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LABlines

News from LABORATORY ALLIANCE of Central New York, LLC

Patient Safety, Our Number One Focus

By Marilyn LeClair, Vice President of Operations

Laboratory Alliance is on a continuous journey of quality improvement. Workflow processes are evaluated daily as we look for opportunities to improve efficiency and, more importantly, accuracy. "Doing what is in the best interest of the patient" is the motto that defines our work, so positive identification is always our number one focus.

In 2010, the College of American Pathologists (CAP) conducted a study focusing on mislabeling of surgical pathology specimens, blocks and slides. The study looked at hundreds of thousands of cases at 136 institutions to determine where errors occur in the procurement, accessioning and processing of surgical specimens. Alarmingly, the study reviewed greater than 427,000 cases and found mislabeled rates of 1.1 per thousand cases, 1.0 per thousand specimens, 1.7 per thousand blocks, and 1.1 per thousand slides. In addition, all New York state laboratories holding a New York State Department of Health (DOH) permit received a letter from the DOH to evaluate all procedures in place to ensure that risk of patient misidentification is mitigated. This action was based on a well-documented instance of patient mis-identification that occurred at a laboratory downstate.

Realizing the devastating impact of one wrong diagnosis of a patient due to a mislabeled specimen, cassette, block or slide, Laboratory Alliance began searching for a software solution that would eliminate the human element from the process. Barcode solutions have proven to be very effective in reducing labeling errors in the clinical laboratory. Therefore, we should be handling tissue specimens in the same way. Until recently, available solutions in anatomic pathology were minimal, or had not reached a point in their development to be an effective software and hardware solution.

Surgical pathology is a very labor-intensive process that involves many steps. Tissue samples are placed into processing cassettes at the gross disection step and, after processing in paraffin wax, the tissue is embedded in additional wax to produce a tissue block. For many years histotechnicians embedded surgical samples, cut paper-thin sections of tissue with a microtome and attached it to a slide labeled with a handwritten block number. After staining the slide, another individual applied a printed label containing the block number and the patient name over the handwritten information. Up until a few years ago this was the only process available.

We all know the age-old saying "to err is human." The possibility of transcribing information incorrectly or having difficulty reading someone's handwriting was always looming in the background. That is why the staff in our Histology Department welcomed Ventana's Vantage specimen identification and tracking system.

Patient safety and sample integrity is a major focus of Laboratory Alliance and regulatory agencies. Cassette barcode labelers along with Ventana's Vantage Workflow Solution identification and tracking system offered a way to both identify and track anatomic pathology specimens through the entire process of accessioning, grossing, processing, embedding, microtomy and transport of the slide back to the pathologist's desk for review and diagnosis. This type of technology eliminated a major source of human error.

Prior to obtaining cassette labelers that could print a 2D barcode, a technician had to handwrite a tracking number from the specimen block onto the slide. The handwritten information was then matched to a paper label containing the block number and patient name. Given our volume of 160,000 blocks per year — 600 to 800 per day — and 250,000 slides per year — 984 slides per day — our manual process was susceptible to error. The cassette labelers, which are interfaced to our Laboratory Information System, print a 2D barcode onto each cassette. The Vantage system reads the 2D barcode to positively identify the specimen through the whole process.

With this system,

- the pathologist or pathologists' assistant at the grossing station verifies that he or she is matching the right specimen with the right cassette; then,

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Patient Safety, Our Number One Focus

Mike Venezia, an anatomic processing assistant at Crouse Hospital, accessions a specimen and labels the container and requisition with a barcode.

Mike Sovocool, a pathologist assistant at Crouse Hospital, scans a cassette confirming the cassette and specimen are correct for this patient. During the grossing process, Mike can add special instructions and information to convey to the Histology Department.

Brian Curtis, a histotechnician at the Operations Center, scans a processed cassette into the Vantage system at the Embedding Center. Vital information and instructions are displayed on the workstation to verify the sample and allow Brian to correctly orient the specimen in a wax tissue block.

Adam Campbell, a histotechnician at the Operations Center, scans a block into the Vantage system at a microtomy workstation. This will verify the sample, convey information and print a label for the slide that Adam prepares from a thin section of this tissue block.

