By eliminating the disadvantages of earlier methods, the Triosorb Sponge has achieved a real breakthrough in thyroid testing. It is an in vitro test unmatched in accuracy, speed and convenience.

Accuracy: Because factors such as red blood cells and exogenous iodine have been eliminated from consideration in the Triosorb Test, it is unmatched in accuracy.

Speed: With only 3 washes and no need for double pipettings, shakers, or incubators, the Triosorb Test can be more rapidly performed than any other T-3 test.

Convenience: Triosorb is in a disposable kit ready for immediate use at room temperature, making it the simplest and most convenient thyroid function test to perform.

McAdams* reported that “The resin sponge (Triosorb) technique is superior to the erythrocyte method for performing the $^{131}$ I T3 test in terms of simplicity, convenience and elimination of errors characteristic of the erythrocyte procedure.”

Triosorb is available to all doctors, hospitals and clinical laboratories—AEC licensing is not required. Because Triosorb will enable far more screenings to be performed, this procedure may soon become as standard as today’s blood counts and urinalyses.

New!
This sponge simplifies iron deficiency anemia testing

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Irosorb-59 is the second in a series of in vitro radio-pharmaceuticals tests developed by Abbott Laboratories. The Irosorb-59 sponge consists of a polyether foam in which is embedded a pre-measured finely divided ion-exchange resin. Irosorb-59 offers a remarkable degree of accuracy and simplicity that makes routine screening a practical matter.

Accuracy: The diagnostic accuracy of the test is unsurpassed in measuring latent iron-binding capacity. What's more, it can be scheduled where other standard methods may not be applicable. For example, it may be used following the administration of ferrous iron.

Speed: Irosorb-59 can be washed quickly, there being only 3 washes. No incubators or shakers are needed.

Convenience: Irosorb-59 is in a disposable kit form ready for immediate use at room temperature.

Safety: No dilution or pipetting of radioactive material is necessary. Since the patient receives no radioactive material, the test can be used in children, pregnant women, or in adults without any hazard of radioactivity.

Flexibility: The test does not require the presence of the patient for the determination of the radioactivity. The serums can be frozen and saved until a sufficient number has been collected to run a rack full of tubes at one time, or serum samples can be mailed to personnel performing the test.

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(What does this suggest to you?)

This fact hopefully suggests—to those contemplating the start (or expansion) of such a service—something about this instrument and the organization behind it. Other compelling points: the Magnascanner is far and away the instrument most widely used for diagnostic purposes by new or established Nuclear Medicine Departments; nearly 2000 hospitals are now serviced by Picker Nuclear. (Most Radioisotope Departments start with us and seem to stay with us.)

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- low background crystals (2 inch thick pure NaI light pipe);
- Gamma-Graphic (patent pending) or slit mask photoscans;
- unequivocal one year warranty anywhere in USA or Canada.

This unparalleled radioisotope scanner is priced at $28,750 with delivery in 90 days guaranteed.

2. Sterile — Every generator is autoclaved before shipment and each elute is forced through a final 0.22 micron sterilizing filter as an extra precaution.

3. Pyrogen-free — Every generator is tested for pyrogenicity before shipment.

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6. Safely — Patient safety derives from points 2 and 3 above and this: every elution is easily and precisely checked for possible molybdenum breakthrough; simple, accurate radioassay materials are included for testing all elutions. Hospital personnel safety is related to point 5 above since speed reduces exposure, and: the generator never leaves its ¼” lead shield or its 6 inch diameter can; and the construction is unbreakable.

7. Reliably — Semi-automatic operation eliminates the risk of improper elution with the wrong solvent, the wrong volume of solvent, or at the wrong rate. (See also: most other points above.)

For more information, contact any Picker Nuclear office or write for file 131N.
"...[pulmonary embolism] may exist in a grave form for a considerable time without objective signs being present on physical examination or routine chest films."

Pulmonary embolism is a mimic. Because its symptoms resemble those of other cardiorespiratory diseases—particularly myocardial infarction, pneumonia—investigators have long sought simple and certain methods of diagnosing it.

Many diagnostic clues—but often no clinical picture
Until a few years ago diagnosis depended primarily on the clinical history, physical findings, chest films, electrocardiograms, angiography, and pulmonary function studies. Each of these was helpful. Sometimes not even all of them were conclusive.

Surgery, prolonged immobilization, metastatic carcinoma and trauma often precede pulmonary embolism—but are not necessarily followed by it. Pain, dyspnea, hemoptysis may signal pulmonary embolism—but they aren't necessarily peculiar to it. The electrocardiogram may be normal in spite of it. And there is no pathognomonic radiographic picture of pulmonary embolism.

To be clinically valuable, however, a new diagnostic test should meet two criteria:
1. It should be correlated with known pathology; i.e., it should be carefully compared with other diagnostic procedures;
2. It should offer information not attainable as easily or as safely by accepted tests.

