in this issue

p53 Reviewed

Leptin in Humans

Errors in Measuring Bilirubin

Detector Limits
• Redefined
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The American Association for Clinical Chemistry, Inc., (AACC) will hold its 48th Annual Meeting & Clinical Laboratory Exposition on July 28 - August 1, 1996. This will be a joint meeting of The American Association for Clinical Chemistry, Inc. and The Canadian Society of Clinical Chemists, held concurrently with the American Society for Clinical Laboratory Science.

The Meeting: AACC’s Annual Meeting & Clinical Laboratory Exposition is your best opportunity during the year to learn about the latest developments in the field and to see the newest products available for your laboratory. Attracting more than 17,000 participants in 1995, this meeting is the leading event in the clinical laboratory profession and the largest exposition dedicated to clinical laboratory science in the world.

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New this year—Five plenary speakers

1965 Nobel Laureate, Michael S. Brown, MD
How Cells Control Cholesterol
University of Texas Southwestern Medical School, Dallas, Texas

Robert C. Gallo, MD
Update on the Pathogenesis of AIDS & HIV
University of Maryland Biotechnology Institute, Baltimore, MD

David W. Yandell, ScD
Practical & Ethical Issues in Screening for Inherited Cancer Predisposition
University of Vermont College of Medicine

Joe W. Hay, PhD
Economic & Clinical Outcomes Issues in Laboratory Testing
University of Southern California, Los Angeles, CA

Thomas K. Murray, PhD
Drug Use in Sports and the Ethics of Competititon
Case Western Reserve University, Cleveland, OH

AACC/CSCC Annual Meeting ▲ July 28–August 1, 1996 ▲ McCormick Place ▲ Chicago, IL

The Canadian Society of Clinical Chemists will be joining the AACC meeting, in addition to the concurrent meeting with ASCLS.
Information for Contributors

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For halftones, submit glossy prints; for line drawings, submit glossy prints or laser prints on coated paper. Verify that symbols and lettering will be legible when reduced to publication size.

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Studies of Diagnostic Accuracy. Follow accepted minimum criteria for methodologic standards: (a) Specify spectrum of evaluated patients (age and sex distributions, eligibility criteria, and summary of symptoms or disease stage). (b) Analyze pertinent subgroups of subjects (e.g., symptomatic and asymptomatic patients). (c) Avoid verification bias (usually by application of "gold-standard" test to all subjects rather than to a clinically selected subset). (d) Categorize test results and patients independently to avoid reviewer bias (usually by performance of tests with blinding to patient information and vice versa). (e) Provide confidence intervals (or SE) for indices of diagnostic accuracy such as sensitivity/specificity, likelihood ratios, and areas under receiver-operator characteristic (ROC) curves. For n > 30 subjects, a 95% CI for observed sensitivity or specificity (p) can be estimated readily as p ± 1.96 (SE), where SE = ѵ(p(1-p)/n). (f) Indicate the number of indeterminate test results and their use (if any) in further data analysis. (g) Provide laboratory data on analytical precision of the test (usually day-to-day CV at 2 or more concentrations) or reproducibility of observer interpretation [e.g., for a dichotomous (e.g., positive/negative) test].

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