

# Laboratory Lines

News from Florida Hospital Clinical Laboratories and Florida Pathology Lab (FPL)

## PANCREATIC AMYLASE

The Laboratory has discontinued the specific test for Pancreatic Amylase. Current instrument platforms allow us to perform only Total Amylase. This is a trend that we have observed in other hospitals and reference laboratories. The possibility still exists to obtain pancreatic isoenzymes, if so desired, but this is a send-out only test, which will need to be performed in a specialized reference laboratory. The reference laboratory test includes the Total Amylase and Pancreatic Amylase, with both results being reported.

If a request is received in the laboratory for Pancreatic Amylase, it will be automatically converted to Total Amylase. If pancreatic isoenzymes are specifically needed, please inform the laboratory. Results from the reference laboratory for pancreatic isoenzymes may not be available until after 3 or 4 days.

Luis A. Guarda, MD  
Pathologist

For further information contact the Laboratory at 407 303 5600, extension 1925.

## URINE ETHANOL SCREENING

Due to changes in instrumentation we can no longer provide a result for urine ethanol screening as part of the toxicology procedure. If ethanol is suspected, please order a serum ethanol level. If you have any questions, please contact Susan White, Orlando campus Chemistry Manager, at ext 4909.

## HIV 1 / 2 ANTIBODY SCREENING

HIV1/2 antibody screening methodology has changed to an automated platform. Bayer Healthcare was the first to receive FDA approval for HIV testing on their Centaur instrument. Reactive patient samples will now be resultated as "repeatedly reactive" (after being tested in triplicate) and will be sent out for Western Blot confirmation. If you

campus Chemistry Manager, at ext 4909.

## SOCIAL SECURITY NUMBERS TO BE REMOVED FROM PATHOLOGY REPORTS

Florida Hospital is dedicated to providing privacy and security to its patients. Therefore, we are taking a proactive approach to ensuring that personal information such as drivers' license numbers, social security numbers and addresses are secure. Effective December 4<sup>th</sup>, 2006, we no longer list the patient's social security number on our pathology reports.

Your office staff can still provide us with a social security number to look up a patient's report since the Laboratory information system will continue to use social security numbers electronically. Please contact the Pathology department if you have any concerns at 407 303 1932, option 1. Thank you very much for your support in this effort to protect the identity of our patients.

## COAGULASE NEGATIVE STAPHYLOCOCCUS ISOLATED FROM BLOOD CULTURES

False-positive blood cultures lead to additional laboratory tests, unnecessary antibiotic use, and longer hospitalizations that increase patient care costs. Assessing the clinical significance of blood cultures that grow potential contaminants can be difficult, but a number of tools have been studied to aid physicians and microbiologists determine whether an isolate is a pathogen or contaminant. One useful aid is the number of blood culture sets that grow microorganisms, especially when measured as a function of the total number obtained. In contrast to patients with endocarditis or other bloodstream infections, in whom all blood cultures or the majority thereof are positive, patients whose blood cultures grow contaminants usually have only a single blood culture (when two or more are obtained) that is positive. One of the organisms considered to be a potential contaminant in blood cultures is coagulase negative staphylococci (CoNS).

Effective January 1, 2007 the Microbiology department discontinued sensitivity testing for blood culture isolates of coagulase negative Staphylococcus (CoNS) when it is isolated from only a single blood culture. The physician will be advised to call the microbiology laboratory if additional workup is needed. When CoNS is isolated from more than one set of blood cultures collected within 48 hours, sensitivities will be provided if they are the same. If the antibiograms are not the same (i.e., two or more differences in susceptibilities—susceptible vs. resistant), the report will be "Two strains of coagulase negative staphylococcus", and susceptibility results will not be provided. Susceptibilities will be provided on all CoNS isolates from neonates, and on any isolate regardless of the number of positive blood cultures sets upon physician request. If you have any questions, please contact Maryanne Ciullo, Orlando campus Microbiology Asst. Manager, at 407 303 7784.

**Florida Hospital Institute of Translational  
Research (FHITR)  
MOLECULAR DIAGNOSTICS LABORATORY  
TEST MENU CHANGES**

Effective October 24<sup>th</sup>, requests for Hepatitis C Virus Genotyping (HCVGNO) are resulted using the new version (v2.0) of the Bayer Versant HCV Genotype Assay (LiPA) kit. The genotyping is based on sequences from the Core Region in addition to the 5'UT Region. This new version will accurately differentiate between subtypes 1a and 1b and will detect genotypes 6c to 6l (currently reported as genotype 1 by 5'UTR-based assays).

On September 9<sup>th</sup>, 2006, the following tests were added to the test menu:

**BKPCR** (BK Virus, Qualitative by Real-Time PCR) or **BKQNT** (BK Virus, Quantitative by Real-Time PCR). BK virus has been associated with hemorrhagic cystitis in bone marrow transplant patients, as well as with ureteral stenosis and transplant-associated nephropathy in patients receiving kidney transplants. BK virus allograft nephropathy (BKVAN) is distinguished by persistent graft dysfunction, often resulting in graft loss. BKVAN is seen in up to 8% of kidney transplant recipients. New intensive immunosuppressive regimens may increase the risk of BKVAN. The superior sensitivity and broad dynamic range of quantitative real-time PCR are useful for excluding the diagnosis of BKVAN, as well as for monitoring a patient's response to treatment.

**CMVPCR** (Cytomegalovirus, Qualitative by Real-Time PCR).

CMV infections in humans are widespread. Infection of normal children and adults usually results in asymptomatic disease, but the infection can cause hepatitis, pneumonia, or a mononucleosis-like illness. If acquired *in utero* or at birth, CMV infection may

result in congenital abnormalities, including hepatosplenomegaly, deafness, and mental retardation. CMV infection is frequent and severe in patients with defects in cellular immunity, such as those with acquired immunodeficiency syndrome (AIDS), recipients of organ transplants, or cancer patients. An important primary source of virus is blood transfusions. Seronegative individuals transfused with blood from seropositive donors have a high risk of developing CMV infection. Thus, serologic testing for CMV is important in screening blood for transfusion to neonates or to immunocompromised patients. Serologic testing for CMV is also included in pregnancy screening tests and as an aid in diagnosing active or recently acquired CMV infections in the mother likely to be acquired by the fetus.

**EBVPCR** (Epstein-Barr Virus, Qualitative by Real-Time PCR)

Epstein-Barr virus is a member of the Herpes virus family, with a tropism for B lymphocytes, where it establishes latency. In transplant settings, it causes post transplantation lymphoproliferative disorder (PTLD). High doses of immunosuppressive drugs allow the virus to escape the immune system, which normally keeps the latent virus in check. Symptoms of PTLD can mimic those of organ rejection, leading to increased immunosuppression, when a decrease in dosage is actually necessary.

If you have any questions, please contact the FHITR MDL at 407 303 2779.