

Dear Fellow Clotter

Welcome to the first ASTH newsletter for 2003. Thankyou to all the members who contributed to this issue. They were given a very short time to produce their pieces and their efforts are greatly appreciated. Special thanks must go to Leonie Klomp for her help in compiling the newsletter and to Claire McClintock and Hatem Salem for supplying the photos for this edition.

It has been around 18 months since the last newsletter, as a result this issue has a lot to cover. On the following pages you will find conference reports from the ISTH Congress, Birmingham, the AIMS/NZIMLS South Pacific Congress held on the Gold Coast and the HSAZ/ANZBT/ASTH meeting recently held in Christchurch. There are also the usual reports from the Clinical Trials Group, the New and Emerging Technologies Group, along with news from the Secretariat and Treasurer. The Presidents report is that which was presented at the recent AGM in Christchurch.

Congratulations to Laura Young (Auckland Hospital) who won the AstraZeneca Medal and the \$2000 prize at the recent HSAZ/ANZBT/ASTH meeting in Christchurch. Runners-up (John Pimanda and Murray Adams) both received \$500 and all winners



Laura Young receiving AstraZeneca Medal from Hatem Salem. Laura's winning abstract was titled "The Rate of Thrombus Resolution following Treatment of DVT is related to the Site and the Precipitating Cause of Thrombosis"

were presented with certificates. Congratulations also to Michael Wheeler from Monash Medical Centre who won the best ASTH poster. The winning abstracts will be printed in the next issue of the newsletter.

In 2004 we are planning 3 issues of the newsletter. Any contributions such as conference reports or short reviews on topics of interest of either a clinical or scientific nature are most welcome.

Merry Christmas and have a safe and happy New Year

Emma Perrin

PRESIDENT'S REPORT

The Society has been fortunate to continue to receive support from the Pharmaceutical Industry. On your behalf, I would like to acknowledge the support of AstraZeneca, Sanofi-Synthelabo, Aventis and Pfizer. All these companies have generously donated unrestricted educational grants that have assisted us in the running of the Society. Without this support the Society would have had trouble carrying out its duties. I am also very grateful to Kim Gould, Commercial Planning manager at AstraZeneca who continues to support the ASTH medal for the best oral communication. The AstraZeneca medal is synonymous with excellence in research in haemostasis and thrombosis.

We are still a young society and we need a fair bit of assistance before we can be completely self-dependent. You will see from the Treasurer's report that we are slowly but surely improving. We however still have a long way to go. I am hopeful that the 2005 congress of the International Society, which will be held in Sydney, will deliver some very

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ASTH COUNCIL 2003-2005

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Dr Paul Harper
Dr Tim Brighton
Dr Mark Smith
Ms Emma Jones-Perrin
Dr Murray Adams
Dr Chris Ward
Dr Ross Baker

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President's Report *Continued*

much-needed surplus that will help consolidate our financial viability. Until then, we have to rely on our pharmaceutical partners for their support.

Plans for the 2004 meeting in Melbourne are well underway, and the scientific committee has already secured leading international experts, and currently finalising what promises to be a most exciting and vibrant educational experience. It is over ten years since the societies have met in Melbourne, and the committee is intent on making this meeting of the highest quality. I urge you all to attend.

It is my pleasure to welcome the ASTH Council for 2003-2005. Returning to Council are myself (VIC), Alex Gallus (SA), Tim Brighton (NSW), Paul Harper (NZ) and Murray Adams (WA). New Councillors are Mark Smith (NZ), Chris Ward (NSW) and Emma Perrin (QLD). Congratulations to all Councillors on being elected.

I would like to take this opportunity to thank all retiring councillors. Phil Hogg, Shaun Jackson and Beverley Rowbotham have all served the Society well and we are very thankful for their contributions. I would also like to thank Tim Brighton who has resigned from his role as Newsletter Editor. Tim did a wonderful job in his role, and his efforts were greatly appreciated.

With my second year as President of the Society drawing near its end, I feel that I have a better understanding of our problems and challenges. There is no doubt that the field of haemostasis and thrombosis is far more exciting today than it has ever been. We have a far better understanding of the basic mechanisms leading to thrombus development, and are beginning to define some key pathways critical for thrombus formation that may not be relevant to the arrest of bleeding.

New diagnostics and therapeutics are springing up all the time. These are very exciting times for all of us, and I would like to think that our annual scientific meeting reflects these major developments. High quality program organisation will ensure that our meetings are highly regarded and hence well attended.