Tess Thompson, a technical processing assistant at the Operations Center, scans finished slides into Vantage to create a tray that will then be transported to a pathologist for interpretation. The system provides tracking and status information about the patient slides.

John Daucher, Histology Department manager, uses the Vantage system to view reports and charts that provide productivity, tracking and workflow data. The data allows John to evaluate processes and workflow and make adjustments to improve productivity and efficiency.

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- the technician scans the tissue block at embedding to view unique instructions for that specimen; and
- the technician scans the block at microtomy to generate a printed label containing the block number and patient name to adhere to the slide before cutting and applying the tissue.

The Vantage system improves case integrity through just-in-time slide labeling, single piece flow and a one-time label approach to slide identification. This eliminates:

- the possibility of incorrectly transcribing handwriting;
- potential error for someone to misread hand-written patient identification; and,
- applying the wrong printed label.

While positive patient identification is its primary purpose, the Vantage system also provides a wide variety of reporting and tracking functions. The laboratory can follow a specimen through the process and track the specific events encountered by that specimen. Furthermore, reporting functions allow the department manager to monitor workflow, evaluate staff productivity and capture quality issues. Data from the system provides the vital information needed to adjust staffing to workload, identify potential problems early in the process and effectively manage a high volume of work.

Our corporate commitment to the highest standards of patient care was demonstrated by the willingness of so many Laboratory Alliance employees to implement this new technology. Our Information Technology Department worked hand-in-hand with the laboratory staff and the vendor to plan the implementation. Considerable effort was extended to provide for a smooth and problem-free transition. The Gross Rooms at our owner hospitals and the Histology Department staff reviewed work processes and made adjustments in order to use the system to its fullest potential. This team approach resulted in a successful and timely installation.

The Ventana Vantage patient ID project is another example of Laboratory Alliance's commitment to the highest level of patient care. Continued investment in new technology, combined with a dedicated and professional team, ensures that the "patient first" philosophy remains at the top of our daily agendas.

Histology Department manager John Daucher, pictured left, contributed to this article. For more information, contact him by email at johndaucher@lacny.com, or call our Customer Service Department at 315-461-3008.

New Testosterone Test Available for Females, Children

By Cheryl M. Haskins, MS, MT(ASCP)SC, Manager, Chemistry and Referral Testing

Laboratory Alliance now offers a highly sophisticated in-house test to evaluate testosterone levels in females and children. The test may also be useful for monitoring male patients diagnosed with hypogonadism.

Although testosterone is most notable for its androgenic properties, and its importance for male health, it is also important for female health. The primary function of testosterone in the male is as a sex hormone; it is responsible for the development of male sex organs and secondary sexual characteristics such as increased muscle, bone mass and the growth of body hair. The primary role of testosterone in females is as an estrogen precursor. In both males and females, testosterone is important for health and plays an important role in bone metabolism, bone remodeling and prevention of osteoporosis.

Our new assay uses liquid chromatography with tandem mass spectrometry detection, and is posted in our test menu as Testosterone by LC/MS/MS, Females or Children. With a low end reporting limit of 2.5 ng/dL, the new test can measure low concentrations of testosterone typically found in women and children, hypogonadal men or patients undergoing antiandrogenic therapies. The circulating concentration of testosterone in women is only five to ten percent of that in men. In children, the circulating concentration of testosterone is age and sex dependent with reference ranges extending down to less than five percent of the adult male testosterone.

Because of its increased sensitivity, LC/MS/MS is the preferred testing method for these patients.

"Although automated immunoassays are widely used for measuring testosterone, most lack the precision at low levels that is required for reporting reliable results in females and children," said Cheryl Haskins, manager of Chemistry and Referral Testing. "Our new assay has the sensitivity and specificity necessary to accurately and precisely measure the low levels typically seen in these populations. To help our clients select the most appropriate assay for their patients, we have designated this assay as being for females and children under age 14, but there are some males that may also need this more sensitive testing. Examples are teens with delayed puberty or hypogonadal adult men."

