different animals does not always eliminate interference due to HAMAs (21, 23), in this case it may.

CA 125 concentrations in patients treated with OC125 fragments should be interpreted with care. In such patients determination of CA 125 should not be performed by means of a homologous assay involving only OC125 antibodies, neither in the native sample nor after IgG removal, because of the very high incidence of false-positive results. The use of test kits involving other antibodies cannot completely eliminate interferences in the native samples. Of the test kits studied, the IMx CA 125 seems to be the most suited for monitoring CA 125 in samples from patients treated with OC125 fragments. Nevertheless, even with this assay, increased CA 125 values seen after OC125 administration should be validated to rule out a false-positive increase caused by interference from newly formed antibodies.

References

Corrections

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p. 517. In the article by L.H. Bernstein, R.A. Rudolph, M.M. Pinto, N. Viner, and H. Zuckerman entitled "Medically significant concentrations of prostate-specific antigen in serum assessed," 1990;36:515–8, the text describing Table 4 reports reversed values for sensitivity and positive predictive value and likewise for specificity and negative predictive value. The text should read, "Table 4, a reorganized Table 3, defines the occurrence of binary class patterns with respect to carcinoma of the prostate by stage compared with nondisease. The table allows the estimation of 44.4% sensitivity, 97.1% specificity, a negative predictive value of 79%, and a positive predictive value of 87.8% for PSA > 22.8 mg/mL."

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p. 2557. In the letter to the editor by J.D. Mitchell, B.J. Perrigo, and V.A. Mason-Daniel entitled "Falsely negative urine drug assay results due to filtration," 1992;38:2556–7, the units in the first paragraph at the top of p. 2557 should have been micrograms per liter (µg/L), not pg/L.