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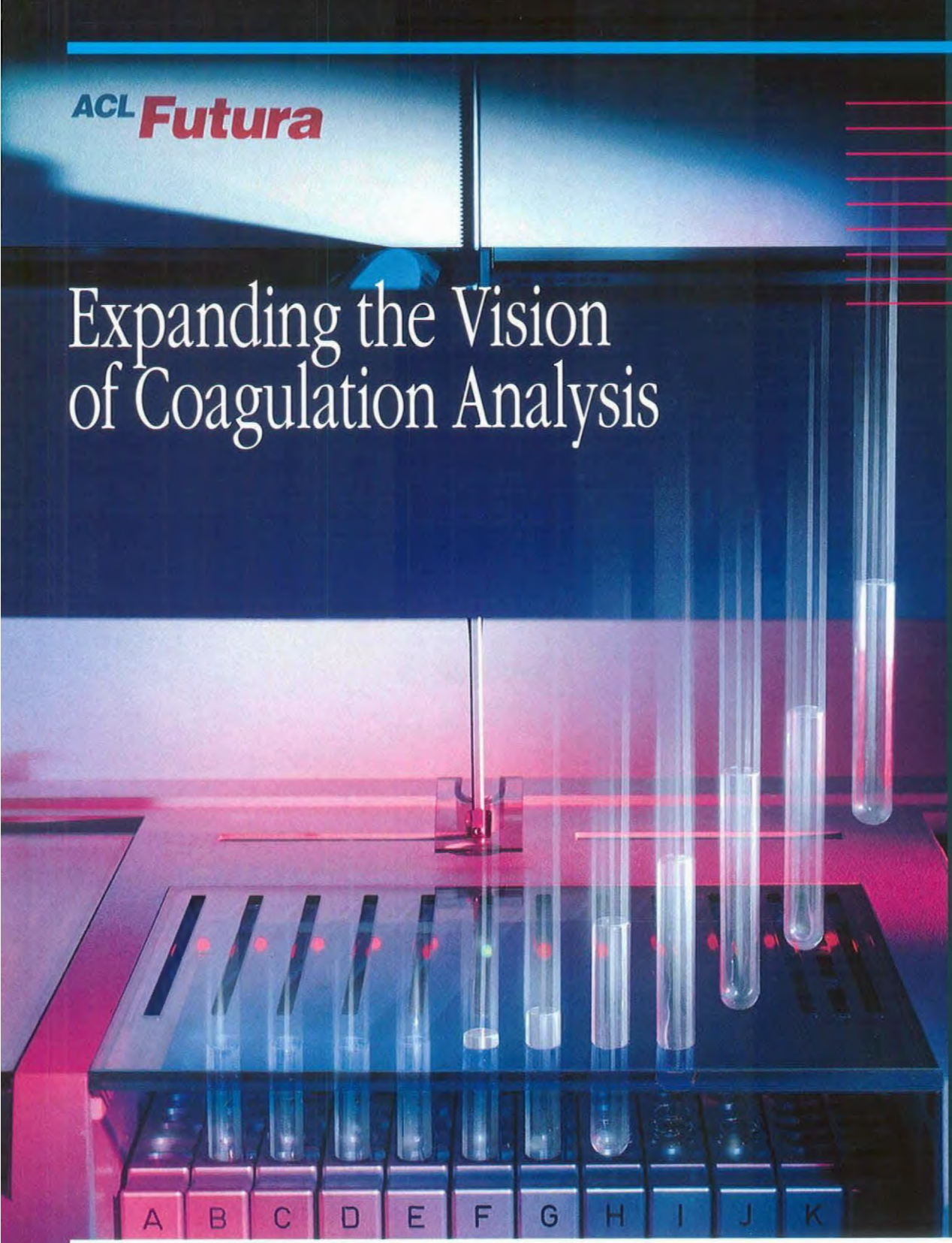

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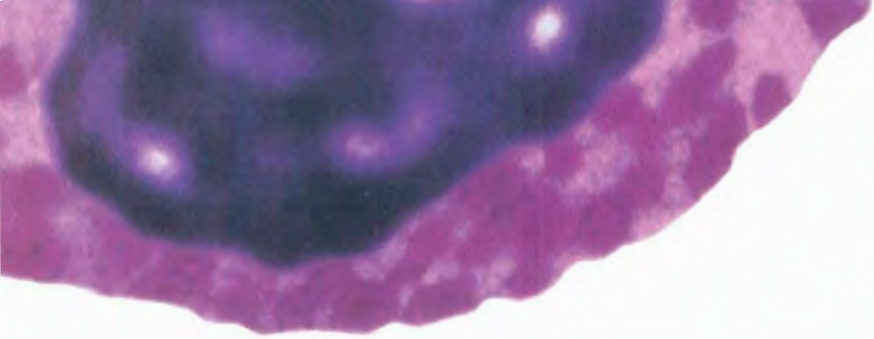

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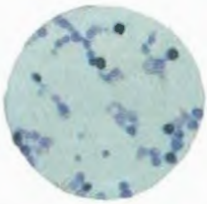

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Submitted papers (**in duplicate**) should be typewritten, in double spacing throughout on one side of A4 paper. Generally each component of the manuscript should begin on a new page in the following sequence.

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* **Text**, in the order of **Introduction, Materials and Methods, Results, Discussion and Conclusion**.

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Two copies of the manuscript are to be addressed to the Editor NZ J Med Lab Science, c/- Department of Medicine, Wellington School of Medicine, PO Box 7343, Wellington South, together with a letter from the corresponding author stating that the work is original, is not under consideration for publication elsewhere, and in the case of multi-authorship that all authors have contributed directly to the planning, execution, analysis or to the writing of the paper.

Editorial

Why Should I Contribute?

Warren Dellow, MNZIMLS,
Med-Bio Enterprises Ltd, Christchurch

As a professional scientific group, the New Zealand Institute of Medical Laboratory Science (NZMLS) promotes (among other things) the presentation and publication of scientific information related to our profession. Obtaining this information has always been a difficult task for the various editors of our Journal as well as the organisers of our annual scientific conference.

Why is this?

It is easy for most of us to come up with excuses. As a result of these excuses, each issue of our Journal has very few published papers and we struggle to fill the scientific programme at our conferences. I know that a lack of good presentation material is not the reason for a lack of presentations. Every medical laboratory in New Zealand has at least one case study, per employee, per year, suitable for presentation. Therefore each one of us could at least write a case report, each year, if we so desired. Those with a little more flair could collate the interesting case studies with common factors, and then write or present a paper on the subject. The important point is, that we work with the starting information for a presentation every day.

So, why don't we do something with this information?

Laziness could be one explanation, but I prefer to think of another reason. That is, that there is no benefit, apart from professional pride, in doing anything like this. Is this correct? In my opinion, this isn't true. I can think of many benefits that come from writing or presenting a paper. I am sure that others will find it easy to add to my list.

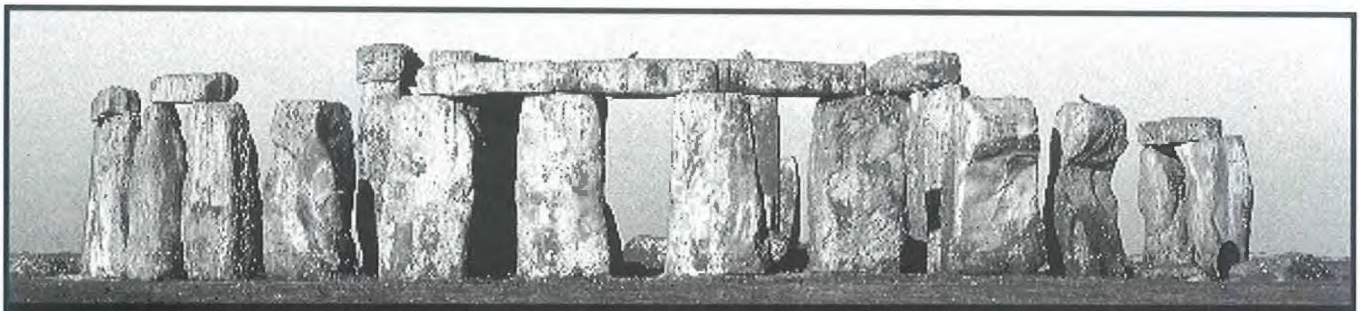
Today, medical laboratory science is a competitive profession. We have seen laboratories amalgamate and positions disappear through redundancies. What can we do to help protect and promote our continuing employment prospects? Obviously it is important to have a high standard of work within your own laboratory. While professional peer recognition won't safeguard a given employment situation, it could give you an advantage in a competitive position. You may be seeking a new job, or working to retain a current position. So, what is the easiest way to get peer recognition? Stand up and be noticed! Write a paper for the journal. Give an oral presentation at the annual conference or at a SIG meeting. Present a poster. Your first attempts may not be great. Like anything new that we do, there has to be a starting point and a learning curve. The good news is that it does get easier. There are also many people who can help ensure that the first attempts aren't failures, or accompanied by embarrassment. All you need to do is ask for guidance or help.

If you do become a regular contributor of papers to the profession, then you quickly gain professional respect. This can be very useful when you are looking for a new employment position. If your good reputation has preceded you, then you have a natural advantage over other applicants. If you can include a list of publications with your CV, this will make an immediate positive statement about your commitment to your chosen profession.

Medical Laboratory Science, like other professions, requires a commitment to lifetime learning. Traditionally this learning process has largely been the responsibility of our employers. Today, many of us have to take an increasing responsibility for this learning process. As a result, much of the learning that we do, is self directed. We largely follow our own interests. We allocate whatever time we think we can afford. Fortunately, we usually learn new information quickly when the topic interests us. In my experience, researching a paper properly will generate a great deal of information that is new to me. This is a very valuable learning experience that is usually useful as work. This in turn adds to my value as an employee.

Once information is presented in either an oral or written form, then it becomes a valuable resource that is available for all of us to learn from. How often, around New Zealand, are people solving the same technical problems? This is a process that takes time and financial resources. In many cases, we could stop reinventing the wheel if we shared this information, but it is seldom used in this way. We are all losers when these opportunities are lost.

Perhaps we should view the writing or presentation of a paper as something that we can do to positively contribute to both our chosen profession as well as our continuing employment. In today's environment there isn't much that we can do to add value to our employment prospects. However, we all have access to information that is suitable for presentation in some form. It may be an interesting case history, method evaluation, technical note or fully researched review paper. To get value from it we must do it! We would see a big difference in our Journal, as well as the different scientific meetings, if each of us offered one scientific article each year. We would all be better off if we all made the effort to contribute.



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Does Training in Science and Technology need the "University" Cachet?

Dr Roy Geddes, Dean, Faculty of Science and Engineering, Auckland Institute of Technology

It is interesting to read in the Times Higher Education Supplement (25 April 1997) that the German *fachhochschulen* consider themselves the poor relations of the German universities because of their lack of access to the title "university". These *fachhochschulen* offer vocationally orientated degrees similar to those offered by a number of our polytechnics. It is also interesting that these "technological universities" do not wish to follow the pattern of change in Britain, where top polytechnics became universities and large numbers of them decreased their commitment to vocational training as a consequence. In New Zealand, we are facing an interesting parallel. Our senior polytechnic, the Auckland Institute of Technology, currently offers 42 degree programmes and, as is well-known, wants the use of the title "university". Its avowed intention, once the use of the title has been gained, is to become the first "University of Technology" – not another middle-class orientated university in the traditional mode. In fact, the model proposed by the Auckland Institute of Technology parallels that of the *fachhochschulen* and, indeed, the technological university model utilised in a number of European countries. This proposal is vital to the continued development of the New Zealand polytechnics in general to vocational training of high quality, is well known and accepted. It would be a tragedy for the country were the top polytechnics to decrease and devalue the importance of vocational training. Firstly the philosophies of the polytechnics must remain focussed on remaining vocational providers who offer complementary courses to the current universities. Secondly the country needs the production of a highly skilled and technologically able work force oriented to its economic needs. It is well established that understandably enough, because of funding restraints, many of our traditional universities have (or are currently doing so) drastically decreased the content of practical training in their Science and Technology degrees. This means that our universities will be producing increasingly graduates who are intellectually well qualified for the *theory* of Science and Technology careers but who will require from their employers a huge increase in the amount of on-the-job training provided by those employers, at their expense. Therefore, the continuation of a complementary system producing graduates of high intellectual capacity but with well developed practical skills is essential in the continuing development of Science and Technology in New Zealand.

