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An international study of how laboratories handle and evaluate patient samples after detecting an unexpected APTT prolongation

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Abstract

Background: An unexpectedly detected prolonged activated partial thromboplastin time (APTT) can be a harmless laboratory finding, but can also reflect a thrombotic tendency or a bleeding disorder. The assistance of laboratory professionals in the interpretation of an unexpectedly detected prolonged APTT (uAPTT) is often required. The way in which uAPTTs are evaluated in laboratories was assessed in this international study with the aim of determining whether laboratory professionals are able to fulfill this need.

Methods: Postanalytical practices after uAPTT were investigated and the mixing study methodology (if used) was studied by circulating a case report with a questionnaire to staff in the invited laboratories. In addition, the interpretations of those staff regarding the presence or absence of inhibitors in three APTT mixing study scenarios were examined.

Results: Large within- and between-country variations were detected in both postanalytical practices and mixing study methodologies among the 990 responding laboratories, 90% of which were in 13 countries. Shortcomings regarding the investigation of uAPTTs leading to potentially incorrect or delayed clinical diagnoses were found in 88% of the laboratories. Of the laboratories to which the interpretative questions were sent, 49% interpreted all mixing study scenarios correctly. uAPTTs were investigated appropriately and all mixing study scenarios interpreted correctly in parallel in only 9.6% of the participating laboratories.

Conclusions: The clinical requirement for the assistance of laboratory professionals in the interpretation of uAPTTs cannot be met at most of the participating laboratories. Laboratory professionals should be trained in the evaluation of ordinary laboratory tests, such as that for uAPTTs.

Keywords: activated partial thromboplastin time (APTT); clinical interpretation; mixing studies; postanalytical phase.

Introduction

Activated partial thromboplastin time (APTT) is a frequently requested coagulation parameter in clinical laboratories that is used to screen for intrinsic coagulopathies (hemorrhages) and thrombotic tendencies [e.g., lupus anticoagulant (LA)], and for monitoring unfractionated heparin therapy [1, 2]. An unexpectedly detected APTT prolongation (uAPTT) can be a harmless laboratory finding with a spurious etiology (e.g., preanalytical errors...
or a reflection of unknown anticoagulant therapy), or can result from clinically insignificant coagulation factor deficiencies (e.g., factor XII or prekallikrein or high molecular weight kininogen deficiencies), or reflect a severe bleeding disorder (e.g., inherited or acquired hemophilia A) or thrombotic tendency (LA) [1]. The interpretation of a prolonged APTT result requires both comprehensive clinical information regarding the patient and laboratory expertise with respect to coagulation testing and interpretation [3].

After excluding spurious etiologies for the uAPTT, it is essential to determine whether the abnormal APTT is due to an inhibitor effect or a factor deficiency [4–6]. This information can be successfully obtained if the laboratory performs a “mixing study” [7, 8], in which the APTT test is repeated on a mixture of the patient’s plasma and normal plasma, and then a decision is made as to the correction or normalization of APTT in the mixture. A correction (normalization) suggests a clotting factor deficiency, while failure of normalization suggests the presence of an inhibitor [7, 8].

Algorithms designed to evaluate a uAPTT [9] and recommendations around how to perform and interpret mixing studies [7, 8, 10] are available. However, the guidelines do not regulate the responsibilities of clinicians and laboratory staff in the differential diagnosis of a uAPTT, and fatal medical errors due to an uninterpreted uAPTT do occur [11]. An increasing number of studies has been published in which it has been reported that some physicians have either found laboratory assistance useful, or required such laboratory assistance in the interpretation of common laboratory tests results, including uAPTTs [12–15]. In addition, prompt laboratory investigation is expected upon the detection of even mild uAPTTs in patients without a prior history of bleeding, due to the potentiality of acquired hemophilias [16].

The aim of the present study was to determine whether the invited laboratories are able to provide the laboratory assistance required for the clinical interpretation of uAPTTs. To this end, the postanalytical practices (i.e., actions performed after the detection of an uAPTT) and mixing study methodologies applied in the evaluation of uAPPTs in these laboratories were explored to determine whether they are appropriate to exclude spurious APTT prolongations and to discriminate between uAPPTs caused by the presence or absence of inhibitors. The skill of the professionals responsible for the coagulation tests in these laboratories to successfully interpret different scenarios of APTT mixing studies results and to decide upon the presence or absence of inhibitors was also investigated.

