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AFTERWARDS

You will find a pdf of a handout at
http://therapeuticseducation.org/handouts

Objectives

In this workshop we will:

1) outline the problem of lab test measurement and reporting and some of the ways it contributes to the overdiagnosis problem

2) demonstrate with some examples (BP, LDL, glucose, bone density)

3) hopefully offer some useful tips, and suggestions and simple charts for how to deal with this extremely important and relevant healthcare conundrum

4) INTERACTIVE
   Poll questions - internet access
   Play with dice - work through a few scenarios

There any many other issues

arbitrary treatment thresholds

the “black and white” of lab reporting

decision making - sensitivity, specificity, likelihood ratios

- **WE WILL PRIMARILY FOCUS ON LAB VARIATION ISSUES**

Just a few of the diagnoses that are solely or partially lab-based dependent

Acid-Base Disorders
Acidosis and Alkalosis
Acidosis/Alkalosis
aCL Syndrome
ACS
Acute DIC
Acute Idiopathic Polyneuritis
Acute Inflammatory Demyelinating Polyneuropathy
Acute Kidney Injury
Acute Myocardial Infarct
Acute Renal Failure
AD
Addison Disease
Adrenal Insufficiency
Adrenal Insufficiency and Addison Disease
AKI
Albuminuria
Alcohol dependence
Alcoholism
Allergies
Alzheimer Dementia
Alzheimer Disease
AMI
Anemia
Anencephaly
Angiitis
Angina
Angina pectoris
Ankylosing Spondylitis
Anthrax
Anticardiolipin Antibody Syndrome
Antiphospholipid Antibody Syndrome
Antiphospholipid Syndrome
aPL Syndrome
APLS
APS
ARF
Arteritis
Arthritis
AS
Asthma
Atypical Mycobacteria
Atypical Pneumonia
Autoimmune Diseases
Autoimmune Thyroiditis
Avian Flu
Bacillus anthracis infection
Bacterial Arthritis
Bacterial Vaginosis
Benign Prostatic Hyperplasia
Benign Prostatic Hypertrophy
Biological Warfare
Bioterrorism Agents
Bleeding Disorders
Blood in the urine
Bone Marrow Disorders
Borrelia burgdorferi Infection
Borrelia mayonii Infection
BPH
Breast Cancer
CAH
Cancer
Candidiasis
Carbohydrate Intolerance
Cardiovascular Disease
Celiac Disease
Celiac Sprue
Cervical Cancer
CF
CFIDS
CFS
CHF
Chlamydia
Chronic Fatigue and Immune Dysfunction Syndrome
Chronic Fatigue Syndrome
Chronic Kidney Disease
Chronic Thyroiditis
Circumscribed Scleroderma
Cirrhosis
CKD
Coagulopathy
Cobalamin Deficiency
Colon Cancer
Colorectal Cancer
Community-Acquired Pneumonia
Congenital Adrenal Hyperplasia
Congenital Alactasia
Congestive Heart Failure
Conn Syndrome
Consumption Coagulopathy
Copper Storage Disease
CREST
Crohn Disease
Cushing Syndrome
Cutaneous anthrax
CVD
Cystic Fibrosis
Degenerative Joint Disease
Dehydration
Dermatosclerosis
Diabetes
Diabetes mellitus
Diarrhea
DIC
Diffuse Cutaneous Scleroderma
Diffuse Thyrotoxic Goiter
Disaccharidase Deficiency
Discoid Lupus
Disseminated Intravascular Coagulation
Disseminated Intravascular Coagulopathy
Disseminated Lupus Erythematosus
DJD
Double Pneumonia
Down Syndrome
Drug-induced Lupus
DS
Dysmetabolic Syndrome
Ebola Hemorrhagic Fever
Ebola Virus Disease
Ebola Virus Infection
Encephalitis
End Stage Renal Disease
Endocrine Syndromes
Endocrine System and Syndromes
Epilepsy
ESRD
EVD
Excessive Clotting Disorders
Extraosseous Plasmacytoma
Fibromyalgia
Flu
Folate Deficiency
Folic Acid or B9 Deficiency
Food and Waterborne Illness
Food Poisoning
Fungal Infections
Gastroenteritis
Gluten-Sensitive Enteropathy
Gonorrhea
Gout
Gouty Arthritis
Graves Disease
GSE
Guillain-Barré Syndrome
H1N1
H3N2
H5N1
H7N9
Hashimoto Thyroiditis
HBP
HD
Healthcare-Associated Pneumonia
Heart Attack
Heart Attack and Acute Coronary Syndrome
Heart Disease
Heart Failure
Hematuria
Hemochromatosis
Hemoglobin Abnormalities
Hemoglobin Barts
Hemoglobin C Disease
Hemoglobin E Disease
Hemoglobin S
Hemoglobin Variants
Hemoglobinopathy
Hepatic Disease
Hepatitis
Hepatolenticular Degeneration
Hereditary Persistence of Fetal Hemoglobin
Herpes
Herpes Zoster
High Blood Pressure
HIV
HIV Infection and AIDS
HL
Hodgkin Disease
Hodgkin Lymphoma
Hospital-Acquired Pneumonia
HPFH
HPV
Hughes Syndrome
Huntington Disease
Huntington's Chorea Disease
Hypercoagulable Disorders or States
Hyperparathyroidism
Hypersensitivity
Hypertension
Hyperthyroidism
Hypoparathyroidism
Hypothyroidism
IBD
Icterus
Infectious Arthritis
Infectious Polyneuritis
Infertility
Inflammatory Bowel Disease
Influenza
Influenza A
Influenza B
Inhalation anthrax
Inherited Copper Toxicity
Insulin Resistance
Insulin Resistance Syndrome
Iron Overload Disease
Iron Storage Disease
Jaundice
JIA
JRA
Juvenile Idiopathic Arthritis
Juvenile Rheumatoid Arthritis
Keratoconjuntivitis Sicca
Kidney Disease
Lactase Deficiency
Lactose Intolerance
Landry's Ascending Paralysis
LE
Lead Poisoning
Leukemia
Limited Cutaneous Scleroderma
Linear Scleroderma
Liver Disease
Lobar Pneumonia
Localized Scleroderma
Lower Respiratory Tract Infection
Lung Cancer
Lung Diseases
Lupus
Lupus Anticoagulant Syndrome
Lupus Erythematosus
Lyme Disease
Lymphocytic Thyroiditis
Lymphoma
Malabsorption
Malaria
Malignancy
Malignant tumor
Malnutrition
MDS
ME
Melanoma
Meningitis and Encephalitis
Meningococcal Meningitis
Menopause
Metabolic Syndrome
MG
MI
Morphea
MOTT
MPDs
MPNs
MRSA
MS
Multiple Myeloma
Multiple Sclerosis
Myalgic Encephalomyelitis
Myasthenia Gravis
Mycobacteria other than tuberculosis
Mycoses
Myelocele
Myelodysplasia
Myelodysplastic Syndrome
Myelomeningocele
Myeloproliferative Disorders
Myeloproliferative Neoplasms
Myocardial Infarct
Neonatal Lupus
Nephrotic Syndrome
Neural Tube Defects
Neuropathy
NHL
Non-Hodgkin lymphoma
Non-Small Cell Lung Cancer
Nontuberculous Mycobacteria
Nontuberculous Mycobacteria Infections
NTD
NTM
OA
Obesity Syndrome
Osteoarthritis
Osteoarthrosis
Osteoporosis
Ovarian Cancer
PA
Pancreatic Cancer
Pancreatic Diseases
Pancreatic Insufficiency
Pancreatitis
Parathyroid Cancer
Parathyroid Diseases
PCOS
Pelvic Inflammatory Disease
Peptic Ulcer
PID
Pituitary Disorders
Plasma Cell Dyscrasia
Plasma Cell Myeloma
Plasma Cell Neoplasm
Plasmacytoma
Plasmacytoma of Bone
Pneumonia
Polycystic Ovary Syndrome
Porphyria
Post-infectious Arthritis
Pre-eclampsia
Pregnancy
Pregnancy-induced Hypertension
Presenile Dementia
Primary Aldosteronism
Primary Hyperaldosteronism
Prinzmetal's angina
Prostate Cancer
Protein in urine
Proteinuria
RA
Reactive Arthritis
Reaven Syndrome
Renal Disease, Kidney Failure
Rheumatoid Arthritis
Rheumatoid Spondylitis
Sarcoidosis
SCD
Scleroderma
SEID
Seizure Disorder
Sepsis
Septic Arthritis
Sexually Transmitted Diseases
Sexually Transmitted Infections
Shingles
Sicca Syndrome
Sickle Cell Anemia
Sickle Cell Disease
Sjögren Syndrome
SLE
Small Cell Lung Cancer
Spina bifida
Spinal dysraphism
Spinal Meningitis
SSc
Stable angina
Staph
Staph aureus
Staph Infections
Staph Infections and Methicillin-Resistant Staphylococcus aureus
Staphylococcus aureus
STDs
Stein-Leventhal Syndrome
Sticky Blood Syndrome
STIs
Stomach Flu
Stroke
Subacute Cutaneous Lupus
Swine Flu
Syndrome X
Syphilis
Systemic Exertion Intolerance Disease
Systemic Lupus Erythematosus
Systemic Scleroderma
Systemic Sclerosis
TB
Testicular Cancer
Thalassemia
Thrombophilia
Thyroid Cancer
Thyroid Diseases
Toxemia
Toxic Diffuse Goiter
Travelers' Diseases
Trich
Trichomonas
Trichomoniasis
Trisomy 21
Tuberculosis
Types of Liver Disease
Ulcerative Colitis
Unstable angina
Urinary Tract Infection
UTI
Vaginal Infection
Vaginitis and Vaginosis
Vaginitis/Vaginosis
Variant angina
Vasculitis
VD
Venereal Diseases
Vitamin B12 and Folate Deficiencies
Vitamin B12 Deficiency
Vitamin K Deficiency
Vulvovaginitis
Walking Pneumonia
West Nile Virus
Wilson Disease
WNV
Wound and Skin Infections

“It is commonly thought that laboratory tests provide two-thirds to three-fourths of the information used for making medical decisions. If so, test results had better tell the truth about what is happening with our patients.”