One facet that our meetings require strengthening is in the basic science of haemostasis and thrombosis. There is excellent basic research carried out throughout Australasia that is not presented at our meeting. This deficiency needs to be corrected. I know that in this year a very large number of abstracts have been submitted and I look forward to some quality presentations. We do need to encourage our trainees to attend and to become excited by the progress in our specialty. This will have a positive impact in drawing them to the laboratory where pertinent questions can be asked and answered. Unless we are successful at attracting and training the next generation of clinician scientists we will be threatening our own existence. While I acknowledge that basic research carried out by scientists can be of the highest quality, I remain of the opinion that clinician scientists represent a very powerful resource in advancing our knowledge in our field. It is the cooperative effort of these individuals working closely with basic scientists that will assure us of progress.

I therefore believe that the Society should put in place plans to encourage trainees to pursue a research path. I would like the Annual General Meeting in 2003 to reflect this feeling and for the members to request Council to put forward a plan where this becomes a reality. This will be a slow but hopefully a steady process that will undoubtedly yield dividends in the future.

The American Society of Haematology has long recognised this problem and has taken several steps to foster trainees. They recruited trainees as associate members, instituted trainees' council to provide advice to clinical fellows and established a scholar program to fund basic research and clinical research by trainees. It is interesting that the fees derived from associate membership are used to sustain these activities. While it may not be possible for us to attract sufficient number of trainees we should be able to come up with novel ideas to help train the future generation. An example of an excellent forum for our trainees is the haemostasis and thrombosis meeting held in Tasmania and sponsored by NovoNordisk. While only in its second year, the meeting has already established itself as an excellent forum for trainees interested in haemostasis and thrombosis to update their knowledge in the field and rub shoulders in an informal environment with their mentors. This to my mind is an excellent way of introducing our trainees to our specialty. Supporting this program will ensure that our trainees' interest is aroused and stimulated.

Finally I would like to thank my fellow councillors and our Executive Director, Ross Baker, for their wisdom and support though the year. Leonie Klomp has worked tirelessly and serves the Society with great vigour and expertise. Her efforts are greatly appreciated.

I hope to see you all in Melbourne next year.

Hatem Salem
President

TREASURER'S REPORT 2002-2003

Introduction

The ASTH finished the 2002-2003 financial year with net assets of \$285,313 and a net surplus of \$109,323. As with the previous financial year, while apparently a solid position, the audited accounts demonstrate that the ASTH's financial position is at best modest.

The ASTH and the ASTH Clinical Trials Group (CTG) in 2002-2003 are dependent almost solely upon (and are very grateful to) Industry for their generous continuing support (in alphabetical order including AstraZeneca, Aventis, Bayer, Bristol-Myers Squibb, Pharmacia (Pfizer) and Sanofi-Synthelabo).

The ASTH financial structure and activities are best understood by separately considering the ASTH and the ASTH CTG accounts (detailed below). The net surplus, as with 2001-2002 financial year, relates entirely to the activities of the ASTH CTG. Therefore, as with the previous financial years, the Society needs to increase membership and build other sources of income. Fortunately, with formal

Treasurer's Report 2002-2003

Continued

partnerships with the HSAZ and ANZSBT, the ASTH will receive a profit share of the Annual Scientific Meetings. This income will cover the running costs of the Society and hopefully allow the Society to build some reserves for the future.

ASTH – General Society

Income to the ASTH includes membership dues (202 financial members with 7 outstanding accounts in 2002-2003 at \$8,017); grants-in-aid from industry (\$14,391, \$6,000 outstanding) and some interest (\$1,174). With the recovery of the seed funding of the Adelaide ASM of \$7,500, the total income for the ASTH Society was \$31,082.

The total expenditure of the Society was \$26,813 including:

1. Auditing accounts (Edward Gwee at \$1,500);
2. ASTH Secretariat's Salary (\$12,000 with \$12,000 unclaimed for financial year 2002-2003);
3. Awards (AstraZeneca Medal 2002 - \$3,781);
4. Bank charges (\$568) - mostly related to maintenance of the creditcard facility;
5. Seed funding for the Christchurch Annual Scientific meeting (\$5,000);
6. Newsletter printing and production (\$637 for one edition);
7. Printing, stationery, postage and courier charges (\$1,495), and
8. ASTH booth and promotional material for HSAZ/ASBT/ASTH ASM in Adelaide 2002 (\$2,050).

As at July 1st, 2002 and June 30th, 2003 the cash at hand for the ASTH was \$63,232 and \$43,627. Considering liabilities and outstanding pledged sponsorships this balance is really \$37,627. This includes a Term Deposit of \$22,331 earning ~4.6% p.a.

ASTH - Clinical Trials Group

Income to the Clinical Trials Group includes interest (\$3,565), investigator donations to the CTG Trust Account (\$137,771) and grants-in-aid to the CTG (\$20,365).

