A primary care evaluation of three near patient coagulometers

E T Murray, D A Fitzmaurice, T F Allan, F D R Hobbs

Abstract

Aim—To compare the reliability and relative costs of three international normalised ratio (INR) near patient tests.

Materials—Protime (ITC Technidyne), Coaguchek (Boehringer Mannheim), and TAS (Diagnostic Testing).

Methods—All patients attending one inner city general practice anticoagulation clinic were asked to participate, with two samples provided by patients not taking warfarin. A 5 ml sample of venous whole blood was taken from each patient and a drop immediately added to the prepared Coaguchek test strip followed by the Protime cuvette. The remainder was added to a citrated bottle. A drop of citrated blood was then placed on the TAS test card and the remainder sent to the reference laboratory for analysis. Parallel INR estimation was performed on the different near patient tests at each weekly anticoagulation clinic from July to December 1997.

Results—19 patients receiving long term warfarin treatment provided 62 INR results. INR results ranged from 0.8–8.2 overall and 1.0–5.7 based on the laboratory method. Taking the laboratory method as the gold standard, 12/62 results were < 2.0 and 2/62 were > 4.5. There were no statistical or clinically significant differences between results from the three systems, although all near patient tests showed slightly higher mean readings than the laboratory, and 19–24% of tests would have resulted in different management decisions based on the machine used in comparison with the laboratory INR value. The cost of the near patient test systems varied substantially.

Conclusions—All three near patient test systems are safe and efficient for producing acceptable and reproducible INR results within the therapeutic range in a primary care setting. All the systems were, however, subject to operator dependent variables at the time of blood letting. Adequate training in capillary blood sampling, specific use of the machines, and quality assurance procedures is therefore essential.


Methods

The study was based in one primary care anticoagulation clinic in an inner city general practice. The clinic was managed by a practice nurse with previous near patient test experience. Patients attending the clinic who had been receiving warfarin for at least six months were eligible for the study. Housebound patients were excluded. Patients were asked to participate and to consent to the venous samples required for the three near patient tests. They were informed that warfarin management would be based on the same near patient tests consistently (Coaguchek). The evaluation was performed following the criteria determined by the near patient testing working party of the British Society of Haematology, including samples across the whole therapeutic INR range, with samples from patients not receiving warfarin and samples above the upper limit of the therapeutic range.

PROCEDURE

- The three near patient test systems were prepared and test cards, reagent strips, and cuvettes held at room temperature for 10 minutes before use.
- Internal quality control (QC) was performed on the Coaguchek (CK) and TAS machines with control material supplied by the manufacturers, and the Protime was switched on to “self check and calibrate.”

TECHNICAL DIFFICULTIES

- Five millilitres of venous whole blood were taken, and a drop immediately added to the Coaguchek test strip followed by the Protime cuvette. The remainder was added to a citrated bottle and mixed well. A drop of citrated blood was then added to the TAS test card and the remainder sent to the reference laboratory for analysis.
- All INR results were recorded centrally.

Parallel INR estimation was performed on the different near patient tests at each weekly anticoagulation clinic from July to December 1997. Paired t tests, regression analysis, and Bland–Altman plots were undertaken to investigate the agreement between the results obtained between the three near patient test systems and the laboratory, although not all methods are reported. The results were also analysed to determine the number of times dose adjustment would have been made depending on whether near patient test values or the laboratory INR value were used.

Results

Nineteen patients (including two not taking warfarin) provided 62 samples for analysis. INR results ranged from 0.8 to 8.2 overall, and 1.0 to 5.7 based on the laboratory method. Taking the laboratory method as the gold standard, 12 of the 62 results were <2.0 and six were >4.5. The largest proportion of patients were receiving warfarin treatment for atrial fibrillation (47%), followed by mitral valve replacement (26%). Approximately 50% of patients were under 65 years of age.