In parallel with the growth of degrees in our polytechnic sector there has been a rapid increase in the recognition of both the research done in that sector and its research potential. The polytechnic sector has an academic cohort with is highly qualified but which traditionally has been burdened with as much as five times the teaching load of its contemporaries in the formal university system. The effect of this has been that research potential has been suppressed, but, fortunately, not eliminated. With the development of the NZQA and its insistence on quality and standards in vocational education, the push towards more research outputs has become a shove, with the end result that a number of our polytechnics are producing significant research outputs and the potential for research in this sector of tertiary education is only now beginning to be fully realised.

Another aspect of our polytechnic system is its largely collegial nature. (This is in contrast with some of the squabbling that goes on between our universities.) Numbers of polytechnics throughout New Zealand are "holding hands" to offer qualifications on a national basis (an excellent example of this is the Bachelor of Applied Sciences degree from the Auckland Institute of Technology, which is shared now among 10 polytechnics nationally – the first truly national degree offered in New Zealand since the dissolution of the University of New Zealand). The reason for this sharing and collegiality is that the polytechnics see the need to offer advanced qualifications to students in rural areas. Without co-operation, this can be a disastrously expensive project, but with co-operation via shared staff, shared facilities and innovative distance learning educational methodologies, the costs can be controlled and opportunities given to students who are unsure of their career potential and, indeed, of their abilities in the tertiary sector. Efficiency in the delivery of top quality Science and Technology courses is not only politically essential (particularly for future funding) but also should be an essential part of the philosophy of courses which train our future scientists and technologists.

Finally, it is worthy of question as to whether traditional universities are performing their role as critic and conscience to society, or whether their role has been taken over by our polytechnics. Our universities have proclaimed, as have universities internationally (notably the United Kingdom), that they are the true, independent, "critics and consciences of society", expressing views on political aspects of government and keeping "the public" aware of the effects and dangers of technological developments, for example. Recent debate, particularly in the United Kingdom, has caused some doubt of this idealistic outlook of the traditional universities. It has been suggested that, in fact, the universities are acting more as conservators and guardians of their own autonomy, rather than active contributors to truly public issues. Our universities seem to be more distanced from real society now and to be highly defensive of their own interests. It is worth while considering whether the polytechnic sector, with its intimate association with industry and with the secondary school system is, in fact, more committed as a critic and conscience of society. Polytechnics do not espouse the "ivory tower" approach, which, as least sections of, our current universities, continue to adhere to. However, the polytechnics do not cover all aspects of interest to the development of our society (notably in the

area of the Arts and parts of Health). The truth therefore lies somewhere in between. Universities will necessarily continue to fight to preserve some measure of autonomy and the polytechnics will continue to develop vocational training aimed at the needs of New Zealand. At this stage we have a unique opportunity to develop co-operatively in our tertiary sector, having in the one hand high quality internationally recognised universities and, in the other, a network of vocationally orientated polytechnics committed to provision of practical skills to the public. In between we have the potential for the University of Technology concept which is a bridge between polytechnics and the international universities and which would be recognised internationally for excellence in vocational training in its own right. This debate continues within New Zealand and we have a real opportunity to go in a new educational direction for the benefit of New Zealand and as an example to the educational world.

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The Incidence of Co^b, and the High Frequency Antigens Ge2 and Sc1 in Polynesians

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Abstract
Polynesian donors who identified themselves as being either Samoan, Tongan, Cook Island, Tokelauan or Niuean were tested for the antigen Co^b (n=384) and the high frequency antigens Ge2 (n=389) and Sc1 (n=251).

Co^b was found to have a frequency of 0.8% in Polynesians, with the antigens Sc1 and Ge2 being present in all samples tested.

These results suggest that the Polynesian frequency for the Ge2 and Sc1 red cell antigens are similar to Caucasians while Co^b differs significantly.

Introduction
Frequencies of red cell antigens in Caucasians are well documented. For Polynesian populations the testing of high and low frequency antigens has been limited[1].

The Colton blood group contains two antithetical antigens, Co^a and Co^b, with a Caucasian frequency of 99.8% and 8.5% respectively [2]. A New Zealand study in Otago of random blood donors found a Co^b frequency of 9.1%[3]. The incidence of this antigen in Polynesians has not been previously reported.

The Gerbich positive phenotype Ge:2,3 has a frequency of 99.9% in Caucasians and the majority of the ethnic groups studied, with the exception of Melanesians, which have a higher frequency of the negative phenotype Ge:-2-3[2]. The Gerbich negative phenotype has been found in two Polynesians with a frequency of less than 1%[4].

The Sc1 red cell antigen has a frequency of 99.2% in Caucasians[3] with no previously reported frequencies in Polynesians.

In order to expand the knowledge about the blood groups of Polynesians, random Polynesian blood donors were tested for the presence of the antigens Co^b, Ge2 and Sc1.

Keywords
Polynesians, Colton, Gerbich, Scianna.

Materials and Methods
The selection of donors was random and based on those individuals who identified themselves as being either Samoan (n=387), Tongan (n=84), Cook Island (n=66), Tokelauan (n=2), or Niuean (n=49) on the donor registration form.

Red cells for testing were collected into EDTA, stored at 4°C and tested within two weeks.

All ABO groups were tested with anti-Co^b. The antisera used was identical to that in the Otago study[3].

The Ge2 antisera was from a donor at the Auckland Regional Blood Centre (serum RA). This was a group A donor with A and O individuals being tested. The specificity of this antisera was confirmed by the International Blood Group Reference Lab, Bristol, England.

Anti-Sc1 from a group O donor was used to test group O samples only. This antisera was a generous gift from Dr Amy Chang of the Red Cross Laboratory, Ottawa, Canada.

The ABO blood groups of the donors were obtained from the donation record.

All antisera used was stored at -30°C and thawed when required.

Antigen testing was performed at 37°C using a 0.8% suspension of unwashed red cells suspended in Cellstab, a commercially produced LISS solution. Sensitisation with antisera was visualised in a sephadex gel test antiglobulin card. (DiaMed, SA, Murten, Switzerland).

Because of the rarity of control cells, controls were only performed with the initial and final batches of antigen testing.

When the antigen Co^b was detected the test was repeated with a different Co^b reagent and a direct antiglobulin test performed to eliminate false positivity.

Table 1
Frequency of the antigens Co^b, Ge2 and Sc1 in random Polynesian donors.

Antigen	n	Positive	Frequency (%)
Co2	384	3	0.8
Ge2	389	389	100
Sc1	251	251	100

Results and Discussion
The antisera used was obtained from blood donors, and as a consequence had to be used on the basis of ABO compatibility. However, as there is no known ABO linkage between the Colton, Scianna and Gerbich blood groups[5], the data obtained can therefore be considered valid for the ABO groups tested.

The Co^b antigen was detected in three individuals giving a frequency of 0.8% in Polynesians. This is much lower than the Co^b frequency of 9.1% reported in Otago[3], and 8.5% in Europeans[2]. Mourant et al[1] have previously cited a frequency for the Co^b antigen in Polynesians as 9.1% based on the results reported from the Otago study[3]. However, this appears to be incorrect as few Polynesians resided in Otago at that time[6], and nothing in the test suggests that

the study included significant numbers of Polynesians.

Of the three positive Co^b individuals one was a Tokelauan and the others were Samoan. With only two Tokelauans tested in this study, this result is remarkable but statistically not significant. Based on the Co^b results further testing of this ethnic group would perhaps be of interest.

For the high frequency antigens, Ge2 and Sc1, no negative individuals were found (Table 1). In Caucasians the frequency of Ge2 is 99.9%[2], while Sc1 is 99.2%[7]. As can be seen in this study these antigens are also of a high frequency in Polynesians in Auckland.

This study was intended to investigate the presence Co^b and the high frequency antigens Ge2 and Sc1 in Polynesians residing in Auckland. It was not intended to establish absolute antigen frequency which would require more extensive testing.

Acknowledgements

The authors would like to thank the staff of the Auckland Regional Blood Centre, especially Alison Wilson, Bob Coleman, Dr Steve Henry and Dr John McKay, Immunology, Auckland Hospital.

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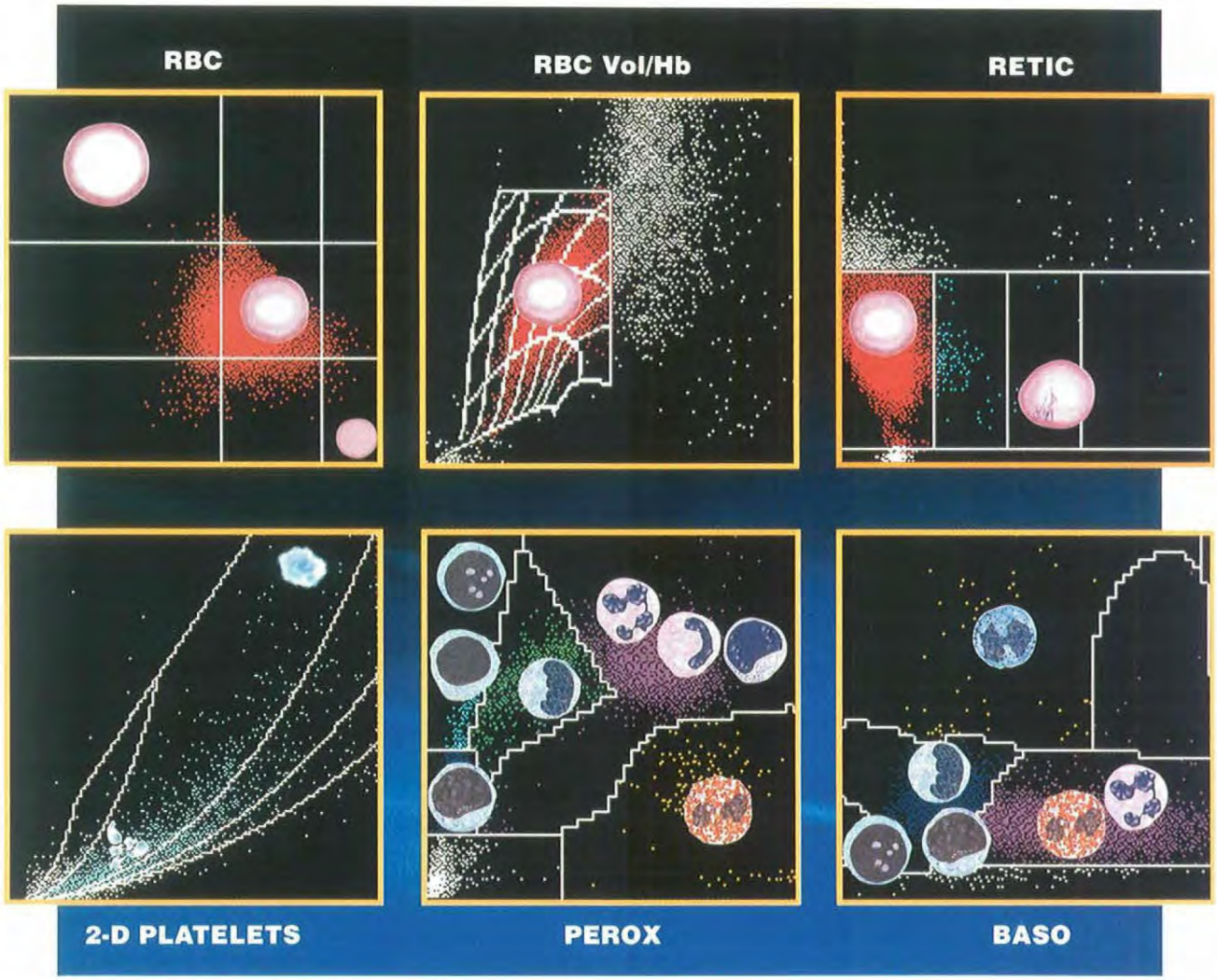

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Interview with the Editor

Name: Anne Paterson
Vice President, N.Z.I.M.L.S.
Present Position: Charge Scientist, Microbiology, Rotorua Hospital

Training & Previous Employment: Dunedin Hospital Laboratory

Elected to Council in 1989 as Region V Representative and appointed to the Steering Committee for the then proposed Bachelor of Medical Laboratory Science Degree at the University of Otago. Subsequently has served as Professional Representative on the University of Otago B.M.L.S.c. Board of Studies & Examinations, the Massey University B.M.L.S. Management Committee and is currently on the Auckland Technical Institute B.M.L.Sc. Advisory Committee. Anne has been Convener of the Education Subcommittee and is currently Convener of the Communication Subcommittee.