Materials and methods

This survey was organized by the joint Working Group (WG) on the Postanalytical Phase of the European Federation of Clinical Chemistry and Laboratory Medicine and the European Organisation for External Quality Assurance Providers in Laboratory Medicine (EQALM). The WG developed a case-history-based questionnaire and submitted it to pilot testing in five countries (Croatia, Hungary, the Netherlands, Norway, and Turkey), and adapted the final questionnaire (Supplemental Data, Table 1 that accompanies the article http://www.degruyter.com/view/j/cclm.2015.53.issue-10/cclm-2014-1183/cclm-2014-1183.xml?format=INT) on the web using the SurveyMonkey online survey tool [17]. Laboratories participating in coagulation schemes of different external quality assurance programs in Europe and beyond were invited to participate in the electronic survey between July and October 2012 by member organizations of EQALM. Senior staff at the invited laboratories were asked to forward the questionnaire to the person(s) responsible for routine coagulation tests, so as to obtain the answers that most accurately reflected the everyday situation in their laboratories. Survey completion was expected within approximately 2 weeks, after which a reminder was sent.

Survey content

A schematic summary of the survey content is shown in Figure 1. The survey participants were provided with a case history of an asymptomatic 7-year-old girl and asked to answer a series of single- and multiple-choice questions about it. The questions targeted key practices of a typical laboratory investigation protocol for patients with a prolonged APTT and normal prothrombin time, and the personal and laboratory particulars of the respondents. In addition, three different patterns of APTT mixing study results (mixing study scenarios) were presented to staff at laboratories in which mixing studies were used routinely (Figure 2A). The questions that were asked of staff at laboratories are shown in Figure 1 and Supplemental Data, Table 1.

Laboratory evaluations used to explore uAPTT

The questionnaire addressed two main areas: 1) uAPTT investigations: postanalytical practices after uAPTT detection and the mixing study methodology; and 2) interpretation of mixing study scenarios.

uAPTT investigations

Postanalytical practices after uAPTT detection: Four key postanalytical practices were studied (Figure 1): 1) exclusion of unfractionated heparin presence; 2) performance of mixing studies; 3) performance of or referring samples for further special testing; and 4) providing written interpretation of the results to the requesting physician. Laboratories were classified according to their activities in each single postanalytical action, as follows (Supplemental Data, Table 2): 1) never do; 2) act exclusively “clinically driven” (i.e., performed at the laboratory using exclusively clinical information and no reflex or reflective testing); and 3) act “laboratory driven” (i.e., using reflex or reflective testing).
The case history:
A 7-year-old girl has suffered from gastroenteritis that lasted for 3 days with fever, vomiting, and mild diarrhea. Two weeks later her citrated blood sample was delivered to your laboratory as a part of a general checkup before elective tonsillectomy. The results were as follows: PT: 11.2 s (reference interval: 9–12 s); INR: 0.98 (reference interval: 0.8–1.2); APTT: 65.0 s (reference interval: 28–35 s).

What would you do? (postanalytical practices):
What do you usually do in your laboratory to exclude heparin contamination? (Q4)
Would you perform APTT mixing studies in this case? (Q5)

How do you usually perform mixing studies? (methodologies):
Type(s) and sensitivity of APTT reagent(s) (Q25–27)
What is the source of normal plasma in the mixture? (Q8)
Is the normal plasma you use for mixing studies buffered or non buffered? (Q9)
Which is the ratio between patient and normal plasma that you use in your mixing study (Q10)
Do you incubate the mixture? (Q11) if yes, please specify for how long? (Q12)
When do you consider the results of mixing studies to indicate factor deficiency? (Q14)

How do you interpret mixing studies? (interpretations):
Three laboratory scenarios (Q15–17)

Would you perform any further investigations on APTT prolongation in this case? (nomixers, Q7; mixers, Q18)
Which way do you report the results of APTT mixing study? (nomixers, Q6; mixers, Q13)

Personal and laboratory particulars:
Age, gender, profession of respondents (Q19–21)
Type (Q22), daily frequency of APTTs tested in the laboratory (Q23), and the most frequent indications of APTT requests (Q24).

