THE CANCER LETTER
RESEARCH EDUCATION CONTROL

Vol. 4 No. 26
June 30, 1978

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Subscription $100 per year

GROUP CHAIRMEN REJECT DCT'S AGENDA FOR CLINICAL TRIALS REVIEW, DEMAND RIGHT TO SELECT SPEAKERS

Cooperative Group chairmen, increasingly apprehensive about the review of clinical research NCI's Div. of Cancer Treatment plans to conduct for the division's Board of Scientific Counselors next year, bitterly rejected the agenda proposed by DCT staff for the two-three day review.

The chairmen, at their semiannual meeting last week, were especially adamant about who will select the persons who will make the presentations to the Board.

DCT Director Vincent DeVita has insisted the review was intended to take a look at all clinical research supported by NCI, although noting that a major part of that is conducted by the Clinical Cooperative Groups. Group chairmen have felt, however, that the review is aimed at them.

DeVita is on sabbatical and was not present at the chairmen's meet-

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In Brief

BROWN NAMED DEAN AT WISCONSIN, CARBONE TO HEAD CANCER CENTER WITH RUSCH RETIREMENT

ARNOLD (BUD) BROWN will become dean of the Univ. of Wisconsin School of Medicine in mid-August, leaving the Mayo Clinic after 19 years. He's been chairman of the Dept. of Pathology & Anatomy there. Brown said the new job will not interfere with his position as chairman of the Clearinghouse on Environmental Carcinogens. In another major personnel change at the university, **PAUL CARBONE** will become director of the cancer center July 1, with the retirement of Harold Rusch. Rusch will continue for one more year on the university faculty until he reaches the mandatory retirement age. Carbone has been chairman of the Dept. of Oncology; that position is now being combined with that of cancer center director. Brown's appointment fills the position vacated by Larry Crowley, who left as dean last fall to return to Stanford. Bernard Nelson has been acting dean, now becomes acting vice chancellor for health affairs. Robert Cook, former vice chancellor, is now president of the Medical College of Virginia. . . . **JOHN KALBERER**, program planning officer in NCI's Div. of Cancer Research Resources & Centers, will be working for four months in the office of NIH Director Donald Fredrickson "to coordinate the NIH responses to the major legislative and administrative initiatives requested by the Secretary (Joseph Califano)," Fredrickson announced. Kalberer also will serve as NIH coordinator for the development of responses to requests with regard to prevention. Robert Ringler, who has been performing that chore, asked to be relieved because his new duties as deputy director of the National Institute on Aging do not permit him to continue as coordinator.

HOLLAND CHARGES DCT IS "JUDGE, JURY, PROSECUTOR, WANTS TO NAME WITNESSES"

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ing. Deputy Director Saul Schepartz and Franco Muggia, director of the Cancer Therapy Evaluation Program, argued DCT's position.

"This will be a basic review of clinical trials—where it is, where it is going," Muggia said.

James Holland, chairman of Cancer & Leukemia Group B, was as usual the most outspoken defender of the Groups' position. "It's been in print. DeVita has said, and I quote, 'If I had it to do again, I might not organize clinical trials the same way. We will look at the Cooperative Groups. I need advice about them.' "

Schepartz insisted, "This will not be an attack on the Cooperative Groups, nor is a defense needed. It is not a review of the groups as such, but of clinical trials."

Holland was furious when he learned that DeVita intended to select the speakers. He was backed by Barth Hoogstraten, chairman of the Group Chairmen's Committee, and the other chairmen.

"The people who make the presentations should be independent. That was the major criticism of the Potomac Conference (the review of the Cooperative Group Program three years ago), that it was self serving."

"We should be in the position to make presentations by people we choose," Holland argued. "When did you decide you would pick the speakers?" he demanded.

"In the last few weeks," Muggia said. "The feeling is, they should be people who are independent."

"Don't you see something is fundamentally wrong, with you being the judge, prosecutor, and jury, and will control selection of the witnesses?"

"I do not see it as an adversary thing," Muggia answered.

"We should have something to say about the selection of speakers," Hoogstraten said. "If 85% of the review is on the Cooperative Groups, I don't want a non-Cooperative Group person doing the presentation on childhood leukemia. That would be stupid."

"We want you to help us pick the people for the presentations," Schepartz said.

"That's offensive," Holland said. "You pick the people who will listen to the review (Board members) and the people to make the review. You can always find someone who can say that nothing is being done about cancer of the eyeball."