Testosterone in serum is largely protein-bound to sex hormone binding globulin (SHBG) and also weakly bound to albumin. A small fraction of testosterone in serum remains as the free hormone. It is the free and weakly bound fractions that are biologically active.

"While working on this project, we also decided to bring in a new automated immunoassay for SHBG. Now that we have this assay in place, we are able to report free testosterone and bioavailable testosterone using highly complex calculations," said Ms. Haskins. "Similar calculations are used with the LC/MS/MS assay and with the immunoassay allowing us to report estimates of the biologically active fractions for male, female and pediatric patient populations."

The table above outlines our full complement of testosterone testing capabilities:

Test Name	Test Code	Includes	Suggested patient population
Testosterone	TSTR	Total testosterone by immunoassay (limit of detection 10 ng/dL)	Adult males, including boys 14 and older
Testosterone LC	TSTLC	Total testosterone by LCMS (limit of detection 2.5 ng/dL)	Females, children, hypogonadal males
Testosterone, Free and Total	TSTRF	Total testosterone by immunoassay, SHBG, calculated free testosterone and % free testosterone	Adult males, including boys 14 years and older
Testosterone LC, Free and Total	TSTLCF	Total testosterone by LCMS, SHBG and calculated free testosterone	Females, children, hypogonadal males
Testosterone, Bioavailable	TSTRB	Total testosterone by immunoassay, SHBG, calculated bioavailable testosterone, free testosterone and % free testosterone	Adult males, including boys 14 years and older
Testosterone LC, Bioavailable	TSTLCB	Total testosterone by LCMS, SHBG, calculated bioavailable testosterone and free testosterone	Females, children, hypogonadal males

The automated, immunoassay-based testosterone testing is available daily. The LC/MS/MS-based testing involves several manual preparation steps to extract the testosterone from the serum matrix. Following the extraction process, the samples are loaded onto the analyzer and allowed to run overnight. Collation of results and reporting takes place the next day, so expected availability of results may be from two to five days depending on the day that the request is received. Any specimens that have been received in the laboratory are set up in the morning on Mondays and Thursdays and results are expected to be reported by the end of the day on Tuesdays and Fridays.

For more information, please contact Ms. Haskins at 315-410-7014 or by email to cherylhaskins@lacny.com.

Men Should Check Testosterone Levels Before Starting Replacement Therapy

Recent headlines read that testosterone prescriptions have tripled over the past decade and the "low T campaign" has spurred some medical professionals, and the media, to ask "what about the risks?"

The Endocrine Society, the medical group that sets clinical guidelines for testosterone replacement therapy, recommends treatment only in men who have unequivocally low testosterone levels. A study in *JAMA Internal Medicine* recently noted that many men who obtain testosterone prescriptions do not have evidence of a deficiency. Researchers are concerned that ads for testosterone prescriptions "may be driving a potentially worrisome amount of overtreatment," ABC World News reported in June, saying between 2001 and 2011, testosterone prescriptions tripled among men over 40, while 25% were put on testosterone without having their levels checked first. The *New England Journal of Medicine* reported "only about 2% of men over 40 should be getting any boost at all," because while it can elevate muscle mass and boost sex drive, some doctors believe too much testosterone may raise the risk of prostate cancer and liver damage.

Laboratory Alliance recommends that anyone considering testosterone supplements talk to a doctor to request that his levels are tested. This involves a simple blood collection. Many patients already have blood tests for PSA or cholesterol screening as part of their routine health care; the specimen for the testosterone levels can conveniently be collected at the same time. For more information, contact our Customer Service Department at 315-461-3008.

Sentinel Antibiotic Susceptibility Prevalence Studies For Groups A and B Streptococci

By Russell Rawling, MS, M(ASCP)SM, RM(NRM)SM, Microbiology Manager

Sentinel antibiotic susceptibility prevalence studies for groups A and B streptococci are performed at least biannually by our Microbiology Department to monitor the emergence of resistance to select antimicrobial agents, namely penicillin, erythromycin and clindamycin.

Group A and group B streptococcal isolates were collected from patient specimens from various physician practices and/or area hospitals throughout Onondaga County so that the results would not be biased by geographic location or physician practice specialty. The following highlights the results of these studies.