Analysis of the responses to the questionnaire
Responses were initially analyzed on basis of the whole study, then according to the following subgroups of respondents: 1) for countries with more than 20 responders, the lowest and the highest frequencies detected in any of these countries are presented in the text as the range of observed frequencies (range f); 2) laboratories in which <50 APTT tests/day (n=392) and ≥50 APTT tests/day (n=356) are usually performed; 3) specialized coagulation laboratories (n=71) and primary care laboratories (n=60); and 4) laboratories for which laboratory specialists (n=373), physicians (n=102), or technologists (n=133) responded.

Statistical analysis of the responses was performed by cross tabulation. The cut-off for statistical significance, which was determined using the t-test and Fisher’s exact test, was set at p<0.05.

Results
Responses from staff at 990 laboratories were analyzed, 90% of which were located in 13 countries, each providing
more than 20 responses, with an overall response rate of 19% (range: 6%–77%). The response rate to individual questions was 78%–100% (Supplemental Data, Table 1). The main characteristics of the laboratories from which responses were received are summarized in Table 1.

**Investigations of uAPTT**

**Postanalytical practices after detection of a uAPTT**

Large within- and between-country variations were observed concerning the postanalytical practices performed upon detection of a uAPTT, and the clinically or laboratory driven characteristic of those practices (Table 2). None of the investigated postanalytical practices were performed in only seven laboratories (0.7%), and all of them were performed in 46%. In the remaining laboratories (53%), the applied practice combinations varied between those in which mixing studies were performed (26%) and those in which they were not (27%). The predominant laboratory practice in most countries was to perform mixing tests; however, in some countries 50%–74% of laboratories never performed mixing studies. The percentages of shortcomings in postanalytical practices with the potential consequence of delayed or misdiagnosis in the various investigated laboratory groups are presented in Table 3.

**Methodologies used in mixing studies**

Only a single APTT reagent was used at 63% of all the responding laboratories (range: 35%–91%). APTT reagents sensitive to factor deficiencies were most frequently used as the first or the only APTT reagent (34% of all laboratories), while APTT reagents sensitive to LA were used in 19%. In the remaining laboratories, staff either did
Table 1  Main characteristics of the responding laboratories.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of invited laboratories</th>
<th>No. of responding laboratories</th>
<th>Response rate to the survey, %</th>
<th>Laboratory type</th>
<th>No. of APTT tests processed daily</th>
<th>Qualification of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Special coagulation laboratories</td>
<td>Non-special coagulation laboratories</td>
<td>Medical doctors (physicians) and laboratory scientists</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>On secondary or tertiary care</td>
<td>In primary care</td>
<td>With specialization in clinical chemistry or laboratory medicine</td>
</tr>
<tr>
<td>Austria</td>
<td>270</td>
<td>46</td>
<td>17</td>
<td>6%</td>
<td>83%</td>
<td>45</td>
</tr>
<tr>
<td>Croatia</td>
<td>199</td>
<td>36</td>
<td>18</td>
<td>3%</td>
<td>84%</td>
<td>30</td>
</tr>
<tr>
<td>Denmark</td>
<td>155</td>
<td>31</td>
<td>20</td>
<td>19%</td>
<td>81%</td>
<td>18</td>
</tr>
<tr>
<td>France</td>
<td>1000</td>
<td>233</td>
<td>23</td>
<td>5%</td>
<td>90%</td>
<td>50</td>
</tr>
<tr>
<td>Germany</td>
<td>760</td>
<td>49</td>
<td>6</td>
<td>6%</td>
<td>90%</td>
<td>100</td>
</tr>
<tr>
<td>Hungary</td>
<td>160</td>
<td>54</td>
<td>34</td>
<td>3%</td>
<td>90%</td>
<td>35</td>
</tr>
<tr>
<td>Ireland</td>
<td>54</td>
<td>37</td>
<td>69</td>
<td>3%</td>
<td>91%</td>
<td>50</td>
</tr>
<tr>
<td>Italy</td>
<td>280</td>
<td>136</td>
<td>49</td>
<td>10%</td>
<td>83%</td>
<td>90</td>
</tr>
<tr>
<td>Norway</td>
<td>73</td>
<td>35</td>
<td>48</td>
<td>3%</td>
<td>94%</td>
<td>3</td>
</tr>
<tr>
<td>Portugal</td>
<td>88</td>
<td>68</td>
<td>77</td>
<td>6%</td>
<td>83%</td>
<td>15</td>
</tr>
<tr>
<td>Switzerland</td>
<td>211</td>
<td>46</td>
<td>22</td>
<td>0%</td>
<td>75%</td>
<td>10</td>
</tr>
<tr>
<td>The Czech Republic</td>
<td>458</td>
<td>45</td>
<td>10</td>
<td>11%</td>
<td>74%</td>
<td>37</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>129</td>
<td>71</td>
<td>55</td>
<td>15%</td>
<td>77%</td>
<td>20</td>
</tr>
<tr>
<td>Other countries*</td>
<td>1452</td>
<td>103</td>
<td>7</td>
<td>32%</td>
<td>68%</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>5289</td>
<td>990</td>
<td>19</td>
<td>9%</td>
<td>83%</td>
<td>40</td>
</tr>
</tbody>
</table>

