The potent erythropoietic actions of Deca-Durabolin may be of particular value in conjunction with specific as well as other supportive measures in the treatment of certain refractory anemias.

An important clinical advantage is that jaundice has not been associated with its use, even at the high dosage levels employed for these cases.

DECA-DURABOLIN®
nandrolone decanoate injection, NF
BRIEF SUMMARY: Please consult full product information in the package insert before prescribing.

NAS/NRC review panels have classified Deca-Durabolin possibly effective adjuvant therapy in certain refractory anemias.

CONTRAINDICATIONS:
1. Male patients with carcinoma of the prostate or breast.
2. Carcinoma of the breast in some females.
3. Pregnancy, because of masculinization of the fetus.
4. Nephrosis or the nephrotic phase of nephritis.

WARNING: Anabolic steroids do not enhance athletic ability.

PRECAUTIONS: 1. Hypercalcemia may develop both spontaneously and as a result of hormonal therapy in women with disseminated breast carcinoma. If it develops while on this agent, the drug should be stopped.
2. Onset is required in administering these agents to patients with cardiac, renal or hepatic disease. Edema may occur occasionally. Comitant administration with adrenal steroids or ACTH may add to the edema.
3. If amenorrhea or menstrual irregularities develop the drug should be discontinued until the etiology is determined.
4. Anabolic steroids may increase sensitivity to oral anticoagulants. Dosage of the anticoagulant may have to be decreased, in order to maintain the prothrombin time at the desired therapeutic level.
5. Anabolic steroids have been shown to alter glucose tolerance tests. Diabetics should be followed carefully and the insulin or oral hypoglycemic dosage adjusted accordingly.
6. Anabolic steroids should be used with caution in patients with benign prostatic hypertrophy.
7. Serum cholesterol may increase during therapy. Therefore, caution is required in administering these agents to patients with a history of myocardial infarction or coronary artery disease. Serial determinations of serum cholesterol should be made and therapy adjusted accordingly.

ADVERSE REACTIONS: 1. In Males. a. Prepubertal: 1) Phallic enlargement, 2) Increased frequency of erections, b. Post-pubertal: 1) Inhibition of testicular function and oligospermia, 2) Gynaecomastia.
2. In Females: a. Hirsutism, male pattern baldness, deepening of the voice and clitoral enlargement. These changes are usually irreversible even after prompt discontinuance of therapy and are not prevented by concomitant use of estrogens, b. Menstrual irregularities, c. Masculinization of the fetus.
4. Alterations in these clinical laboratory tests: a. The metyrapone test, b. Glucose tolerance test, c. The thyroid function tests: a decrease in the PBI, in thyroxine-binding capacity and radioactive iodine uptake, d. The electrolytes: retention of sodium, chloride, water, potassium, phosphates and calcium. e. Liver function tests: 1) increased serum cholesterol, 2) Suppression of clotting factors II, V, VII, and X.

SUPPLIED: Deca-Durabolin (in sterile sesame oil solution for intramuscular injection) is available in a potency of 50 mg./cc. with 10% benzyl alcohol (preservative): 1 cc. ampuls, box of 4 NDC 0052-0696-14
2 cc. multiple dose: NDC 0052-0696-02
Also available in a potency of 100 mg./cc. with 10% benzyl alcohol (preservative): 2 cc. multiple dose: NDC 0052-0697-02

CAUTION: Federal law prohibits dispensing without prescription.

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ULT 1985
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In Canada: Canlab, Fisher Scientific, Ingram & Bell.
Self-reliance for the

On a camping trip. Or at home. Koate® enables the hemophiliac to treat himself. Quickly. Safely. Conveniently.

Koate® reconstitutes in less than five minutes. Provides 250 AHF units in only 10 ml of solution. And travels anywhere without refrigeration for up to four weeks.
More important, Koate® has low total protein levels, providing the assurance you need to let him treat himself.

See sections entitled "Indications" and "Warning" for description of hepatitis risk.

This product is prepared from human venous plasma. Each individual unit of plasma has been found nonreactive for hepatitis B surface antigen using the radioimmunoassay method. Unfortunately, this test does not preclude the presence of hepatitis virus. See warning.