When Muggia commented that the presentations should be "a balanced view, not by people handpicked by the Cooperative Groups," Holland responded, "I think you should have confidence we would select people who would make balanced presentations."

The agenda for the review proposed by DCT staff would open with a discussion of overall accomplishments and needs of clinical trials by DeVita. The chairman of the Group Chairmen's Committee was to follow with a presentation on the Cooperative Group Program. Jerome DeCosse, chairman of the Cancer Clinical Investigation Review Committee, which reviews Cooperative Group grants, was to discuss peer review of the groups. Muggia was to present a history of contract support and clinical trials at NIH.

Group representatives would have an hour and a half to discuss special needs of surgical oncology, radiation oncology, pathology and statistics.

Up to that point, the group chairmen offered no major objections, although Holland thought it was not appropriate for DeVita "to be the leadoff hitter."

The portion of the agenda which drew the fire was that set aside for "Disease Strategy: Accomplishments in Clinical Research." The agenda proposal noted that members of the Board would have documents from the Cooperative Groups, those "assembled by staff including CCIRC prepared discussion," and contracts. Thirty minute presentations followed by 15 minute discussions would be held on pediatric and adult acute leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, pediatric solid tumors, gastrointestinal cancer, lung cancer, breast cancer, ovarian cancer and sarcomas.

An overall discussion on clinical trials resources and needs would follow, with these questions being addressed:

—Does mechanism of funding affect the conduct of clinical research?

—What has been and is likely to be the optimal use of the contract mechanism?

—What are clinical research areas that have not been exploited? Why?

—What are the drawbacks of current approaches? How can they be overcome?

Holland moved that a short note be sent by Hoogstraten to John Ultmann, chairman of the Board of Scientific Counselors, stating that the chairmen had rejected the proposed agenda and "We've decided to substitute our own."

"That's confrontation politics," commented Stephen Carter, chairman of the Northern California Oncology Group.

"I don't think so," Holland said. "I see an agenda I don't like. I see a change in the ground rules. I'm not rolling over and playing dead. I think this is extremely important to the future of clinical research."

Hoogstraten suggested that "we make up the agenda for the time allocated to the Cooperative Groups. We should not interweave contracts with the groups."

"It would be wrong for the Cooperative Groups to present the entire clinical trials program," Muggia said.

"We don't want to make all the presentations," Hoogstraten said. "Just the time allotted to the groups."

"Is Dr. Muggia a free agent to respond to suggestions?" Holland asked.

"We've heard you, and we will respond, and agree to appropriate modifications," Muggia said.

DeCosse said he wanted to "defend Franco. There is something fundamentally wrong with this setup. It ought to be re-examined. If the Board of Scientific Counselors wants a review of clinical trials, it is not appropriate to be in the hands of group chairmen. Something is not right."

DeCosse said that the statements on the state of the art by disease "gives us a package that would enable us to look at the science in the Cooperative Groups, and the packages could be updated periodically."

John Durant, chairman of the Southeastern Cancer Study Group, said, "I don't understand the purpose of the review. We need a committee to study the purposes, so the meeting can address the needs of everyone."

"The Board should give us some idea what should come out of the review," Hoogstraten said.

"The Board doesn't have any idea," Muggia said. "They are exposed to all DCT programs. Clinical trials are a very large, growing part of the division's effort."

Marvin Zelen, who heads the Clinical Coordinating Center that provides statistical and computing support for the Eastern Cooperative Oncology Group and the Radiation Therapy Oncology Group, suggested the agenda be broadened to include, in addition to research conducted by the Cooperative Groups and DCT contractors, single institution studies and foreign contractors.

Zelen suggested that a planning committee consisting of representatives of the groups, NCI, and the Board of Scientific Counselors draft an agenda and select the speakers.

"John Ultmann should not select the speakers," Hoogstraten said. "He's there to listen."

Carter supported Zelen on the single institution studies, commenting that examples would be Stanford Univ. on Hodgkin's disease, and Sloan-Kettering and M.D. Anderson on other diseases.

Holland disagreed. "That would diffuse the entire program. This should be limited to those things funded by DCT. To the extent that these other things are interesting, we will get them at scientific meetings and in publications. We can't cover the world of clinical research in two or three days."

George Higgins, chairman of the VA Surgical Adjuvant Group, asked if such problems as difficulties in accruing patients and finding oncologists to participate in trials would be discussed. "We are getting more oncologists, but they are not unlimited in numbers. It is becoming more difficult all the time getting patients into adjuvant trials," Higgins said.