*Albania, Australia, Belarus, Belgium, Canada, Finland, Kosovo, Latvia, Macedonia, Monaco, Poland, Romania, Slovenia, South Africa, Spain, Ukraine, UK. Parameters of the overall survey are shown in bold.
Table 2  The activity of responding laboratories in the investigated postanalytical practices after detection of a uAPTT.

<table>
<thead>
<tr>
<th>Activity after the finding of a uAPTT</th>
<th>Percentage of key postanalytical practices, mean (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heparin exclusion</td>
</tr>
<tr>
<td>Never do</td>
<td>3 (0–17)</td>
</tr>
<tr>
<td>Practice exclusively clinically driven: Performed by the laboratory using exclusively clinical information and no reflex or reflective testing</td>
<td>58 (47–86)</td>
</tr>
<tr>
<td>Practice laboratory driven: by using reflex or reflective testing</td>
<td>39 (8–51)</td>
</tr>
</tbody>
</table>

Data are percentages of all responding laboratories. The ranges of observed frequencies detected in any of the 13 countries, each providing more than 20 responses, are indicated in parentheses. NA, not applicable.

not know the sensitivity of their APTT reagents (22%), or else they used APTT reagents with unspecified sensitivity (25%). LA-sensitive reagents were most often chosen as the second APTT reagent (in 54% of laboratories in which two reagents were used).

In 90% of the laboratories in which mixing studies were performed (range: 63%–98%), a 1:1 ratio of patient plasma to normal plasma was used in the testing. The source of the normal plasma in the mixing studies was commercial or home-made pooled plasma for 83% of laboratories (range: 50%–100%). An incubation step was applied in the mixing studies in 56% of the responding laboratories (range: 33%–91%). A large variation in the duration of incubation was found, with 2 h of incubation as the most frequent condition (44%; range: 27%–67%). Plasma buffering was applied in mixing studies by only 17% of the responding laboratories (range: 9%–50%).

In most countries, all decision rules listed in the questionnaire (Supplemental Data, Table 1, Q14) were applied to some extent for interpretation of the mixing studies, but the Rosner index [20] was the most frequently used (34% of the respondents, range: 5%–83%).

The frequencies of shortcomings in mixing methodologies with the potential consequence of delayed or misdiagnosis in the investigated laboratory groups are presented in Table 3.