Indications
Antihemophilic Factor (Human). Koate® is indicated for the treatment of classical hemophilia (hemophilia A), in which there is a demonstrated deficiency of the plasma clotting factor VIII. Koate® provides a means of temporarily replacing the clotting factor in order to correct or prevent bleeding episodes or in order to perform emergency and elective surgery.

Warning
Koate® concentrate is a purified dried fraction of pooled plasma obtained from many blood donors. The presence of hepatitis virus should be assumed and the hazard of administering Koate® concentrate should be weighed against the medical consequence of withholding it, particularly in persons with few previous transfusions of blood and plasma products.

Kasper and Kipnis have concluded that those who had little exposure to blood products had a high risk of developing hepatitis after introduction of clotting factor concentrates, such as this product. For those patients, especially those with mild hemophilia, they recommend single donor products. However, for patients with moderate or severe hemophilia who have received numerous infusions of blood and plasma products, they feel that the risk of hepatitis is small. They believe that the clotting factor concentrates have so greatly improved the management of severe hemophilia that these products should not be denied to appropriate patients.

Precautions
1. Antihemophilic Factor (Human). Koate® is intended for treatment of bleeding disorders arising from a deficiency in Factor VIII. This deficiency should be proven prior to administering Koate® since no benefit may be expected from its use in treating other causes of hemorrhage.

2. Antihemophilic Factor (Human). Koate® should be kept at a temperature below 2°-8° C (35°-46° F) until reconstituted for use. After reconstitution, administer promptly (within 3 hours). Do not refrigerate after reconstitution. NOTE: The recommendation to administer promptly after reconstitution is intended to avoid the ill effect of any possible bacterial contamination occurring during reconstitution. Koate® is stable, without potency loss for at least 24 hours at room temperature after reconstitution.

3. Administer only by the intravenous route.

4. A filter should be used prior to administering the reconstituted Koate® solution. This may be accomplished using the enclosed sterile filter needle. See Reconstitution and Administration directions.

5. Koate® contains measurable levels of blood group iso-agglutinins which are not clinically significant when controlling relatively minor bleeding episodes. When large or frequently repeated doses are required in patients of blood groups A, B, or AB, the possibility of intravascular hemolysis should be considered. Also, the administration of type-specific cryoprecipitate has been recommended for maintaining adequate Factor VIII levels.

6. Administration equipment and any reconstituted Koate® not used should be discarded.

Adverse Reactions
No severe adverse reactions were reported during the clinical trials of Koate®. One patient experienced transient chest discomfort and cough beginning 20 minutes after infusion and lasting for one hour. During subsequent infusions this patient had no further reactions. A second patient developed transient dizziness following each of eight infusions. Mild allergic reactions may result from the administration of AHF preparations.

When large or frequently repeated doses are required in patients other than those of blood type O, there is a possibility of intravascular hemolysis. Should this condition occur leading to progressive anemia, administration of serologically compatible type O packed red blood cells should be considered. Also, the administration of type-specific cryoprecipitate has been recommended for maintaining adequate Factor VIII levels.

How Supplied
Antihemophilic Factor (Human). Koate® is supplied in single-dose bottles with the total units of Factor VIII activity and total grams of protein stated on the label of each bottle.

A suitable volume of Sterile Water for Injection, U S P. and a sterile filter needle is provided.

Limited Warranty
A number of factors beyond our control could reduce the efficacy of this product or even result in an ill effect following its use. These include storage and handling of the product after it leaves our hands, diagnosis, dosage, method of administration, and biologic differences in individual patients. Because of these factors, it is important that this product be stored properly and that the directions be followed carefully during use, and that the risk of transmitting hepatitis be carefully weighed before the product is prescribed.

No warranty express or implied, including any warranty of merchantability or fitness is made. Representatives of the Company are not authorized to vary the terms or the contents of the printed labeling or to make any promise or representation not contained in the labeling. The product is sold only with the labeling herein described, and no other labeling or instructions may accompany the product.

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One of a number of malignancies in which Adriamycin is of importance.

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(doxorubicin hydrochloride)
for Injection
FOR INTRAVENOUS USE ONLY
10 mg and 50 mg vials

For complete prescribing information, please see the following page.