Hoogstraten agreed those subjects would be assigned to one of the concept speakers.

Holland modified his motion to the effect that the DCT proposed agenda be rejected and that Muggia and Hoogstraten collaborate on developing a new one. It was approved unanimously. Hoogstraten added that DeCosse would take part in those discussions.

In a letter to Ultmann, Hoogstraten reviewed preparations being made by the Groups for the review.

"Dr. DeCosse and I have discussed the review and we arrived at an agreement that the CCIRC will prepare its own review of the cooperative trials and that the group chairmen will have an opportunity to read and comment on the prepared report before it is finalized," Hoogstraten wrote. "The CCIRC will not make an oral presentation to the Board concerning this report. Instead, the chairmen or their designates will make oral presentations of the scientific achievements made by the groups. The groups will keep the CCIRC fully informed about plans and progress."

Hoogstraten has organized task forces of three to five persons to develop presentations for each disease, modalities, and concepts.

The disease oriented task forces and chairmen are: adult leukemia, Freireich; lymphoma, Coltman; adult hematology, McIntyre; childhood leukemia, Chard; pediatric solid tumor, D'Angio; brain, Horton; breast, Tormey; GI, Moertel; GU, Caldwell; GYN, Lewis; head & neck, Lerner; Lung, Wolf; melanoma, Costanzi; and sarcoma, Presant.

Modalities: drug evaluation, Ellison; pathology, McDivitt; surgery, Higgins; radiotherapy, Kramer; immunotherapy, Leventhal; and statistics, Zelen.

Concepts: multimodality, Carbone; education, Loeb; internal review, Brady; groups vis-a-vis NCI, FDA, centers, etc., Holland; groups vis-a-vis clinical research in general, Kramer; and groups and basic science, Valeriote.

Hoogstraten said the chairmen have decided that those reports, which are due to be completed by the end of the year, will be presented to a publishing company for publication as a book. He said about $17,000 would be available from SWOG to help pay for an editor and other costs, and asked the other groups to contribute to help pay for copying and postage costs. Muggia said a supplemental grant might be made available for that purpose.

Hoogstraten commented that the committee's executive committee had assigned, tentatively, a percentage of the space in the book to each of the diseases covered. Holland objected to limiting GYN cancer to 2%, when sarcomas would have 15%. "GYN cancer is an area where substantial interest lies, and is one of considerable accomplishment."

Higgins pointed out that GI tract cancers make up

the largest group, but Hoogstraten said the executive committee specifically did not look at the number of patients "but rather the effort put in by the Cooperative Groups and the achievements."

The review is scheduled for the summer or fall of 1979.

CARBONE HEADS CHAIRMEN'S COMMITTEE

Paul Carbone, chairman of the Eastern Cooperative Oncology Group, was elected chairman of the Cooperative Group Chairmen's Committee at the committee's meeting last week. Barth Hoogstraten is the retiring chairman.

Elected to the executive committee were John Durant, Bernard Fischer, James Holland and Simon Kramer.

MORE ONCOPATHOLOGY RESEARCH ASKED, DEVELOPMENT WORKSHOP APPROVED

A prominent pathologist asked the National Cancer Advisory Board to support a workshop "for surgical pathologists from cancer and other centers, as well as some of the experimentalists, to develop a comprehensive program of research in oncopathology and come back to the Board with specific recommendations."

F. Kash Mostofi, chairman of the Center for Advanced Pathology of the Armed Forces Institute of Pathology, is an ex-officio member of the NCAB. He presented a report to the Board outlining needs, problems and opportunities for research in oncopathology.

"Despite claims that biochemistry, radiology and immunology will replace it, pathomorphology in the form of cytology and pathology remains the basis of all cancer diagnoses and treatment," Mostofi said. "It is also an essential component of all cancer research in which the study produces tissue for examination—thus pathomorphology is an integral part of the entire cancer program, but any objective analysis of the situation leads to the conclusion that it is sorely in need of help.

"1. Diagnosis—There has been a long standing feeling that the level of accuracy of pathological diagnosis of cancer is not very high. It was this concern which led me, some 25 years ago, to initiate a program of continuing education of pathologists. The response of the practicing pathologists to that program has led to a large scale expansion of such educational programs in the last 10 years. Recently, as part of a quality control program I sent out slides of a prostatic carcinoma removed by transurethral resection to some 150 hospitals. With one exception they all made the diagnosis of malignancy but they used many different terms. I believe it is safe to say that although misdiagnoses are made, the average practicing pathologist can and does recognize the usual malignancies that he may encounter in his daily practice. What is confusing is the diversity of criteria for diagnosis and terminology that he uses in reporting the results.