Group A streptococcal study results

From June 4 to July 26, 2013, 54 isolates of group A streptococci (GAS) recovered from adult and pediatric pharyngeal specimens were randomly selected for testing against penicillin, erythromycin and clindamycin. As expected, all 54 isolates (100%) were susceptible to penicillin but, notably, only 65% of the GAS were susceptible to erythromycin and 69% were susceptible to clindamycin. In the past, this has appeared to correlate with increased use of azithromycin. As there can be cross-resistance between macrolides and clindamycin, there may not have been overuse of clindamycin.

Table 1 shows the comparative results of the antibiotic sentinel studies that were performed in 2007, 2009, 2011, 2012 and 2013

Year	Antibiotic Tested (% Susceptible)		
	Penicillin	Erythromycin	Clindamycin
2007	100%	94%	98%
2009	100%	82%	84%
2011	100%	100%	100%
2012	100%	68%	72%
2013	100%	65%	69%

The 2013 susceptibility patterns for erythromycin and clindamycin represented a continued increased resistance as was detected for these antibiotics over the last sentinel study period of 2012 and follows trends seen in prior years of increased resistance with the exception of 2011.

The results of this limited sentinel study indicates that penicillin continues to be effective therapy for the treatment of GAS pharyngitis in the non-penicillin allergic patient and that erythromycin and clindamycin may be effective alternative therapeutic choices in the penicillin-allergic patient, but only with susceptibility testing to verify activity against these drugs. This antibiotic susceptibility trend will be monitored and tracked by performing periodic sentinel studies.

Group B streptococcal study results

A similar antibiotic susceptibility prevalence study was performed on 60 randomly selected group B streptococci (GBS) recovered from vaginal specimens over a similar time period. Table 2 shows the comparative results for the sentinel studies conducted in 2007, 2009, 2011, 2012 and 2013.

Table 2 is the Comparative GBS Sentinel Study for 2007, 2009, 2011, 2012 and 2013

Year	Antibiotic Tested (% Susceptible)		
	Penicillin	Erythromycin	Clindamycin
2007	100%	46%	54%
2009	100%	50%	64%
2011	100%	24%	38%
2012	100%	32%	50%
2013	100%	22%	45%

As expected, all GBS isolates were susceptible to penicillin. However, an alarming and continued significant resistance to erythromycin and clindamycin was noted with only 32% and 50% of the GBS isolates tested susceptible to these respective antibiotics. **Although erythromycin and clindamycin are the recommended antibiotics of choice for the treatment of GBS colonizations or infections in the penicillin-allergic patient, this astounding increase in resistance to erythromycin and clindamycin may be due to the increased use of these antibiotics to treat GBS colonized or infected patients who are not penicillin allergic.**

If treatment is indicated for GBS, penicillin remains the agent of choice for intrapartum antibiotic prophylaxis in the non-penicillin allergic patient. Ampicillin is an acceptable alternative but penicillin is preferred because it has a narrower spectrum of activity and is less likely to select for bacterial resistance. Importantly, physicians are reminded that confirmed GBS resistance to penicillin has not been reported to date and, as such, antimicrobial susceptibility testing against this agent is not performed.

For penicillin-allergic women at risk for anaphylaxis, cefazolin, clindamycin and erythromycin are possible therapeutic options as recommended by the Centers for Disease Control. While there is no GBS reported resistance to cefazolin, the results of this sentinel study show that only 22% and 45% of the GBS isolates tested were susceptible to erythromycin and clindamycin respectively. Since antimicrobial susceptibility testing is not routinely performed on GBS isolates, physicians may specifically request such testing when considering erythromycin or clindamycin as therapeutic options.