The monies accumulating in the CTG Trust account from investigator donations are designated for research. CTG members by due process resolved to provide for a salary to establish an ASPIRE Study Coordinator who is currently employed at the NH&MRC Clinical Trials Centre in Sydney (\$30,030). A further \$20,000 (\$5,673 spent) was committed to setting up the pilot phase of the ASPIRE Study which commenced recruitment in May 2003.

The grants-in-aid to the CTG are specifically used for defraying travel/accommodation costs for investigators to attend the twice-yearly CTG meetings. This is a limited resource but fortunately all investigators travelling to Melbourne in November 2002 and Sydney in April 2003 were fully reimbursed (\$18,064). The CTG meeting in Melbourne was supported wholly by Aventis and Pharmacia provided for travel and accommodation of investigators and study coordinators.

As at July 1st, 2002 and June 30th, 2003 the cash at hand for the CTG was \$115,704 and \$234,953 respectively. This favourable increase is solely due to investigator donations to the CTG trust account.

Summary

In summary, the income of the ASTH is quite modest. The anticipated revenue derived from the Annual Scientific Meetings will cover projected expenditure and allow gradual building of reserves. The profit-loss partnership with the HSAZ and ANZSBT is in place for three years (Adelaide 2002, Christchurch 2003 and Melbourne 2004). In 2005 the ASTH will be co-hosting the ISTH with the AVBS and will also meet with the HSAZ and ANZSBT. Formal arrangements have not been made for these meetings. The incoming ASTH Council will need to develop improved strategies for income generation and address these issues.

Tim Brighton
Treasurer

UPCOMING MEETINGS

MEETING	WHERE/DATES	CONTACT
RCPA Pathology Update	Sydney – 12-14 March 2004	Catherine Sheehan - Phone: 61 2 8356 5826 www.rcpa.edu.au/pathologyupdate
XVIIth International Congress on Fibrinolysis and Proteolysis	Melbourne – 21-25 March 2004	www.icms.com.au/isfp2004
44th British Society of Haematology ASM	Cardiff – 19-21 April 2004	www.b-s-h.org.uk
XVIIth International Symposium on Technological Innovations in Laboratory Haematology	Barcelona, Spain – 13-15 May 2004	www.islh.org
50th Annual Scientific and Standardization Committee Meeting	Venice, Italy – 17-19 June 2004	www.sscvenice.it
18th International Congress on Thrombosis	Ljubljana, Slovenia – 20-24 June 2004	www.thrombosis2004.org
AIMS National Workshops	Perth – 30 June – 2 July 2004	www.aims.org.au
33rd Annual Scientific Meeting of the International Society for Experimental Haematology	New Orleans, USA, – 17-20 July 2004	www.iseh.org
6th HSAZ/ANZBT/ASTH ASM	Melbourne – 17-20 October 2004	www.asth.org.au
XIth International Congress on Antiphospholipid Antibodies	Sydney – 14-18 November 2004	http://www.xith-icaa2004.unsw.edu.au/sydney/index.html
The American Society of Haematology 46th Annual Meeting	San Diego – 4-7 December 2004	www.hematology.org

SECRETARIAT NEWS

The ASTH has received 32 new membership applications since the last edition of the newsletter in June last year. Welcome to the following members:

NSW	Dr Alessandra BIANCHI	Concord Hospital	Concord
NSW	Dr David BRIEGER	Concord Hospital	Concord
NSW	Mr David CONNOR	St Vincent's Hospital	Darlinghurst
NSW	Dr John HEWSON	Westmead Millennium Institute	Westmead
NSW	Mr Geoffrey KERSHAW	Royal Prince Alfred Hospital	Camperdown
NSW	Dr Huong Lan Giang PHAN	Westmead Hospital	Westmead
NSW	Dr John PIMANDA	Centre for Thrombosis & Vascular Research	Sydney
NSW	Dr Peter RANKIN	Lismore Base Hospital	Lismore
NSW	Miss Rebecca SMITH	Gradipore Ltd	Frenchs Forest
NSW	Dr Juliana TEO	Westmead Hospital	Castle Hill
NSW	Dr Judith TROTMAN	Concord Hospital	Concord
QLD	Mr Bruce EVANS	Abacus Diagnostics	Yeerongpilly
QLD	Dr Michael GEROMETTA	Agenix Ltd	Acacia Ridge
QLD	Dr Tee Beng KENG	Sullivan & Nicolaides Pathology	Indooroopilly
QLD	Dr Luke SOO	Queensland Medical Laboratory	West End
QLD	Mr Mark WILLIAMS	Mater Health Services Pathology	South Brisbane
SA	Ms Jeanette LAKE	The Queen Elizabeth Hospital	Woodville
TAS	Dr Daniel OWENS	Hobart Pathology	Battery Point
VIC	Mr Terry FAWCETT	Biospecifix Pty Ltd	North Box Hill
VIC	Dr Harshal NANDURKAR	St Vincent's Hospital	Fitzroy
WA	Dr Ben CARNLEY	Royal Perth Hospital	Shenton Park
WA	Ms Vanessa COLE	Royal Perth Hospital	Perth
WA	Dr Julie CRAWFORD	Royal Perth Hospital	Perth
WA	Mr Paul ELLERY	Curtin University of WA	Perth
WA	Dr Ian IRVING	St John of God Pathology	Nedlands
WA	Ms Kate MASLEN	Royal Perth Hospital	Perth
WA	Dr Cheryl PECH	University of Western Australia	Fremantle
WA	Dr Janelle STATON	Royal Perth Hospital	Gwelup
New Zealand	Ms Alison INDER	Christchurch Hospital	Christchurch
New Zealand	Dr Sharon JACKSON	Middlemore Hospital, Otahuhu	Auckland
New Zealand	Dr Mark SMITH	Canterbury Health Laboratories	Christchurch
New Zealand	Dr Laura YOUNG	Auckland Hospital (LabPlus) Remuera	Auckland

