Rotorua 2012
Dilemma's investigating patients
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Microbiology.

Affiliations.

- BPAC advisory group.
- South Canterbury Primary and Community Clinical Governance group.
- DHBSS coordinating update of schedule – microbiology.
- Medical microbiology representation to IANZ.

Outline.

- Laboratory schedule and community testing.
- Examples of some of the issues which arise in the community. GP/Lab.

Issues with laboratory testing in the community.

- In NZ have had the laboratory “schedule”. This meant tests frequently used in the community could be performed in community laboratories funded on a price per test basis.
- Now many bulk funded lab. contracts and old “schedule “ out of date.
- New schedule project (unfortunately same name) DHBSS.

Community tests.

- Diagnosis for personal health.
- Detection infectious diseases of public health importance.
- System to supply epidemiological information eg. a/b susceptibility profiles and serotype information.

Seems simple.

- Taking Bordetella pertussis as an example.
- New NAAT tests for diagnosis – have become robust and cost effective.
- Detect more cases – more sensitive.
- Should we stop culturing then?
- Culture less sensitive but 100% specific, NAAT not 100% specific
- Culture have an organism to serotype and enables susceptibility testing to be performed.

BUT.

- Culture and NAAT give optimal results in first 14 days after onset of cough.
- How many cases present in first 14 days?
- What about serology?
- Divergent opinions on usefulness of serology CDC do not advocate it but UK and Australia do.

Testing urines in females with uncomplicated UTI.

- Best practice is not to order culture and susceptibility in the above group.

- This is correct. BUT with the emergence of AMR gram negative organisms in various parts of the country regular checks of susceptibility should be performed to allow optimal selection of empiric antibiotic treatment.

Screening of Contacts.

- Recurrent Staphylococcal disease.
- Is/ should it be recommended?

The End.