"The National Cancer Institute, American Cancer Society, College of American Pathologists, Armed Forces Institute of Pathology, World Health Organization and International Agency for Cancer Research have done a great deal for promoting standardization in oncopathology diagnosis but much remains to be done.

"In modern day practice of medicine, however, with the great advances that have been made by the basic scientists and by our clinical colleagues, it is not enough to simply make a diagnosis of cancer or grade a tumor according to the old systems. Some 50 years ago Broders introduced grading as a method of prognostication. Unfortunately, since the system is subjective and interpretive, it is not unusual to have pathologists disagree on the grading of the same slide of a tumor. There has been one recent serious effort to do something about this situation. The National Prostatic Cancer Project has supported three studies to evaluate grading systems . . . . This should be done for other cancers as well, This is still subjective. Techniques are available to measure DNA content of the nucleus, to map the chromatin distribution and to computerize the results. This could give us an objective grading system but it is not being used because it is expensive.

"2. Basic Research—Current research in pathology is almost all oriented to basic animal research. This is absolutely necessary. Thus we have the experimental pathologist who can apply the most modern techniques of biology, biochemistry, immunology and biophysics to the study of the mechanism of carcinogenesis in animals. He has very little problem in getting research grants from one source or the other.

"On the other hand we have the surgical pathologist who is responsible for diagnosis of cancer in man. Almost all pathological diagnosis of cancer is made on formalin fixed paraffin embedded and hematoxylin and eosin stained slides. The first thing the pathologist does after examining the tissue is to fix it in formalin. This makes it impossible to do tissue culture, electron microscopy, histochemistry, enzymatology, hormone determinations, electrophoresis, autoradiography, and high pressure liquid chromatography.

"Although a few centers have the facilities to do some or all of these, most surgical pathologists, even in some of our large cancer centers, are not in a position to do them. They do not know how to do these themselves, they cannot find the young fellow or even the technician to do them and even if they did find such talent the university or the hospital can not afford to support them, and the equipment is quite expensive. Some of these techniques may or may not help with the diagnosis but without these, the surgical pathologist cannot contribute to basic mechanism of structural alterations in neoplastic transformation,

the relationship of morphologic changes to functional changes in human carcinogenesis or the exact mechanism of tissue response to various forms of therapy.

"3. Clinicopathologic Research—There is another area of research—clinicopathologic research—which needs support. A number of centers throughout the country, e.g., Massachusetts General Hospital, Sloan-Kettering Memorial Hospital, and even an institution in this city have pathological material from a large number of neoplastic diseases collected over many years and buried in the files. Much could be learned from such material to elucidate the natural history of certain cancers and their response to treatment.

"Let me give one example. In a recent study of such file material it was demonstrated that while many of the patients who underwent enucleation of the eye for malignant melanoma developed metastasis—it was rare for a malignant melanoma of the eye which had not been diagnosed or operated on to develop metastasis. This observation has already led to the introduction of a new approach to the treatment of these tumors.

"We have heard about changing incidence of certain tumors—what we have not heard about is changing morphology of tumors. For example, the morphology of the prostatic tumors that I see today is quite different from what I saw 10-15 years ago. The question that we would like to resolve is whether there is such change in other tumors, what the exact nature of the change is and what are the possible environmental or other factors that have led to such changes.

"4. Pathology support of other research—There is another aspect of pathology and this is the support that pathology must provide for all experimental and clinical studies which depend on tissue diagnosis. You may recall that reading the slides of these research projects has been a continuous problem and the cause of much dealy in completing the work. What happens to often is that research—clinical or basic—is funded without regard to pathology support.

"5. Training and education, fellowships and research career awards in pathology—At the present, after finishing medical school those who decide to go into pathology get an internship followed by residency of three-four years. At the end of five years they take their Boards in pathology. During this period they may or may not have any exposure to basic research methods. The large majority do not. As soon as these residents finish their training, if they are any good they have job offers either from universities or private or government hospitals. There are very few fellowships, training grants or research career development programs in pathology to attract these individuals to get one-two-three years of training in basic research. Perhaps not many physicians with their Boards in pathology and the opportunity to make a good living will wish to put in two or three more years of training in research. But I think if such opportunities were available there would be a fair number who would take them.