Subscription Renewals

The 2003/2004 subscription renewal notices have been emailed instead of posted this year (I received the first notice 10 minutes after emailing it!) If you did not receive your renewal notice, please let me know ASAP so I can send you one. Thanks to all those members who have already sent their renewals in.

As you may have noticed on the renewal form, I have asked you to provide your contact details again (I usually pre-print the notices with members' current details on file). The reason for this is because the contact details you provide me now will be used in the next edition of the membership booklet (if you have given your consent).

Some gentle reminders:

- The final date for receipt of subscription renewals is December 26, 2003. After this date, no further correspondence will be sent until payment has been received.
- Please ensure creditcard numbers are correct and cards have not expired.
- If you are applying for Associate membership, please include a letter with your renewal form signed by your Head of Department or supervisor confirming your eligibility for Associate membership.

Water Bottles

The ASTH gave away high-quality 750ml water bottles to members who visited the ASTH booth at the Christchurch

conference. Those members who did not collect their bottle or who did not attend the conference should have received one by now; however if you haven't, please let me know.

Have a great Christmas and New Year and don't eat too much.

Leonie Klomp

SUNCORP DONATION

A good news story (at last!!). In September of 2002 I was approached by Suncorp Metway in Brisbane who were keen to donate some money to further research into travel-related thrombosis. Unfortunately a young lady on their staff died from pulmonary embolism associated with travel to Europe. The money had been collected from the staff and also Suncorp Metway made a donation. After 12 months of effort the ASTH has now fulfilled all criteria to be considered a Deductible Gift Recipient as per the ATO. The final step was the special resolution that was passed at the recent AGM in Christchurch to insert 3 clauses to our constitution. As a DGR organisation donations to the society are tax deductible. I will now establish a specific gift account and please encourage all opportunities for further donations.

Tim Brighton
Treasurer

CLINICAL TRIALS GROUP REPORT

The ASTH Clinical Trials Group (CTG) meet in Christchurch during October 2003. It was a small but enthusiastic group. Additionally we were privileged to have Prof. Giancarlo Agnelli (Italy) and Prof. John Simes (NH MRC Clinical Trials Centre, Sydney) in attendance for the meeting.

The ASPIRE study is now really gathering momentum. This study examines the efficacy and safety of low-dose aspirin as prophylaxis against recurrent venous thrombosis after initial warfarin therapy in patients with unprovoked DVT or pulmonary embolism. A pilot phase commenced recruitment in May 2003 and has 18 patients from three centres in Australia on study. Funding from the ASTH CTG, Bayer International, NSW Department of Health and also the NH MRC Clinical Trials centre has been forthcoming to run a 200 patient pilot study. The pilot phase will be essential for refining recruitment strategies and the study/data management for the main ASPIRE study. Clearly the question of low-dose aspirin is still a very important one. Prof Giancarlo Agnelli and his colleagues in Italy are about to commence a similar study (WARFASA). During the Christchurch meeting Prof Agnelli committed his group to collaborating with the ASPIRE study. There will be at a minimum a planned combined analysis of the 2 studies. At the CTG meeting members unanimously supported a proposal to committing a further \$50,000 to boost recruitment of sites and patients to the pilot phase. The most exciting news was that the NH & MRC have awarded the ASPIRE investigators \$1.07Mill over 5 years. While this is less than we asked for it is a great outcome. The ASPIRE steering committee is confident that the remaining \$1million to run the main study will be achieved. The main ASPIRE study will now commence in 2004. I encourage investigators to become involved and pioneer sub-studies off the main project. There are of course many questions relating to laboratory (d-dimer) and radiological (residual thrombus burden) surrogates in predicting recurrence. With 3000 patients and about 400 recurrent events a number of important questions should be asked with this data.

