lead to stillbirths, and newborn and infant deaths. If they survive, babies can develop permanent problems including hearing or vision loss, or cerebral palsy.

GBS is the most common cause of severe infection in newborn babies and of meningitis in babies under 3 months old. Most early onset GBS infections (in babies aged 0-6 days) can be prevented by giving intravenous (not oral) antibiotics during labour to women whose babies are at raised risk of GBS infection.

TEST	CODE	SAMPLE REQUIREMENTS	TAT
Group B Strep (Lower vaginal and lower rectal culture swabs, collected from 35 weeks)	GBS	**GBS Collection Pack –** Includes 2 x culture swab and instructions for self-collection	3 days

CHANGE: HPV and Gynae Cytology page 157

Human papillomavirus (HPV) is a common virus transmitted through sexual contact. Persistent presence of high risk HPV is associated with an increased risk of developing cervical cancer. Evidence shows HPV testing is a more sensitive test with a high negative predictive value. This helps to identify women at risk of cervical cancer.

What is changing?

Primary HR-HPV testing will be fully implemented in the cervical screening programme during 2019. Sample taking remains unchanged: HR-HPV testing is carried out from cervical sample/ Thin Prep Vial. This is important because the same cervical sample/Thin Prep will be used in triage if HR-HPV is detected.

What does this change mean?

It means that HPV testing is the **FIRST LINE TEST**. It will be carried out as a single test, with a single result reported as Detected/Not Detected.

From 1st January 2019 all TDL requests for HPV will be processed as follows:

- If HPV is requested as a single test, and the result is Negative/ Not detected, the HPV as a single test will be charged.
- If HPV is requested as a single test and the result is Positive/ Detected, the HPV as a single test will be charged and the PAPT will not be charged as an additional test.
- If PAPT is specifically requested with a request for HPV, both tests will be charged.
- If PAPT is specifically requested with NO request for HPV, the HPV will be carried out and both tests will be charged.
- If HPV only has been requested and the HPV result is Positive, cervical cytology (PAPT) will be processed, even if not requested. The PAPT smear will NOT be charged additionally.
- If cervical cytology (PAPT) is requested as a single test, HPV will always be processed as a co-test with the PAPT. The PAPT and the HPV will both be charged as two single tests.

- If HR-HPV is NEGATIVE (Not Detected) – this means no further testing is needed for your patient: she returns to Routine Recall. You will be charged for the HR HPV test only.
- If HR-HPV is POSITIVE (Detected) – this means that **CYTOLOGY** will be processed from the same cervical sample/Thin Prep Vial. **A further specimen is not required**. There will be no additional charge for the PAPT.
- **If the CYTOLOGY result from this sample is NEGATIVE** – the patient management recall will be refer to colposcopy or manage at clinician's discretion.
- **If the CYTOLOGY result from this sample is ABNORMAL** the recommendation will be to refer this patient for COLPOSCOPY, or manage at clinician's discretion.

https://www.gov.uk/government/publications/cervical-screening-hpv-primary-screening

Understanding the significance of HPV testing

The benefit of a negative HPV result is its negative predictive value – meaning that a negative HPV result indicates that a patient is at very low risk of developing cervical disease. The negative predictive value of both DNA and mRNA testing is the same. The difference between DNA and mRNA is that DNA tests detect presence of virus only whilst an mRNA test detects the presence of viral oncogenic expression.

Requests for Cervical Cytology (PAPT) only will no longer be processed without HPV.
If PAPT is requested, HPV testing will be carried out and charged as two single tests.

TDL Andrology page 54

Infertility as a couple problem is fairly common – it affects about one in seven couples – which is about 15% of the population – 30% female, 30% male and the rest is both male and female. A meta-analysis of 185 studies involving nearly 43,000 men from 6 continents (and 50 countries) showed a mean sperm count reduction of 52.4% over a period of 35 years*.

A Comprehensive Semen Analysis looks at the count (how many) and morphology (sperm shape) and motility (their swim capability).