Tuberculosis — An Old Disease with A New Test For Its Rapid Diagnosis

By Paul A. Granato, Ph.D., Director of Microbiology

Tuberculosis (TB) is an infectious disease caused by *Mycobacterium tuberculosis* complex (Mtb). The disease has been an important cause of human infection throughout recorded history and continues to be a significant cause of disease throughout the world today. With over two billion people (or one-third of the world's population) infected with Mtb, the World Health Organization (WHO) has declared TB as a "global health emergency." Fortunately, 90% of individuals have latent or asymptomatic TB infection that will not go on to produce active disease. Individuals with latent infection do not pose a health risk for disease transmission to others. However, the remaining 10% of infected people will develop active or symptomatic disease. In years past, even though TB was regarded as a serious infectious disease, if diagnosed in the early, symptomatic stages of acute disease, these patients could be successfully treated with a combination of antituberculous drugs, such as isoniazid and rifampin, because Mtb had not yet developed resistance to these antibiotics.

In 2011, the WHO estimated that there were 8.7 million new cases of active tuberculosis worldwide resulting in over 1.4 million deaths. In the early 1900s, TB was the leading cause of death in the U.S. Currently, the U.S. incidence of TB is at its lowest level since 1953. However, rapid and accurate diagnosis of TB continues to be a challenge, especially among immunocompromised patients and the elderly. For example, in 2011 alone, Mtb caused active disease in over 1.1 million HIV-infected patients worldwide resulting in over 430,000 deaths, making TB the leading cause of death in HIV-infected patients. According to the CDC, 63% of TB cases reported in the U.S. for the year 2012 occurred in foreign-born persons, with case rates that were 11.5 times higher than among U.S. born individuals. Yet, any nationality can fall victim to the disease. Returning U.S. travelers may also carry the disease and it can be just as deadly, especially if the Mtb strain causing the infection is multidrug resistant.

TB most commonly causes pulmonary infections but almost any other organ system may become infected as well, though much less frequently. The symptoms of pulmonary TB in its early stages of acute disease are similar to many different types of respiratory infections. In the more advanced stages of disease, the patient typically experiences significant weight loss, drenching night sweats, and a cough with the production of lower respiratory secretions, called sputum, which often contains blood. The advanced stages of TB can debilitate a patient to such an extreme extent that the disease was often called "consumption."

Traditionally, the successful treatment of the early onset stages of active TB involved the use of combination antibiotic therapy with drugs, such as isoniazid and rifampin, as well as several others. Patients usually responded well when treated in the early stages of disease because Mtb isolates were typically universally susceptible to these antibiotics. However, with the widespread emergence of HIV infections in the late 1980s, the incidence of reactivated TB disease increased markedly in this patient group due to the underlying immunosuppressive nature of the HIV infection. As such, antituberculous therapies were used to treat these infections and, due to a host of reasons, some strains of Mtb eventually developed resistance to these agents. Currently, health authorities have estimated that, in 2011 alone, there were over 310,000 documented worldwide cases of multidrug-resistant tuberculosis caused by Mtb strains that were resistant to at least isoniazid and rifampin.

The diagnosis of active pulmonary tuberculosis is suspected based upon the signs and symptoms of the patient, the presence of a characteristic pulmonary infiltrate on chest x-ray, and/or evidence of a recent tuberculin skin test conversion or having a positive QuantiFERON®-TB Gold In-Tube (interferon gamma release assay) test result. The diagnosis of TB is confirmed by performing laboratory tests. Traditional tests involve the cultural recovery of Mtb from a clinical specimen, followed by its identification, and the performance of an antibiotic susceptibility test against the therapeutic agents normally used for treatment.

Since Mtb is a very slow-growing bacterium, the cultural recovery and identification of the organism is an extremely time-dependent process often requiring many weeks if not several months. As such, much time would pass before the clinician caring for the patient had laboratory information regarding the presence of Mtb in the specimen and whether the isolate was a multidrug-resistant strain. Patients infected with a multidrug-resistant strain of Mtb require intense and prolonged therapy with alternative, second-line antibiotic agents.

Within recent years, gene amplification technologies, such as polymerase chain reaction (PCR) assays, have been developed and used for the rapid and highly reliable diagnosis of a wide variety of infectious disease processes. The use of this technology has become commonplace in many clinical microbiology laboratories in the U.S. and throughout the world. Within the last few months, a new PCR test has been developed that detects the presence of Mtb-complex directly in clinical specimens and also screens for the presence of the rpoB gene mutation which is a surrogate marker for multidrug resistance. This new PCR assay can be completed within two hours of specimen receipt thereby informing the physician whether the patient is infected with Mtb that may or may not be multidrug resistant many weeks sooner than by using conventional cultural methods.