What are your main interests in Microbiology?

The role of liaison and communication between Microbiology and medical staff to provide an effective Microbiology Service and promote wise use of resources especially in the areas of Infection Control and rationale use of antibiotics.

What do you consider to be the highlight of your career?

Comments of appreciation concerning my reliability and/or quality of work as a Microbiologist, especially during or after challenging situations.

What has been the worst moment of your career?

At 2am, on callout one morning, knocking a bottle of alcohol from a low shelf through the bunsen flame and setting fire to an entire bench. I successfully destroyed several polyester gowns (they were the most handy things) before succeeding in smothering it. The evidence of the charred linoleum was evident to all later that morning.

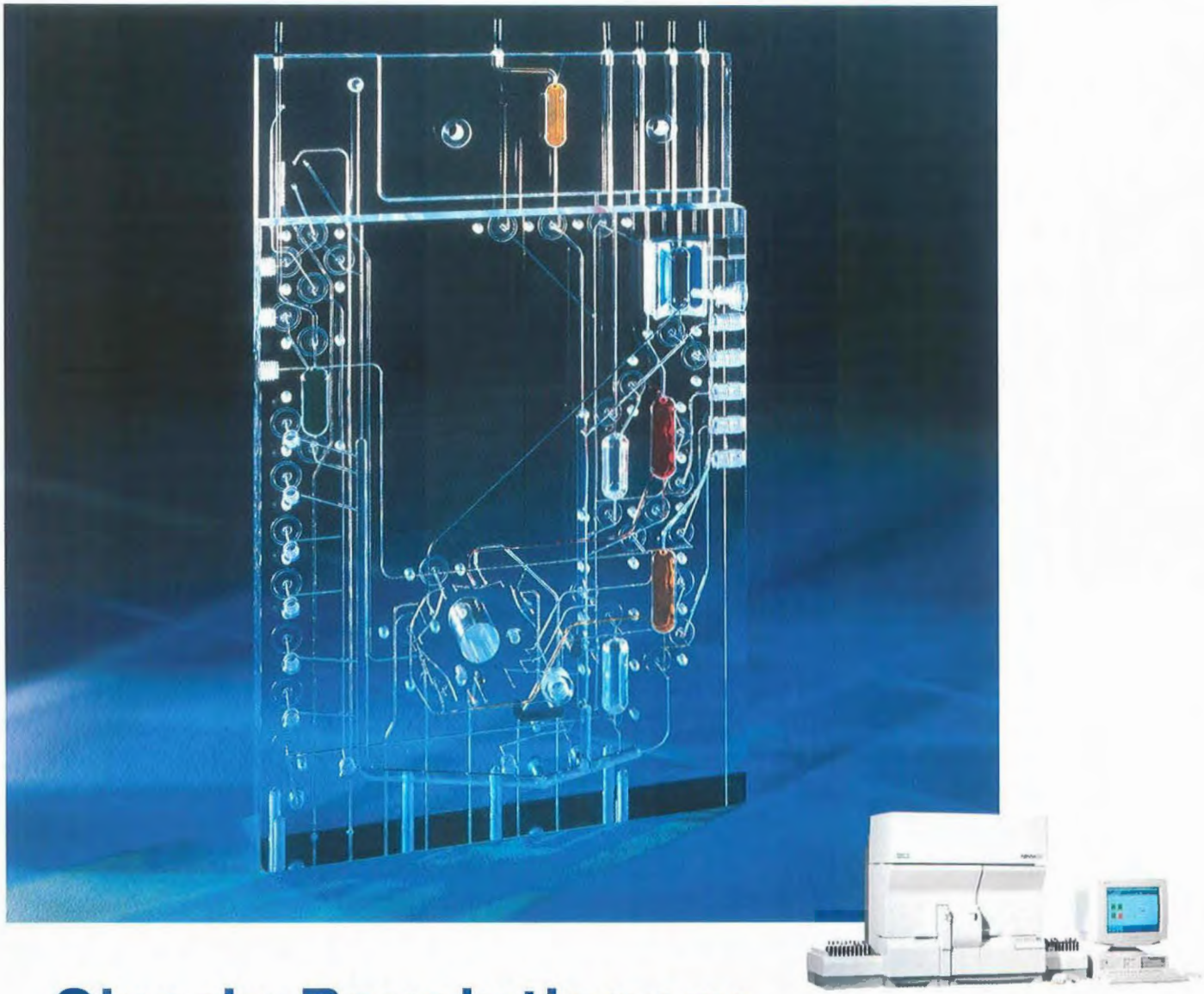
What do you think is the main issue facing Medical Laboratory Scientists today?

The personal balancing for each one of us between professional quality and ethics and an environment that is dollar driven.

During your term as Vice President of the N.Z.I.M.L.S. what do you hope to achieve?

To promote and achieve full and active membership of our professional society that will ensure that knowledge and skills of our profession belong first and foremost to our profession and its members.
In joining a profession one has a responsibility to learn the skills and knowledge to be recognised as a Member. Once this is achieved the personal responsibility shifts to developing and progressing their expertise, then share it with other Members and those that follow.

Anne and her husband John at the 50th Jubilee Ball, Auckland, 1996.



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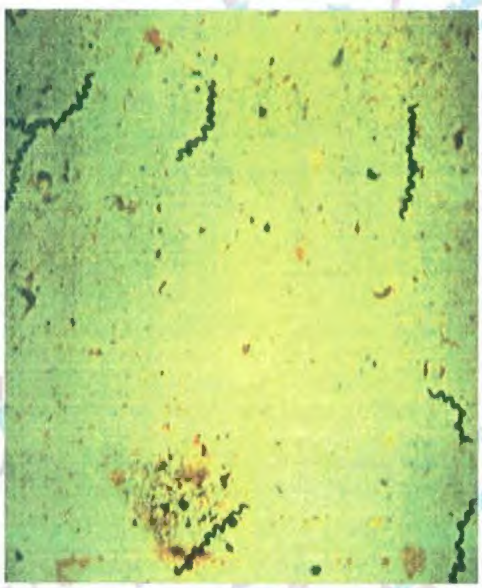

In Clinical Diagnostics:
detection of antibodies to *T. pallidum* at all stages of infection

In Blood Screening:
enhanced security in ensuring the safety of the blood supply

Unique Assay Format:
- IgG and IgM antibody capture combined with antigen sandwich format
- Tripartite recombinant antigen
- Engineered to ensure high specificity
- Antigen detects antibodies produced during all stages of infection

Key Features:
- Utilises proven EIA technology
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- Incorporates SAM and colour coded reagents
- Simple to perform - no sample pre-dilution
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- Suitable for serum or plasma samples
- Ready to use or easily prepared reagents
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Benefits:
- Reliable detection of syphilis infection
- High sensitivity and specificity
- Suitable for screening or confirmation
- Suitable for automated or manual processing
- Objective result reading
- EIA format with in-process controls - SAM and colour coded reagents - improves handling and enhances confidence in results

Performance:
Sensitivity - 414 specimens patients at various clinical stages of *T. pallidum* infection were tested. A total of 413 samples were reactive with ICE Syphilis but only 407 of these were detected by other diagnostic syphilis EIA assays
Specificity - assessments at European blood banks demonstrated a specificity of 99.95% (8027 out of 8031)

murex

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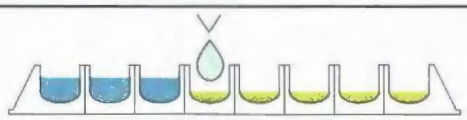
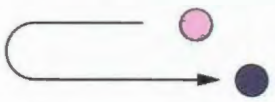
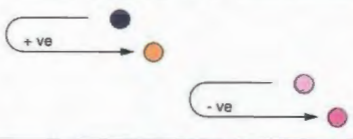
1. Prepare Conjugate	Add about 2 ml (1 plate kit) or 5 ml (5 plate kit) of conjugate diluent to freeze dried conjugate. Add the entire volume of reconstituted conjugate to the bottle of conjugate diluent.	
2. Prepare Wash Fluid	Make a 1: 20 dilution in water Glycine/Borate (x 20 conc.) 125 ml	
3. Prepare Substrate Solution (during conjugate incubation)	Strip: 1 ml Substrate Concentrate + 1 ml Substrate Diluent 1 Plate: 6 ml Substrate Concentrate + 6 ml Substrate Diluent	
4. Select the number of wells required for the test		
5. Add **Assay Diluent** (50µl) to each well		
6. Add **Samples** and then **Controls** (50µl)		Colour darkens as sample/ control is added
7. Cover and incubate for 30 minutes at 37°C under humid conditions		
8. Wash x 5 using 500µl of wash fluid per well and 30 seconds per cycle		
9. Add **Conjugate** (50µl)		
10. Cover and incubate for 60 minutes at 37°C under humid conditions		
11. Wash x 5 using 500µl of wash fluid per well and 30 seconds per cycle		
12. Add **Substrate** (100µl)		
13. Cover and incubate for 30 minutes at 37°C under humid conditions		
14. Add Stop solution (50µl) Read at 450nm using 620nm to 690nm as reference		

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ICE Syphilis	96/480	400E/500E	EIA
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Syfacard-R	100/150	VD32/VD33	Carbon Antigen Kit
VDRL Carbon Antigen	250/2500	VD24/VD25	Carbon Antigen

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Amicon has long been recognised as the market leader in ultrafiltration devices used for protein purification in life science research. Amicon also offers unique products and expertise in both process-scale ultrafiltration and chromatography systems. For scientists and engineers alike, Amicon has become a name synonymous with ultrafiltration.

Millipore, (Bedford, Mass., USA) is a worldwide leader in the manufacture of micro- and ultrafiltration membranes, devices and related equipment. Through international manufacturing, sales and distribution, Millipore provides purification technology for many lab oratory and process applications. With the integration of a proven and reputable range such as Amicon, Millipore continues a tradition of offering outstanding value for its customers. Broad selection, leading-edge technology and seamless scale-up capabilities set Millipore apart in the filtration industry.

In New Zealand, Millipore products are distributed by Biolab Scientific Ltd. Biolab offers the complete Millipore Analytical, Lab Water and Bioprocess ranges. These encompass filtration products and water purification systems used in analytical, research and clinical laboratories, and process-scale filters for use in biopharmaceutical applications.

For further information, contact Jeff Winegar, Millipore Products Manager, Biolab Scientific, on (09) 480-3432, or 0800-807-809, ext 707. On the internet please refer to http://biolab.co.nz and http://millipore com.