Guidelines for producing Semen Samples:

- It is important to **make an appointment** for all semen samples **020 7025 7940**
- Ideally samples should be produced on site at TDL Andrology, 76 Wimpole Street, London W1G 9RT
- Ideally patients should abstain from ejaculation for 2-3 days prior to testing – no less than 2 days and no longer than 5 days
- Ideally two separate semen analyses should be performed before any diagnosis is made.

**Human Reproduction Update, Volume 23, Issue 6, 1 November 2017, pages 646–659.*

TDL Andrology Sperm DNA Fragmentation page 56

Sperm DNA fragmentation

High sperm DNA fragmentation is associated with reduced natural pregnancy rates, higher miscarriage rates and assisted conception pregnancy rates as well as live birth rates. In addition, DNA fragmentation leads to higher miscarriage rates as published in the ESHRE Recurrent Pregnancy Loss 2017 Guideline. High levels of DNA fragmentation may be reduced by considering varicocele repair, treatment of underlying infections or inflammation, changes in lifestyle or with antioxidant supplements.

When requesting Sperm DNA Fragmentation there are **two options**. Please specify whether the request is for sperm DNA fragmentation by SCSA or COMET.

- ### Sperm Chromatin Structure Assay (SCSA®) [SEXT]

  This test has the ability to measure large numbers of cells (between 5,000 and 10,000 sperm), rapidly in an ejaculate. The SCSA® test monitors the changes in fluorescence of a probe, acridine orange, to detect both single and double DNA strand breaks using flow cytometry. It has been developed using human and animal models over the last 35 years and is one of the most statistically robust tests available for sperm DNA fragmentation. It is a standardised, validated CLIA approved test with high reproducibility and low variability. The test requires a minimum sperm count of approximately 1 million/ml.

- ### NEW Sperm COMET® Assay [CMET]

  When sperm counts are limited, DNA fragmentation can be effectively assessed using the Comet® assay as only ~5,000 sperm are required. The Comet® assay uses electrophoresis to determine abnormal sperm, and can measure both single and double strand breaks. Unlike the SCSA® test, the comet assay may be subject to inter-observer variability and may be less statistically robust as it measures low counts of 50 to 100 sperm cells from each sample.

	TEST	CODE	SAMPLE REQUIREMENTS	TAT
NEW	**Sperm Comet®**	CMET	**Semen**	1-2 weeks
	Sperm DNA Fragmentation (SCSA)	SEXT	**Semen**	1-2 weeks

Sperm aneuploidy page 56

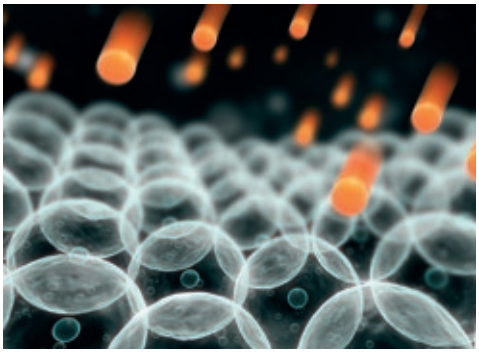
Sperm chromosome anomalies arise as a result of errors during meiosis, and cannot be detected by a blood karyotype analysis. These anomalies can only be detected by looking at the sperm chromosomes directly. Studies have shown that sperm with a high rate of aneuploidy have a negative impact on pregnancy rate and are associated with recurrent pregnancy loss.

This test uses FISH to label individual chromosomes with specific probes. Hundreds of sperm are assessed from one ejaculate. There are limitations to the test as only 5 probes are currently used routinely for analysis (three of the 22 autosomes: chromosomes 13, 18 and 21, and the sex chromosomes, X and Y), although others are available upon specific request. The results are reported showing incidence of disomy or nullisomy for each of the autosomes and for both sex chromosomes. A sex chromosome ratio is also reported.