In addition to advanced metastatic cancer of the breast, other disseminated neoplastic conditions have responded to Adriamycin and include: acute lymphoblastic leukemia, acute myeloblastic leukemia, Wilms' tumor, osteogenic and soft tissue sarcoma, neuroblastoma, ovarian carcinoma, transitional cell bladder carcinoma, thyroid carcinoma, lymphoma of both Hodgkin's and non-Hodgkin's type, and bronchogenic lung carcinoma in which the small cell histologic type is the most responsive compared to other cell types. Adriamycin should be administered only under the direction of specialists qualified in the administration of such drugs.

Severe local tissue necrosis will occur if there is extravasation during administration.

Severe irreversible myocardial toxicity with delayed congestive failure often unresponsive to any cardiac supportive therapy may be encountered as total dosage approaches 550 mg/m². This toxicity may occur at lower cumulative doses in patients with prior mediastinal irradiation or on concurrent cyclophosphamide therapy.

The incidence of bone marrow depression is high. Hematopoietic toxicity may limit dosage.

In patients with impaired hepatic function, dosage should be reduced.

For information on the use of Adriamycin, call collect (302) 575-7830.
ADRIAMYCIN® (doxorubicin hydrochloride) for Injection
FOR INTRAVENOUS USE ONLY

WARNINGS
1. Severe local tissue necrosis will occur if there is extravasation during administration. Adriamycin must be given by the intravenous or subcutaneous route.
2. Serious irreversible myocardial toxicity with delayed congestive failure is often unresponsive to any cardiac support therapy may be encountered as total dosage approaches 550 mg/m². Adriamycin may occur at lower cumulative doses in patients with poor left ventricular function or on concurrent cyclophosphamide therapy.
3. Dosage should be reduced in patients with impaired hepatic function.
4. Severe myelosuppression may occur.
5. Adriamycin should be administered only under the supervision of a physician who is experienced in the use of cancer chemotherapy agents.

DESCRIPTION
Doxorubicin is a cytotoxic antitumor antibiotic isolated from cultures of Streptomyces peucetius var. caesius and contains the hydrochloride form of a three-branched powder containing lactose.

CLINICAL PHARMACOLOGY
Though not completely elucidated, the mechanism of action of doxorubicin is related to its ability to bind to DNA and inhibit nucleic acid synthesis. Cell culture studies have demonstrated rapid cell penetration and perinuclear chromatin binding, rapid inhibition of mitotic activity and cell synthesis, mutagenicity and chromosomal aberrations. Animal studies have shown activity in a spectrum of experimental tumors, immunosuppression, carcinogenic properties in rodents, induction of a variety of toxic effects, including delayed and progressive cardiac toxicity in rats, myelosuppression in all species and toxicity to testes in rats and dogs.

PHARMACOKINETICS Studies show the extravasated dose of normal or radionatiated Adriamycin (doxorubicin hydrochloride) for injection is followed by rapid plasma clearance and significant tissue disposition. Maximal plasma concentrations are achieved within 5 minutes for most patients. The terminal phase of plasma concentration is determined by pharmacokinetic methods for approximately 4-5% of the administered dose in five days. Bilirubin excretion represents the major excretion route. 40-50% of the administered dose being recovered in the urine or the feces in seven days. Impaired renal function results in slower excretion and, consequently, increased retention and accumulation in plasma and tissues. Adriamycin does not cross the blood brain barrier.

INDICATIONS
Adriamycin has been used successfully to produce regression in disseminated neoplastic conditions such as acute lymphocytic leukemia, acute myelogenous leukemia, Wilms tumor, neuroblastoma, acute myelocytic leukemia, breast carcinoma, head and neck carcinoma, transitional cell bladder carcinoma, thyroid carcinoma, lymphomas of both Hodgkin and non-Hodgkin types and bronchogenic carcinoma in which the small cell histologic type is the most responsive compared to other cell types. A number of other solid tumors have also shown some responsiveness but in numbers too limited to justify specific recommendation. Studies to date have shown malignant melanoma, kidney carcinoma, large bowel carcinoma, brain tumors and metastases to the Central Nervous System not to be significantly responsive to Adriamycin therapy.

CONTRAINDICATIONS
Adriamycin therapy should not be started in patients who have marked myelosuppression induced by previous treatment with other antitumor agents or by radiotherapy. Conclusive data are not available on pre-existing heart disease as a co-factor of increased risk of Adriamycin induced cardiac toxicity. Preliminary data suggest that in such cases cardiac toxicity may occur at doses lower than the recommended cumulative limit. It is therefore not recommended to start Adriamycin in such cases. Adriamycin treatment is contraindicated in patients who received previous treatment with complete cumulative doses of Adriamycin and daunorubicin.