Clinica Chimica Acta 2004;346:3-11

THESIS

"For much in medicine, we knowingly sell preeminent precision even though we all know in our heart of hearts we can only deliver educated estimates.
I believe most patients would be very understanding about this imprecision if we were just more open about it."
-James McCormack, Pharm D (1959 - hopefully not soon)

"We also CAN'T be precise about the imprecision"

We are speaking in general, and do realise there are always some exceptions

We are presenting concepts

We will be providing ball-park estimates

Two Problems with Faking Precision

FALSE BELIEFS

BELIEF #1 - the good/bad thresholds are relatively black and white

BELIEF #2 -when the numbers change these changes are real

These beliefs can potentially lead to inappropriate feelings
of fear, happiness, frustration, confusion…

Both in patients AND clinicians

Sources of Imprecision

Lab Error

0.3%

~60% pre-analytical
~15% analytical
~ 25% post analytical

Analytic variation

CV~1-5%

Biologic variation

CV~1-25%

Measurement Landscape

Assuming no pre-analytic issues - timing/labelling etc

Population-based reference intervals

Analytical Variation

Analytic variation

CVA - analytical variation

Biological Variation

Biologic variation

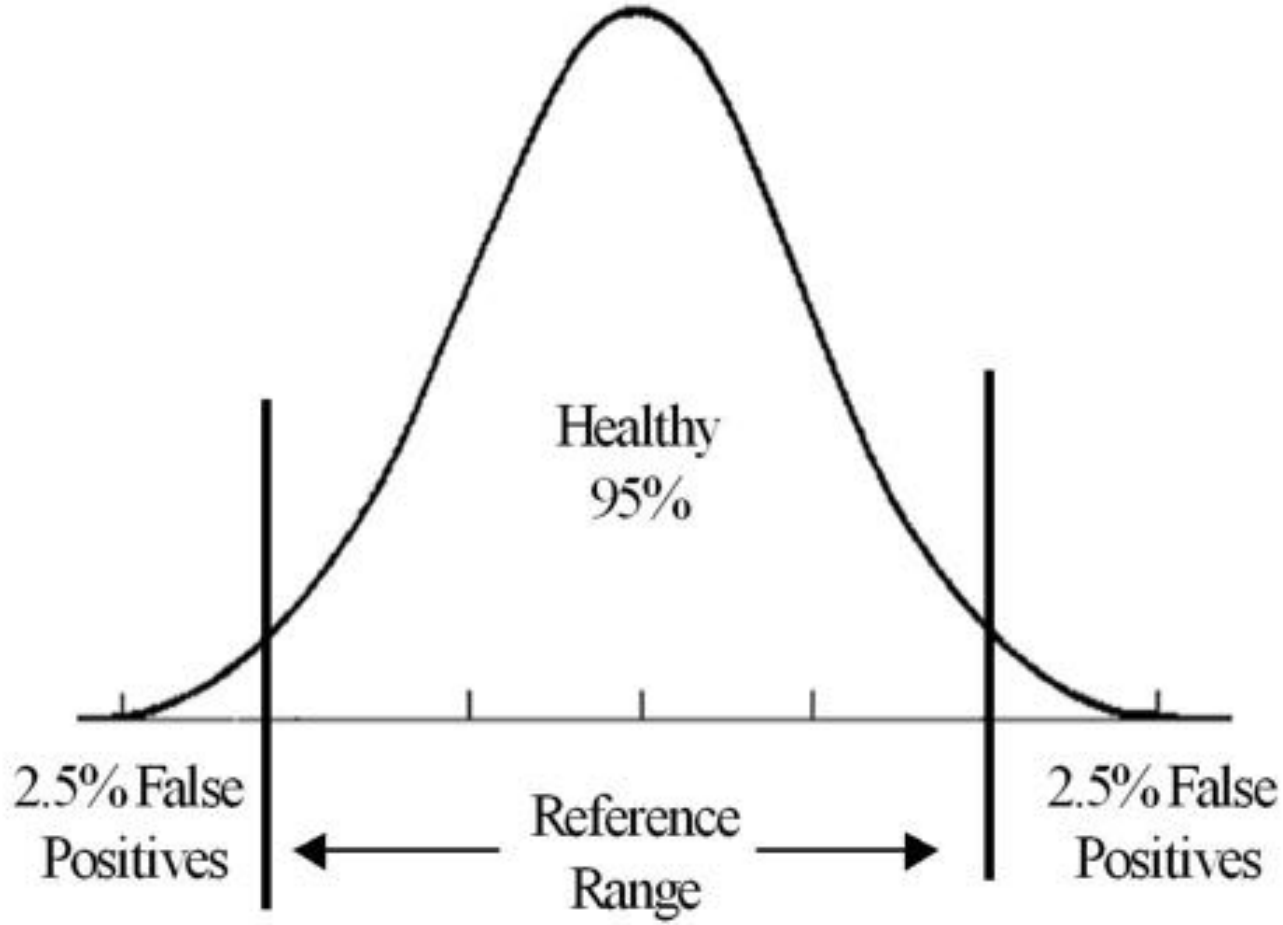
CVI - within subject

CVG - between subject

Reference change values (RCV)

Population-based reference intervals

The interval/range where 95% of healthy people fall



Lab results report
exact numbers
BUT
Every test result is
really only a range
that hopefully includes
the true result
+/- 1-2% up to
+/-20-30% or more

YOU CANNOT BE SERIOUS!!
That ball was on the line

Number of Tests Ordered	Probability of at Least One Abnormal Test
1	5%
2	10%
5	23%
10	40%
15	54%
20	64%

When we do tests, typically we are wondering

what are the results NOW, and/or

have they changed from PREVIOUS measurements

Analytic variation

Biologic variation

Every “measurement” will be “different”

Analytic variability
Biologic variability

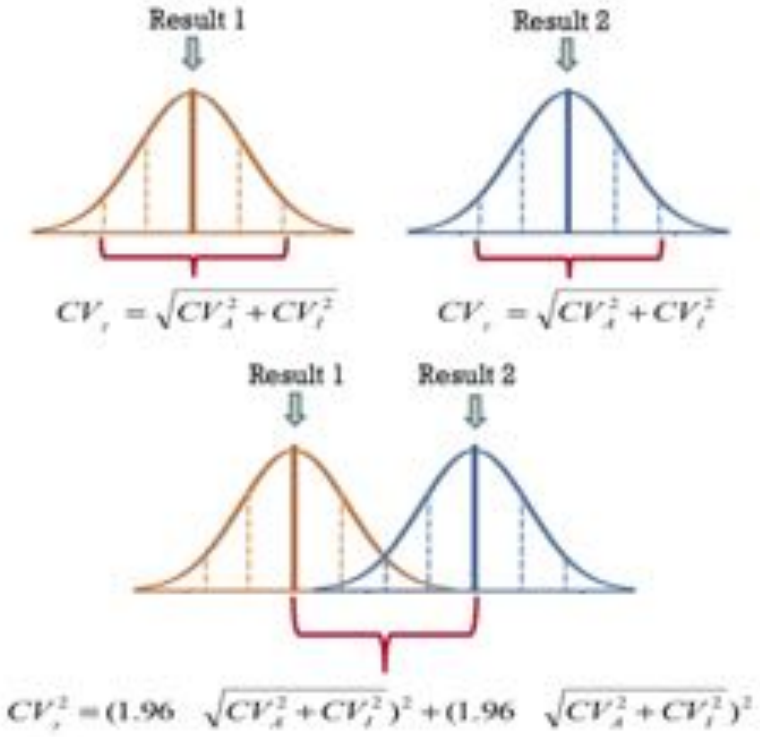
Reference Change Values (RCV)

a tool for assessment of the significance of differences in serial results from an individual

Reference Change Values

Used with SERIAL results to help deal with the analytic imprecision and biologic variation

Coefficients of Variation (total) = analytic PLUS biologic variation



MINIMUM DIFFERENCE between two consecutive results which needs to be EXCEEDED in order for one to state a STATISTICALLY SIGNIFICANT change has taken place

How good, analytically speaking, does a “test” need to be

“The analytical CV (CVA) should be less than one-half the average within-subject biological variation (CVI)”

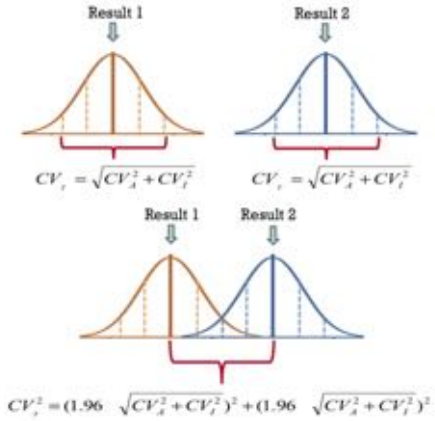
When it is, the CVA has almost no impact on the RCV - the RCV is pretty much determined by the CVI

Reference Change Values

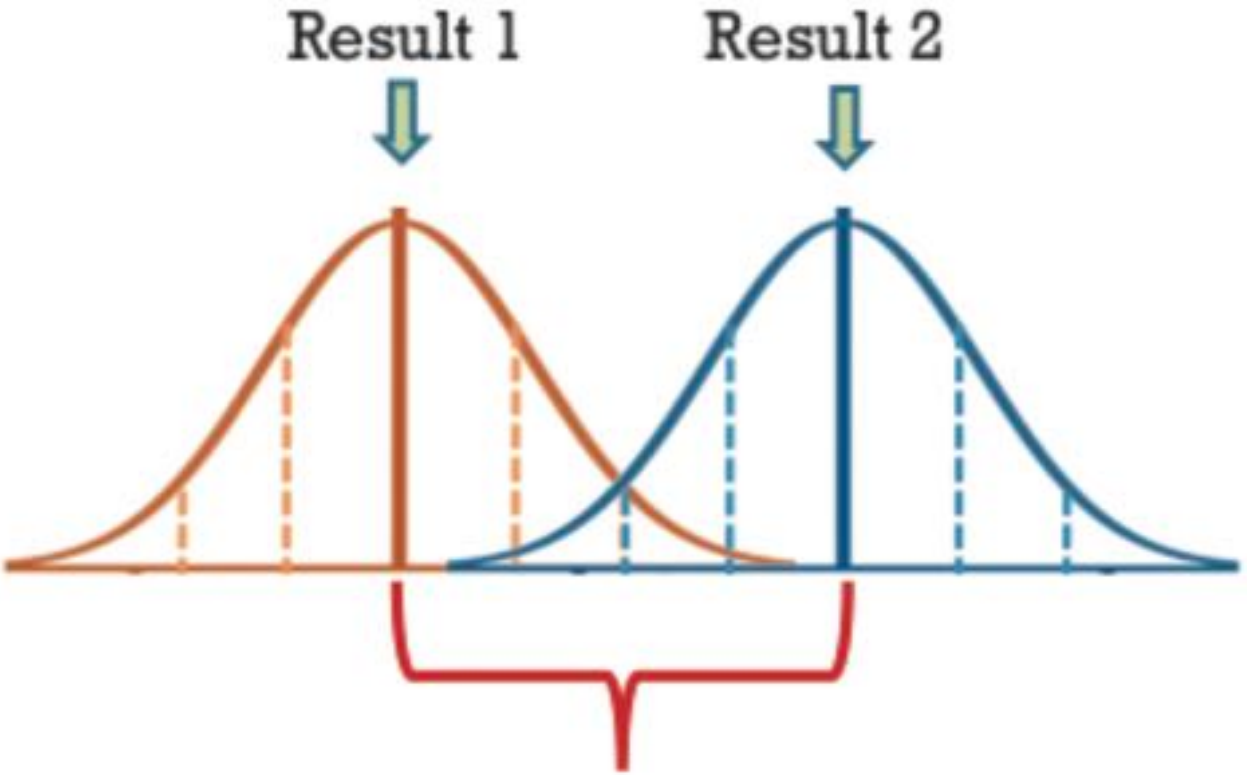
findings of a “significant difference" JUST means we are ruling out that the difference seen is due to chance

NOT

THAT THE MAGNITUDE OF THE DIFFERENCE SEEN IS THE ACTUAL MAGNITUDE OF THE DIFFERENCE



We believe these two results are different



can’t necessarily quantify this difference with any precision

What about multiple measurements?

Table 1. RCV using multiple estimates of the initial and new set points, expressed as a fraction of traditional RCV from two singleton measurements.