Laboratory Alliance's Microbiology Department is currently the only laboratory in the Central New York area that offers this rapid PCR assay, which screens for Mtb directly in clinical specimens and determines whether the strain, if present, is multidrug resistant. The availability of this test will help eliminate physician guesswork and delays in the diagnosis of TB that will significantly improve patient outcomes by guiding appropriate therapy early in the course of patient management.

For more information, contact Dr. Granato at Laboratory Alliance at 315-461-3008 or by email to paulgranatophd@lacny.com.

Presentation Focused on Managing Millennials

Forty-five Laboratory Alliance staff members from five sites, including vice presidents, directors, managers and supervisors, benefitted from a training session to learn more about the Millennial generation, also known as Generation Y. While there is not an exact age for this group, it includes those born roughly between the early 1980s and the early 2000s and is the fastest growing segment of today's workforce.

The presentation focused on Millennial employees' motives and values and highlighted ways employers can tap into their strengths, effectively communicate with and manage Millennial employees while guiding them to do their best.

"Millennial employees are motivated by relationships, and thus benefit from being managed differently than other generations," says Adam Bidegary, a technical supervisor for specimen processing at ARUP Laboratories, who led the session at Laboratory Alliance's Corporate Office on Sept. 18. "The Millennial generation is defined by work-life balance, multi-tasking and an integration of technology in all parts of life."

"It was a phenomenal presentation," Barbara Guiffrida, vice president of human resources, said. "Adam kept everyone's undivided attention for nearly two hours."

Due to staff who retire, move away or take a new job, Laboratory Alliance hires roughly 50 to 60 employees each year, with 45 to 55 percent in the Millennial age group.

Adam has 11 years of laboratory experience with six years of direct laboratory management and is working toward a Ph.D. in Industrial/Organizational Psychology. Along with his management responsibilities related to specimen processing and training,

Adam has gained expertise in employee performance, error management, motivation, leadership development and process design and re-design.

ARUP Laboratories is a national clinical and anatomic pathology reference laboratory and an enterprise of the University of Utah and its Department of Pathology. ARUP has been Laboratory Alliance's primary reference laboratory since 2002.

Announcements

Marilyn LeClair, Vice President of Operations, Will Retire in December

Marilyn LeClair, BS, MT(ASCP),SH, vice president of operations at Laboratory Alliance for 10 of her 16 years with the company, will retire at the end of December.

Marilyn has been with Laboratory Alliance since its inception in 1998, serving as director of hospital operations from 2002 to 2004. She was laboratory manager of Community General Hospital's Rapid Response Laboratory from 1999 to 2002 and a technical supervisor from 1998 to 1999.

Marilyn's legacy is that she championed Lean Process Improvement at our four laboratory locations – a process that began in 2010.

Leading up to her departure, Marilyn has continued her dedicated service mentoring staff to ease the transition of overseeing operations. These responsibilities will now be shared by Maria Dillon, director of hospital operations, and Rita Romano, director of the Operations Center.

Marilyn looks forward to spending a few months during the winter in Arizona with her husband, Ron, exploring the west and enjoying golf.

Jeff Peterson, George Popp, Marilyn LeClair and Mark Adkins represented Laboratory Alliance at the St. Joseph's Hospital Health Center 21st Annual Golf Classic held at Turning Stone Casino Resort. Laboratory Alliance was a corporate sponsor.

Maria Dillon to Direct Hospital Operations

Maria Dillon has been promoted to director of Laboratory Alliance's Hospital Operations. She will continue to oversee operations at our largest Rapid Response Laboratory at St. Joseph's Hospital Health Center, a position she has held since 2011.

Maria is an experienced scientist, leader, trainer and communicator with more than 30 years of experience in medical technology. She joined the staff at our Rapid Response Laboratory at Community General Hospital in 1994, serving as manager from 2005 to 2011.

Maria earned her Bachelor of Science in Medical Technology from Daemen College in Amherst, N.Y., is certified by the American Society of Clinical Pathologists and is a member of the Central New York chapter of Clinical Laboratory Management Association.