Instructions for collection of Sperm DNA and Aneuploidy specimens

Sperm DNA Fragmentation or Sperm Aneuploidy testing are not part of the Comprehensive Semen Analysis and need to be requested as separate tests. Semen samples ideally need to be frozen as soon as possible after liquefaction, and no later than 60 minutes post ejaculation. Samples must be snap-frozen for Sperm DNA Fragmentation and cryopreserved in TYB for Sperm Aneuploidy. Two cryovials containing not less than 0.25 mls of semen are required. Frozen samples can be sent to, or collected by TDL, by arrangement, and must be accompanied with relevant patient details, the sperm count and GDPR consent form. Please contact Andrology for details on 020 7025 7940. A count of a minimum 1 million/ml is required for accurate DNA and aneuploidy reporting.

NEW: Oxidative Stress in Semen (ROS and MIOXSYS) and Male Infertility page 57



There is now growing evidence to support a link between oxidative stress and male infertility. It is the underlying cause of sperm DNA damage and impairs semen parameters and fertilisation, adversely affects embryo development and is associated with reduced pregnancy rates. It may also increase the risk of miscarriage. High levels of ROS may be reduced by considering varicocele repair, treatment of underlying infections or inflammation, changes in lifestyle or with antioxidant supplements.

TDL provides a comprehensive assessment of oxidative stress by combined measurement of Reactive Oxygen Species and Redox Potential.

Oxidative Stress in Semen includes combined testing for:

- **Chemiluminescence Assay for Reactive Oxygen Species**

  Reactive Oxidative stress may be measured by a simple chemiluminescence test in semen, which measures the level of reactive oxygen species.

- **MIOXSYS Electrochemical Assay for Redox Potential**

  Oxidative stress may be determined by an electrochemical assay which measures the redox potential in semen. This test measures the overall difference between total oxidants and antioxidants in the system.

References

Homa ST, Vessey W, Perez-Miranda A, Riyait T, Agarwal A (2015). Reactive oxygen species (ROS) in human semen: determination of a reference range. J Assist Reprod Genet 32(5):757-64.

Vessey W, Perez-Miranda A, Macfarquhar R, Agarwal A, Homa S. (2014). Reactive oxygen species (ROS) in human semen: validation and qualification of a chemiluminescence assay. Fertil Steril. 102:1576-1583.

	TEST	CODE	SAMPLE REQUIREMENTS	TAT
NEW	**Oxidative Stress in Semen (ROS + MIOXSYS)**	SROS	**Semen**	1 day

NEW: HbA1c (GHB) – Abnormal Haemoglobin Variant

The term Abnormal Haemoglobin Variant is well recognised, and even anticipated for certain categories of patients. It does not allow for an HbA1c result. To date we have provided a comment, recommending further testing with Fructosamine.

Going forward when an HbA1c shows a result confirming “Abnormal Haemoglobin Variant”, the sample will be automatically reflexed to HbA1c Boronate Affinity and Haptoglobin from the same sample. If this allows the HbA1c to be reportable, the result will shown that the HbA1c sample has been analysed with Boronate Affinity.

However if it remains unreportable, the same sample will be reflexed again, for Fructosamine.

There will be NO CHARGE for these reflexed tests. The practice will be contacted if there is insufficient EDTA sample for these reflex tests.

UPDATE/NEW: Harmony® – Screening in the UK, NIPT in 3-5 days pages 121-122

Harmony® in the UK including 22q 11.2 deletion

The Harmony® in the UK Prenatal Test is available for:

- Screening for Trisomies 21, 18, and 13, sex chromosome aneuploidy, Monosomy X, Fetal Sex.
- **NEW**: option to include screening for singleton pregnancies for a deletion in chromosome 22q 11.2 deletion.
- All Singleton and Twin Pregnancies from 10 weeks.
- Validated for pregnant women of women aged 18-48 years and all risk categories.
- All IVF pregnancies including singleton, twin and egg-donor eggs.
- Optional X and Y chromosome aneuploidy or analysis for monosomy X only for singleton pregnancies, if appropriate.
- Additional option for fetal sexing for twin pregnancies, if appropriate.
- Results include fetal fraction (cell free DNA percentage) in line with the recommendation from the International Society of Prenatal Diagnosis (ISPD).
- Results available within 3-5 days from receipt of samples.

THE RELIABILITY YOU WANT, AND THE ACCURACY YOU NEED.