		Number of results estimating initial set point				
		1	2	3	4	5
Number of results estimating new set point	1	1.00	0.87	0.82	0.79	0.77
	2	0.87	0.71	0.65	0.61	0.59
	3	0.82	0.65	0.58	0.54	0.52
	4	0.79	0.61	0.54	0.50	0.47
	5	0.77	0.59	0.52	0.47	0.45

with 4 measurements before and 4 afterwards
(vs 1 before and 1 after)
you can lower the RCV by 50%

Annals of Clinical Biochemistry 2016;53:413-4

Lab
Error

Analytic
variation

Biologic variation

This is the problem and it is NOT fixable, it is only KNOWABLE

REMEMBER - these numbers are ballpark because

all estimates are rounded

analytic quality varies between labs

biologic variability can include daily, monthly, seasonal variation

biologic variation is unknown for your particular patient

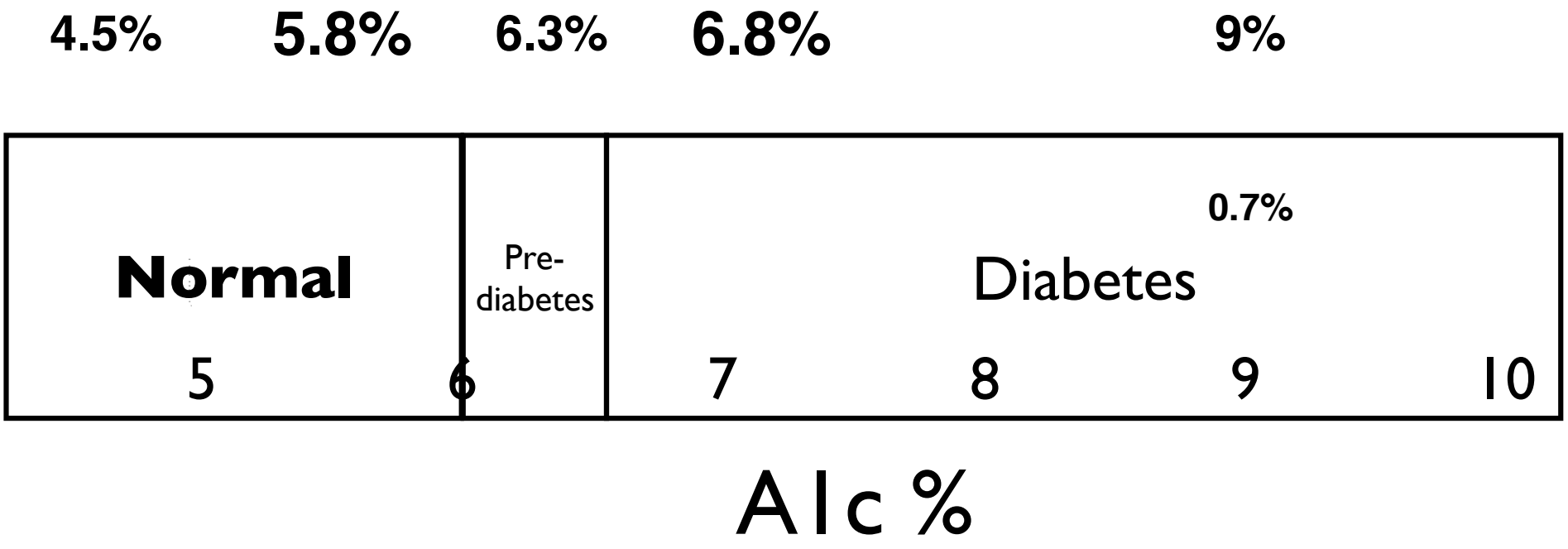
we are arbitrarily choosing ~2 SD

Glucose
Blood pressure
Cholesterol
Bone Density

Glucose

Precisely Imprecise

What an A1c result really means

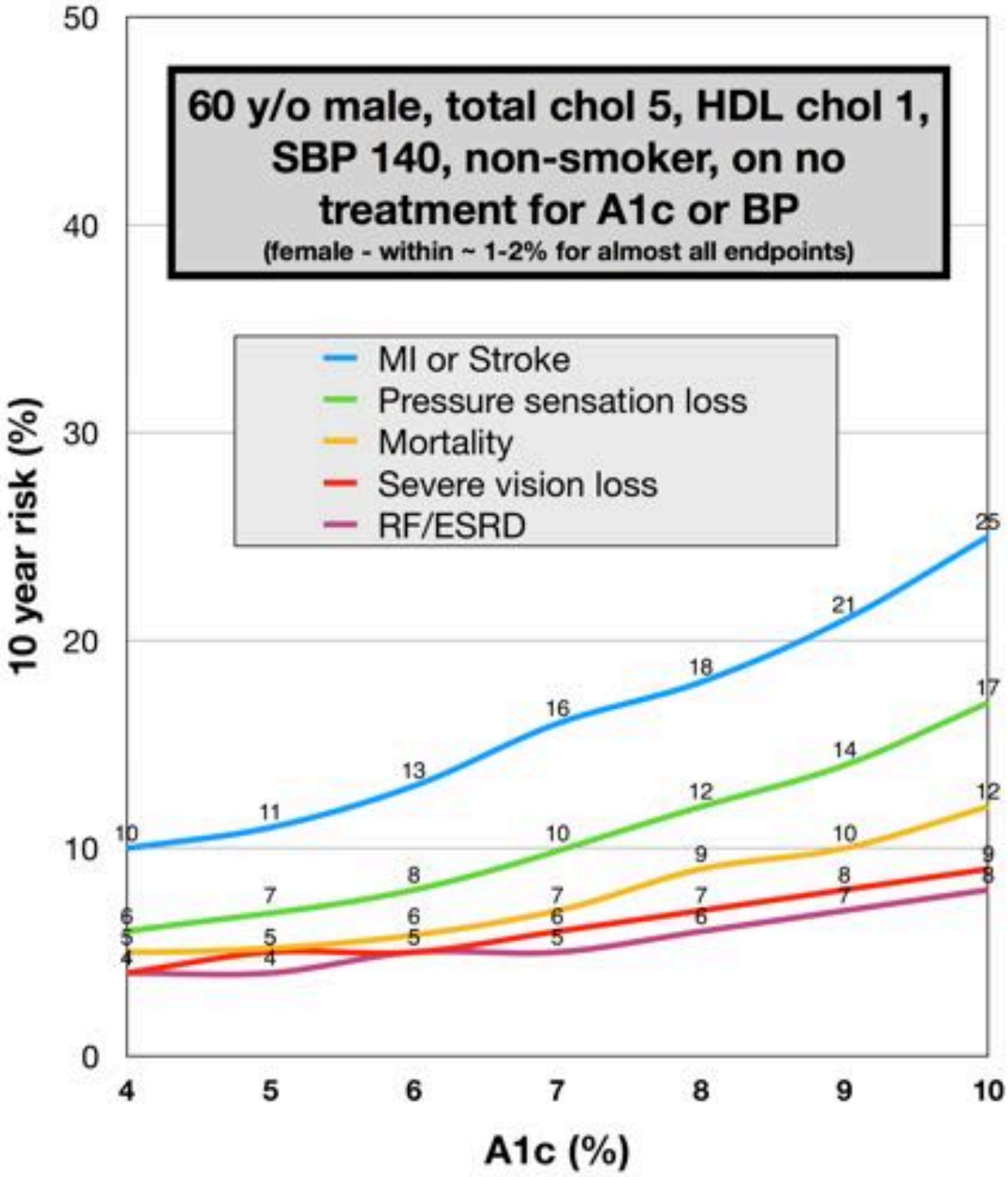


Typical A1c change seen with a medication = 0.7% ⬇

Seasonal variation 0.2-0.5%
Higher in the winter

Am J Epi 2004;161:565-74

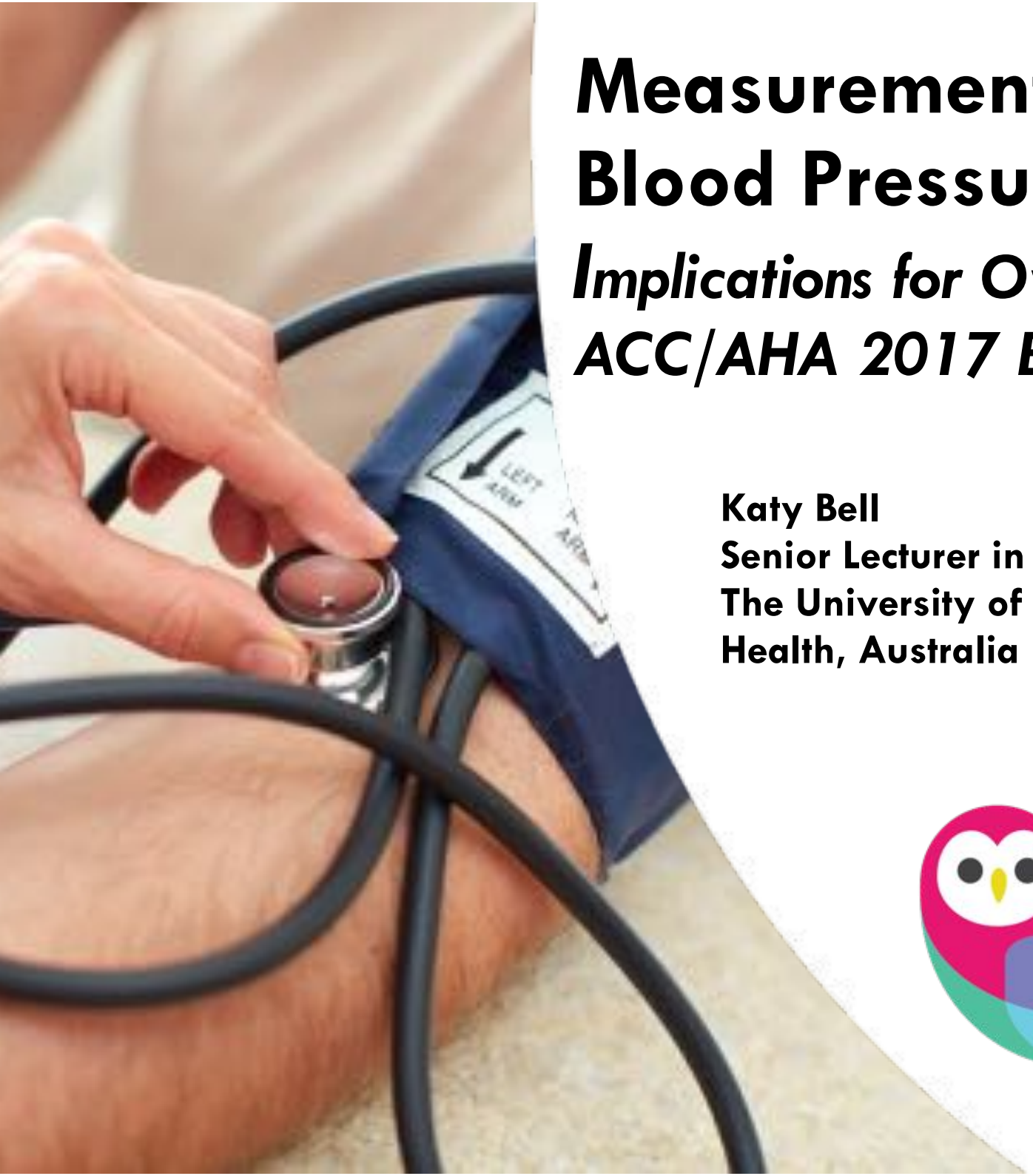
Assume your A1c
is definitely 6.3%



T2DM risk should not be categorized as YES or NO

https://sanjaybasu.shinyapps.io/recodesi/ - from the ACCORD study

Blood pressure



Measurement Variation in Blood Pressure

Implications for Overdiagnosis under ACC/AHA 2017 BP guideline

Katy Bell
Senior Lecturer in Clinical Epidemiology, The University of Sydney School of Public Health, Australia

WISER HEALTHCARE
A RESEARCH COLLABORATION FOR REDUCING OVERDIAGNOSIS AND OVERTREATMENT

“Hypertension”

- The 2017 ACC/AHA lowered the diagnostic threshold for defining hypertension from 140/90 mmHg to 130/80 mm Hg
- Hypertension is a risk factor for cardiovascular disease, not a disease in itself
- No discrete boundary that defines the hypertensive state from the non-hypertensive one

8-Item checklist for modifying the definition of disease

1. What are the differences between the previous and new definition?
2. How will the new disease definition change the incidence and prevalence of the disease?
3. What is the trigger for considering the modification of the disease definition?
4. How well does the new definition of disease predict clinically important outcomes compared with the previous definition?
5. **What is the repeatability, reproducibility and accuracy of the new disease definition?**
6. What is the incremental benefit for patients classified by the new definition vs the previous definition?
7. What is the incremental harm for patients classified by the new definition vs the previous definition?
8. What is the net benefit and harm for patients classified by the new definition vs the previous definition?