Paul Harper presented during the meeting the preliminary results from the D-dimer study. This study examines managing of patients with a low clinical suspicion of DVT and a negative D-dimer without ultrasound. Paul Harper developed an internet-based data collection and analysis for the study. The study recruited only in New Zealand and the data suggests that this approach is safe and cost saving. Well done Paul for all your efforts.

There may still be a life left for the TRAVEL study. While currently unfunded, the International Airline Association has requested the WHO to release the funds accrued for study of travel-related thrombosis (~ 10Mill Euros) to fund the TRAVEL study. The previous International collaborative study has apparently fallen over. The process forward is not clear but Ross will update the membership as appropriate.

Tim Brighton presented a draft protocol for a randomised study of prednisone versus dexamethasone in adult ITP. The protocol will be circulated for comment and contact Tim Brighton for details.

CTG Investigators are also busy with industry-sponsored proposals. These studies bring resources to the group for collaborative research and international recognition of the ASTH. Many of these studies have been very successful and results have been presented in the last 12 months including the CLOT in Cancer (Pharmacia), MATISSE PE and DVT studies (Sanofi-Synthelabo & Organon), PENTHIFRA PLUS (Sanofi-Synthelabo), THRIVE II (AstraZeneca), and prophylaxis studies in medical patients with pentasaccharide (ARTEMIS, Sanofi-Synthelabo). Current active studies amongst members of the CTG include extended prophylaxis in medical patients with clexane (EXCLAIM, Aventis Pharma) and the Van Gogh DVT and PE treatment studies with idraparinux (Sanofi-Synthelabo & Organon).

The next full-day meeting of the CTG will possibly be in Melbourne around the International Fibrinolysis meeting to be held in March. Please read the emails and I encourage all to attend the full-day CTG. See you in Melbourne.

Comments and suggestions are always welcome.

Tim Brighton
Chairman CTG

WEBSITE NOTE

Does anyone have suggestions for improvements or knows of any new pages/links ? Any other comments are welcomed. Please contact Neville Marsh at neville.marsh@adelaide.edu.au

FEEDBACK

Recently published in the ASTH New and Emerging Technologies Group Newsletter #3

I enjoyed reading the conference updates in Newsletter #2. I would like to add my comments to those of Emmanuel Favaloro, regarding the ISTH meeting to be held in 2005 in Sydney. Having now worked in Cambodia for nearly 3 years, words cannot describe the disparity between the level of knowledge of coagulation problems and treatment in developing countries compared to the western world. It would be wonderful if the conference conveners could have a session on the problems one is faced with, in a developing country. The plight of haemophiliacs for one thing is appalling. There is a huge need in developing countries for very basic education and training in both the diagnosis and treatment of patients with bleeding or thrombotic problems.

Warm regards
Robyn

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NEW AND EMERGING TECHNOLOGIES GROUP REPORT

In the late 1990's the ASTH tried to establish a "New and Emerging Technologies Group" for laboratory scientists. For various reasons this didn't eventuate, but 2003 has seen the resurrection of this group.

The directions of the New and Emerging Technologies Group are to:

- Increase the profile of the ASTH for laboratory scientists.
- Increase communication between coagulation laboratories.
- Provide a forum for sharing information eg. troubleshooting, advice, etc.
- Increase participation of laboratory scientists at ASTH annual scientific meetings.
- Develop collaboration between laboratories eg. for new method evaluation.

A useful starting point for this group has been development of a newsletter. Three have been circulated this year (by email) and have provided feedback for members unable to attend meetings such as the ISTH, ASTH and the successful Coagulation Workshop at Westmead Hospital. There have also been interesting articles from Robyn Devenish who is working at the Angkor Hospital for Children in Cambodia and Jim Thom who attended the UK NEQAS (Blood Coagulation) annual meeting in Sheffield. It is probable that this "e-newsletter" will be streamlined and

incorporated into the ASTH newsletter, now edited by Emma Perrin, so that everyone in the ASTH is kept up to date about the New and Emerging Technologies Group and its activities.

A mailing list of interested laboratory scientists is currently being collated. The list will be circulated to members to ensure that continuity of communication (ie. via email) between laboratories is maintained. A list of special haemostasis tests that has been previously circulated (in various forms) is now being updated and will be distributed to those on the mailing list. If you would like to be added to this list so that you are "kept in the loop", please contact me.

Thank you to everyone who has provided me with ideas and feedback for the New and Emerging Technologies Group. While the "resurrection" of this group in 2003 has been promising, and the "e-newsletter" a good starting point, the challenge now is for the group to move forward. Ultimately it would be great to increase the communication between laboratories to develop multi-lab collaborations that would be of benefit to the ASTH and the haemostasis community.