Discussion

The findings of this study revealed considerable diversity in both the investigations of uAPTTs in the responding laboratories and in their interpretations of the APTT mixing study scenarios. A significant percentage of the laboratories exhibited shortcomings with respect to investigations of uAPTTs with the potential consequence of delayed or misdiagnosis of the patients. All three mixing study scenarios were correctly interpreted by staff at only 49% (range: 30%–68%) of the laboratories who assessed them. All of the scenarios were interpreted incorrectly by staff at only one laboratory. An incorrect diagnosis of absence or presence of an inhibitor in one or more of the three scenarios was made by staff at 16% (range: 9%–19%) of the laboratories; responses were not received for any of the scenarios from staff at 25% (range: 13%–52%) of these laboratories. Staff at only 9.6% of all participating laboratories reported investigations of uAPTTs appropriately (Table 3) and yet simultaneously interpreted all mixing study scenarios correctly. The ways in which the three mixing study scenarios were interpreted in the different laboratory groups are presented in Figure 3.
Table 3  Frequency of shortcomings with the potential consequence of delayed or misdiagnosis in investigations of uAPTT.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percentage of the practices in the survey</th>
<th>Percentage in laboratories</th>
<th>Percentage in primary care laboratories</th>
<th>Percentage in special coagulation laboratories</th>
<th>Percentage in laboratories with p-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50 APTT tests/day</td>
<td>≥50 APTT tests/day</td>
<td>Technologists</td>
<td>Specialists</td>
<td>MDs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(%)</td>
<td>(%)</td>
<td>(%)</td>
<td>(%)</td>
<td>(%)</td>
<td>(%)</td>
</tr>
<tr>
<td>Shortcomings in postanalytical practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to exclude unfractionated heparin presence [7, 8, 18]</td>
<td>61</td>
<td>76</td>
<td>42</td>
<td>&lt;0.01</td>
<td>70</td>
<td>14</td>
</tr>
<tr>
<td>Failure in performing mixing studies [7–9, 18]</td>
<td>28</td>
<td>43</td>
<td>18</td>
<td>&lt;0.01</td>
<td>47</td>
<td>14</td>
</tr>
<tr>
<td>Shortcomings in mixing methodologies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity of the first or only APTT reagent is unknown [19]</td>
<td>17</td>
<td>32</td>
<td>10</td>
<td>&lt;0.01</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>Sensitivity of the second APTT reagent is unknown [19]</td>
<td>4</td>
<td>17</td>
<td>2</td>
<td>&lt;0.01 a</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Single donor’s plasma used in mixing studies [7–9]</td>
<td>17</td>
<td>23</td>
<td>14</td>
<td>&lt;0.01</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td>No incubation in mixing studies [7, 8, 18]</td>
<td>44</td>
<td>46</td>
<td>40</td>
<td>0.17</td>
<td>50</td>
<td>37</td>
</tr>
<tr>
<td>Any of the above shortcomings</td>
<td>88</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
</tr>
<tr>
<td>No. of laboratories:</td>
<td>990</td>
<td>392</td>
<td>356</td>
<td>NA</td>
<td>60</td>
<td>71</td>
</tr>
<tr>
<td>Median daily no. of APTT tests:</td>
<td>40</td>
<td>13</td>
<td>100</td>
<td>NA</td>
<td>20</td>
<td>150</td>
</tr>
</tbody>
</table>

Detected frequencies are shown as percentages of all responding laboratories in the group. References of the recommended practice are given in parentheses. *Calculated using Fisher’s exact test. NA, not applicable; NC, not calculated.
but some kind of shortfall was found with respect to postanalytical investigations of uAPTTs. These laboratories are at risk of providing a misdiagnosis due to inappropriate laboratory characterization of the abnormality underlying certain uAPTTs.

**Investigations of uAPTTs**

The timely and appropriate evaluation of a uAPTT is most effective if the responsibilities of both the clinicians and laboratory staff are clear and their practices are correct and concerted. The observed great variations both within and between countries concerning which postanalytical practices were performed in laboratories that participated in this study, and concerning whether the practices were clinically or laboratory driven indicate that either the guidelines [8, 10] were not followed or else they did not deliver harmonized instructions as to how to organize the postanalytical evaluation of uAPTTs.

However, regarding the methodology of mixing studies, the most clearly stated recommendations in existing guidelines were followed by staff at most of the participating laboratories; APTT reagents with known sensitivity, a 1:1 ratio of patient plasma:normal plasma, and pooled normal plasma were applied at 80%–90% of the laboratories [7, 8, 10, 19]. At the same time plasma buffering was rarely (17%) applied and there were large variations between laboratories with respect to the duration of incubation and the applied decision rules regarding the evaluation of mixing studies, likely reflecting the heterogeneity of the existing recommendations [7–10, 18, 21, 22]. Despite the clearly stated recommendations regarding its inclusion in mixing studies [7–9, 18, 21], an incubation step was included in only 56% of laboratories.

