

NLMC Glossary of Terms

Term	Definition	Additional Comments
Analysed Specimen type	This is the type of specimen upon which the actual analysis is performed. The analysed specimen type is always generated by processing of the collected specimen type e.g. plasma or serum	See also entry for collected specimen type
Analyte	A substance which can be quantitatively or qualitatively analysed.	
Collected Specimen Type	This is the type of specimen collected from the patient to be sent to the laboratory for analysis e.g. blood or urine	
Collection Method	See Specimen collection method	
implementation version of the NLMC (imp.NLMC)	A database tool that contains a list of items some of which will be system dependant, together with attributes pertaining to the configuration and implementation of Care Record Services (CRS) systems. Some of these attributes relate to Electronic Order Communications e.g. specimen, container type.	Core information will be obtained from the NLMC following approval from the Governance process. The imp.NLMC is capable of upgrading its own data following releases from the NLMC.
Investigation	A procedure (or series of related procedures) initiated by a clinician to elucidate information to support a clinical process. This could include diagnostic confirmation, diagnostic exclusion, screening, monitoring or control.	An investigation may include multiple requests which may include many orderables resulting in the execution of multiple tests generating multiple results.
Test Methodology	The particular technical method used to analyse a specimen during the execution of a test. E.g. ELISA, EIA , chromatography, PCR etc.	A given test may have multiple valid methodologies associated with it. The choice of what methodology is used is largely driven by the local pathology service and as such test methodologies are not currently part of the NLMC dataset.
Laterality	Used where appropriate to aspects pertaining to the test or that help identify the test. Left right and both are the possible codes	
Local Pathology Handbook (LPH)	An electronic manual that contains localised information, investigative tests and services offered by a local pathology provider. The template will be Nationally agreed with content predominantly being owned and populated locally.	Built around the NLMC core, with extracted obtained from the imp.NLMC and presented in a standardised format to provide information unique to the local Pathology service provider to supply to clinicians wanting to use their service.
Management Tool	A method which ensures that items approved for use by the NLMC are populated correctly with additional attributes to enable distribution to local handbooks.	Enables the smooth integration of all necessary components for inclusion in to the local handbooks to be deployed.
Morphology	Attributes or properties of the outward appearance and form of body structures such as tumours, bones and organs. including the <u>shape</u> , <u>structure</u> , <u>colour</u> , <u>pattern</u>	Refers to the prominent or principal aspects. A description would include, for example, its overall shape, overall colour, main markings etc

National Laboratory Medicine Catalogue (NLMC)	A Nationally defined and managed, system independent dataset that contains the nationally validated core attributes that are common to any valid Pathology request. For example test request name and associated valid specimen types would both be attributes within the NLMC.	The NLMC dataset may expand in the future to include other attributes e.g. reportables.
NLMC Governance Board	A organisation consisting mainly of expert pathology practitioners and senior NHS Managers hosted by the Royal College of Pathologists (RCPath) to assure and manage the governance relating to the content quality of the NLMC on behalf of the NHS.	Provides a professional seal of approval, quality assurance and universal support to the NLMC.
Pathology Order set	An order set comprises a grouped set of individual requests that can be automatically requested at the same time by placing a single request for the parent order set. The order set request components can usually be ordered individually in their own right and may be comprised of requests that require different specimens and/or specimen types.	As a request item an order set is a wrapper for a group of requests that have a common clinical currency which may not be formally defined. When requested the order set automatically explodes to generate individual requests for each of its components. Components of order sets are not currently nationally defined within the NLMC although the order set name may be. Within this definition Urea and Electrolytes and Dynamic Function Tests such as the Glucose Tolerance Test (GTT) are examples order sets (See also entry for Profile). Order sets may also in some instances include calculations. Not to be confused with 'Battery Headers' which are used in the report cycle of PMIP.
Pathology orderable	Any pathology investigation that can be requested from a Pathology Service Provider.	
Pathology Request (Order)	A request is a type of procedure placed by a clinician and sent to a diagnostic service to carry out investigations on a patient. The results a request, when reported, help inform diagnosis, screening or monitoring. A pathology request can include one or more pathology orderables (see Order sets and profiles). http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/request_for_pathology_investigation.asp	
Patient Precondition	Describes the patient circumstance at the time the specimen was collected e.g. "Fasting" is a patient precondition	Preconditions are sometimes included in the test request display name e.g. Fasting glucose level although there is a valid argument for this information to be provided as additional clinical information at the time of request not in the request name.