I welcome any discussion.

Season's greetings.

Murray Adams

Phone: (08) 9266 4316 Email: m.adams@curtin.edu.au

CONFERENCE REPORTS

Jottings from the XIX Congress of the International Society on Thrombosis and Haemostasis held at the International Conference Centre, Birmingham, UK from 12-18 July, 2003.

Michael Ray

The Prince Charles Hospital, Brisbane

Birmingham welcomed us with balmy warm summer days and a great opportunity to catch up again with fellow-clotters. This lovely old city is interlaced with a canal system, which, if you wish to take a barge, or walk the towpaths, will take you as far as London and beyond. The conference centre was picturesquely situated on one such canal. The first two days were devoted to the 49th Annual Scientific Standardisation Committee meeting. Two presentations of interest:

Alan Michelson originally from Australia and now working at Massachusetts Medical School one hours drive from Boston. He has become one of the world platelet gurus and spoke on microparticles for the Working Group on Vascular Biology. This was of particular interest to me as we are currently measuring platelet-derived microparticles (PDMP) during angioplasty. Microparticles may originate from platelets, red blood cells, granulocytes, T cells, monocytes or endothelial cells and arise when these cells are stressed. We have found that coronary artery disease causes an increase in the concentration of PDMP. PDMP form in response to platelet agonists, complement, soluble P-selectin, high shear forces and platelet storage. (Possibly they are the procoagulant constituent of platelet rich plasma which is active in reducing bleeding). Their function is to provide a procoagulant surface as they have receptors for factor V and VIII and also contain tissue factor. Thus this platelet dust hijacks these procoagulant factors to the site

where the thrombin generation is occurring. PDMP have a haemostatic effect such as in ITP where numbers are increased but bleeding is less than expected for any given platelet count or in uraemic patients where PDMP numbers are also increased and there is increased thrombosis.

Nigel Mackman from Scripps explained how this blood borne tissue factor is important for fibrin formation in a thrombus. As well as being present in PDMP, tissue factor is found in microvesicles in the monocyte membrane. These can fuse with the platelet membrane, thus transporting tissue factor to the platelet.

The Congress commenced on Monday and continued for the next 5 days. Ximelagatran received a lot of attention as a prospective replacement for Warfarin. It is a direct thrombin inhibitor with free and clot-bound thrombin as its target. It is taken orally, after which it is converted to its active form, melagatran. It has a wide therapeutic window that means that monitoring is unnecessary (farewell INRs ??). The THRIVE study randomised 2490 patients with DVT (37% with PE) for 6 months treatment with ximelagatran alone or sc enoxaparin for 5 days followed by warfarin. Ximelagatran was equivalent to warfarin and showed a trend towards less bleeding. C W Francis of Rochester presented another study of 2301 patients comparing Ximelagatran with warfarin in the prevention of venous thromboembolism after total knee replacement. Ximelagatran at 36 mg bid provided superior efficacy to Warfarin in prevention of distal and/or proximal DVT, and/or confirmed symptomatic DVT or PE and/or all-cause mortality with no increase in bleeding.

Matisse Study. This was a multinational study of the new direct factor Xa inhibitor, fondaparinux (marketed as

Arixtra). This synthetic pentasaccharide has a shorter molecule than low molecular weight heparin and does not bind to platelet factor 4 so is unlikely to cause heparin induced thrombocytopenia. Many Australian centres including ours participated in this study. In cases of confirmed, acute symptomatic DVT and PE, patients were randomised to a fixed once daily dose of 7.5 mg of fondaparinux or twice daily enoxaparin 1mg/kg. These were continued for at least 5 days until anticoagulation with Warfarin produced an INR of 2-3. The fondaparinux was at least as effective and safe as enoxaparin in treating the DVT and PE.

MRI imaging of thrombosis. As blood clots, the haemoglobin involved undergoes changes that result in the formation of methaemoglobin. This acts as an endogenous contrast agent that allows the imaging of thrombus using T1 weighted magnetic resonance imaging. This technique not only allows imaging of thrombus in deep vein thrombosis and pulmonary embolus, but is also able to image the atherosclerosis and plaque in the arteries of patients with coronary artery disease. Examples of this technique showed very clear imaging of thrombosis and, being non-invasive, might be the way of the future in imaging blood clots.

The 6th AIMS NZIMLS South Pacific Congress held at Conrad Jupiters, Gold Coast 6-10 October, offered an excellent program for those of us clotting inclined.