WARNINGS
Special attention must be given to the cardiac toxicity exhibited by Adriamycin. Although uncommon, cardio toxicity (cardiac failure) has occurred, particularly in patients who have received total dosage of the drug exceeding the currently recommended limit of 550 mg/m². This limit appears to be lower (400 mg/m²) in patients who received radiotherapy to the mediastinal area or concomitant therapy with other potentially cardiotoxic agents such as cyclophosphamide. Adriamycin does not appear to be related to the individual dose administered to the patient. The patient must be observed closely for signs of cardiac toxicity. Adriamycin therapy must be interrupted if there is evidence of myocardial or cardiac damage.

There is a high incidence of bone marrow depression, particularly of leukocytes, requiring careful hematologic evaluation. The usual dosage schedule, leukopenia is usually present, reaching its nadir at 10-14 days after recovery usually occurring by the 21st day. When leukopenia occurs, a low leukocyte count as expected during treatment with appropriate doses of Adriamycin. Red blood cell and platelet levels should also be monitored since they may also be depressed. Hematologic toxicity may require dose reduction or suspension or delay of Adriamycin therapy. Persistent severe myelosuppression may result in the need for platelet or whole blood transfusions. Adriamycin therapy must be interrupted if there is evidence of myocardial or cardiac damage.

TOXICITY
Toxicity to recommended doses of Adriamycin is enhanced by hepatic impairment. Therefore, the individual dosage adjustment is of the patient's medical condition and laboratory findings. Adriamycin may be given by the intravenous route. The treatment of Adriamycin should not be given by the intravenous route. The treatment of Adriamycin should not be given by the intravenous route.

PRECAUTIONS
Initial treatment with Adriamycin requires close observation of the patient and extensive laboratory monitoring. If it is recommended, therefore, that patients be hospitalized at least during the first phase of the treatment. There is no adequate information on whether this drug may adversely affect fertility in human males or females, or have a teratogenic potential or other adverse effects on the fetus. Experimental teratology studies, though not showing a definite increase in specific or nonspecific malformations indicate a moderate interference with the viability of embryos and fetuses. Adriamycin has not been shown to be teratogenic when given in high doses to rabbits. Therefore the benefits to the pregnant patient should be weighed against the potential toxicity to fetus and embryo. Adriamycin and related compounds have also been shown to have mutagenic and carcinogenic properties when tested in experimental models.

Like other cytotoxic drugs, Adriamycin may induce hypersensitivity reactions. For 9-15% of patients with high doses and administration. Patients should be advised to discontinue treatment if any of the above occur.

ADVERSE REACTIONS
Dose limiting toxicities of therapy are myelosuppression and cardiotoxicity (see Warnings). Other reactions reported are:

Gastrointestinal: Acute nausea and vomiting occurs frequently and may be severe. This may be alleviated by antiemetic therapy. Myelosuppression (leukocytopenia and thrombocytopenia) may occur 5-10 days after administration. The effect may be severe leading to leukopenia and represent a site of origin for severe infections. The incidence and severity of myelosuppression is greater with the 3 successive daily dosage regimen. Anemia and thrombocytopenia has been occasionally reported.

Neurological: Seizures have been reported especially when small veins are used or a single vein is used for repeated administration. Facial flushing may occur if the injection is given too rapidly.

Local: Severe cutaneous, vesication and tissue necrosis will occur if Adriamycin is extravasated during administration. Erythematous streaking along the veins proximal to the site of the injection has been reported.

Hypersensitivity: Fever, chills and urticaria have been reported occasionally. Anaphylaxis may also occur. A case of apparent cross sensitivity to leucovorin has been reported.

CONTRAINDICATIONS
Adriamycin therapy should not be started in patients who have marked myelosuppression induced by previous treatment with other antitumor agents or by radiotherapy. Conclusive data are not available on pre-existing heart disease as a co-factor of increased risk of Adriamycin induced cardiac toxicity. Preliminary data suggest that in such cases cardiac toxicity may occur at lower doses than the recommended cumulative limit. It is therefore not recommended to start Adriamycin in such cases. Adriamycin treatment is contraindicated in patients who received previous treatment with complete cumulative doses of Adriamycin and daunorubicin.