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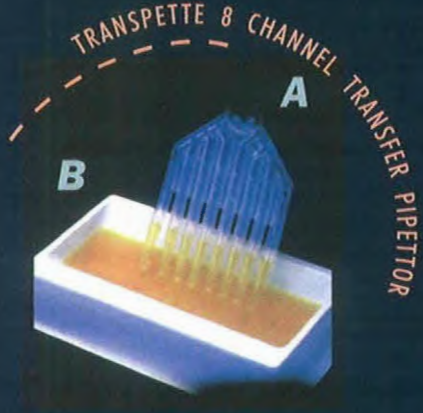

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The Pacific Way

Filariasis Survey in Niue:

Manilla Nosa
Laboratory Technologist
Health Department
Niue

A filariasis survey was conducted in the Central Pacific Island of Niue towards the end of 1996 to determine the prevalence of positive microfilaraemia among the Niue population. Just over 1000 blood samples were collected and analysed by both microscopy and a new antigen test. This new test was the ICT Filariasis kitset from ICT Diagnostics, Australia. It is a rapid immunochromatographic test for the qualitative detection of *Wuchereria bancrofti*, antigen in serum or plasma and can be performed in about 5 minutes (and with increased sensitivity up to 30 minutes). No cross reactivity occurs with *onchocerca, brugia mansonella* or *loa filaria*.

The antigen test showed that 5% of the samples were positive whereas the microscope test showed that only 2% were positive for filaria. All the microscope positive samples were positive by the antigen test.

The ICT antigen method proved easy to use, rapid and gave reliable results and will definitely give the microscope a long rest. Niue is one of the first nations in the Pacific to have used this test.

Fishes on the Reef by Bullumakau

Dr S.T. Han, Regional Director of the WHO for the Western Pacific reported on World Health Day, 7 April 1997, that the world is faced with many threats to the health of its people. Diseases that were once controlled are reappearing. Some diseases have been increasing in incidence and are expected to increase further in the future. In the last two decades more than 30 new, highly contagious diseases have been identified such as HIV/AIDS and the Ebola-type viral haemorrhagic fever. At the same time old diseases such as tuberculosis, diphtheria, cholera and dengue fever have reappeared. The Western Pacific, WHO has established the Outbreak Response Task Force to improve the Region's preparedness and timeleness of response during disease outbreaks.

••••••

The WHO reports that the re-emergence of tuberculosis could become pandemic and it has called for worldwide commitment in the implementation of the short-course DOTS (Directly Observed Treatment) strategy to prevent the disease spreading further. Tuberculosis kills about three million people annually and about half a million are in the Western Pacific Region. With DOTS the cure rate in many countries in the Western Pacific Region is about 90%. However, in some countries in the Region that do not use DOTS the cure rate is only 60%.

••••••

The Government of Malaysia, in collaboration with the WHO has developed measures on food safety to be implemented during the Commonwealth Games to be held in Malaysia next year. It will help to make the athletes run faster.

••••••

Bulumakau spotted Mike Lynch, Tutor Coordinator of The PPTC in the WHO Offices in Manila a few weeks ago. The rumours have it that he was reporting on a consultancy he had carried out in Vanuatu, Fiji, Tonga and Samoa. Others say that he was the cause of a tropical downpour that flooded most of Manila including the WHO office. While a few others say he was in Manila to check up on the quality of the San Miguel.

••••••

Bulumakau's spies relate that Wilson Kikolo is now Chief Technician in Honiara, that Faapulou Auvaa has the same post in Apia and that Daniel Kalorib who was once Chief Technologist in Port Vila has now risen through the ranks and is Acting Director General of Health. Well done all of you.

••••••

Bulumakau was informed that the new MacDonalds fast food outlet in Apia was almost devoid of customers when his reporter visited lately. Perhaps it has something to do with the cost of the Big Mac, fries and Coke. At a nearby local eating house for the same cost as the fast food you can feed four adults with local food. Taro taste better.

••••••

The Pacific Way welcomes two new pathologists to the Pacific scene. Greetings to Dr Krishna Murli at CWM Hospital, Suva, and to Dr Siale Akau'ola at the laboratory at Vaiola Hospital, Tonga.

••••••

Bulumakau noticed an article on the safety of Tongan drinking water in a recent issue of the Pacific Health Dialogue journal. It seems that in the Kingdom that the levels in drinking water for the following constituents, faecal coliform, total hardness, pH, chloride and heavy metals are within the WHO maximal safety limits but nevertheless somewhat above the Tongan desired limits. Could this refute the saying – "when in a developing country don't drink the water and when in a developed country don't breath."

••••••

The same journal reports on a review of leptospirosis within an area of the Federated States of Micronesia. It seems that leptospirosis is being diagnosed more often in some areas of the Pacific. It was recommended that the main emphasis in dealing with the disease should be in the area of primary prevention (eg. animal control, vaccination of animals and better hygiene). This is getting too close to home for Bulumakau and his fellow pigs and dogs. If you want further information see Pacific Health Dialogue Vol 3, No. 2.

The following is an extract from TDR news.

TDR news is published three times a year by the UNDP/WORLD BANK/WHO Special Programme for Research and Training in Tropical Diseases (TDR).

All material submitted to TDR news undergoes editorial review.

Cochrane Collaboration Infectious Diseases Group

"Will it work? Is it better than what we have already?" Such

Continued p109

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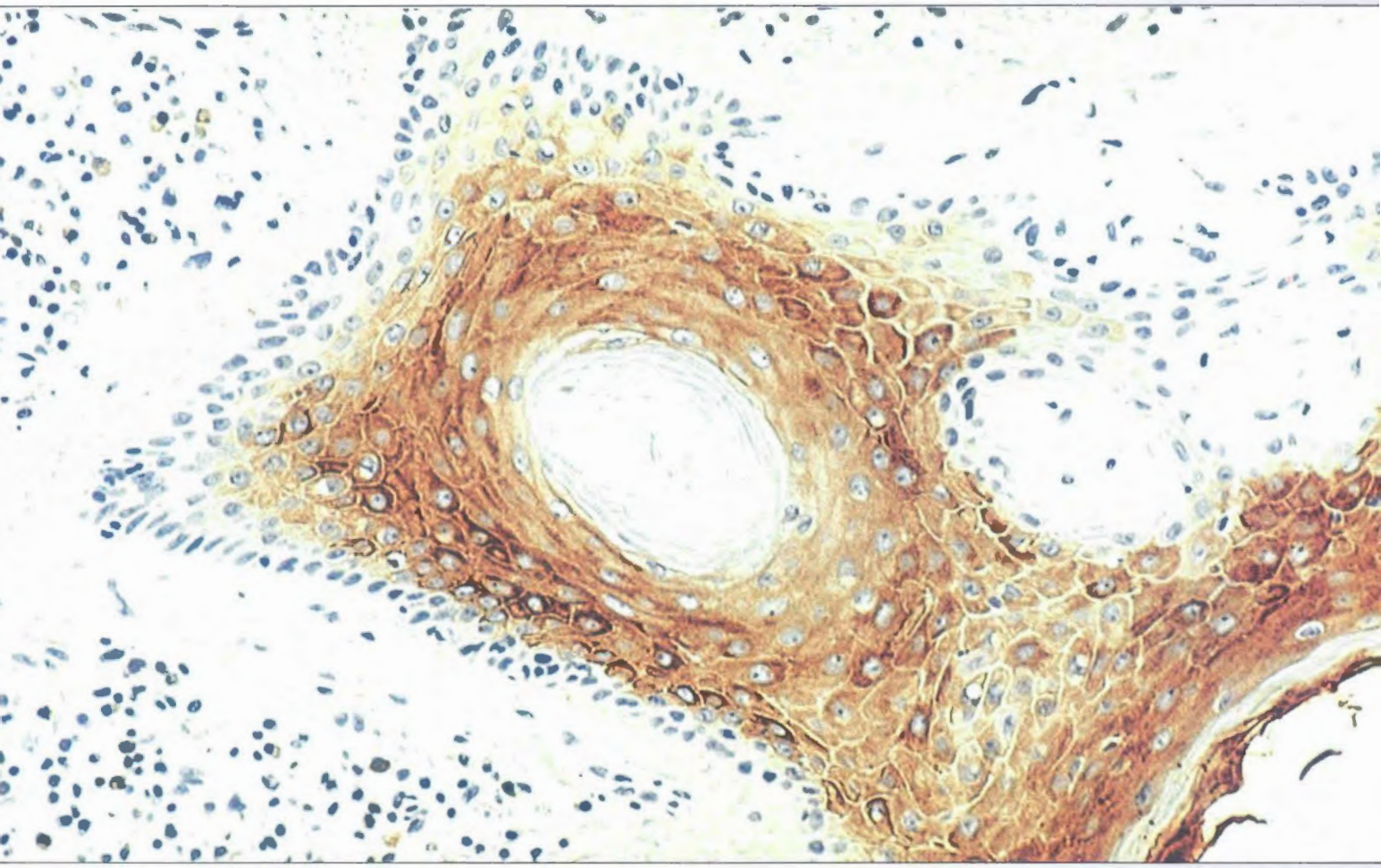

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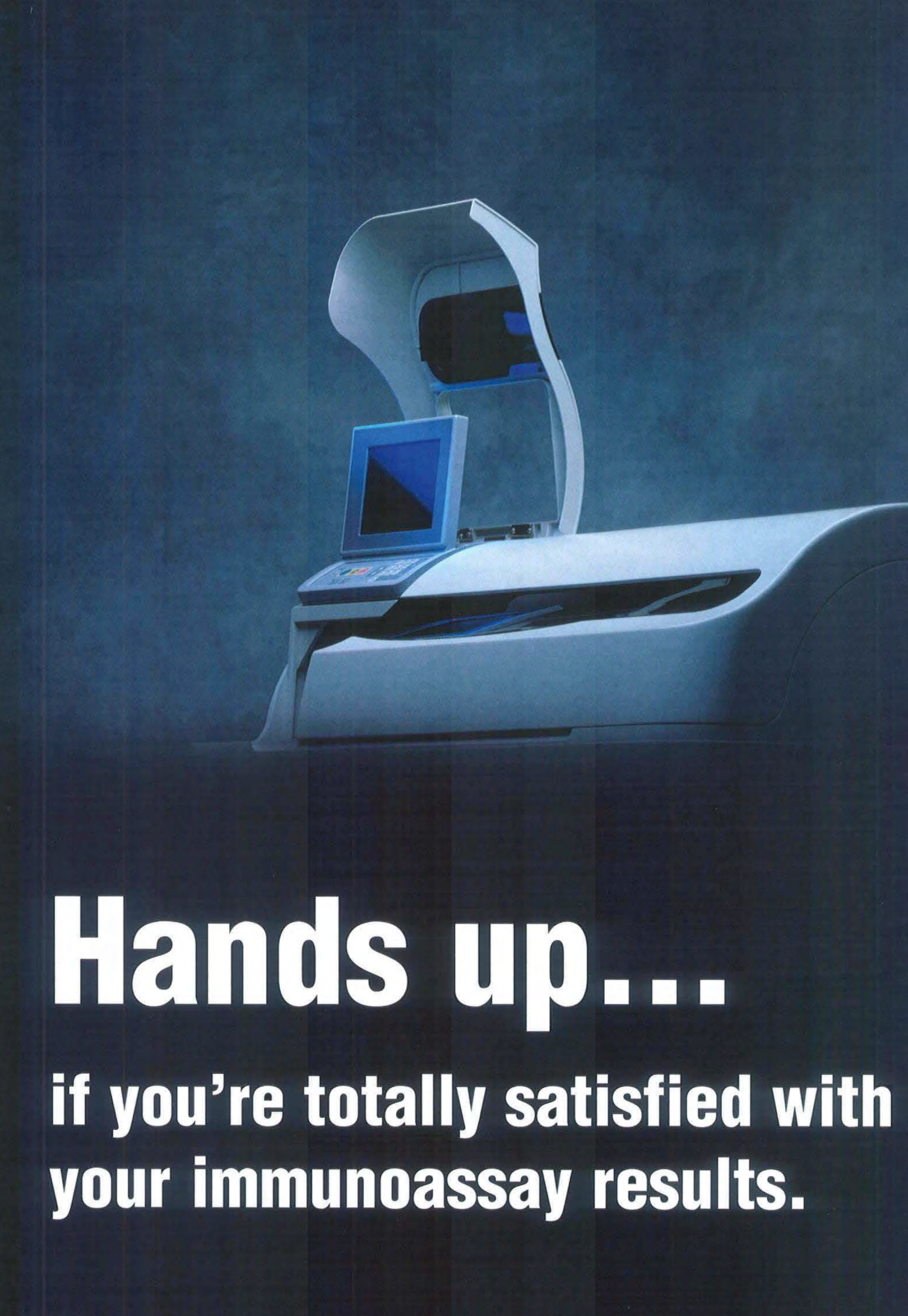
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hCG	0.5 – 10000 IU/L	4.4	5.7	4.2	2.7
Troponin T	0.01 – 25 µg/L	5.8	5.4	2.5	2.7
CEA	0.2 – 1000 µg/L	2.6	2.2	1.3	1.6
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(1) Using BM Hitachi 5-hole racks. (2) BM evaluation data (see table above).