Pulmonary arteriography meets the first criterion and is a most reliable diagnostic tool. It is, however, a time-consuming procedure and one that requires experienced personnel.

"...lung scintiscanning can detect an obstruction of the pulmonary circulation as soon as it is established."

Not only is the diagnostic procedure of lung scanning both safe and easy, but there is information that is not attainable on chest films. It appears that the lung scan can point to the site of the embolic lesions before signs of lung infarction are recognizable on plain chest films.

The scan and the x-ray shown confirm this statement. The photoflash of this female patient, aged 58, was taken August 13, 1965 with Albumotope-LS (Squibb Aggregated Radioiodinated [131] Albumin [Human]). Pulmonary emboli are clearly evident. The x-ray, taken the same day, shows no radiographic evidence of pulmonary emboli.

Lung scanning meets both criteria for a clinically valuable diagnostic test. Findings are correlated with pulmonary function studies, angiography, pathology, and the clinical state of the patient. And, scanning with Albumotope-LS has been proven to be "simple, rapid, and safe in the diagnosis, localization and ultimate fate of pulmonary embolism."

But the lung scan should not be relied upon as the only diagnostic procedure in the diagnosis of pulmonary embolism.

Disease and Scanning Procedure: Recommended scan dose of 150 to 300 microcuries of Albumotope-LS (Squibb Aggregated Radioiodinated [131] Albumin [Human]) depends on the instrumentation available and the techniques employed. Scanning can immediately follow administration of slow intravenous injection or be delayed up to 1 to 1.5 hours depending on preferred technic.

The Lung Scan Should Not Be Relyed Upon as the Only Diagnostic Procedure

Available: As a sterile, non-pyrogenic, aqueous suspension. Each cc. contains approximately 1 mg. aggregated human serum albumin labeled with 800-1500 microcuries of iodine-131 at time of manufacture. Also contains 0.9% benzyl alcohol as a preservative.


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Complete System includes the new TechnneKow-CS (closed system) Generator... completely sterile and pyrogen-free to meet all of the requirements of the US AEC and agreement states. An exclusive double chamber design permits injection of the eluant solution into the unique vacuum/pressure eluting system... also provides a reservoir below for complete solution removal from the alumina column.

Milking is simple and rapid. The vacuum in the collecting vial, combined with elevated pressure in the generator, causes the eluate solution to be forced rapidly through the milking system. The milking needle makes no contact with the alumina. The closed milking system eliminates venting to the atmosphere. And the TechnneKow Shielded Dispenser offers additional convenience, eliminating the necessity for a cumbersome “hot lab”.

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Mallinckrodt/Nuclear will be happy to answer all inquiries and render assistance in obtaining necessary user licenses. Call or write today.

CONTRAINdications — Radiopharmaceuticals are contraindicated in pregnancy and during lactation and in persons less than 18 years of age, unless in the judgment of the physician the situation requires their use.

Sodium pertechnetate 99mTc should not be administered orally to patients who have recently ingested aluminum hydroxide or other similar antacid preparations, since such compounds may interfere with the absorption of the radiisotope.

PRECAUTIONS — Adequate care should be taken to minimize radiation exposure to the patient and other individuals involved in the procedure. Any physician employing a radioactive drug should be thoroughly familiar with the technique and the clinical literature as well as the equipment required for its use. In addition, users should be knowledgeable concerning the safe handling of radioactive materials.

When making withdrawals from the Collecting Vial, do not remove the Vial from its protective lead shield. Note: Solutions obtained from the TechnneKow-CS Generator should be free of particulate matter. Any solutions containing visible particulate matter should not be administered.

SIDE EFFECTS — At the dosages employed in diagnostic scanning procedures, side effects are rarely, if ever, encountered.
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Announcement to Authors

Preliminary Notes

Space will be reserved in each issue of THE JOURNAL OF NUCLEAR MEDICINE for the publication of one preliminary note concerning new original work that is an important contribution in Nuclear Medicine.

Selection of the preliminary note shall be on a competitive basis for each issue. One will be selected after careful screening and review by the Editors. Those not selected will be returned immediately to the authors without criticism. Authors may resubmit a rejected or revised preliminary note for consideration for publication in a later issue. The subject material of all rejected manuscripts will be considered confidential.

The text of the manuscript should not exceed 1200 words. Either two illustrations, two tables, or one illustration and one table will be permitted. An additional 400 words of text may be submitted if no tables or illustrations are required. Only the minimum number of references should be cited.

Manuscripts should be mailed to the Editor, Dr. George E. Thoma, St. Louis University Medical Center, 1402 South Grand Blvd., St. Louis, Missouri 63104. They must be received before the first day of the month preceding the publication month of the next issue, e.g., preliminary notes to be considered for the October 1967 issue must be in the hands of the Editor before September 1, 1967.
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SIDE EFFECTS: None reported to date; however, care should be exercised in administration. Comprehensive literature available on request.

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