Connie Solano

Princess Alexandra Hospital, Brisbane

At the initial HITTS workshop, Professor Beng Chong reviewed the molecular basis, aetiology, clinical and laboratory diagnosis of HITTS. Sarah Just presented laboratory correlation data (Diamed ID-PF4 assay vs ELISA and/or Platelet Aggregation HITTS tests) as well as several interesting case studies, while Dr Darren Walters, an Interventional Cardiologist provided a clinical perspective. With a particular emphasis on cardiac patients, he discussed the results of a retrospective review of cardiac transplant patients (66% of this group had prior exposure to heparin and importantly, 45% HIT Ab positive patients developed thrombosis). Finally Dr Peter Wood provided an overview of other drug related thrombocytopenias and the difficult differential diagnosis in some cases. An interesting discussion about the pros and cons of screening at risk patients for HITTS ensued but generally it was felt that a high index of suspicion should precede any testing. Additionally, it was felt laboratory staff could be more proactive in the surveillance of potential HITTS cases via the use of LIS algorithms which autolists APTT patients where the platelet count has decreased by 50% and autocomments suggesting a platelet count request where no result can be found.

The Congress Scientific Programme provided haemostasis related topics and/or sessions each day. Michael Ray discussed a number of the near patient testing instruments, which had been evaluated in his laboratory and Dr John Rowell presented an update on the molecular biology of haemophilia and von Willebrand's disease. Emmanuel Favalaro chaired an interesting session, which "provided a mix of old and young presenters". I (the old presenter) spoke about our statewide coagulation QC programme, followed by the very young Glen Devenie who

presented some interesting thromboelastogram data from a haemophiliac case (pity the All Blacks didn't perform as well Glen). Roslyn Bosnar updated us on the RCPA Haemostasis and Point of Care programmes, followed by an unusual factor V inhibitor case study by Sarah Just. Liz Duncan (sorry Liz – another oldie) raised the issues of in vitro vs ex vivo procedures for setting unfractionated heparin therapeutic ranges as well as instrument/reagent effects. A quick poll of the audience revealed heparin-spiking was more commonly used to set these ranges. Kylie Rushford closed this interactive session with an evaluation of a commercial modified APTT-based APCR assay which provided good differentiation and correlation with genetic FVL testing. Another highlight for many of us was the last haemostasis session of the Congress. Paul Masci spoke about novel applications of snake venom components and his current research projects certainly drew some media attention. Dr Chris Ward provided an excellent update on the growing list of new anticoagulants with non-user friendly drug names such as Fondaparinux, Idaparinux, Ximelagatran and Exanta. From the laboratory perspective, no routine monitoring is necessary (that's good), but effective antidotes are not available should problems arise. If monitoring is requested, at this stage anyway, more complex laboratory tests will be required (not so good). And what better way to conclude the haemostasis scientific programme than to be educated and entertained by Dr Bev Rowbotham's topic "New ideas in coagulation". Thank you all very much.

As we come to expect from Congress meetings, the Trade Display, in conjunction with the various User Group Meetings, showcased new coagulation instruments, kits and reagents. Additionally, a small, but interesting selection of haemostasis poster presentations complimented the programme.

I thoroughly enjoyed myself (though it was exhausting), and certainly wish to pass on our thanks to the Organising Committee.

HSANZ ANZBT ASTH Combined Meeting Christchurch October 19th–22nd

Sunjeev Chunilal

Queen Elizabeth Hospital, Adelaide

My congratulations to the HSANZ organising committee for the Christchurch 2003 meeting. From my perspective and from the comments that I have had from my colleagues on this side of the Tasman, the meeting was successful both from the educational as well as social perspective.

This year there was a number of high calibre speakers including Professor Giancarlo Agnelli from Perugia, Ken Bauer from Harvard University Boston, Robin Carrell from Cambridge who gave the Carl De Gruchy Lecture, Ulla Hedner from Sweden, Marcel Levi from Amsterdam as well as local speakers such as Michael Berndt, Shaun Jackson, Emmanuel Favalaro, Ross Baker and John Lloyd.

For me, the highlights of the meeting were the excellent lecture delivered by Robin Carrell on Serpins, Heparins and Thrombosis and the Carl De Gruchy Lecture "from Dingo's to Dingbat's". An aptly named lecture detailing the incredibly shoddy lack of any credible scientific standards used in the trial of Lindy Chamberlain, which Professor Carrell summarised as, "do not necessarily expect justice on the base of logic and truth".

CONFERENCE REPORTS *Continued*

We were treated to a wonderful lecture from Dr David Milne about the pitfalls of spiral CT and its limitations in the diagnosis of pulmonary embolism. One of the take home messages for myself was insuring that the interpreting radiologist has carefully scrutinised the lung windows in conjunction with the arterial phase to reduce the possibility of false positive diagnoses.