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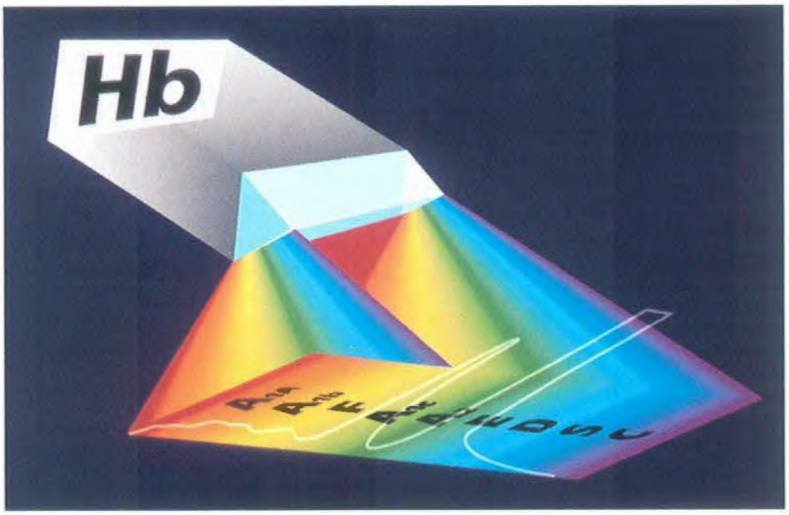

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from p104

questions are asked by researchers, policy-makers and users of health care alike, and are ones that we need reliable answers for. Scientists work hard in evaluating what forms of care are effective, but for some reason scientific principles are often forgotten in reviewing. Now the process of producing reliable, up-to-date systematic reviews of available evidence is moving into tropical diseases, and a small network of hardworking people is helping make this happen. The Cochrane Infectious Diseases Group deals mainly with randomised, controlled trials, and each review is treated as a scientific process. A protocol is written, peer reviewed and edited – it contains a "materials and methods" section with objectives, trial inclusion criteria, an explicit search strategy for identifying the literature, and pre-specified analyses.

As there is a bias in published journals towards positive trial findings, the group takes great pain to identify unpublished trials; and, because electronic reference databases are so often badly indexed, journals are searched manually to identify all possible trials to be considered for inclusion in a review.

The group started less than two years ago. Reviewers come from a variety of backgrounds but have a common purpose – to produce and update (every three or six months) reliable systematic reviews. The group has four editors and about fourteen active reviewers from around the world. Piero Olliaro, Manager of TDR's CHEMAL, and both a reviewer and an editor, recently completed a review of amodiaquine in the treatment of malaria. Seventy-two studies were found, of which 40 met the inclusion criteria – and of these, a number were published in French or Portuguese while 23 were unpublished. This massive piece of work pulled together evidence from around the world and is helping inform WHO about its global policy for the treatment of malaria. The results of this review were published in "The Lancet". A review of malaria prophylaxis in pregnancy has also been completed and has been published in the Bulletin of the World Health Organisation. A malaria vaccine review is being updated following the publication of the recent Thailand study; and a review of bednets is also currently being prepared.

Apart from malaria, many other reviews are at various stages in the pipeline – between the idea stage and the just-published. Topics of reviews extend from other TDR parasites and drugs treatment – such as aminosidine, AmBisome and pyronaridine – to afflictions such as toxoplasmosis and hydatid disease, scabies and headlice, and fungal infections, and to nutritional conditions such as iron and folic acid pregnancy.

Policy-makers have come to recognise the importance of evidence-based medicine. Systematic reviews are a tool to help them decide which intervention should be used. The rationale for conducting a systematic review before starting a new trial is: to avoid repeating research where the answer is already known but may not be obvious; and to guide the researcher as to what questions have not been addressed. The Medical Research Council in the UK only considers grants for trials if a systematic review has already been undertaken, and other research funders are moving in the same direction.

The Group's administrator and co-ordinating editor are based in the International Health Division at the School of Tropical Medicine in Liverpool, and are supported by the Overseas Development Administration (UK). Inquiries may be addressed to Dr Paul Garner, Co-ordinating editor, Cochrane Collaboration Infectious Diseases Group, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, United Kingdom.

The Liverpool School of Tropical Medicine

Since TDR began, the Liverpool School of Tropical Medicine has been closely involved in working with the programme through steering committees, undertaking projects in Liverpool and overseas, and training students in Liverpool and in country. As TDR has evolved, so has the relationship between the school and TDR's activities.

The School has always recognised that its impact must be in the developing world and has sought to collaborate with TDR in field projects. The School's emphasis on overseas partnerships commenced in the 1960s with the establishment of its historic links with the Faculty of Medicine, Mahidol University, Bangkok, currently one of the major recipients of TDR support in South East Asia. The current portfolio of links between Liverpool and TDR is focused on the disease-related and health system expertise in Liverpool which provides for student supervision associated with institutions in Latin America, Africa, South Asia and South East Asia. The topics being studied include how pre-packaging of antimalarials affects compliance with treatment regimes and how compliance may be influenced by patient counselling. Other studies include a comparison of the relative efficacy and cost of microscopy and presumptive diagnosis, and the development of algorithms for diagnosis.

The School has a strong research base in leishmaniasis and recent TDR-supported research has involved field studies of the risk factors, diagnosis and treatment strategies of cutaneous leishmaniasis by Byron Arana in Guatemala (including a clinical trial on the efficacy of topical treatment with paromomycin).

The School has also worked recently with TDR on sleeping sickness where, through TDR support, the Quantitative Buffy Coat (QBC) test was developed as the most sensitive parasitological diagnostic test for African trypanosomiasis – field testing of this test in parallel with other methods was undertaken in Cote d'Ivoire and Uganda. Dr Taylor from the School has projects in Myanmar and Papua New Guinea (PNG).

In Myanmar, in collaboration with Dr Nay Soc Maung, three studies are under way on prevalence using rapid assessment techniques to determine the optimal time for DEC administration in relation to microfilarial periodicity and assess the possible association of filariasis with cerebral malaria. IN PNG with Dr Turner of Australia's James Cook University, studies are under way to define the optimum control strategies using DEC and invermectin or albendazole.

The studies outlined above reflect the commitment of both Liverpool and TDR to relevant and targeted research on the TDR diseases. The interactions emphasise the need for partnership, the key philosophy of both TDR and the School; commitment to assisting and developing both developing country scientists and institutions; and a spectrum of science, from the bench on the one hand, to operational research in the field linked to the reality of limited resources of district health systems and the recognition that any intervention must be sustainable within, and usable by, the health services. Liverpool staff and TDR enjoy a friendly, co-operative and understanding professional relationship as, over the years, programmes have developed, research has been completed and problems have been shared and solved.

Reduction in Chagas Disease – Brazil

The Brazilian National Control Programme reported the elimination of transmission of Chagas disease in that country in the WHO Weekly Epidemiological record of January 1997. This is a major accomplishment within the "Initiative of the Southern Cone countries" and it is expected that certification of the interruption of vectorial and transfusional transmission will be carried out by an independent international commission in 1998. Brazil is the biggest country endemic for Chagas disease in the South American continent and accounted for over 40% of the prevalence of the disease.

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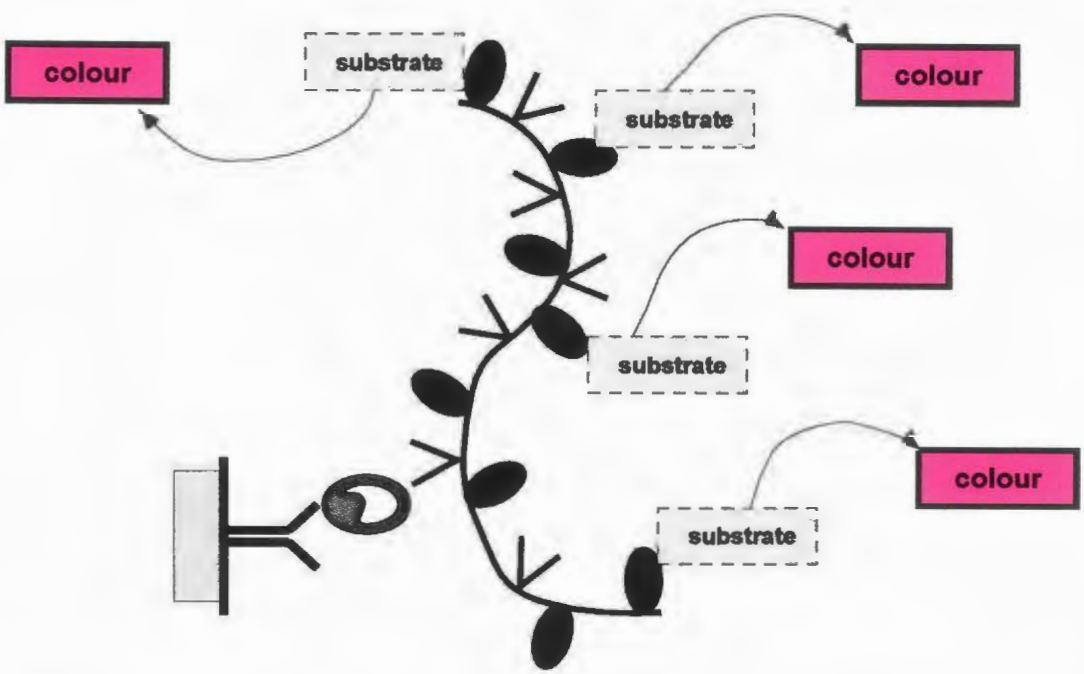

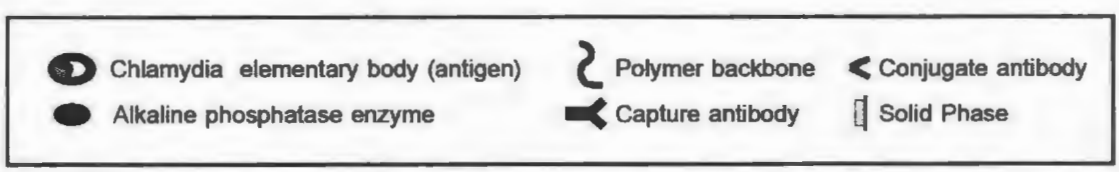

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Book Review

The following book review was provided by Gilbert Rose.

Infectious Diseases: Colonising the Pacific?
Written by John Miles and published by the University of Otago Press, 1997.
ISBN 1 1 77133 26 4; pages 123; paperback

John Miles is a former Head of Department and Professor of Microbiology at the University of Otago. Having worked in Fiji, Solomon Islands and Vanuatu and travelled widely in the area he has had a long interest in the history of infectious diseases in the Pacific.

