CONCISE REPORTS

The Editors of BLOOD are pleased to announce a new policy regarding the rapid publication of concise manuscripts. It is already possible for BLOOD to publish many papers within 10-12 weeks of acceptance. We will now consider for rapid editorial review and decision concise reports of original investigations of scientific importance in order to further speed up the publication process for accepted manuscripts that meet the criteria for Concise Reports.

Manuscripts to be considered as concise reports may deal with any laboratory or clinical investigations within the broad discipline of hematology. Manuscripts submitted for consideration as Concise Reports must represent original and definitive studies and must include adequate description of experimental methods, documentation of findings, and references to the literature. The Editors will provide decisions on such manuscripts within two weeks of receipt at the BLOOD Office. These decisions will not be accompanied by detailed reviewers' comments such as are returned with manuscripts handled in the ordinary manner. Papers deemed not suitable for rapid publication as Concise Reports may be resubmitted for consideration as regular manuscripts.

The request for consideration as a Concise Report must be made in the author's covering letter upon submission. Concise Reports cannot exceed ten typed pages, including tables, figures and figure legends, and references (count two graphs or one photomicrograph as the equivalent of a typed page). In order to assure rapid publication, authors must accept the responsibility of conforming to the instructions in "Information to Contributors" contained in each BLOOD issue.

Concise Reports will not replace any of the current material appearing in BLOOD. We will continue to consider Letters to the Editor that represent important commentary on previous BLOOD articles. Reports of preliminary or original observations not relevant to published BLOOD articles will not be considered suitable for publication as Letters to the Editor.

ANNOUNCEMENT

WORKSHOP ON CLONING HUMAN TUMOR STEM CELLS

A practical workshop on soft agar cloning methods for human tumor stem cells will be held at the University of Arizona, College of Medicine, in Tucson, January 3-5, 1979, under the sponsorship of the Cancer Center Division. The workshop will be presented by Dr. Sydney E. Salmon, Dr. Anne Hamburger, Dr. David S. Alberts, Dr. Ronald N. Buick, and colleagues. Further information may be obtained by writing to the Cancer Center Division, University of Arizona, Health Sciences Center, Tucson, Ariz. 85724, or by phoning Dr. Ronald Buick at (602) 626-6408.
American Society of Hematology
Twenty-first Annual Meeting
New Orleans Hilton Hotel, New Orleans, Louisiana
December 2-5, 1978

SUMMARY OF PROGRAM

Saturday, December 2

Morning: Education Program
Acute Leukemia
Antithrombotic Therapy
Audiovisuals—How to Do it Better
Cell Growth
Chronic Leukemia
General Oncology (Sat.)—New Agents (Sun.)
Hematology and Public Policy
Hemoglobinopathy
Hemolytic Anemia
Immunohematology—Blood Transfusion
Lymphoma
Monoclonal Gammopathy
Myeloproliferative Disease
Pediatric Hematology
Refractory Anemia

Afternoon: Education Program
Scientific Subcommittee Symposia
Immunohematology
Leukocyte Physiology
Red Blood Cell
Forum on the Practice of Hematology

Sunday, December 3

Morning: Education Program
Scientific Subcommittee Symposia
Erythropoietin and Cell Proliferation
Neoplasia
Nutritional Anemias
Pediatric Hematology/Oncology

Afternoon: Presidential Symposium
(“Hematology—1978”)

(Continued on following page)
(Continued from preceding page)

**Monday, December 4**

**Morning:**
- President’s Report and First Business Meeting
- Dameshek Award
- Plenary Session
- Stratton Lecture—Dr. William N. Valentine
  ("Hemolytic Anemia and Inborn Errors of Metabolism")

**Afternoon:**
- Simultaneous Scientific Sessions
- Business Meeting

**Tuesday, December 5**

**Morning:**
- Simultaneous Scientific Sessions

**Afternoon:**
- Simultaneous Scientific Sessions

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**Housing Arrangements for**
**The 1978 Annual Meeting**
**American Society of Hematology**

Multiple hotels will be utilized in New Orleans this year to house convention registrants. Housing will be handled through the New Orleans Tourist and Convention Commission. To obtain your housing form please write to the ASH Business Office, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N.J. 08086.
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- **Leukemias, lymphomas:**
  May be given prophylactically to prevent tissue urate deposition, acute urate nephropathy, or renal calculi in patients with leukemias, lymphomas or certain other malignancies¹ ² ³ who are receiving cancer chemotherapy or radiation therapy.

- **Polycythemia vera, myeloid metaplasia:**
  For the treatment of secondary hyperuricemia, with or without gout, which occurs in polycythemia vera, myeloid metaplasia, leukemia, or other blood dyscrasias.
INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is indicated for:
1. Gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemia, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevation in serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNING: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory. Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300 mg of allopurinol per day may result in a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage In Pregnancy and Women of Childbearing Age: Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normally high serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicoumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of allopurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported. Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported. A few cases of alopecia have been reported, both with and without accompanying dermatitis have been reported. In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been implicated but not excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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<tr>
<td>Factor V, VII, XI, XII or XIII</td>
<td>10 ml — $40.00</td>
<td>250 ml — $252.00</td>
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<tr>
<td></td>
<td>25 ml — 85.00</td>
<td>500 ml — 950.00</td>
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<td>50 ml — 150.00</td>
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<td>Factor VIII</td>
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