REFERENCES
Preparation of solution: Adriamycin 10 mg vials and 50 mg vials should be reconstituted with Sodium Chloride Injection USP 5 mg and 25 mg respectively. Prior to use, reconstitute the total volume of 2-5 mg of doxorubicin hydrochloride.

Dosage and Administration: Both powder and solution must be handled with care. If Adriamycin powder or solution contacts the skin or mucosa, wash thoroughly with soap and water.

Recommended Dose

<table>
<thead>
<tr>
<th>Serum Bilirubin Levels</th>
<th>BSP Retention</th>
<th>Recommended Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2-3.0 mg/dl</td>
<td>9.15%</td>
<td>1/2 normal dose</td>
</tr>
<tr>
<td>&gt;3.0 mg/dl</td>
<td>&lt;15%</td>
<td>1/2 normal dose</td>
</tr>
</tbody>
</table>

Adriamycin is not an anti-microbial agent.

Dosage and Administration
Care in the administration of Adriamycin will reduce the chance of pervious withdrawal. It may also decrease the local reaction of such toxicities as urticaria and erythematous streaking.

The recommended dosage is 80-75 mg/m² as a single intravenous injection administered at 21-day intervals. The lower dose should be given to patients with moderate marrow reserves due to old age, or prior therapy, or neoplastic marrow infiltration. An alternate dose schedule is 30 mg/m² on each of three successive days repeated every 4 weeks. Adriamycin dosage must be reduced if hepatic function is impaired according to the following table.

DOSE OF ADRIAMYCIN

Adriamycin is supplied in 10 mg vials and 50 mg vials.

HOW SUPPLIED
Adriamycin (doxorubicin hydrochloride) for Injection is available in two sizes: 10 mg - Each 10 mg powder contains 50 mg doxorubicin hydrochloride HCl and 50 mg lactose U.S.P. as a sterile red-orange lyophilized powder. Packaged and supplied in 10 vial cartons NDC: 38242-874-10
50 mg - Each 10 mg powder contains 50 mg doxorubicin hydrochloride HCl and 50 mg lactose U.S.P. as a sterile red-orange lyophilized powder. Packaged and supplied in 1 vial carton NDC: 38242-875-90

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Mr. Robert Vitello, Chairman
Blood Center Personnel Search Subcommittee
HARICOMP, INC.
Post Office Box 9627 Providence, RI 02940

The Rhode Island Blood Center and HARICOMP are Equal Opportunity Employers. Applications from minority groups and women are encouraged.
INFORMATION FOR CONTRIBUTORS

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BLOOD, The Journal of the American Society of Hematology, provides an international forum for the publication of original articles describing basic laboratory and clinical investigations encompassed in the broad discipline of hematology. The scope of the journal covers all aspects of hematology, including disorders of leukocytes, both benign and malignant, erythrocytes, platelets, hemostatic mechanisms, and immunology, as well as major developments in clinical laboratory diagnosis and blood banking.

Manuscripts are accepted for consideration on the condition that they are contributed solely to BLOOD. No substantial part of a paper may have been or may be published elsewhere, except for an abstract of 500 words or less. Manuscripts will be critically reviewed by the Editor, the appropriate Associate Editor, and other independent referees. Acceptance of papers for publication is based upon the originality of the observation or investigation, the quality of the work described, and the clarity of the presentation. Papers will ordinarily be published in the order in which they are finally accepted for publication and not in the order of submission.

Acknowledgments to other investigators for advice, assistance, and data must be substantiated by written authorization to the Editor-in-Chief specifically granting permission to the authors for such citations.

Letters to the Editor: Letters to the Editor are welcomed and will be published if appropriate. They should be typewritten, double spaced, and, generally, should not be more than two typewritten pages in length.

Editorials, Brief Reviews: Editorials and Brief Reviews may be solicited by the Editors, and may be submitted for consideration without solicitation. These manuscripts must be prepared in a manner appropriate for any other papers and will be reviewed as are original articles submitted for consideration.

Articles, editorials, letters to the editor, and other text material in BLOOD represent the opinions of the authors and do not reflect the opinions of the American Society of Hematology, the publisher, or the institution with which the author is affiliated, unless the contrary is clearly specified.