TDL Genetics will provide Harmony sample taking packs including:

- Request forms
- Patient information and consent forms
- Specific blood collection tubes
- Packaging and/or postage material

See pages 121-122 in the Laboratory Guide for further information.

Test Limitations

- The Harmony test cannot be performed on multiple pregnancies other than twins.
- The Harmony test cannot be performed on vanishing twin pregnancies.
- NIPT is a screening test – an invasive diagnostic test would be required to receive a definitive diagnosis.

For further information, and to order Harmony packs, contact TDL Genetics on **020 7307 7409** or **NIPT@tdlpathology.com**

TEST	CODE	SAMPLE REQUIREMENTS	TAT
Non-Invasive Prenatal Testing – common aneuploidy screening from maternal blood	NIPT	Two 10ml tubes of maternal blood – special tubes provided by the laboratory	3-5 days
NEW **Non-Invasive Prenatal Testing** – common aneuploidy screening from maternal blood plus 22q11.2 del	NIPQ	Two 10ml tubes of maternal blood – special tubes provided by the laboratory	3-5 days

UPDATE: General Data Protection Regulations (GDPR) page 11

The General Data Protection Regulation (GDPR) came in to force in May 2018 and has had a significant impact upon the way that personal data is managed; placing legal requirements upon data processors and controllers to manage that information securely, maintain records of the processing that is carried out, and report when breaches of the regulation do occur. This has impacted the way many businesses operate, and is not restricted to the healthcare sector.

The GDPR requirements have been implemented within the context of a mature ISO 27001 Information Security Management System – the globally accepted standard by which information is secured. This ensures that senior management have regular visibility of the threats to the confidentiality, availability and integrity of the information that we process, and are able to steer the efforts of their teams to provide an efficient service that places the confidentiality of our customers and their patients at the heart of everything we do.

In order to support our customers compliance with the regulation and as a part of a wider GDPR compliance project TDL has updated its standard terms and conditions to include revised data processing clauses, which are mandatory when providing personal data to another organisation.

CHANGE: Important change for processing Urines (UCEM) using a Manual Pathology

The Infection Science laboratory has been reconfigured to enable all urine sampled to be cultured manually. This may seem a retrograde step, moving from automated to manual but this change has been adopted to enable the laboratory to meet the more stringent criteria of the new UK standards for Microbiology Investigations (SMIs) for urine cultures and in response to several clinical requests. The manual culture of urines, enables the reporting of cultures down to 10^3 cfu/mL that is required by the SMI and achieves enhanced differentiation for mixed cultures.

The aim is to reduce the number of results which were being reported with Mixed Growth – we think this will make a big difference.
All sensitivity testing for urine cultures will be being performed through the Phoenix. The reporting will utilise the same front of form lines and there will be no discernible difference in the appearance of the end result for the end user systems.

CHANGE: Coeliac Disease diagnostic laboratory testing – new procedures page 75

Coeliac disease is a lifelong autoimmune disease caused by a reaction to gluten. Its prevalence in the UK is 1:100 people. Symptoms include diarrhoea, constipation, vomiting, stomach cramps, mouth ulcers, fatigue and anaemia. In undiagnosed, untreated coeliac disease there is a greater risk of complications including anaemia, osteoporosis, neurological conditions such as gluten ataxia and neuropathy, and although rare there's an increased risk of small bowel cancer and intestinal lymphoma. Once diagnosed, it is treated by following a gluten free diet for life. Dermatitis herpetiformis is the skin manifestation of coeliac disease.

There have been recent guidelines (NICE, ESPGHAN, BSPGHAN, BSG*) and improvements in diagnosis and monitoring of coeliac disease/autoimmune gluten-sensitive enteropathy but there has been a need to harmonise best laboratory practice for revised procedures and diagnostic algorithms. It is important for an initial diagnosis, that patients need to be eating gluten, as without recent challenge, serology and biopsy may be negative.