With his many years of microbiological research and field work; the South Pacific Commission and the World Health Organisation have both used his expertise as a consultant and a committee member.

The book contains ten chapters which are well written, interesting and easy to read.

The chapters are:

1. Some Medical Effects of Isolation
2. Malaria and Scrub Typhus
3. Eighteenth-century European Explorers
4. Leprosy
5. Yaws and Sexually Transmitted Diseases
6. Tuberculosis
7. Animal Parasites
8. Eye Diseases
9. Other Bacterial, Fungal and Viral Infections
10. The End of Isolation

Throughout the book there are many extracts from historical writings, reports of past epidemics and how the indigenous peoples treated the diseases with their own traditional remedies.

The early movement of the Pacific people themselves and then the sixteenth- through to the eighteenth-century European explorers brought new diseases to the area; in particular those who travelled to the area in the late 1600s and the 1700s.

Mapping the timing of the voyages as well as the use of evidence from the Austronesian languages the spread of infectious diseases can then be traced through the Pacific. In this respect the history of the occurrence of tuberculosis, leprosy and the sexually transmitted diseases is of great interest.

An extensive bibliography for those wishing to read further concludes the book.

This book must appeal to those with an interest in general microbiology, epidemiology and the history of the Pacific Islands.

Blood Bank Technology Course
February – April 1997

Back Row: Vilitonu Soakai (Tonga): Mike Lynch (PPTC): Tirath Lakshman (Tutor): John Elliot (PPTC): Pasuna Tuaga (Tuvalu): Donald Tahani (Solomons)
Front Row: Nixon Dalipanda (Solomons): Fetalaiga Faiumu (Western Samoa): Jopi Pitis (PNG): Mul Fuko (PNG)

Shirley Gainsford, President NZIMLS, presenting blood bank technology course certificate to Mul Fuko from Papua New Guinea. Mike Lynch, Tutor Co-ordinator PPTC, in background.

New Zealand Institute of Medical Laboratory Sciences (Inc)

Minutes of the 52nd Annual General Meeting held at the Ellerslie Convention Centre, Auckland on Wednesday 28 August 1996

Chairman
The President (Mr D Reilly) presided over the attendance of approximately 130 members.

Apologies
It was resolved that the following apologies be accepted:
Roger Austin
Ian Wilkinson
Leanne Mayhew
Murray Robinson

A Paterson/C Kendrick

Proxies
A list of 6 proxies representing 8 proxies was read by the Secretary.

Minutes
It was resolved that the Minutes of the 51st Annual General Meeting held on Wednesday 27 July 1995 be taken as read and confirmed.

R Siebers/C Kendrick

Business Arising
Registration
K McLoughlin outlined the steps that the Medical Laboratory Technologists Board was taking. They have put a submission document to the Ministry of Health supporting registration. There are also avenues of appeal if necessary.

Annual Report
It was resolved that the Annual Report be received.

A Paterson/S Gainsford

Discussion:
- Concern was expressed that students were not getting jobs in particular laboratories because the have trained in another laboratory.
- Noted that some laboratories are not training students. If laboratories do not take in students during the fourth year, the degree could become a three year course.
- Managers need to be encouraged to keep taking on fourth year students.
- Council can be proactive by writing to the laboratories concerned.

It was resolved that the Annual Report be adopted.

W Wilson/L Milligan

Financial Report
It was resolved that the Financial Report be received.

P McLeod/A Paterson

P McLeod spoke to the report.

Noted that:
- Creditor of $25,394 will not have much impact as it is mainly made up of Journal accounts owing at 31 March 1996.
- SIG activities becoming more significant. Seminars need to cover costs.
- Examinations will continue to cost money. Examinations have high fixed overheads.
- Auditors fee particularly high for 1995/96. This has been addressed by engaging a local accountant and auditor.
- Travelling expenses are high due to additional costs for the history publication.
- Journal account high because there were five issues in the one year.

It was resolved that the Financial Report be adopted.

P McLeod/D Dixon-McIver

Election of Officers
The following members of Council were elected unopposed:

President	S Gainsford
Vice President	A Paterson
Region 5 Representative	L Milligan

An election was necessary for the position of Secretary/Treasurer and Region 3 Representative.

The election result was:

Secretary/Treasurer	D Dixon-McIver	79
	T Rollinson	109
Region 3 Representative	A Kempthorne	14
	C Kendrick	35

T Rollinson and C Kendrick were declared elected to the positions of Secretary/Treasurer and Region 3 representative respectively.
No nominations had been received for the positions of Region 1, Region 2 and Region 4 representatives. The incoming Council will consider these vacant positions.

Remits
It was resolved that Policy Decision Number 3 be reaffirmed.
"Policy Decision No 3 (1972): Council will make and administer awards to members of the Institute, the details of each award will be recorded and may be amended from time to time by resolution of Council. The summary of these details shall be published annually in the Newsletter.

A Paterson/T Rollinson

It was resolved that Policy Decision Number 5 be reaffirmed.

"Policy Decision No 5 (1978): That medical supply companies should

not be approached to aid in the finance of Specialist Interest Group meetings; companies may be invited to Regional Seminars and although donations may be accepted money is not to be solicited.

P McLeod/D Dixon-McIver

It was moved that subscription rates for membership be adjusted from April 1, 1997 to be:

Members	$101.40
Associate members	$48.10
Non-practising members	$44.20

P McLeod/B Main

Discussion:

- Members were concerned that the increase would not cover expenditure.
- Membership subscription rates should be looked at on an annual basis.
- Council should be aiming to make a small surplus each year.
- Analysis should be done of how many members may be lost due to subscription increase. May negate the increase.
- Council should do a two year budget and a projected three year budget and come back to the membership with a subscription fee that will cover the three year projection.
- It was felt that instead of a 10% increase in 1997, that the subscription should be a rounded off figure.

It was moved that an amendment be made to the suggested subscription rates as follows:

Members	$104.00
Associate members	$52.00
Non-practising members	$44.20

This amendment was withdrawn.

Further discussion:

- Some members disagreed with the increase of 10% as inflation is running at 2% and laboratory workers wages are not increasing. Felt that it would be more realistic at a 4-6% increase.
- Noted that the increase has not been done annually. The fees increased last year which was the first time in over five years.
- Felt there is a need to increase membership numbers.
- Non-members are paying an extra fee for Institute activities. This should be pointed out to non-members and encourage them to join.

It was resolved that the subscription rates for membership be adjusted from April 1, 1997 as submitted under remits. That is:

Members	$101.40
Associate members	$48.10
Non practising members	$44.20

P McLeod/B Main
Carried

Fellowship

T Rollinson spoke to the discussion document which was circulated to members in the NZIMLS Journal.

It was resolved that the Fellowship proposal as outlined in the discussion document be adopted.

T Rollinson/B Main

Discussion:

- Noted that the three avenues proposal, does not allow for an exemption category and that the door should not be closed on this avenue.
- Questioned why Council are considering dropping an examination that people are sitting to bring in something that people are not sitting.
- Part one of Fellowship will be as per the Specialist examination. There is nothing to stop a person sitting part one and not going any further.
- Noted that it is important to have a post graduate qualification run by the profession.
- Response from the Universities is that the Institute should go it alone and keep the Fellowship as a qualification for the profession.
- Would not recommend that Fellowship be replaced by Masters.
- The Institute has had problems by giving Fellowship by exemption.
- Some members felt that exemption should be an avenue to Fellowship.
- Fellowship by way of publication would require that the author of the publication was the main author.
- Those with a Specialist examination will have the opportunity to sit part 2 of Rout 1 to gain a Fellowship.
- A time limit will be put on part two. That is after completing part one, a treatise should be submitted in 1-3 years. This will keep people focused and this is also in line with most Institutions fellowships.
- Regulations will be developed.

It was resolved that the proposed Fellowship document as outlined in the NZIMLS Journal be adopted.

T Rollinson/B Main
Carried

Six voted against.

Awards

Trust Awards

The Medical Laboratory Science Trust had given awards during the year to:

- Grant Storey
- Jan Hutchin
- Les Milligan
- Maurice Roberts

The Trust and the profession are very grateful to Abbott Diagnostics for their donation made to the Trust each year.

The award winners were announced and the awards where possible were presented by the President.

Qualified Technical Assistant Awards

Clinical Biochemistry	Rachel Deuchrass, Southland Medlab
Haematology	Rosa Mendes, Diagnostic Laboratory
Histology	Penelope Ashton, Medlab Tauranga
General	Patricia Warrington, Dunedin Hospital
Immunology	Jennifer Lucas, Medlab South
Medical Cytology	Elizabeth Millar, Southland Medlab
Microbiology	Edward Edelman, Palmerston North Hospital
Transfusion Science	Roanne Barnes, Palmerston North Hospital

Certificate Awards

Histology	Angela Woods, Cardinal Community Laboratories
Transfusion Science	Anne Burnand, Waikato Hospital
Virology	Peter Johns, Dunedin Hospital

Specialist Certificate Awards

Haematology	Louise McGregor, Auckland Hospital
Immunology	Lisa Brennan, Wellington Pathology

Microbiology	Trevor Anderson, Canterbury Health Laboratories
Transfusion Science	Stephen Silk, Hutt Hospital

Journal Awards

NZIMLS Journal Award	Ann Thornton, Wellington School of Medicine
Dade Diagnostic Award	Brian Millar, Diagnostic Laboratory
Roche Diagnostic Clinical Chemistry Award	Russell Sargon, Greenlane Hospital
Editors 50th Jubilee Award	Stephen Henry, Auckland Regional Blood Service

Other Awards

Jim Le Grice Student Award	Penny Newton, Canterbury Health Laboratories

Honoraria

It was resolved that no honoraria be paid.

S Gainsford/W Wilson

Auditor

It was resolved that Hillson, Fagerlund and Keyse be appointed as the Institute's auditors.

P McLeod/T Rollinson

General Business

Ron Mackenzie expressed a vote of thanks to the Institute for their continuing support of the PPTC by way of a $5,000 donation towards the Pacific Quality Control programme. Without this donation the programme would not be able to be kept going.

Voting Papers

It was resolved that the voting papers be destroyed.

D Dixon-McIver/A Paterson

Health and Safety Act

G McLeay suggested that the profession make submission to the Health and Safety regulations. Asked that people write to the Ministry for the Environment advising what they think would be required in the regulations as once the regulations are set, they would be difficult to change.

Acknowledgement

S Gainsford acknowledged and thanked D Reilly and P McLeod for their contribution to the Institute and the profession during their time on Council. A vote of thanks was also expressed to L Mayhew for her term of office, especially for her newsletter which she sent to her region.

Membership

A Paterson challenged the membership to get new members.

1997 Annual Scientific Meeting

Will be held in Wellington and Convened by Gerard Verkaaik, Blenheim.

1998 Annual Scientific Meeting

There were no offers to organise the 1998 conference.

The meeting closed at 6.10pm

INSTITUTE BUSINESS
Office Bearers of the N.Z.I.M.L.S. 1996-1997

President
Shirley Gainsford
Valley Diagnostics, Lower Hutt

Vice President
Anne Patterson
Lakeland Health, Rotorua

Secretary/Treasurer
Trevor Rollinson
Southern Community Laboratories, Dunedin

Council
Pip Sarcich, Chris Kendrick, Les Milligan
Tony Mace, Grant Moore

Executive Officer
Fran van Til
P.O. Box 3270, Christchurch
Phone/Fax (03) 313-4761.

Please address all correspondence to the Executive Officer, including Examination and Membership enquiries.