"Such training in oncopathology with a master's or even a doctor's degree in pathology would add immeasurably to the availability of talent in human oncopathology research.

"6. Factors responsible for the present state of oncopathology research—There are several factors responsible for this situation. By and large surgical pathologists in our large centers are overworked and have no time to devote to such research.

"We need to create an atmosphere in which the surgical pathologist who has expertise in diagnosis of human cancer can utilize the tools that are available to the experimentalist. We need to bring the surgical pathologist together with the immunologist, biochemist, biophysicist and the experimentalist. We need to have fellowships to attract physicians and veterinarians to go into oncopathology. We must make it possible for the surgical tissue pathologist to have the time to do research in oncopathology," Mostofi concluded.

Director Arthur Upton suggested a small planning group be convened to organize the conference Mostofi requested. The Board agreed.

REVIEW OF DCCR ACTIVITIES UNCOVERS PROBLEMS, ASSIGNS SCORES TO EACH

A progress report on the review of all Div. of Cancer Control & Rehabilitation activities requested by the National Cancer Advisory Board was presented to the Board by William Shingleton, chairman of the DCCR Advisory Committee and a Board member himself.

Shingleton commented that the review had identified a number of problems so far:

1. Difficulty of definition; confusion with research and/or medical practice "or something in between."
2. Societal factors resisting control efforts—industry, the medical profession, public reaction (as regarding cigarette smoking).
3. Isolation of control activity from research.
4. Relative lack of scientifically valid technology to "transfer," as well as understanding how best to make the "transfer."

DCCR staff, consultants and principal investigators in projects being reviewed have presented an overview of the various programs to the advisory committee at its recent meetings. Committee members assigned three scores to each program, evaluating its objective, priority and approach.

Since the evaluation was done over an extended time and had no particular standards to apply to all programs, the priority scores were not consistent in the view of some members and DCCR staff. The committee will take another look and consider each program again in the light of the entire range of

DCCR activities.

Shingleton said that a rating of 200 was considered good, 250 average and 300 below average. Following are the projects Shingleton described to the Board, with the ratings:

Head & Neck Cancer Network—Establish networks of cooperating hospitals as demonstration programs of multidisciplinary care of head & neck cancer patients. FY 1977, $1.836 million. Seven projects, one complete, three more to be completed in 1979, three in 1980. Rated 190 on objective, 220 on priority, 250 on approach.

Breast Cancer Network—Establish network of community hospitals as demonstration programs of specific techniques for screening, diagnosis, treatment and rehabilitation of breast cancer patients. FY 1977, $3 million, 4,000 patients involved. Rated 200, 200, 280.

Rehabilitation—Three at home projects, nine (of which five were funded) demonstration programs for rehabilitation services, four to train maxillofacial prosthodontists. Total funds $2.6 million. Composite rating of 120, 160, 290.

Clinical Cooperative Groups—These are programs to help bring advances in treatment research to practicing physicians through the Clinical Cooperative Groups. In addition to ongoing programs with the Children's Cancer Study Group and the Southwest Oncology Group, three new projects were initiated with the Radiation Therapy Oncology Group, Gynecologic Oncology Group, and Eastern Cooperative Oncology Group. A sixth project, with the National Surgical Adjuvant Breast Program, began in February 1978. Five projects funded at $2.25 million in FY 1977. Rated 260, 310, 340.

Breast Cancer Detection Demonstration Project—27 projects to screen asymptomatic women for early breast cancer utilizing physical examination, mammography and (until it was discontinued) thermography. FY 1977, $6.8 million from NCI, plus additional $1.53 million for support projects, $.34 million for mammography training, and $8.7 million from the American Cancer Society. Rated 100, 110, 270.

Cervical Cancer Screening Program—Mandated by Congress, this program was designed to work through state health departments to reach low income, high risk women. Of 31 projects, six had expired by 1977 and now 22 are screening through funding by DCCR. Total funding in FY 1977 was $3.7 million. In addition, eight projects had received forward funding from previous years. One million screenings done. Rated 200, 250, 300.

DES-Adenosis Projects—To assess health hazards to daughters of DES exposed mothers. The program has identified a population of women whose mothers received DES during pregnancy and is examining these daughters at regular intervals to assess health hazards. DCCR experience in this area led to appointment of DCCR Director Diane Fink as chairman of an HEW DES Task Force to assess a variety of medical projects associated with use of estrogens. Four projects plus the coordinating center, $1.76 million in 1977. Rated 130, 130, 120.