The serological screening test detects IgA autoantibody to tissue transglutaminase (tTG, the disease-specific protein antigen in gliadin and endomysium). If the result is high, indirect immunofluorescence for IgA to endomysium will be detected for diagnostic confirmation. In adults, the gold standard confirmatory diagnostic test is still small bowel biopsy; in children, high levels of IgA anti tTG followed by positive HLA DQ2 and/or HLA DQ8 testing obviates the need for biopsy.

What are the changes?

- If TTG is **LOW** (< 0.1 U/ml) reflex testing for total IgA will be undertaken.
- If Total IgA is **LOW** (< 0.1 g/L) reflex testing for Gliadin IgG will be undertaken.
- If TTG IgA is **HIGH** (> 10 U/ml) reflex testing for Endomysial IgA will be undertaken as a confirmatory test.

This means that

- Endomysial IgA will not be available as a stand-alone test – it has been replaced with TTG IgA as a screening test and that the endomysial IgA will be used to confirm positives.
- Endomysial IgG is no longer available.
- Gliadin IgA will not be available as a single test – if requested, the request will default to TTG IgA.

GLUTEN SENSITIVITY EVALUATION (COELIAC DISEASE ANTIBODY)

Tissue Transglutaminase (IgA)
Gliadin deamidated IgG
Total IgA
Endomysial IgA

CHANGE 2019 | TAT 2 DAYS

GSA

B

COELIAC DISEASE PROFILE 2

Tissue Transglutaminase (IgA)
Gliadin deamidated IgG
Total IgA
HLA DQ2/DQ8
Endomysial IgA

CHANGE 2019 | TAT 10 DAYS

GSA2

A B

GLUTEN ALLERGY PROFILE

Tissue Transglutaminase IgA
Gluten single IgE Allergen
Gliadin Abs deamidated IgG
HLA DQ2/DQ8
Total IgA
Endomysial Abs IgA

CHANGE 2019 | TAT 10 DAYS

GLUT

A B B

* NICE guideline NG20 Coeliac Disease: recognition, assessment and management September 2015.

Murch S *et al.* Joint BSPGHAN and Coeliac UK guidelines for the diagnosis and management of coeliac disease in children. Arch Dis Child 2013;98:806-811.

Ludvigsson JF *et al.* Diagnosis and management of adult coeliac disease: guidelines from the British Society of Gastroenterology. Gut 2014; 63:1210-1228.

Shahnaz A *et al.* Tissue transglutaminase antibody levels predict IgA deficiency Arch Dis Child 2013; 98:873-876.

NEW: Respiratory PCR testing page 92

We have introduced multiplex realtime PCR testing for the rapid and qualitative detection from upper and lower respiratory track specimens obtained from individuals who show signs and symptoms of respiratory tract infection. Specimen types include nasopharyngeal swab specimens, bronchoalveolar lavages and bronchial washes.

Specimens should ideally be collected into Copan swab tubes and transferred to a tube containing specimen transport media (STM) that lyses the cells, releases target nucleic acid and protects them from degradation during storage.

TARGETS FROM 13 ANALYTES

Influenza A Virus	Rhinovirus
Respiratory syncytial virus A+B	Adenovirus
Influenza B virus	Human Metapneumovirus
Parainfluenza 1	Coronavirus
Parainfluenza 2	Parechovirus
Parainfluenza 3	Enterovirus
Parainfluenza 4	

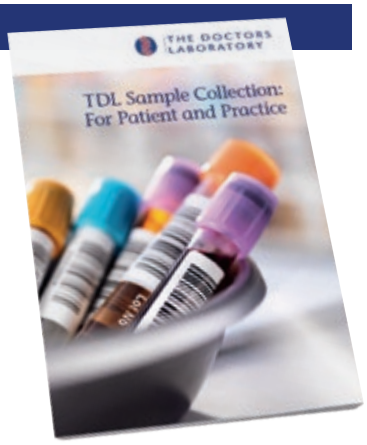
DISCONTINUED SERVICES

- Reticulin Antibodies are no longer included in Coeliac Profiles.
- Endomysial Antibodies IgA (AEAB) is no longer being offered as a standalone test.
- Respiratory Viral Screens from blood are no longer available – please replace with PCR swab – and wherever possible please use a COPAN swab with Viral Transport Medium (order from supplies@tdlpathology.com).
- CFT as a method will no longer be run in the laboratory (see changes to VIRAL and NEUROLOGICAL VIRAL Screens).
- Codes for Histology CAT1 – CAT5 will be discontinued – and replaced by site specific codes (see CHANGE above).