In a surprisingly large percentage of the participating laboratories (88%), the practices implemented to investigate a uAPTT had the potential to result in a misdiagnosis or delay in the diagnosis of the patient (Table 3). In general, shortcomings in the diagnostic workup of
a uAPTT were observed less frequently in laboratories in which ≥50 APTT tests/day are performed, in special coagulation laboratories, and sometimes in laboratories where physicians/specialists responded, compared to laboratories in which <50 APTT tests/day are performed, primary care laboratories, or where technicians responded. These findings suggest that more practice and an advanced educational background in coagulation leads to a better methodological understanding, and in turn to fewer shortcomings in uAPTT investigations. The exception was the lack of an incubation step in the mixing studies, which were equally distributed between the analyzed laboratory groups (Table 3), probably due to the rare occurrence of coagulation inhibitors [6, 23]. In agreement with the findings of this study, failure to detect coagulation inhibitors in samples due to the lack of an incubation step has even been observed in specialized coagulation laboratories [18, 24].

Interpretations of uAPTT in mixing study scenarios

It is generally advisable that only professionals with clear expertise in the particular laboratory field should be charged with interpreting laboratory results [25, 26]. It is alarming that although in the present study laboratory professionals responsible for coagulation were asked to interpret the mixing studies, only staff at 49% of the laboratories in which mixing studies were implemented could adequately discriminate between inhibitory and non-inhibitory forms of uAPTT in all three scenarios. These results are similar to those of the postanalytical Quality Assurance Program in Australia, wherein participants were asked to add interpretative comments to a set of non-esoteric laboratory test results, and in which ≥50% of the interpretations were inappropriate and/or misleading [25].

The laboratory groups with fewer shortcomings in the diagnostic workup of uAPTTs (i.e., laboratories in which ≥50 APTT tests/day are performed, special coagulation laboratories, and those in which physicians/specialists responded) provided more frequently correct interpretations of the mixing case scenarios compared with other participants (Figure 3A–C). The laboratories with correct postanalytical investigation performed best regarding the interpretations of case scenarios (Figure 3D). However, it is worrying that even staff at 20% of laboratories that had correct postanalytical practices misinterpreted the mixing study scenarios, suggesting that the implementation of good postanalytical practices for investigations of uAPTTs in itself will not perfect the analyst’s understanding of the clinical meaning of the applied laboratory tests. The acquisition and training regarding interpretative knowledge requires a special focus on the education and training of laboratory professionals in this specific field [27].

Limitations and strengths

A limitation of the present survey was that the method of selecting the laboratories to which invitations were to be sent was not fully standardized, resulting in a response rate that varied according to the country and it is not known whether those that responded are representative of the laboratories in their country. Therefore, it was difficult to compare findings from different countries.

The main strengths of this study are that almost 1000 laboratories were included, with response rates to individual questions of 78%–100%, and that the postanalytical laboratory practices regarding investigations of uAPTT and the interpretation skills of the staff at those laboratories were studied in parallel. While the fact that the questionnaire was circulated in English could have been a barrier in some countries, it could also have been considered an advantage since translation errors were avoided. Staff at a large number of laboratories at secondary and tertiary healthcare institutions responded to the survey, suggesting that the targeted population (i.e., laboratories at which uAPTT are detected on a daily basis) was successfully reached.

Conclusions

The clinical requirement for prompt further investigation of even mild uAPTTs in patients without a prior history of bleeding [16] cannot be fulfilled at most of the laboratories included in this study. The present findings reveal a need to harmonize postanalytical uAPTT investigations [28] and suggest that staff at laboratories should be trained in the clinical interpretation of ordinary laboratory tests, such as that for uAPTT. Therefore, training programs designed to educate laboratory professionals in postanalytical investigations and test interpretation, as well as external quality assurance programs focusing on interpretative commenting for ordinary laboratory test results should be organized.

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