From: **Guidance for Modifying the Definition of Diseases. A Checklist**
Doust et al, JAMA Intern Med. 2017;177:1020-1025.

What are the measurement recommendations?

Type of BP measurement	ACC/AHA 2017
Office measurement	• Occasion: 2 readings (1 min apart) • BP: use average of all readings obtained on ≥2 occasions
Ambulatory BP measurement	• Occasion: readings over 12-24 hours (15-60 mins apart) • BP: use average of all readings obtained on ≥1 occasions
Home BP measurement	• Occasion: 2 readings (1 min apart) twice daily. • BP: use average of all readings made on ≥2 occasions

Empirical estimates of within person variation in 163 adults

Personal characteristics	
Mean age, years (SD)	46.9 (11.7)
Sex, males:females	76:87
Mean BMI, kg/m^2 (SD)	29.8 (4.4)
Medical history, *n* (%)	
Hypertension	74 (45.4)
BP lowering medication	51 (31.3)
Family history of cardiovascular disease	24 (14.7)

BP within person variation using measurement recommendations

Type of BP measurement	**Bseline BP, mmHg**	**6 week BP, mmHg**	**CV, % (95% CI)**	***n***
Office	135.4	131.3	8.6 (7.6 to 9.6)	141
Ambulatory	142.0	142.7	5.5 (4.8 to 6.3)	107
Home	135.1	133.0	4.2 (3.6 to 4.7)	109

From: Warren et al. Br J Gen Pract 2010

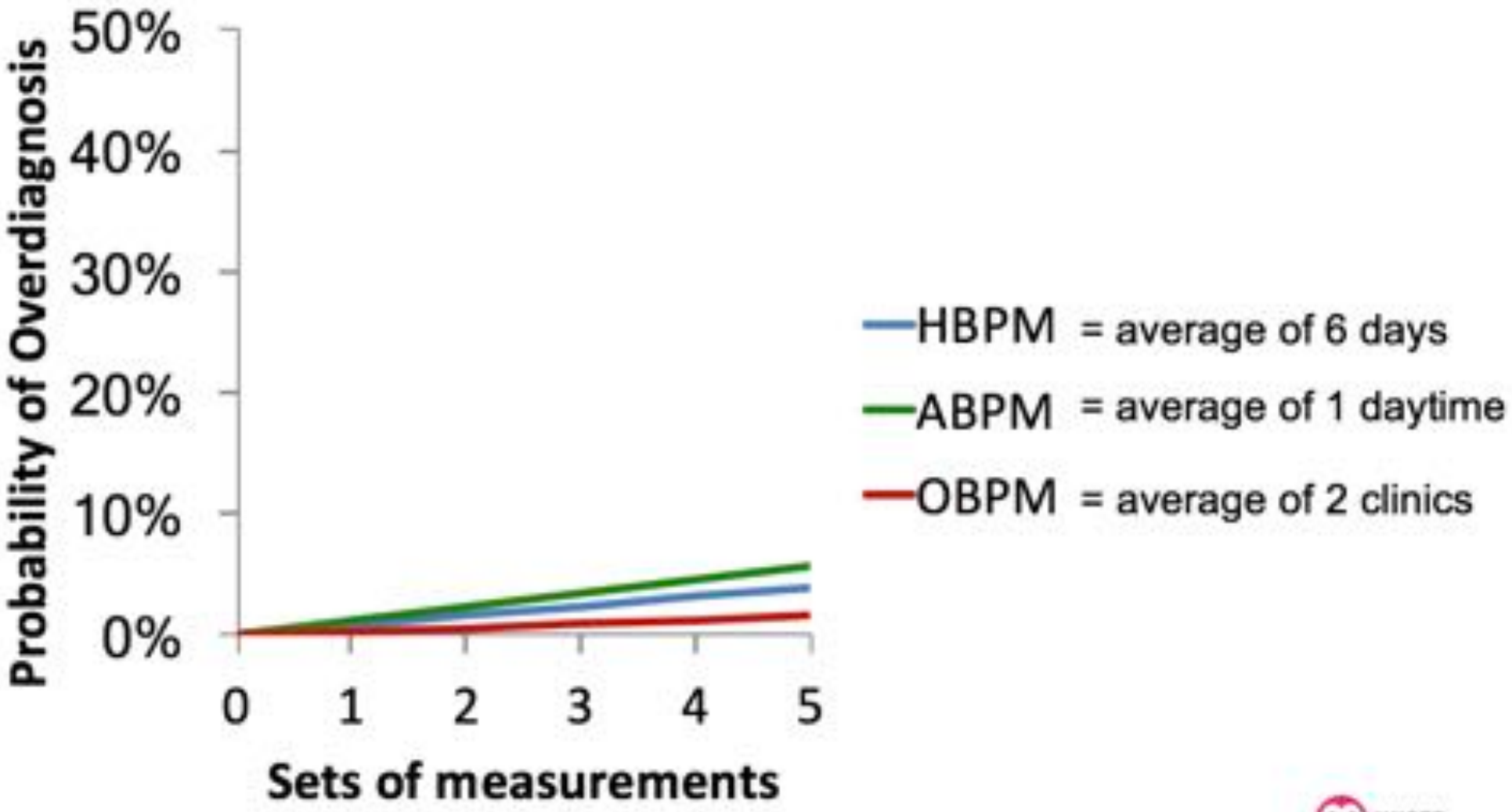
Cumulative probability of “Hypertension” Diagnosis

- Diagnosis of hypertension is an "absorbing state“
  - do not later become undiagnosed if have lower BP readings.

- Simulation to estimate cumulative probability of hypertension diagnosis
  - Applies the binomial theorem to empirical estimates of variation of measurements under ideal conditions
  - Average of duplicate office bp measurements on 2 occasions or average daytime ABPM or 6 days of HBPM measurements as recommended by ACC/AHA guideline

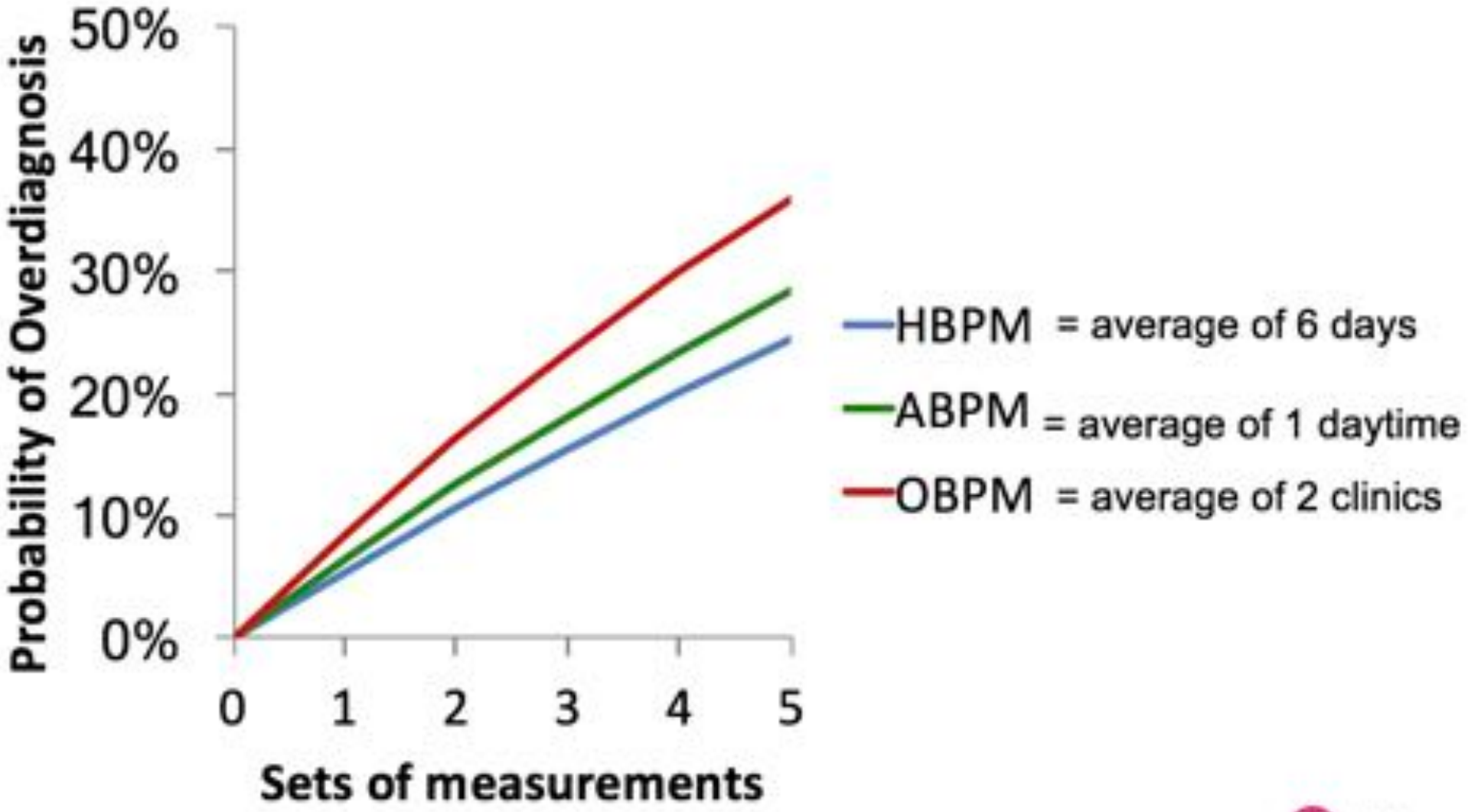
Probability of Overdiagnosis for individual with SBP=120 mmHg