Editor
Rob Siebers
Dept. of Medicine, Wellington
School of Medicine, P.O. Box 7343
Wellington South.
E-Mail:rob@wnmeds.ac.nz

Membership Fees and Enquiries
Membership fees for the year beginning April 1, 1997 are:

For Fellows – $101.40 GST inclusive

For Members – $101.40 GST inclusive

For Associates – $48.10 GST inclusive

For Non-practising members – $44.20 GST inclusive

All membership fees, change of address or particulars, applications for membership or changes in status should be sent to the Executive Officer at the address given above.
Members wishing to receive their publications by airmail should contact the Editor to make the necessary arrangement.

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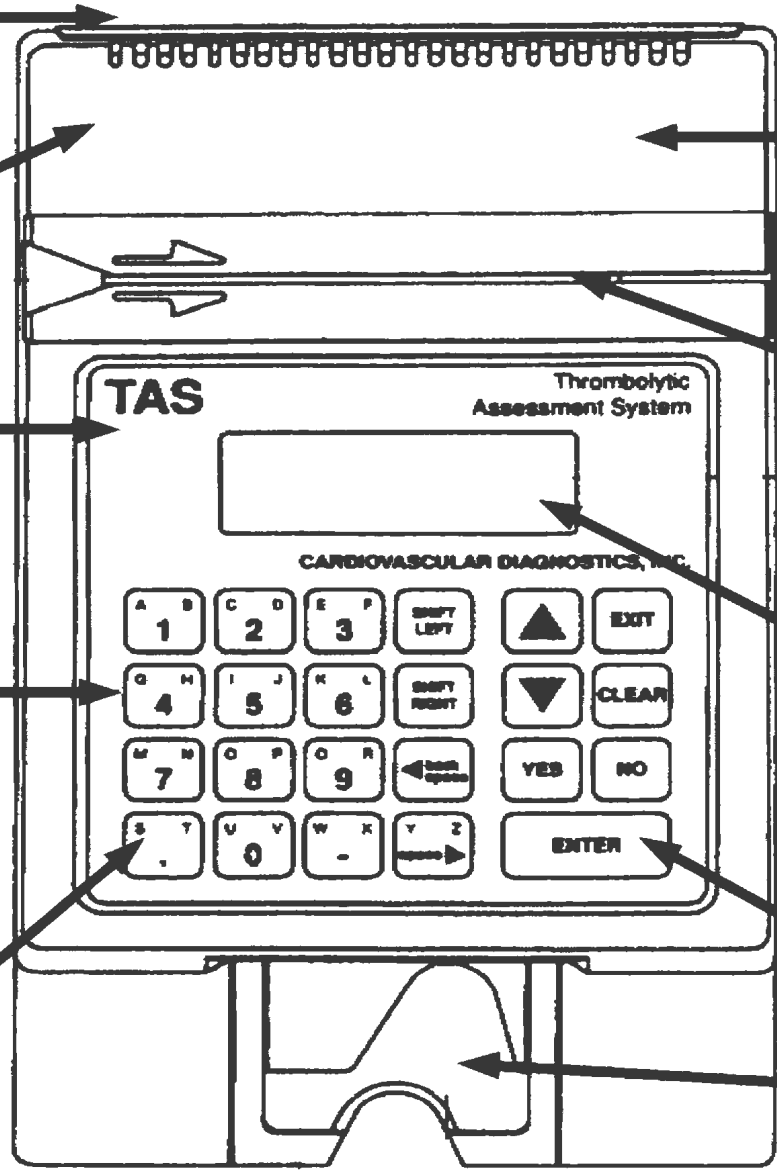

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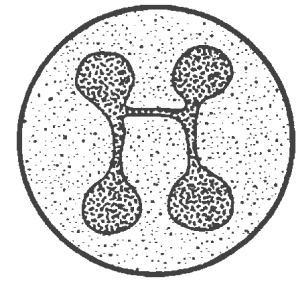


Journal Based Learning Questionnaire

So how did every one get on? Hope the article wasn't too lengthy and you did manage to retain some of the detail, or revise what you already knew.

Thanks to all those Technologists who did participate in our first 'Journal Based Learning Questionnaire'. I have had enquiries from as far south as Invercargill to right up north in Whangarei. The programme seems to be well accepted among the smaller laboratories and thanks again to the positive feedback that we have received. Unfortunately we have missed the deadline date for the next NZIMLS journal but do look out in the following journal (published in November) for our next questionnaire. We hope that it will be based on the subject of Coagulation.

Answers to the Journal Article

The Pathology of the Chronic Lymphoid Leukaemias. Kroft SH, Finn WG, Peterson LC. *Blood Reviews* 1995; 9:234-250

1. F the leukaemic phases are included in the classification
2. T
3. F the classification also included the presence or absence of cytopenias
4. T
5. T
6. F process weak surface immunoglobulin
7. T
8. F Richter's syndrome occurs in 5-10% but not more than 10%
9. F T-cell origin also
10. F without lymphadenopathy
11. F they infrequently express CD5
12. T
13. T
14. T
15. F also specific although a wide variety of haematological neoplasms may rarely show positive staining
16. T
17. F negative for CD25 and TRAP
18. T
19. F T-helper phenotype is CD4+/CD8-
20. T
21. T
22. F SS less bizarre appearance than ATLL cells
23. T

Answers to the Table of Results

Patient 1 B-PLL
Patient 2 HCL

MOLS-Maintenance of Laboratory Standards

We all know what it stands for but what else do we know?

It is a pilot programme to be carried out for a four year period, starting in January 1996. It has been developed by the Medical Laboratory Technologist Board (MLTB) but is administered by the New Zealand Institute of Medical Laboratory Science (NZIMLS).

That every practising Registered Medical Laboratory Technologist in NZ is eligible for the scheme and was sent a booklet – 'Information Kit' some time ago (December 1995) which outlined the purpose of the programme.

Which was what exactly? 'Greater concern for continuing professional competence is occurring in a number of countries where a number of professional bodies are exploring the implementation of obligatory programmes. The MLTB has the philosophy that technologists should attend continuing education as an essential part of the competent practice, but also the maintenance of that competence be demonstrated by documented evidence.' To ensure that technologists are involved in a range of ongoing educational activities which maintain their professional standards once registration has been granted, so that they continue to provide the highest quality of laboratory medicine.' (This was taken straight from the MOLS information kit.)

The HSIG have recently met with one of the MLTB members to discuss some of the issues that we feel needed to be addressed, also putting forward some suggestions which were welcomed and shall be considered along with any other ideas that they have been presented with so far.

Some questions that you have have (as we certainly did).

I never received a MOLS booklet (which has all the relevant tally sheets and breakdown of credits in it), so where can I get another one from?

There are plans for the MLTB to reprint the MOLS information kit and send it out to the Charge Technologist in each laboratory. You will be able to obtain this from your Charge Tech, then photocopy the appropriate pages (6-11) and keep this among your own records of attendance of seminars, conferences etc.

I found the MOLS booklet not particularly user-friendly, do I have to use it?

You can keep your own record on whatever format that works best for yourself, but it should be transferred into the MLTB tally sheets if you are asked to provide it. If you find the tally sheets too difficult to work with, then send a letter outlining exactly what is the problem with it in your opinion, this can be assessed along with any other comments that technologists may have about the pilot programme. The HSIG suggested that they print a tally sheet in the journal that could be torn out and photocopied if need be, this would be a lot less expensive to print and post out to each technologist. *It can not be stressed enough that it is very important to give any form of feedback/suggestions to the MLTB while we are still in the four year period of the pilot programme..*

Why should I keep a record of my credits as it is only a pilot programme? What will happen if I do not hand in my tally sheet at the end of the year.

Firstly only 5-10% of the registered Medical Laboratory Technologists will be asked to send in their booklets (or copy of) for assessment at the end of each year during the pilot programme. If you choose not to keep a tally of your own credits then it will be of no help to the MLTB who are trying to set up a programme that could one day be compulsory (maybe even a requirement for your annual practising

licence). Which is why it is very important now to establish where the faults are with the programme and suggest any changes while we can.

As a part timer I feel severely disadvantaged, at this stage over 2/3 of the credits can be made up by just working full time, is this fair?
HSIG have met with a member of the MLTB and discussed this issue at great length. Remember too that the MLTB have had back their first 10% of practising registered technologists tally sheets (of which some of those must have been part timers). They do recognize that there is a problem and will no doubt address it. While we are still in the pilot programme this may be an excellent time to keep a record of your credits obtained over the year and then send it in to the MLTB to be assessed along with the other 5-10%, showing them on paper the difficulties you may be finding in making up those credits.

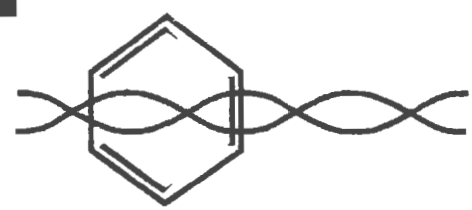
In the Continuing Laboratory Education there seems to be points allocated to various meetings/workshops, is there any points allocated to in-house continuing education programmes?
It was established that there would only be points allocated to those present at an in-house continuing education meeting, and even those others that were attending the meeting were also learning it was actually just 'good laboratory practice'.

Remember that all feedback/suggestions are welcome and probably essential during this pilot programme, so if you do have something to add, please put it in writing and post it to the:
Executive Officer
The New Zealand Institute of Medical Laboratory Science,
PO Box 3270, Christchurch

Biochemistry

Special Interest Group

Convenor: Alison Buchanan
Clinical Biochemistry
Main Building
Auckland Hospital
Ph: (09) 307 4949
Ext: 7553
Fax: (09) 307 4939



Are There Any Biochemists Out There???

The Biochemistry Special Interest Group is still alive but not so well. We regret having to cancel the BSIG seminar due to the lack of registrations and speakers.

Thank you to all those who volunteered their services.

The BSIG committee is a small group of people endeavouring to keep up the interest in biochemistry.

WE NEED YOUR SUPPORT!!!
Without your support, it is difficult to run seminars where biochemists from all over New Zealand can meet and exchange ideas.

Does your laboratory have a continuing education programme? Here at Auckland, there is a fortnightly continuing education programme. The different sections in Clinical Chemistry give short presentations (10-15 minutes) on current topics. The topics may be related to a new method, an interesting case study or a change in procedure. Guest speakers from other departments in the hospital are also invited to speak. It is an opportunity to keep staff informed and is an excellent forum for discussion.

Some of the topics: Creatine Kinase
Blood Gases and QC of results
Specimen Reception protocols
Ionised Calcium measurement
Catecholamines
STD specimens and protocols
Therapeutic drug monitoring

Let us know what your laboratory is doing – however small, however big. These are the things that seminars are made of. The BSIG committee will then know the topics of interest from around other laboratories in the country and we will be able to organise seminars that will be of benefit to all.

Other News
MLTB examinations will be run for the last time this year, but we still need examiners for Specialist/Fellowship and QTA examinations. We have a small team – some of whom wish to retire – so we would really like to hear from anyone else who would like to volunteer their services. We wouldn't throw you in at the deep end. There would be support from experienced examiners.

Remember, when you were doing your training, someone was investing their time and efforts to set exam papers to enable you to qualify. Can you give some of your time in return?

Histology

Special Interest Group

Convenor: Elaine Mullins
Contract Address: C/o Pathology, Taranaki Base Hospital, Private Bag, New Plymouth
Phone: 06 7536139 Ext 7874
Fax: 06 7532956

HISTOLOGY SPECIAL INTEREST GROUP SEMINAR 1996

The Histology Special Interest Group Seminar 1996 was the effort of a committee drawn from all the medical laboratories in Christchurch. A rare feat in these competitive times (and we are all still talking to each other).

The response to our first newsletter/questionnaire was tremendous and after a few initial hiccups we decided our seminar venue would be the Quality Hotel.

The seminar drew a record number of 80 delegates from all areas of the country and most aspects of Histology.