Ken Bauer gave us insight into two trials. The Pegasus Trial compared Dalteparin versus Fondaparinux for VTE prophylaxis for patients undergoing general surgery. This was non-inferiority trial randomising 2,900 patients but was unable to demonstrate superiority of Fondaparinux. The Artemis trial was a randomised placebo controlled venographic end point study in medical patients over the age of sixty. This study was able to demonstrate a benefit in favour of fondaparinux with an overall event rate of 5.6% versus 10.5% ($p=0.029$).

Dr Agnelli provided some data by Grifoni et al (Circulation June 2000) looking at risk-stratifying patients with suspected pulmonary embolism based on systolic blood pressure, RV dysfunction on 2D-echo and the presence of shock. Normotensive patients without echocardiographic RV dysfunction (47% of group) had a low mortality rate (0% (95% CI 0 - 3.5%)), suggesting these patients could be safely managed as outpatients. However, PE-related mortality was 5% in normotensive patients with RV dysfunction and no shock, highlighting the need to explore other therapeutic options for these patients.

The other interesting observation from Professor Agnelli as part of the WODIT PE and DVT studies was the observation of increased mortality due to stroke and myocardial infarction in those patients that have had a previous idiopathic venous thromboembolic event. The high rates of mortality in patients following an idiopathic venous thromboembolic event was also observed by Laura Young and the Auckland Hospital Thrombosis group.

Congratulations to Dr Laura Young, AstraZeneca Young Investigators award winner, for her excellent presentation, a retrospective analyses of the rate of thrombus resolution in 344 patients who completed three to six months of anti coagulant therapy. She demonstrated that patients with malignancy have a significantly lower rate of thrombus resolution following proximal deep vein thrombosis compared to patients without malignancy, highlighting the difficulties in managing this patient population.

Within the same symposium there was an excellent paper presented by Miss S Wan, a fourth year medical student from Western Australia under the guidance of Dr Eikelboom, presenting a meta-analysis on the efficacy of thrombolysis compared to Heparin for the treatment of pulmonary embolism. They demonstrated a non significant trend towards a reduction of recurrent PE or death in patients receiving thrombolytic therapy with an odds ratio of 0.65 (95% CI .39 - 1.09) but an associated non significant increase in the risks of major bleeding, OR 1.59 (95% CI .91 - 2.79) and a significant increase in non major bleeding, OR 2.5 (95% CI 1.54 - 4.3). These data do not confirm clinical benefit of thrombolytic therapy as part of routine use but show an increased risk of non-major bleeding. The question needs to be answered with a good randomised controlled trial evaluating the efficacy and safety of lytic therapy in this patient population.

CONFERENCE PHOTOS

(a) Giancarlo Agnelli and Ken Bauer

(b) Robin Carrell and Paul Harper



(c) ASTH Council taken at the Christchurch Conference Dinner (L-R) Hatem Salem, Leonie Klomp, Emma Perrin, Ross Baker, Murray Adams, Chris Ward and Tim Brighton (Absent Paul Harper, Mark Smith and Alex Gallus)



I enjoyed the symposium on Wednesday morning on running a clinical trial where I think the stand out talk was that by Nancy Oliveri looking at the legal and ethical issues of industry funded trials. Dr Oliveri outlined the trials and tribulations she has faced over the last decade in relation to her study looking at an oral iron chelation drug, deferiprone. These included being fired and then reinstated by the University of Toronto on four occasions, a number of e-mail and postal threats of personal harm and a significant number of legal challenges, all of which to date Nancy has successfully appealed and won, thereby clearing her name. It highlighted the importance of appropriate government funding for clinical trials to protect investigators looking at potentially controversial questions and the difficulty investigators have in reporting the results of clinical trials when the results are unfavourable.

The final session of the meeting was capped off by a symposium on massive transfusion highlighting the role of recombinant FVIIa in a massive transfusion program. Professor Alison Street highlighted the Australia New Zealand experience since 1988 where 170 cases of uncontrolled haemorrhage have been reported, 81 in the last twelve months alone. The message from this symposium was the critical importance of the Haematologist in co-ordinating appropriate management in conjunction with the coagulation and blood transfusion service providing a pivotal role in managing these patients. In many instances prompting anaesthetic ICU and surgical staff to the appropriate use of blood products and also the appropriate and timely use of recombinant FVIIa. No doubt this is an area where we will hear of further advances in future years.

In summary, the beauty of the HSNZ meeting remains the ability to interact with one's colleagues within Australia and New Zealand in a relatively relaxed atmosphere. Additionally this forum provides opportunities to talk with the international experts that attend these meetings.

I think the main message from this meeting for me, was the importance for the ASTH clinical trials group to proceed with the Aspire Study, given the Italian experience of high rates of death following idiopathic venous thrombosis due to cardiovascular mortality. Following the successful NH&MRC application for the Aspire Study, I think we are in a unique position as an Australasian organisation to design, run and analyse potentially a landmark trial and enhance the credibility of our group.