Thresholds: 140 mmHg OBPM, 135 mmHg ABPM/HBPM



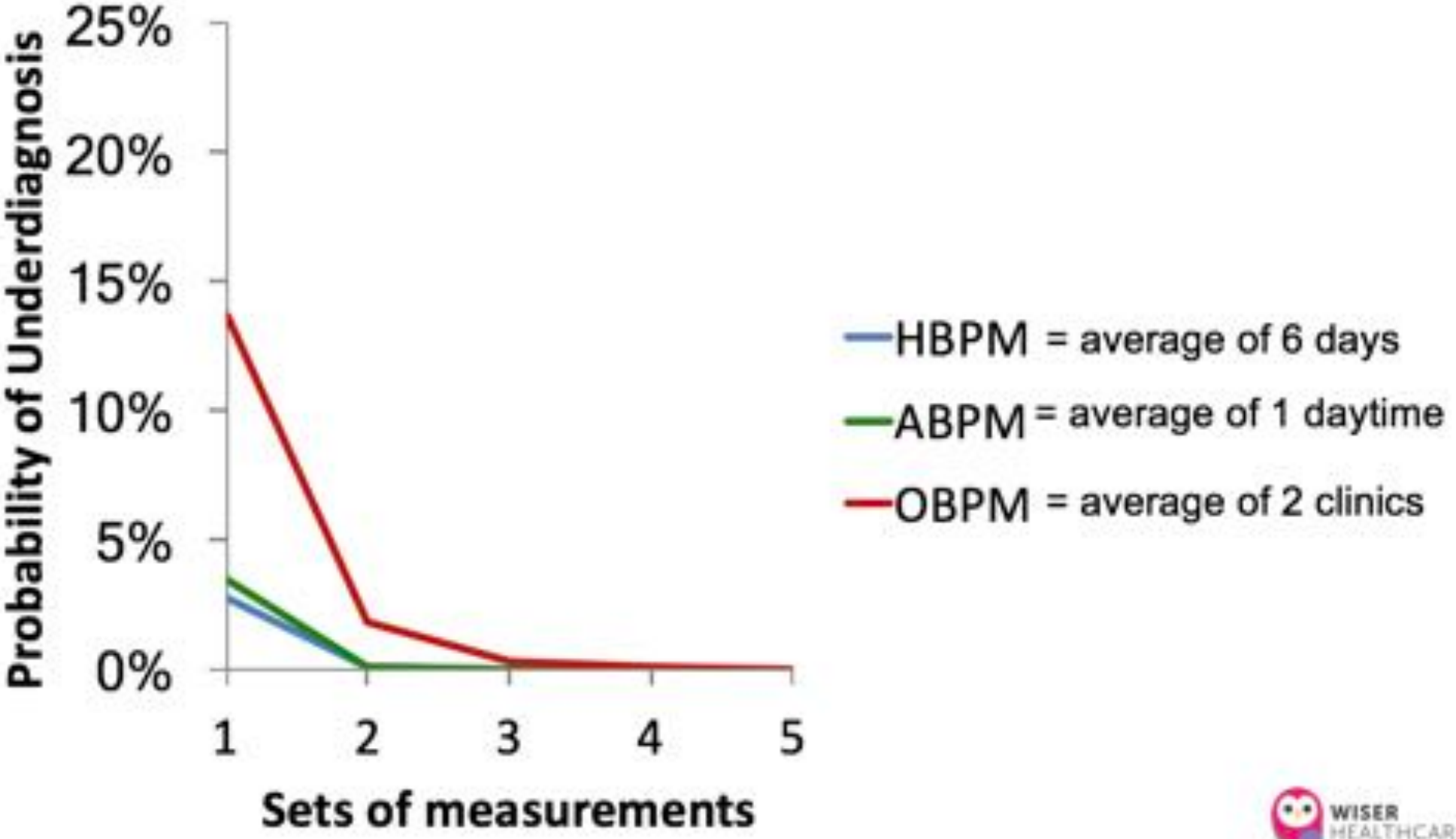
Probability of Overdiagnosis for individual with SBP=120 mmHg

130 mmHg threshold OBPM, ABPM, HBPM



Probability of Underdiagnosis for individual with SBP=150 mmHg

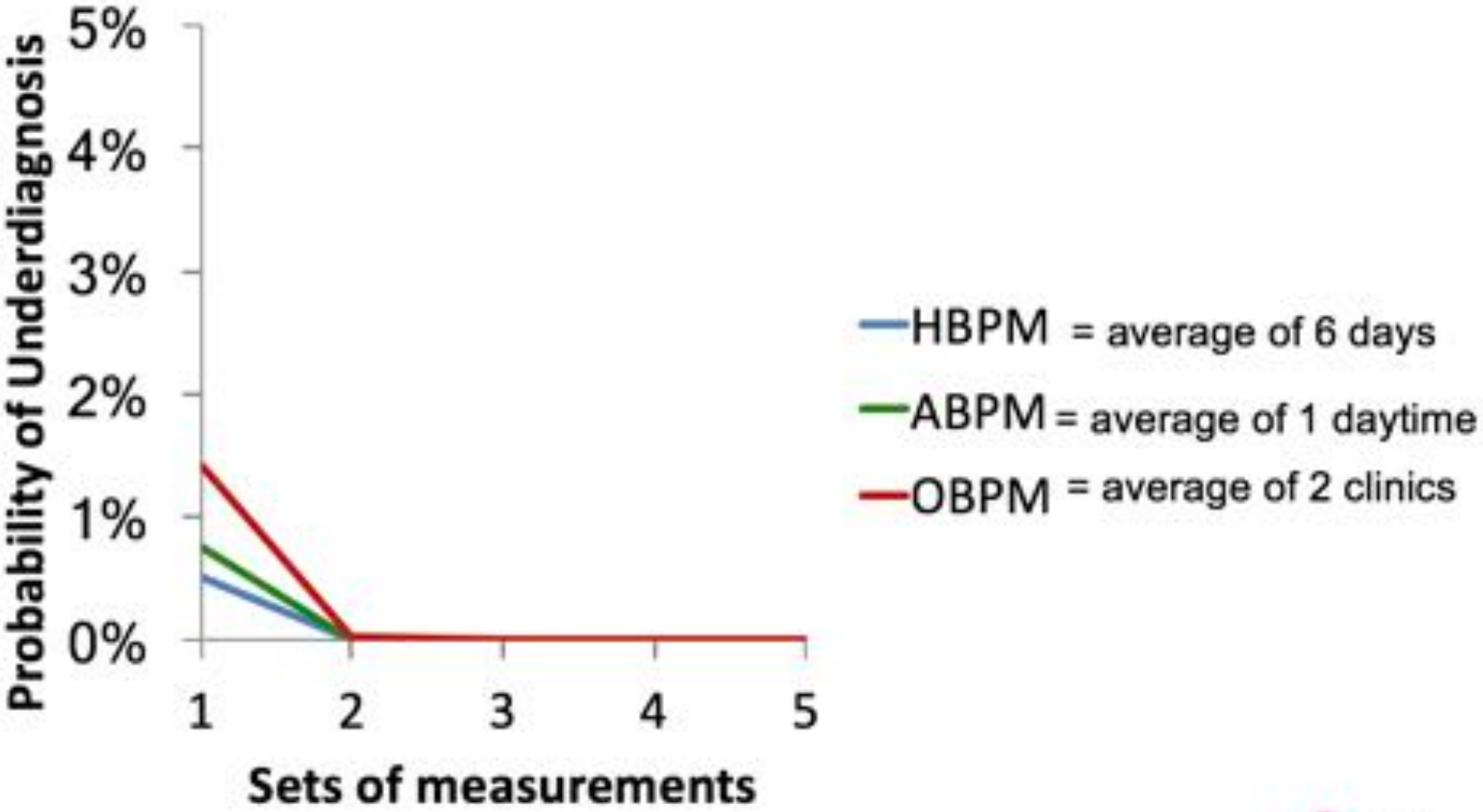
Thresholds: 140 mmHg OBPM, 135 mmHg ABPM/HBPM



WISER HEALTHCARE

Probability of Underdiagnosis for individual with SBP=150 mmHg

130 mmHg threshold OBPM, ABPM, HBPM



WISER HEALTHCARE

Conclusions

- Substantial risk of overdiagnosis with repeat measurements with 130 mmHg threshold
  - even using out of office BP

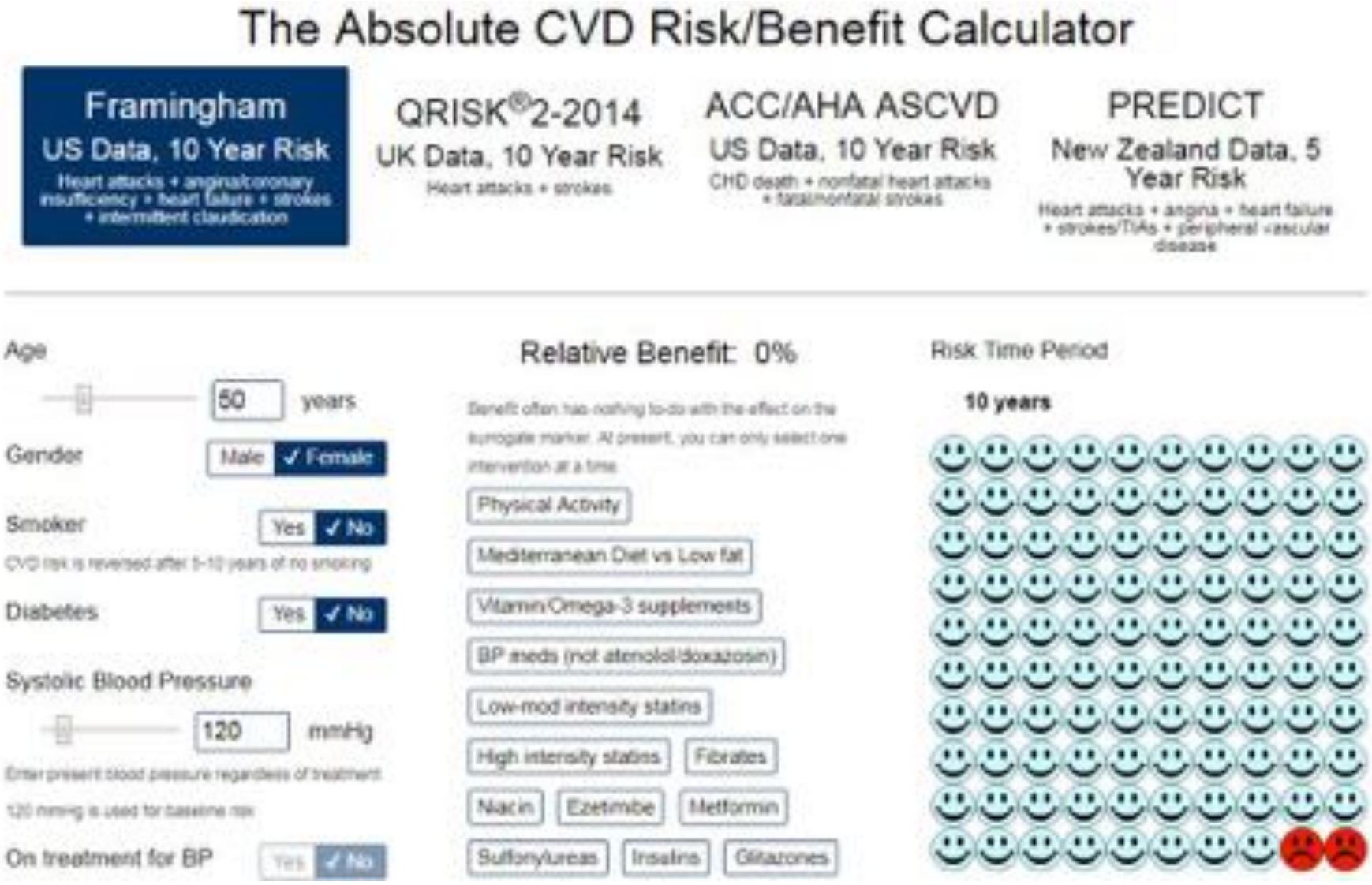
(24-36% risk after 5 repeat sets of measurements for true SBP 120 mmHg)

- Risk of underdiagnosis with 140 mmHg threshold
  - (14% after 1 set of OBPM for true SBP 150 mmHg)
  - minimised if office BP repeated, or if use out of office BP

Conclusions

- Instead of dichotomising a single risk factor using diagnostic thresholds:
- A more useful approach for shared decision making is to use individual's predicted absolute risk

Conclusions



www.preventingoverdiagnosis.net

2016 Canadian Cardiovascular Society Guidelines for the Management of Dyslipidemia for the Prevention of Cardiovascular Disease in the Adult

"In individuals with a modified FRS of 5%-9%, yearly monitoring could be used to evaluate change in risk"

AACE 2017 Guidelines

AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS AND AMERICAN COLLEGE OF ENDOCRINOLOGY GUIDELINES FOR MANAGEMENT OF DYSLIPIDEMIA AND PREVENTION OF CARDIOVASCULAR DISEASE

"Lipid status should be re-assessed 6 weeks after therapy initiation and again at 6-week intervals until the treatment goal is achieved."

"While on stable lipid therapy, individuals should be tested at 6-to 12-month intervals"

ARTICLE | Annals of Internal Medicine

Monitoring Cholesterol Levels: Measurement Error or True Change?