CHANGE: Histopathology SITE codes page 162

To make it easier to know what the charge will be for histology, the change to coding by site or discipline has been made.

NEW: TDL Sample Collection for practice's and their patients



This Sample Collection guide is a reference for clinicians and their patients who are collecting samples, or preparing to collect samples which require special instruction.

The collection of appropriate and optimum samples is the responsibility of the laboratory, even though the collection process is often carried out in the hospital, clinic or practice or patient's home. Collection procedures involve consideration of various instructions, which include a range of information about the tests that are being requested. This covers sample type, timing for sample collection, patient preparation and expectation, clinical information, correct containers, labelling and sample handling. Patient samples collected by the patient themselves need to be supported by appropriate instruction for collection, sample collection kits, with user friendly safety and labelling details.

The guide provides Information sheets which can be copied and distributed to patients.

Service email addresses, who to contact to make arrangements

addons@tdlpathology.com	Request **ADDITIONAL TESTS** from a sample in the laboratory	see page 8
andrology@tdlpathology.com	Arrange an **APPOINTMENT FOR SEMEN ANALYSIS (Tel: 020 7025 7940)**	see page 7
couriers@tdlpathology.com	Contact couriers as an alternative to **ONLINE BOOKING**	see page 8
eview@tdlpathology.com	Arrange secure Login/Password to **VIEW RESULTS ONLINE**	see page 10
finance@tdlpathology.com	Contact credit control for **INVOICE RELATED QUERIES**	see page 11
homevisits@tdlpathology.com	**ARRANGE A HOME VISIT** for your London based patients	see page 8
logo@tdlpathology.com	Include your **LOGO** (GIF format) for all emailed results	see page 10
patientreception@tdlpathology.com	Email ahead to make **SPECIAL ARRANGEMENTS** for your patients	see page 6
phlebotomy@tdlpathology.com	Email to make **SPECIAL ARRANGEMENTS** for your patients	see page 6
queries@tdlpathology.com	**SPECIAL INSTRUCTIONS** for the laboratory for samples that have been sent or received by TDL	
supplies@tdlpathology.com	**ORDER PATHOLOLOGY SUPPLIES/POSTAL PACKS** for TDL samples (Supplies Reorder Form – see inside back cover)	see page 10
tdl@tdlpathology.com	**GENERAL ENQUIRIES**	

TDL's Laboratory Guide 2019 is designed to give you an easy to use reference, for the most regularly requested tests and profiles. If you need help or advice in finding information about tests or services, please contact the laboratory on 020 7307 7373 or email tdl@tdlpathology.com. We continue to develop clinically relevant diagnostic services and our aim is to offer commitment to customer service, strong working relationships and help and support to doctors and their practises.

TDL Patient Reception – TDL Sample Collection for practice's and their patients

Patient Reception is at 76 Wimpole Street, London W1G 9RT.
There are new opening times for Patient Reception on Saturdays.

Opening times are Monday to Friday 7.00am – 7.00pm, **Saturday 7.00am – 5.00pm**.

Appointments are only necessary if a patient needs specialised investigations or care. Patients should always bring a request form or referral letter with them. Instructions can be faxed or telephoned ahead of the patient's attendance, if this is more convenient.

Patient Reception Direct line tel: 020 7307 7383 Fax: 020 7307 7371

Sample taking is undertaken by qualified staff for which a standard sample taking fee of £35.00 is charged to patients. A nominal fee of £11.50 is charged to doctors and clinics for each patient. Sample taking services for extended tests and Drugs of Abuse with Chain of Custody are routinely available. Cervical cytology, HVS and cervical swabs are not taken at 76 Wimpole Street.

Patient Reception sample taking services are not available in Manchester.

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