<p>PBCL</p>	<p>Pathology Bounded Code List is a subset of Read codes agreed for usage in the Pathology message.</p>	<p>An essential element of PMIP. The approach covered much of chemistry and haematology but lacked much of microbiology, immunology, histopathology and genetics. It is maintained by the NHS CFH Terminology Service.</p>
<p>Post-coordination</p>	<p>Post-coordination describes representation of a clinical meaning using a combination of two or more codes. SNOMED CT allows many concepts to be represented in a post-coordinated form. One form of post-coordination involves creating a single expression consisting of several concepts related by attributes using a collection of several SCT-ID's. The unique concept can only be created once all the relevant information has been recorded so pre-assignment of a single SNOMED code is not possible. Guidance on the rendering of post-coordinated concepts is available in the document "Message genesis and Spine interactions (NPFIT-NCR-DES-0437.02)".</p>	<p>Meaningful combination created from a series of pre-determined drop down menus e.g. Specimen type – swab Body site – eye Laterality – Left</p> <p>This approach allows considerable reduction in the line items in the catalogue as well as offering opportunities for a much more useable user interface.</p> <p>This approach is only possible if the front end design and the post-coordination rendering is supported within the application software</p>
<p>Pre-coordination</p>	<p>When a single concept identifier is used to represent a clinical idea. SNOMED CT also allows the use of post-coordinated expressions (see post-coordination) to represent a meaning using a combination of two or more concept identifiers. Including commonly used concepts in a pre-coordinated form makes the terminology easier to use.</p>	<p>In order to Pre-coordinate orderable items within an order catalogue the line item names would have to be long and detailed. This could result in long lists of orderable items for similar requests e.g. a "CEA level" each of which only differed by the specimen type and point of origin (body site) expressed in the test name. This leads to a very large list of all the combinations of pre-coordinated SNOMED concepts which in turn yields a very large list of order catalogue items that can be requested.</p>
<p>Pathology Profile</p>	<p>A profile consists of a single investigation (request) which returns a number of test results, typically derived from analysis of the same specimen, that are reported together. The single request does not explode into additional requests as with an order set. The individual result components are usually not requested individually in their own right</p>	<p>Within this definition many analyser panels become examples of profiles. A Full Blood Count is also an example of a profile. Profile components are not currently defined within the NLMC because of local variance although the parent order set orderable may be.</p>
<p>READ Codes</p>	<p>Read codes were named after Dr James Read, a UK GP, who developed a simple clinical coding system. This was adopted by the NHS and developed into the Clinical Terms Project, later subsumed into SNOMED-CT. Read Codes Version 2 is UK Crown Copyright</p>	<p>Though READ codes have been superseded by SNOMED-CT most laboratories are still using READ as the main test identity codes for external use.</p> <p>The PMIP bounded code list will therefore be the mainstay for test codes in the first phase of this project though later conversion to SNOMED CT will be borne in mind at all stages.</p>

<p>Report</p>	<p>The combined output of the analytical process. At its most generic level a report will contain the result output (numeric or textual) from the initiating request. However a report can be supplemented with other elements such as reference data, interpretive comments or derived calculations to aid investigation and diagnosis.</p>	
<p>Reportable</p>	<p>Any informational element that is generated in response to an order/service request.</p>	<p>Some reportable elements generated in response to a request have standard recommended formats e.g. date and time of request others, such as units of measure and reference ranges, are currently determined by the local pathology service.</p>
<p>Result</p>	<p>The outcome of an investigation, which could be reported discretely or as part of a report. Results may be numeric, alphanumeric, formatted or unformatted. Is a component part of a report (electronic, paper or verbal</p>	<p>Test name Result expressed as: Presence, concentration, activity, free text description, numeric value. Reference value (if appropriate) Units (if appropriate)</p>
<p>Screen</p>	<p>A quantitative or non quantitative test or group of tests requested as an investigation to determine the likelihood of a condition being present.</p>	<p>Screening test are applied to populations (either total or at higher risk) and the subjects are usually asymptomatic. Positive tests are subject to further confirmatory analysis. In the laboratory such cascade testing may be used to triage work, for example to determine absence or presence of an analyte or organism before proceeding to more elaborate tests.</p>
<p>SCTID</p>	<p>A unique identifier applied to each SNOMED CT component (Concept, Description, Relationship, Subset, etc.). The SCTID can include an item identifier, namespace identifier, a check-digit and a partition identifier. It doesn't always include a namespace identifier.</p>	<p>This unique code of request or result allows linkage to other data bases whether for laboratory management, financial flows, knowledge for use of results, cancer registries etc</p>
<p>SNOMED CT Binding</p>	<p>The process of assigning unique SNOMED codes to clinical terms and other informational elements to allow unambiguous identification of a valid clinical idea or concept</p>	<p>There are two main approaches to SNOMED CT binding Pre-coordinated and Post-coordinated, see appropriate entries</p>
<p>SNOMED-CT</p>	<p>SNOMED-CT or SNOMED Clinical Terms or Systematised Nomenclature of Medicine Clinical Terms.</p>	<p>The clinical terminology maintained and distributed by the SNOMED International Authority. Within the UK the development and quality maintenance of SNOMED is through the UK Terminology Centre of NHS Connecting for Health. Historically developed from a merger between SNOMED (College of American Pathologists) and Read / Clinical Terms Project (NHS)</p>

Pathology Specimen	A quantity of a biological substance or organism delivered to a service for the purpose of analysis.	
Specimen collection method	This is a property or attribute of the collected specimen type in the NLMC	For example the collected specimen type of "Blood" could have collection methods of arterial, venous and capillary associated with it in the NLMC
System Specific Attributes	Proprietary information required by different supplier solutions to configure and implement their particular product. e.g. A LIMS, PAS or Order Communications solution.	Information is often unique to the individual products and as such is not nationally definable. On this basis such attributes do not qualify for inclusion in the NLMC dataset but are very much the focus of the impNLMC.
Pathology Test	A specific procedure performed on a specimen in response to a request or as part of an investigation either of which may involve single or multiple tests. See glossary entries for Request and Investigation	Investigations may involve multiple requests that may involve multiple tests
Topography	This identifies the part of the body being investigated.	It will be used to identify orders which require further definition before being requested. This is necessary in some instances where an order is not specific enough or could be used with variations of the subsets.