Paul P. Glasziou, MBBS, PhD; Les Irwig, MBBS, PhD; Stephane Heritier, PhD; R. John Simes, MBBS, MD; and Andrew Tonkin, MBBS, MD, for the LIPID Study Investigators

Background: Cholesterol level monitoring is a common clinical activity, but the optimal monitoring interval is unknown and practice varies.

Objective: To estimate, in patients receiving cholesterol-lowering medication, the variation in initial response to treatment, the long-term drift from initial response, and the detectability of long-term changes in on-treatment cholesterol level ("signal") given short-term, within-person variation ("noise").

Design: Analysis of cholesterol measurement data in the LIPID

of variation, 7%) to 0.60 mmol/L (23 mg/dL) (coefficient of variation, 11%), but it took almost 4 years for the long-term variation to exceed the short-term variation. This slow increase in variation and the modest increase in mean cholesterol level, about 2% per year, suggest that most of the variation in the study is due to short-term biological and analytic variability. Our calculations suggest that, for patients with levels that are 0.5 mmol/L or more (≥19 mg/dL) under target, monitoring is likely to detect many more false-positive results than true-positive results for at least the first 3 years after treatment has commenced.

Ann Intern Med 2008;148:656-61

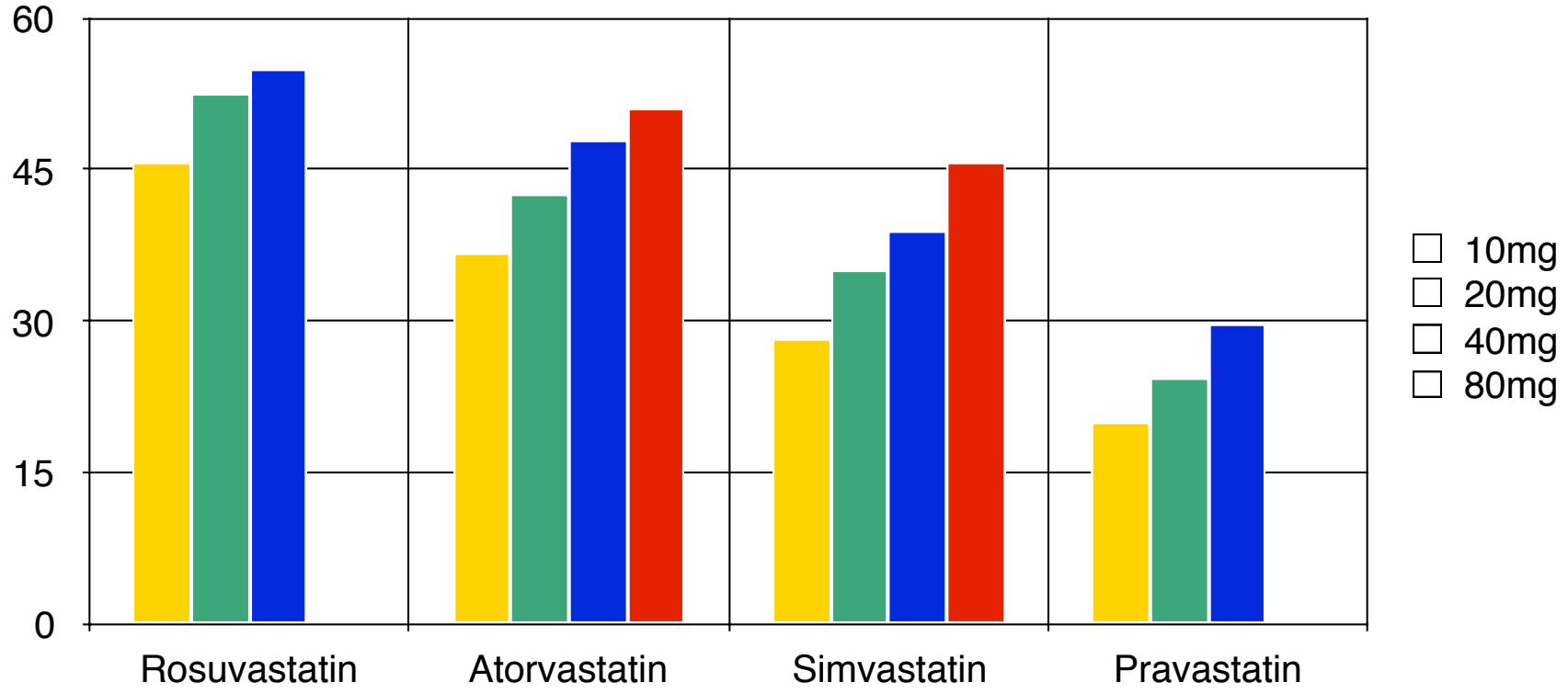
VARIATION
Total chol ~ - 0.80 to 0.80 mmol/L (~30 mg/dL)
LDL chol ~ - 0.5 to 0.5 mmol/L (~20 mg/dL)

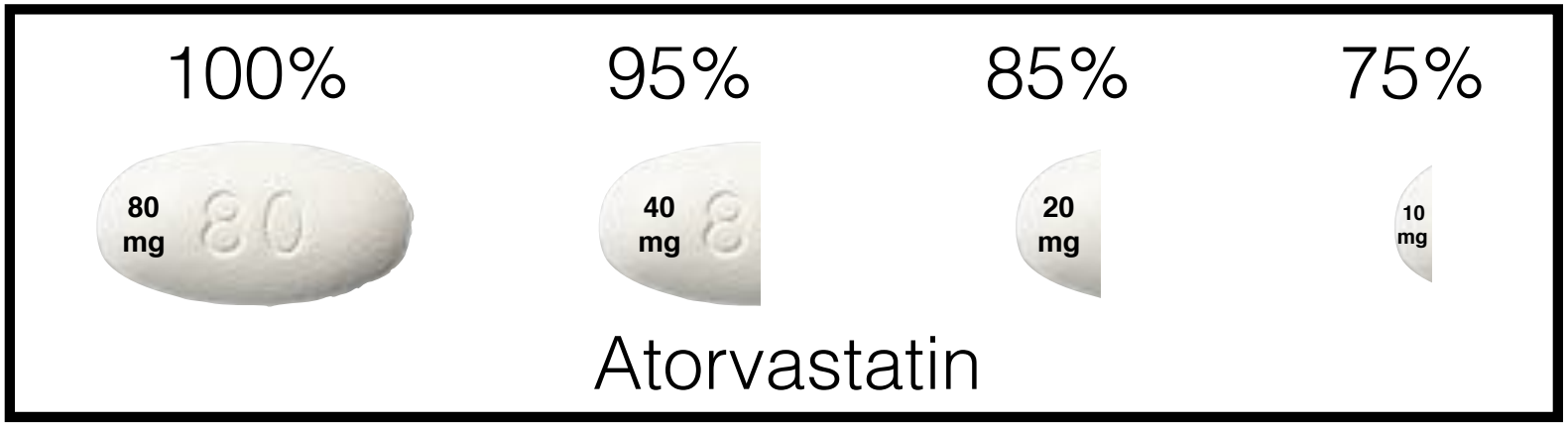
Average increase in cholesterol is 0.5-1%/year

"After initial change only measure every 3-5 years"

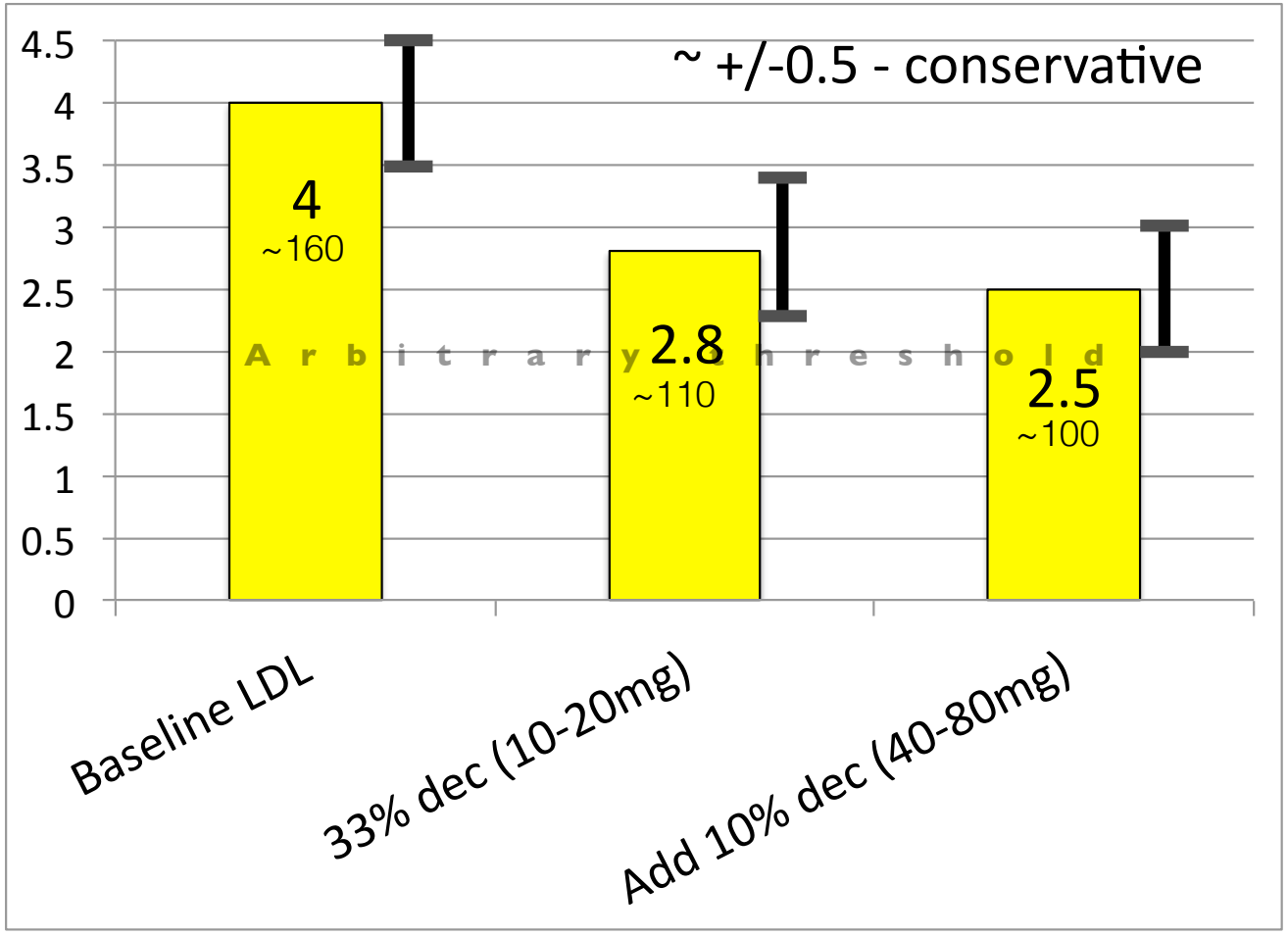
DOSE increases do not lead to proportional EFFECT increases