In order to comply with the requirements of the insurance carrier, authors of accepted manuscripts and letters will be requested to provide the following signed statement, effective January 1, 1977: "The writer/author represents and warrants that his/her part of the work as submitted will in no way violate any copyright, or any other right and will contain nothing libelous or otherwise unlawful.”

Manuscripts and all communications concerning editorial matters should be addressed to the Editor-in-Chief, Dr. Ernst R. Jaffé, Albert Einstein College of Medicine of Yeshiva University, 1300 Morris Park Avenue, Bronx, New York 10461, telephone (212) 430-4040.

Papers reporting human experimentation will be reviewed in accordance with the precepts established by the Helsinki Declaration. Copies of this declaration may be obtained by writing to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois. Such papers must include a statement that the human investigations were performed after approval by a local Human Investigations Committee and in accord with an assurance filed with and approved by the Department of Health, Education, and Welfare where appropriate.

All manuscripts dealing with recombinant DNA research must include a description of the physical and biologic containment procedures practiced to aid and forewarn others who might consider repeating the work, in accord with the National Institutes of Health Guidelines for Research Involving Recombinant DNA Molecules.

PREPARING THE MANUSCRIPT

Manuscripts must be typewritten, double or triple-spaced on good quality 8½-by-11-inch white paper with margins of at least one inch. Please do not use erasable bond. The

(Continued on page xxiv)
TOPICS IN BLOOD BANKING. By NEVA M. ABELSON, M.D., University of Pennsylvania, Philadelphia. A lucid and practical discussion of selected topics in blood banking and blood transfusion, providing informative reviews of recent developments in many important areas. These include autologous transfusion, blood component therapy and exchange, and fetal transfusion. Methods of liquid blood storage, cryopreservation, and production and standardization of diagnostic reagents and pretransfusion tests are thoroughly considered. 163 pp. (7 x 10), 10 illus., 1974, $9.75.

HEMATOLOGY: Principles and Procedures, 2nd ed. By BARBARA A. BROWN, M.T. (ASCP), Tufts New England Medical Center Hospital, Boston, Massachusetts. Medical technologists and laboratory technicians will find this to be an indispensable work. Materials have been added in all sections, with the inclusion of newer procedures and instrumentation. A detailed section on automation in hematology is presented for the first time. "... an effective text for the instruction of basic hematologic principles and methodology"—The American Journal of Medical Technology. 336 pp. (7 x 10), 216 illus. (3 color plates), 1976, $15.00.

CLINICAL HEMATOLOGY, 7th ed. By MAXWELL M. WINTROBE, M.D., Ph.D., and G. RICHARD LEE, M.D., both of the University of Utah, Salt Lake City; DANE R. BOGGS, M.D., University of Pittsburgh; THOMAS C. BITHELL, M.D., University of Virginia; JOHN W. ATHENS, M.D., University of Utah; and JOHN FOERSTER, M.D., University of Manitoba. Truly a classic in every sense of the word, this book continues to be the recognized source on the subject. An authoritative text that thoroughly explains underlying basic physiology, biochemistry and pathology. 1896 pp. (7 1/4 x 10 1/4), 543 illus. (24 color plates), 1974, $42.50.

TEXT-ATLAS OF HEMATOLOGY. By MATTHEW H. BLOCK, Ph.D., M.D., University of Colorado Medical Center, Denver. This text differs from the traditional hematology atlas by providing a means of translating static morphological observations of hematopoietic tissues into pathophysiological concepts used to solve clinical problems. The reader is guided through a stepwise, logical analysis of the mechanisms by which the histopathology of each disease is expressed. Treatment is analyzed in a similar manner. Illustrations of plastic (methacrylate) embedded sections portray almost every tissue in which hematologic abnormalities occur. The use of this embedding compound provides clarity of microphotography. Outstanding color plates add a great deal of dimension to the text. 651 pp. (7 1/4 x 10 1/4), 1185 illus. (517 in color), 1976, $76.50.

THE ROLE OF THE LABORATORY IN HEMOLYTIC DISEASE OF THE NEWBORN. By JOHN G. GORMAN, M.B., Presbyterian Hospital in the City of New York. The clinical significance of laboratory tests in hemolytic disease is presented in this book for all who perform them, interpret them, or rely on their results. The relationship between laboratory tests and the clinical picture, pathogenesis and epidemiology of this syndrome is presented in a logically organized format. This presentation facilitates a sound understanding of the subject that will allow the reader to appropriately handle problems and questions. The principles and practice of laboratory diagnostics are considered. New facts and insights in blood banking are introduced. 228 pp. (7 x 10), illus., 1975, $12.00.

