

**A powerful new trend in cancer diagnosis and treatment.**

All of the data, from both Bogoch et al. (ref 04) and from the independent study performed by Smith-Kline Laboratories (ref 06) support the fact that the AMA (Anti-Malignin Antibody) is elevated almost **regardless of the site or cell type of the malignancy**; that is, AMA is a general transformation antibody, not just for one particular kind of cancer. For sera shipped overnight, false positives are 5 percent and false negatives 7 percent (3,315 double-blind tests of patients and controls, (ref 04,06,08).

**Proven in over 50,000 tests.**

Anti-Malignin Antibody is elevated in 93 to 100 percent of cases in which active non-terminal malignancy is the clinical-pathological diagnosis. Overall asymptomatic ('false') positives are 5 percent in sera shipped overnight (ref 04-08).

AMA is normal in 96 percent of cancer patients who no longer have evidence of disease (ref 04, 06). Internally run, inter-technician-same-lab, and inter-lab variability are low, as reported in the Smith-Kline study (ref 06).

**Every AMAS test is run under rigorous quality control.**

Control solutions containing known amounts of standard monoclonal AMA are run with each test. AMA, when produced in vivo as mouse (ref 03) or as human (ref 07) immunoglobulin, and when isolated from human serum (ref 07) is predominantly IgM. Target® reagent shelf life is as long as 7 years.

**The AMAS test may be useful as a diagnostic test.**

A common clinical situation involves signs or symptoms suggesting a disorder which may or may not be malignant. While neither AMAS nor any other clinical laboratory test can by itself answer this question, **AMAS test results may help the physician in the diagnostic process.**

**Measuring levels of a specific antibody, not an antigen.**

AMA is the antibody to Malignin, a 10,000 Dalton polypeptide which has been found to be present in most malignant cells regardless of cell type or location (ref 01-08).

Unlike tests such as CEA, which measure less well-defined antigens whose serum levels tend to be inconstant but elevated late in the disease, the AMAS test measures a well-defined antibody whose serum levels rise early in the course of the disease. In some cases, the AMAS test has been positive (elevated) early, i.e. **1 to 19 months before clinical detection.**

On the other hand, since antibody failure often occurs late in the malignancy, elevated antibody is then no longer available as evidence of the presence of antigen and therefore, late in the disease, the AMAS test cannot be used as a diagnostic test, but may be useful for monitoring (ref 04).

**Oncolab Inc.**

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## Covered by Medicare.

The AMAS test is covered by standard Medicare reimbursement to Oncolab. While we do not work directly with private insurers, HMOs, or PPO plans, we can provide you with a receipt which you may be able to use to get reimbursement from your provider.

## How do I get tested?

Please ask your doctor. Physicians around the country are recommending and administering the AMAS test on a regular basis for patients at high risk for cancer, and for follow-up purposes on patients already diagnosed and/or treated for cancer.

If your doctor is not familiar with the test and does not have a shipping kit, please call and we can send a free kit.

The kit contains reprints of scientific papers on the test, a requisition form, and all supplies for drawing and sending a blood serum sample. The kit includes a styrofoam packing box and silicone-free test tubes, as well as step-by-step instructions for the lab. The only other requirements are a centrifuge and a local supplier of dry ice for shipping. Your doctor should receive the results within 72 hours of our receiving the serum sample.

## Limitations and Warnings.

The low false-positive and false-negative rates have permitted successful screening in selected high-risk populations, as in chemical workers (ref 08) and in the preclinical detection of cancer in 2.3 percent of medical-surgical cases (ref 04) but the efficacy of screening in larger normal populations has yet to be determined. A low AMA level can occur in non-cancer, in advanced and terminal cancer, and in successfully treated cancer in which there is no further evidence of disease; clinical status must be used to distinguish these states. As in all clinical laboratory tests, the AMAS test is not by itself diagnostic of the presence of absence of disease, and its results can only be assessed as an aid to diagnosis, detection or monitoring of disease in relation to the history, medical signs, and symptoms and the overall condition of the patient.

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