The host hospital should have:
(*a*) A cardiac arrest team trained in cardiopulmonary resuscitation
(*b*) A cardiac care unit with facilities for temporary pacing
(*c*) A volume of work sufficient to maintain expertise. Levels agreed in the document "Strategic planning for cardiac services and the internal market: role of catheterisation laboratories in district general hospitals" seem appropriate for individual operators
(*d*) Links with a specialist/surgical centre for urgent transfer of patients if needed.

The host hospitals should ensure:
(*a*) That their radiological protection officer, infection control officer, and fire prevention officer all are satisfied about arrangements both for routine operating and in case of emergency
(*b*) That the mobile catheter laboratory is linked directly to the host hospital switchboard
(*c*) That all the potential members of the host hospital's cardiac arrest team (physicians, anaesthetists, and porters) are aware of the location of the mobile laboratory and how to gain access when required in an emergency
(*d*) That appropriate arrangements are made for patients to go between the mobile catheter laboratory and an area for recovery staffed by nurses who have had specific training in the care of arterial puncture sites and complications of catheterisation. This area should have full resuscitation equipment
(*e*) That all personnel directly involved in patient care have read any procedure manual agreed between the parties
(*f*) That all patients using the mobile catheter laboratory have adequate registration data and case records and that all records of the procedure (film, video, pressure data) are archived at an agreed site
(*g*) That the manager of the mobile catheter laboratory is given 36 hours' warning if any of the patients is infected with HIV or hepatitis B or presents any other infection risk
(*h*) That if patients are catheterised in a district general hospital the consultant cardiologist is on site and immediately available
(*i*) That if patients are catheterised in the mobile laboratory by a visiting cardiologist, the local physician who has responsibility for the patients is clearly defined and that he/she is suitably trained to manage complications of catheterisation after the visiting cardiologist has left the site.

The manager of the mobile catheter laboratory is responsible for:
(*a*) Ensuring that the parties agree procedures and responsibilities before clinical work begins
(*b*) Ensuring the smooth operating of the equipment and that all safety standards are met
(*c*) That all staff provided by the mobile catheter laboratory company are adequately trained for their roles
(*d*) That full and functioning resuscitation equipment is carried on the mobile catheter laboratories and that staff are proficient in cardiopulmonary resuscitation.

APPROPRIATE PROCEDURES

Where a mobile laboratory is used in a hospital that also has a fixed catheterisation laboratory all catheterisation procedures including coronary angioplasty can be undertaken.

If the mobile laboratory is visiting a hospital that does not have a fixed laboratory only diagnostic catheterisation should be undertaken. Angioplasty is not appropriate because if there is a vessel occlusion after the mobile laboratory has left the premises there will be no facilities available for imaging. Patients likely to require urgent intervention should be referred to a tertiary centre.

Provided that these guidelines are adhered to there is no reason to suppose that safety standards will be any different in mobile laboratories and fixed laboratories. We recommend, however, that the UK Confidential Enquiry into Cardiac Catheter Complications develop a means of identifying cases catheterised in mobile laboratories to enable appropriate audit so that complication rates can be compared with those of fixed laboratories. Both NHS and private laboratories should return data.

NOTICE

The 1994 Annual Meeting of the **British Cardiac Society** will take place at the Riviera Centre, Torquay from 17 to 20 May.

CORRECTION

Novel approach to the interpretation of long-term "deterioration" in ejection fraction in individual patients with coronary artery disease. *Richard Lim, Lorraine Dyke, Janice Thomas, Duncan S Dymond*

Several errors appeared in the appendix to this article (*Br Heart J* 1993;70:226–32). A corrected version appears below.

Appendix

For a given baseline measurement x_0, the estimated standard deviation (SD_e) of individual predicted 6-month values is given by

$$SD_e = SD_{res}\sqrt{1+(1/n)+\{(x_0-\bar{x})^2/S_{xx}\}}$$

where n = sample size

$\bar{x}$ = mean of X values

$S_{xx} = \Sigma x_i^2 - \{(\Sigma x_i)^2/n\}$

that is, the sum of squares of X values about their mean.

The residual standard deviation (SD_{res}) is a measure of the goodness-of-fit of the regression line in the units of measurement, and is given by

$$SD_{res} = \sqrt{(S_{yy} - bS_{xy})/(n-2)}$$

where $S_{yy} = \Sigma y_i^2 - \{(\Sigma y_i)^2/n\}$

that is, the sum of square of Y values about their mean.

$$S_{xy} = \Sigma x_i y_i - \{(\Sigma x_i \Sigma y_i)/n\}$$

that is, the sum of products.

b = slope of regression line.

Thus for a given baseline measurement the 95% prediction interval for a predicted 6-month value

= Predicted 6-month value ± $(t_{0.975} \times SD_e)$

where t is on $n-2$ degrees of freedom.