INR COMPARISONS

There were no statistical or clinically significant differences in terms of correlation coefficients (fig 1) or Bland–Altman plots (fig 2) between results from the three systems, although all near patient tests showed slightly higher mean readings than the laboratory (table 1). In terms of clinical decisions, 12 of 62 (19%) would have been altered when comparing Coaguchek and TAS with the laboratory, and 15 of 62 (24%) when comparing Protime with the laboratory.

| Table 1 Differences in the international normalised ratio between the four methods used (n=62) |
|---------------------------------|------------------------------|------------------------------|
| Coaguchek | Protime | TAS |
| Laboratory | −0.10 (0.05) / 0.960 | −0.28 (0.06) / 0.921 | −0.10 (0.06) / 0.912 |
| Coaguchek | −0.19 (0.05) / 0.951 | 0.00 (0.05) / 0.937 | 0.19 (0.06) / 0.906 |

Values are mean (SE) difference / correlation coefficient.
therefore with poor fingerstick technique there is a risk of an inadequate capillary sample. Otherwise, each system has built in error coded for operator mistakes. Both the Coaguchek and Protime can use either venous or capillary samples. TAS at the time of the study required citrated whole blood or plasma; however, the manufacturers have recently produced test cards for non-citrated samples.

COSTS
The cost of the different systems varied substantially (table 3). The test reagents of two machines were comparable, but the Protime system was more expensive. However, the Protime reagent cuvette has a built in lancet device which precludes additional costs for finger pricking equipment.

QUALITY ASSURANCE PROCEDURES
For Coaguchek, calibration and internal quality control systems are quick and simple to use at the start of each clinic. External quality control is available through NEQAS, although this only offers comparison with other Coaguchek users. For Protime, calibration and two levels of internal quality control are integral to each test performed. External quality control is unnecessary according to the manufacturers. NEQAS, however, suggest sending a comparison venous sample to the laboratory every 10 tests. For TAS, the system performs self diagnostic tests to verify the hardware integrity, and calibration is performed on each test card. Quality control is performed with each test by checking test card validation, date and time verification, sufficient sample verification, and sample type verification. A control plasma test is also performed before each clinic. External quality assurance for TAS is available through NEQAS.

OTHER FACILITIES INCORPORATED
All three systems have menu options for date and time and memory capability for at least 30 previous results. They also have the capability to link to both a printer and computerised decision support software. Protime offers a graphical display of patient results within the therapeutic range for patients performing home monitoring, which gives a clearer idea of their INR control. TAS offers a menu option for operator identity so that aberrant results can be traced to the operator. It has memory capability for up to 1000 previous results. All three systems offer at least a 12 month warranty and a service contract, with a promise of a replacement machine. Both Coaguchek and Protime are small and lightweight with the facility to be battery operated for increased portability. TAS, in contrast, is heavier and therefore less appropriate for domiciliary use.

Discussion
INR COMPARABILITY
Three systems previously validated in laboratory conditions were assessed for use in a non-laboratory setting. The INR results showed no significant disagreement between the systems. Agreement was shown for all therapeutic ranges although, as shown in other studies, as absolute INR increases results become more diverse, with near patient test results considerably higher. This was shown consistently in all three systems. Given that management is clinically based under these circumstances, this was not a clinically important finding. Different dosing decisions would have been made on around 20% of occasions. This compares favourably with interlaboratory comparisons, where up to 50% of results would suggest different dose decisions.

All three near patient test systems are therefore safe and efficient for producing acceptable and reproducible INR results within the therapeutic range in a primary care setting. All three systems, however, were subject to operator dependent variables at the time of blood letting. Adequate training in both capillary blood sampling, specific use of the machines, and quality assurance procedures is therefore essential.

CONCLUSIONS
The three instruments used in this study showed good correlation within the therapeutic ranges, were easy to operate, and required little sample preparation or instrument maintenance. They are all, therefore, appropriate for...
primary care use as long as the correct procedures are followed. The near patient testing site, in liaison with the local reference laboratory, should take responsibility for assessing the accuracy and precision of the machines and it is essential to have standard operating procedures developed to ensure optimum care.

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