There were 13 papers presented, all to a very high standard. The award for Best First Time Speaker went to Edith Schofield – Canterbury Health Laboratories for her paper 'Diagnosis of Hirschprungs Disease', Edith also won best over all paper. The runner up was Ann Thornton – Wellington School of Medicine for her paper 'LEA. 135 Expression Correlates With Tumour Progression for Transitional Cell Carcinoma of the Bladder'.

The highlight of the day was a delightful presentation on 'The Liver Sieve' by our guest speaker Professor Robin Fraser - Christchurch School of Medicine.

The committee was grateful for the support and assistance given by so many. We believe their contributions and advice helped make the Seminar the great success that it was.

The Seminar culminated in a very enjoyable dinner and social evening.

1997 News

In 1997 a committee from Wellington's laboratories will be organising what we are sure will be another great Seminar for the Histology Special Interest Group. This will be held in conjunction with the NZ Society of Cytology Conference, and a preliminary notice from Wellington advises this will be at the Quality Hotel, Oriental Bay. At this stage, the Histology part of proceedings will be on Saturday 18 October. This is a very good opportunity for those with dual interests to attend both meetings.

14th March 1998

❖

KEEP THIS DATE FREE FOR THE MICROBIOLOGY SPECIAL INTEREST GROUP SEMINAR.

VENUE AND OTHER DETAILS TO BE FINALISED.

WATCH THIS SPACE FOR MORE DETAILS

❖

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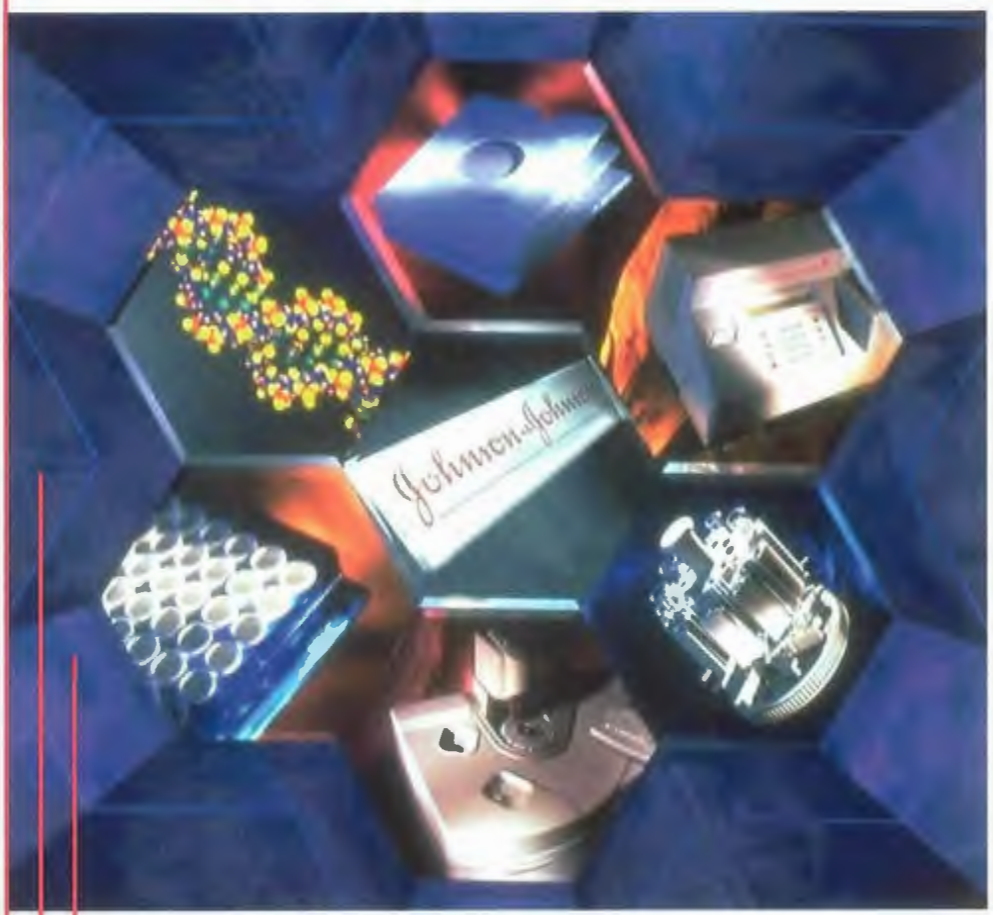

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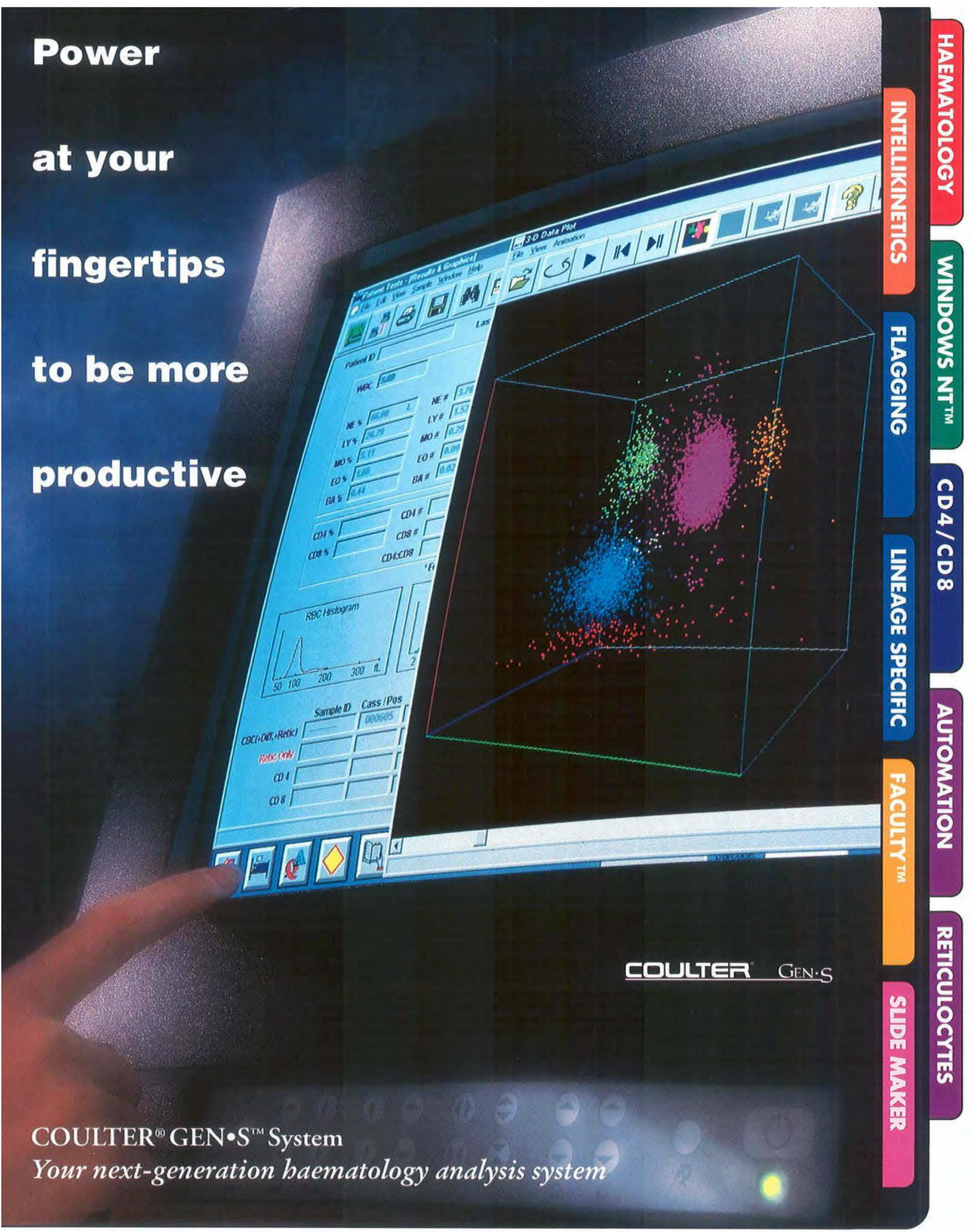

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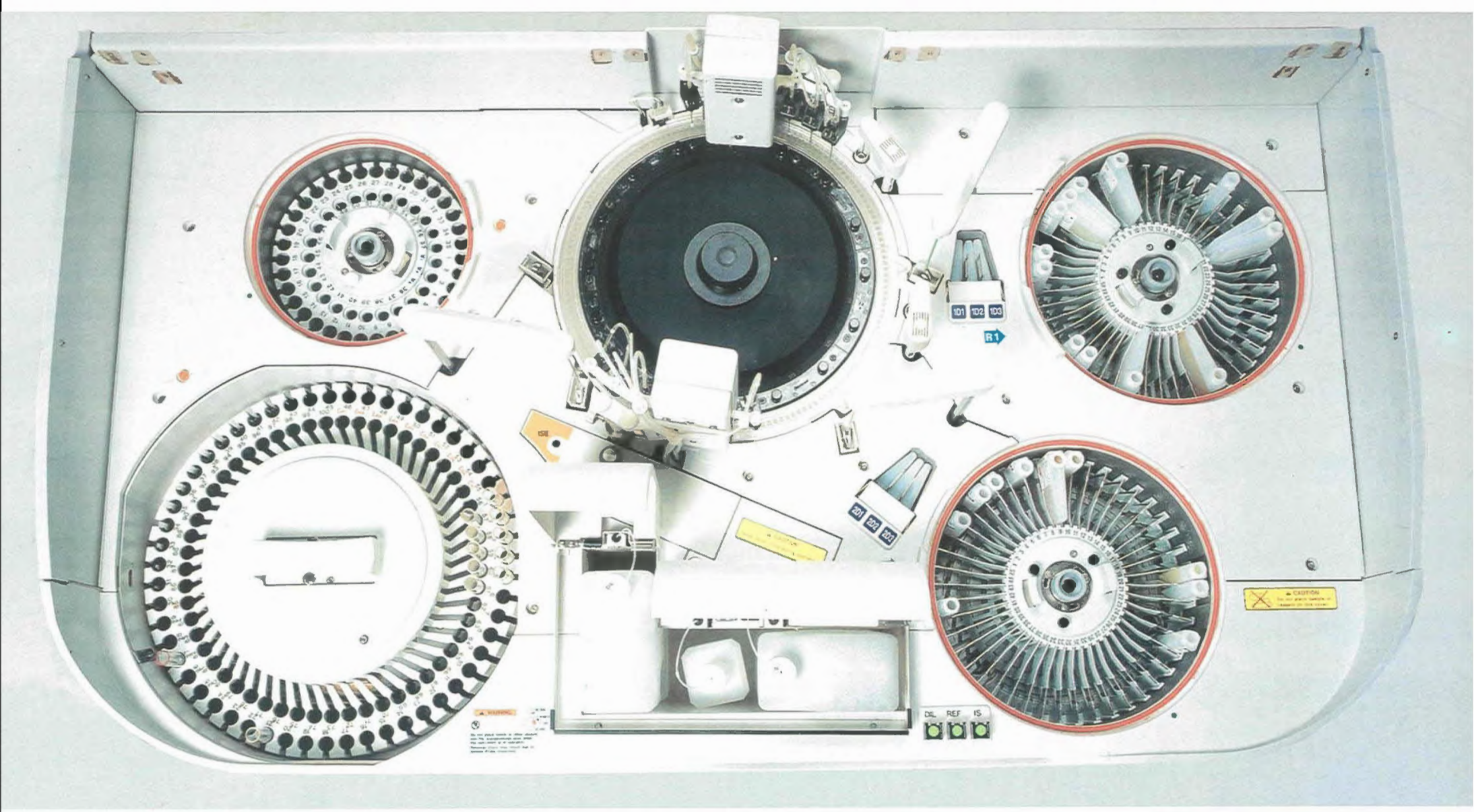

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