% reduction in LDL cholesterol





LDL cholesterol - 2 mmol/L ~80mg/dL

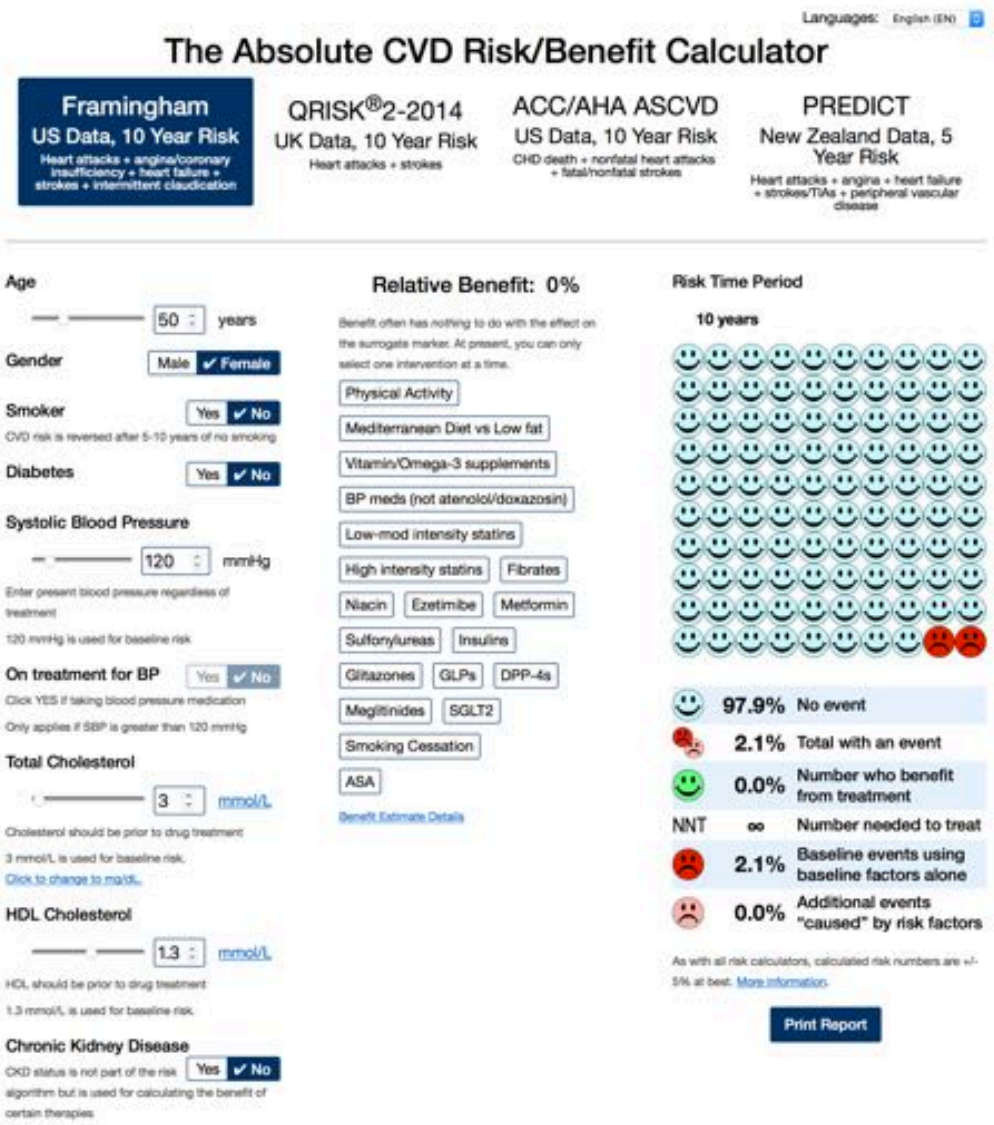


RESEARCH

When to remeasure cardiovascular risk in untreated people at low and intermediate risk: observational study

BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f1895 (Published 3 April 2013)
Cite this as: *BMJ* 2013;346:f1895

"Repeat risk estimation before 8-10 years is not warranted for most people initially not requiring treatment"



Calculate ballpark 5/10-yr risk of CVD - BP, chol, diabetes
Make estimate of benefit based on the best available evidence
Gives a list of adverse effects to discuss

cvdcalculator.com

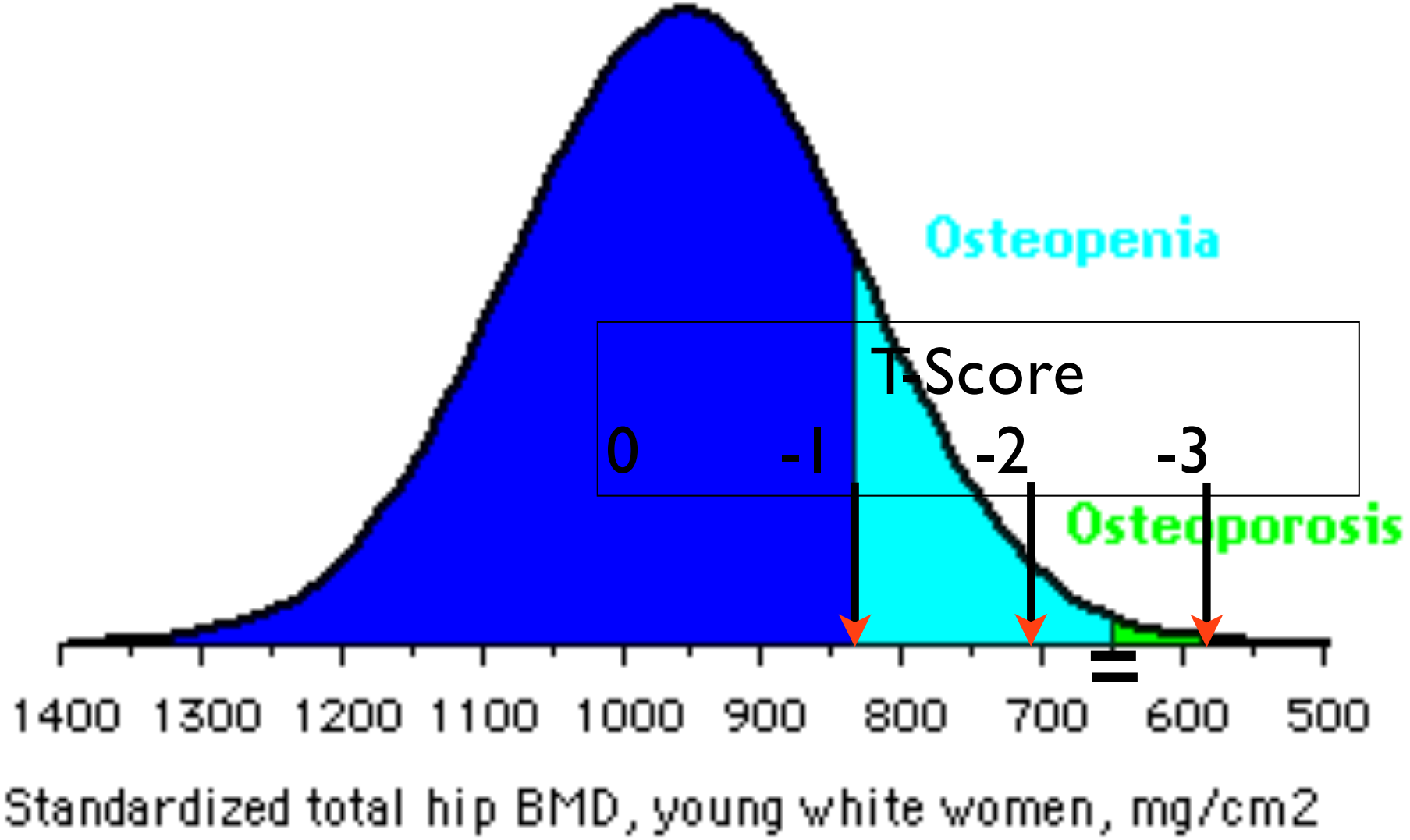
AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS MEDICAL GUIDELINES FOR CLINICAL PRACTICE FOR THE DIAGNOSIS AND TREATMENT OF POSTMENOPAUSAL OSTEOPOROSIS **2010**

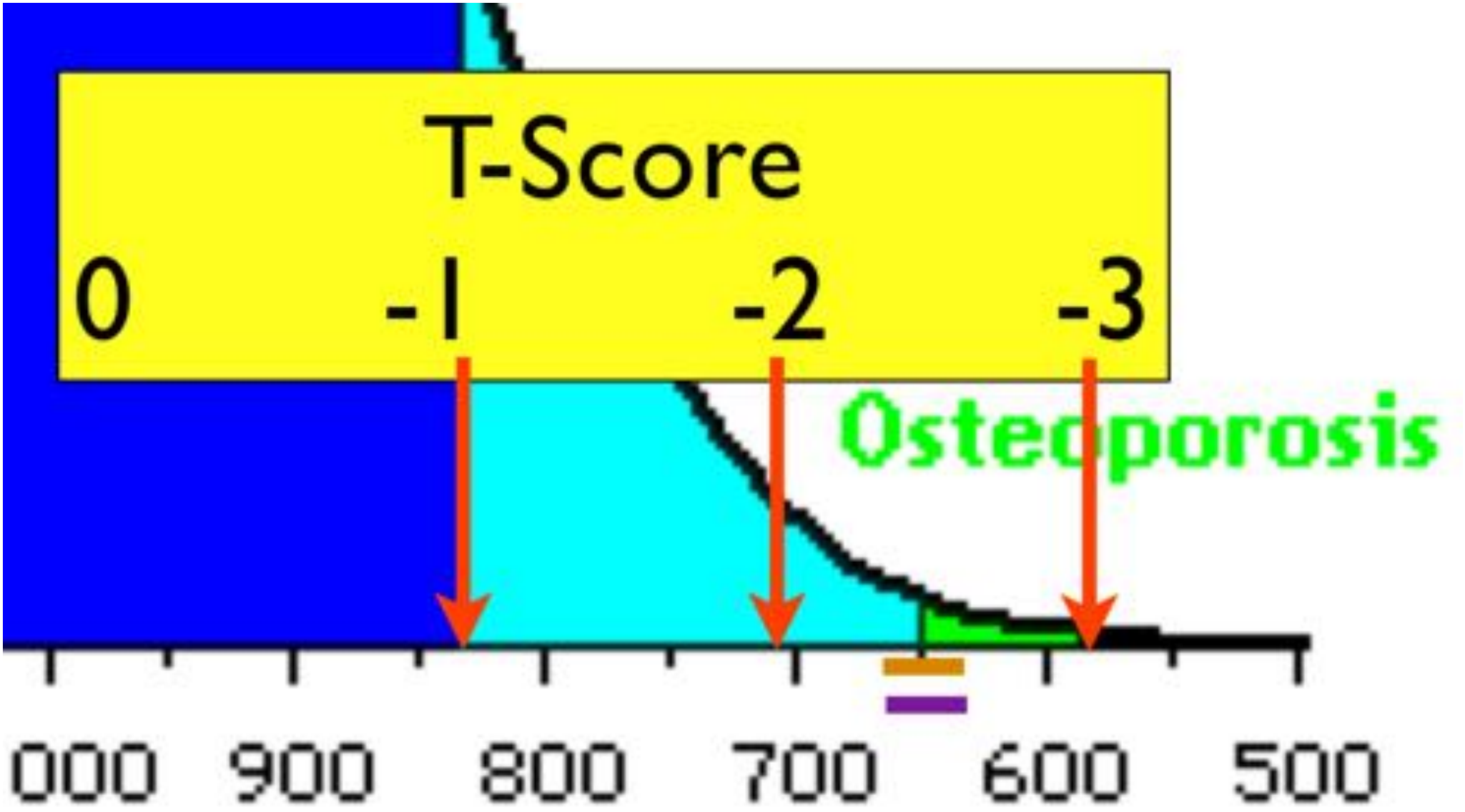
"Obtain a baseline DXA, and repeat DXA every 1 to 2 years until findings are stable. Continue with follow-up DXA every 2 years or at a less frequent interval"

1) Average bone loss per year ~ 0.6%

2) Difference in BMD between drug and placebo - 3 years ~5%

3) BMD measurement precision +/- 2-3%




T-Score
0
-1
-2
-3
Osteoporosis
000
900
800
700
600
500

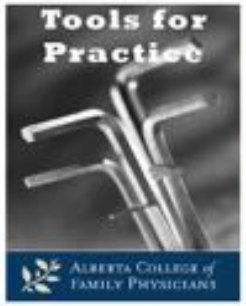
Other Smarter People

Value of routine monitoring of bone mineral density after starting bisphosphonate treatment: secondary analysis of trial data

Katy J L Bell, Andrew Hayen, Petra Macaskill, Les Irwig, Jonathan C Craig, Kristine Ensrud and Douglas C Bauer

BMJ 2009;338;b2266;

"Monitoring BMD in the first 3 years after starting treatment with a bisphosphonate is unnecessary and may be misleading"



Bone Mineral Density – Too much of a good thing?