Plan to visit us at Booth 55 at The American Society of Hematology meeting in San Diego, California, December 3–5, 1977.
1. collect blood
2. mix blood and allow to clot
3. ring clot and stand tube at room temperature
4. separate serum from clot
5. number empty test tubes (1) & (2)
6. add saline buffer
7. add serum sample
8. pipette to reaction slide
9. add latex suspension
10. stir serum/latex mixture
11. rock and read
   Nonagglutinated pattern: FDP concentration less than 2 µg per ml
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Tables and illustrations must be cited in order in the text using arabic numerals. All line drawings should be submitted as clear, glossy, black and white photographs. Legible copies may be used with the duplicate manuscript. Photomicrographs and other photographic illustrations must be submitted in duplicate; copies are not acceptable. Legends for illustrations should be typewritten, double-spaced, on a separate sheet, and included at the end of the manuscript. A legend must accompany each illustration. Contributors will pay all charges involved in processing and printing of color photographs.

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Personal communications and references to publications in press by authors other than those submitting the paper must be substantiated by a letter from the investigator(s) concerned confirming the data or observations and granting the authors permission to cite the material.

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Journal article, two or more authors:

Journal article, in press:

Complete book:

Chapter of book:

Chapter of book that is part of published meeting:

(Continued on following page)
Chapter of book that is part of unpublished meeting:

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ANNOUNCEMENTS
Announcements of meetings, conferences, and the like which are of interest to the readership of BLOOD should be sent to the Editor at least three months before the first day of the month of issue. These items should be as concise as possible. When considered appropriate, they will be published as promptly as possible, subject to the availability of space in the journal.

RECOMMENDATION FOR USAGE OF UNITS
The International Committee for Standardization in Hematology has recommended that the following units be used in the hematologic literature.

<table>
<thead>
<tr>
<th>Component</th>
<th>Normal Range in SI Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin</td>
<td>14.4 g/dl*, t</td>
</tr>
<tr>
<td>RBC (RCC)</td>
<td>4.5 x 10^12/l</td>
</tr>
<tr>
<td>PCV</td>
<td>0.41 ± 1</td>
</tr>
<tr>
<td>MCV</td>
<td>75-95 fl</td>
</tr>
<tr>
<td>MCH</td>
<td>27–32 pg</td>
</tr>
<tr>
<td>MCHC</td>
<td>30–35 g/dl</td>
</tr>
<tr>
<td>WBC (WCC)</td>
<td>4.0–11.0 x 10^9/l</td>
</tr>
<tr>
<td>Platelets</td>
<td>150–400 x 10^9/l</td>
</tr>
<tr>
<td>Red cell diameter</td>
<td>6.7–7.7 μm</td>
</tr>
<tr>
<td>Reticulocytes</td>
<td>0.2–2.0%</td>
</tr>
<tr>
<td></td>
<td>10–100 x 10^9/l</td>
</tr>
<tr>
<td>Serum iron</td>
<td>14–29 μmol/l/1</td>
</tr>
<tr>
<td>Total iron binding capacity</td>
<td>45–72 μmol/l/1</td>
</tr>
<tr>
<td>Transferrin</td>
<td>1.2–2.0 g/l</td>
</tr>
<tr>
<td>Serum haptoglobins (Hb binding)</td>
<td>0.3–2.0 g/l</td>
</tr>
<tr>
<td>Serum B12</td>
<td>160–925 ng/l</td>
</tr>
<tr>
<td>(as cyanocobalamin equivalents)</td>
<td></td>
</tr>
<tr>
<td>Serum folate</td>
<td>3–20 μg/l</td>
</tr>
<tr>
<td>Plasma fibrinogen</td>
<td>1.5–4.0 g/l</td>
</tr>
</tbody>
</table>

* As the normal range varies with age and sex, only one measurement in the normal range has been given as an example.
† dl, deciliter.
‡ (3) No unit necessary; l/l is implied.
§ fl = femtoliter.
¶ Calculated from the molecular weight of iron (55.95).
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