She is an outdoor enthusiast and enjoys traveling with her husband Patrick.

LA Newsmakers

New Employees

Please welcome our new employees

At our Operations Center

Allison Borasky – Technical Processing Assistant
Melissa Carter – Medical Technologist
Julia Collier – Phlebotomist
Brian Curtis – Histotechnician
Sara Elsafty – Laboratory Office Assistant
Christine Flaherty – Courier
Nadia Goode – Medical Technologist
Melleny Hale – Medical Technologist
Kerry Hanifin – Courier
Gloria Hunt – Courier
Christian Janowski – Phlebotomist
Dominick Leo – Courier
Elizabeth Montreal – Courier
Cortney Payne – Phlebotomist
Amy Schiano – Phlebotomist
Tara Wellman – Histotechnician
Angela Williams – Phlebotomist

At our Rapid Response Laboratory at Crouse Hospital

Kimberly Guanciale – Laboratory Office Assistant
Joanna Urban – Administrative Secretary

At our Rapid Response Laboratory at St. Joseph's Hospital

Katherine McKissick – Medical Technologist

At our Rapid Response Laboratory at UUH Community Campus

Abigail Diez – Medical Technologist

Employee Anniversaries

October, 10 Years

Eileen Sheehan

October, 15 Years

Kelly Brunelle
Judith Burns
Christine Carrington
Anne Chamberlain
Michele Connor
Shelley Murphy
Kathleen Real
Jane Roller
Ellen Searles
John Vormwald
Katrina Zeglin

November, 15 Years

Maria Dillon
Barbara Guiffrida
Carl Huppman
Anne Marie Mullin
Dhirajben Patel
Diana Signore
Lonnie Stallcup, Jr.
Theresa Weller

December, 15 Years

Jeffrey Coyne
Nancy Flattery
Lynn Trickey

Welcome to our New Clients

Dewitt Counseling Associates
Syracuse, N.Y.

Hamilton College Student Health Center
Clinton, N.Y.

Technology Corner

The following new tests and test methods have been added to the menu of tests performed by Laboratory Alliance:

Testosterone by LC/MS/MS, Females or Children

Laboratory Alliance was recognized with the Eldercare Corporate Champion Award from the Eldercare Foundation at a dinner in early October. *Above*, several of our employees were on hand to celebrate, including Jane Roller, Rita Romano, Joan Rusin, Carrie Nappa, Joan Riffanacht and Jane Riffanacht.

Photo right, Senior Vice President Anne Marie Mullin, center, accepts the award from presenter Thomas Quinn and Eldercare Foundation President M. Kate Rolf.

Community Connections

Thursday, Nov. 14 - Friday, Nov. 15
Clinical Laboratory Management Association and American Association for Clinical Chemistry Annual Conference and Exhibition, Turning Stone Casino Resort, Oneida. *Laboratory Alliance is a flagship sponsor and exhibitor.*

Monday, Nov. 18
Onondaga County Medical Society Annual Dinner Meeting at Holiday Inn, Liverpool. *Laboratory Alliance is a corporate sponsor.*

Saturday, Nov. 23
Upstate Gala at Nicholas J. Pirro Convention Center, Syracuse. *Laboratory Alliance is a corporate sponsor.*

Laboratory Alliance was again recognized as a CenterState CEO Economic Champion at the Economic Champions Luncheon on Oct. 17. Each year we are honored for the role we play as an economic engine in the Central New York community.

Francis House is grateful for Laboratory Alliance's continued support that included corporate underwriting, volunteers and generous employee contributions. This year our staff contributed more than $900 to the "No Place Like Home" raffle.

Enjoying the "No Place Like Home" fundraising event on Oct. 16 were (*top photo*) Malinda Desjardins, Kathy Shumway, Karl Lawton, Jane Riffanacht, Olga Farrell and Sue Maloney, and (*bottom photo*) Vickie Campany, Margie Grosick and Joan Rusin.

Laboratory Alliance is encouraging anyone born between 1945 and 1965 to be tested for the hepatitis C virus. We are promoting this message in ads, on posters and in news releases to the media.