Clinical Question: Once we have initiated bisphosphonate therapy, how frequently should we check bone mineral density (BMD)?

#32 Christina Korownyk & Michael R. Kolber

"Repeating BMD in the first three years after starting treatment with a bisphosphonate is unnecessary and potentially confusing. The vast majority of patients taking a bisphosphonate will get an adequate increase in BMD after three years and have a reduced fracture risk regardless of BMD changes"

ACP American College of Physicians
Leading Internal Medicine, Improving Lives

2017 CLINICAL GUIDELINE

Treatment of Low Bone Density or Osteoporosis to Prevent Fractures in Men and Women: A Clinical Practice Guideline Update from the American College of Physicians

2017

"The data do not support monitoring BMD during the initial 5 years of treatment in patients receiving pharmacologic agents to treat osteoporosis."

Other Smarter People

Average bone loss per year ~ 0.6%

Evaluating the Value of Repeat Bone Mineral Density Measurement and Prediction of Fractures in Older Women

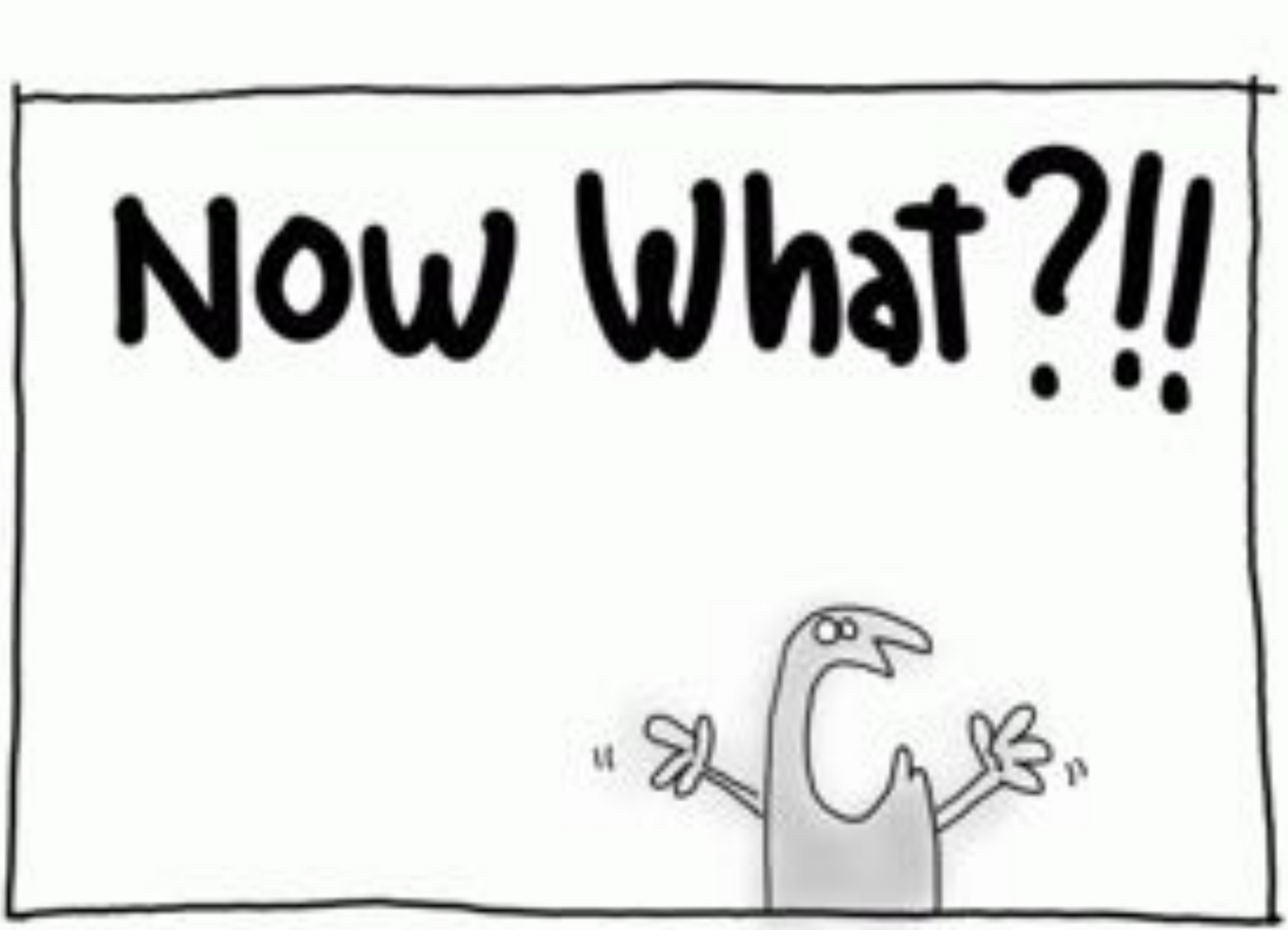
The Study of Osteoporotic Fractures

Teresa A. Hillier, MD, MS; Katie L. Stone, PhD; Doug C. Bauer, MD; Joanne H. Rizzo, MS; Kathryn L. Pedula, MS; Jane A. Cauley, DrPH; Kristine E. Ensrud, MD, MPH; Marc C. Hochberg, MD; Steve R. Cummings, MD

Arch Intern Med. 2007;167(2):155-160.

"repeat BMD [8 years] measurement provides little additional benefit as a screening tool"

Arch Intern Med 2007;167:155-60


Now What?!!

The Problem
is
NOT Fixable,
it is
Only
KNOWABLE

Magnitude of the Imprecision Around Routinely Ordered Medical Measurements*

	Chloride **Sodium** **Osmolality**	**Calcium** **Protein** **Bone density** **Hemoglobin A1 C** **Albumin** **Systolic BP**	**Magnesium** **Glucose** **Potassium** **pCO2** **Cholesterol** **Creatinine** **Alk phos** **PTT**	**LDL** **HDL** **INR** **Total Cholesterol** **Phosphate** **LDH** **Uric acid** **Rheumatoid factor** **Testosterone**	**AST** **GGT** **Vitamin D** **BUN**	**Vitamin B12** **ALT** **TSH** **Triglyceride** **Bilirubin total** **Iron** **Folate** **Lactate**
SINGLE MEASUREMENT +/- range*	**~1-3%**	**~5-7%**	**~8-14%**	**~15-25%**	**~26-30%**	**~40-50%**
SERIAL MEASUREMENTS Change required**	**~2-5%**	**~6-10%**	**~11-20%**	**~21-30%**	**~35-45%**	**~50-75%**

* based on the analytic and biologic variation
** also known as the reference change value

REVISED

Data collated primarily from here - https://www.westgard.com/biodatabase1.htm
but some taken and confirmed from a few other sources - numbers rounded off for ease of use
James McCormack BSc (Pharm), Pharm D - therapeuticseducation.org

If I was the boss of “LAB” result reporting

All of this could be done today

Shift from a laboratory perspective to a patient-centered viewpoint

Using BALLPARK estimates

ALWAYS provide the imprecision

Provide MUCH more definitive guidance

Stop using terms like low, medium, high or significant

If they are “risk factor” measurements then they should only be provided with “risk” estimates

Do not do a test without discussion of a pre-test probability and then provide a post-test probability

Make many tests more “inconvenient”?

As much as humanely possible

DO NOT use “flags”, adjectives, or mention SDs, Gaussian distributions, two-sided tests, Z-scores, T-scores, confidence intervals, or p-values.

Not sure if we even need point estimates

Report Details

Close

Patient Information — Show More Patient Details

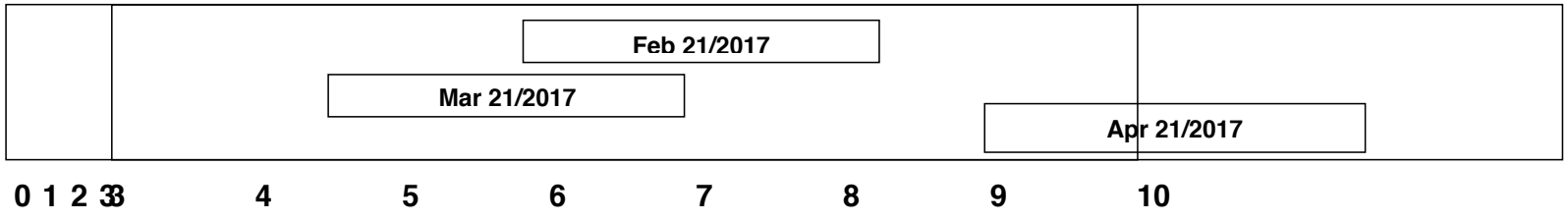
Patient:	LLOYD, TESSA JANE ELSWITHA				
PHN:	9083126918	**Phone:**	(604)538-7132	**Lab No:**	17-141460231

	Flags	Results	Reference Range	Units

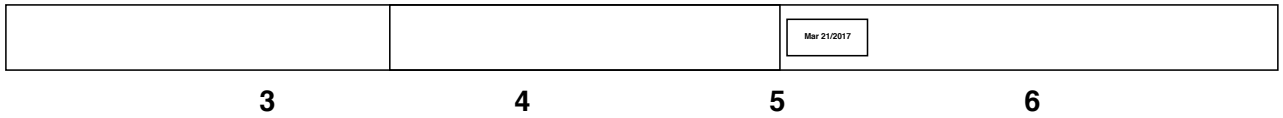
General Comments Because of lab test and human variation, lab tests results can only be provided within a range

YOUR TRUE VALUE IS LIKELY SOMEWHERE IN THE RANGE INDICATED BY THE YELLOW STRIP

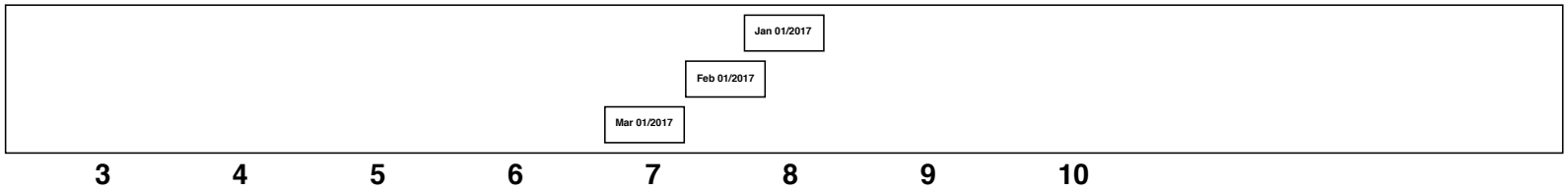
White blood cells



Potassium (mEq/L)



HbA1c (%)



95% of HEALTHY people have results somewhere in this range — Typically, results in this range are considered in the "normal" range

5% of HEALTHY people have results somewhere in this range — Typically, results in this range are considered outside of the "normal" range

There is no "normal/abnormal "range - the higher the value the higher your CVD risk - discuss your risk with your HCP

DATE 1

DATE 2

Typically, if 2 test results from different times overlap we consider the results to not be different
If they don't overlap then we likely think they have changed

- Deals with the reference interval
- Deals with the analytical and human variability
- Deals with risk lab tests

DATE 1

DATE 2

OVERLAP Deals with reference change values

When someone does something wrong, don't forget all the things they did right.