Patterns of Care in Radiation Therapy—Contract with the American College of Radiology, $1.731 million, to determine existing patterns and standards of radiotherapy; to determine influence of educational and geographic factors; to relate outcomes of therapy to variations in patterns of care; and to develop educational programs to increase the quality of radiotherapy. Shingleton noted that about half of all cancer patients receive radiotherapy, 60% of them in community hospitals. Rated 180, 210, 190.

Prototype Clinical Chemotherapy in Cancer Centers—Six projects, $.721 million in 1977. This program promotes the use of various leukemia-lymphoma therapies among community physicians, with concentration on children. Emphasis was on the development of protocols for leukemia, Hodgkins disease, other malignant lymphomas and providing education materials to physicians and hospitals on the use of these protocols in the network. Rated 250, 320, 340.

Psychosocial Projects—To identify the most significant psychosocial problems affecting breast cancer patients and families, and design and implement interventions. $1.9 million in 1977. Also, early identification projects to demonstrate benefits of early identification of psychosocial problems and early intervention, $.5 million in 1977. Rated 210, 240, 270.

Rehabilitation Research Grants—27 renewal grants in 1977, plus nine new ones, $4.609 million. Includes research on physical impairments which may be alleviated by prostheses, psychosocial problems of children with cancer, biomedical materials, late effects of cancer treatment, new techniques for improving reconstructive surgery. Rated outstanding by the committee, with scores of 100, 110, 130.

Pain Research Grants—Seven grants in 1977, $.668 million, which accounts for 90% of all NCI funding for pain projects. Grants range from basic neurophysiology studies to controlled and comparative trials of pain treatment, from studies of electrical stimulation to pharmacological approaches to psychological approaches including hypnosis and biofeedback. Rated outstanding in all respects, at 100, 110, 130.

Nurse Oncology Programs—19 contracts, $.506 million in 1977, three enterostromal therapy contracts, four oncology nursing in community hospitals, 11 nursing education in centers, one continuing care coordinating team. Planning is under way to work with universities which have ongoing oncology nursing programs to develop a post masters fellowship program for training key faculty members. Rated 140, 150, 220.

Hospice– Three projects, $1.056 million in 1977. Rated 110, 110, 200.

NCAB member Denman Hammond pointed out that the ratings were for each program as a whole and "it could be that while a program is not doing too well, an individual grantee or contractor in the program is making a unique, valuable contribution."

FORMER RESIDENT DEFENDS RADIOTHERAPY AT MIAMI AGAINST NCAB CRITICISM

H. Brian Balfour was a resident in radiation therapy at the Univ. of Maimi from 1972-1975. Now at the Methodist Medical Center of Illinois in Peoria, Balfour took exception to criticism of the Miami radiotherapy program which was made by National Cancer Advisory Board reviewers of the Florida Comprehensive Cancer Center at the university.

The summary evaluation of the center (***The Cancer Letter,*** May 26) commented that since Gordon Zubrod became director of the center, "significant and positive changes have been made and should be considered in the overall judgment of this center. He has clearly enhanced the evolution of the center, particularly in clinical resources and capabilities, although certain weaknesses do exist within the clinical programs, particularly in pediatrics, radiotherapy and clinical research."

Balfour said that while he was at the university, Komanduri Charyulu, director of the Radiation Therapy Div., "had designed and implemented many interdisciplinary intra-institutional clinical protocols for the treatment of cancer patients. Emphasis was placed on cooperative ventures. Within the Dept. of Surgery, a pre-operative breast irradiation protocol for carcinoma of the breast was instituted. Unfortunately, this technique was not readily accepted by the surgeons of that department.

"There were several cooperative protocols with the Dept. of Otolaryngology which provided for both early and advanced cancer a study of preoperative, postoperative, radiation therapy alone, and surgery alone to ascertain the most effective technique for controlling each primary.

"Within the Dept. of Urology, there was an ongoing study to determine the value of lymphadenectomy versus irradiation and the use of I-125 implants for adenocarcinoma of the prostate. A study was instituted with the Dept. of Gynecologic Oncology which provided for surgical staging of carcinoma of the cervix followed by radiation. The study was designed to determine the feasibility of prophylactic irradiation of the periaortic nodes.

"A study was also designed with the Dept. of Dermatology for the assessment of total skin electron beam therapy for mycosis fungoides. Likewise, there was a study to determine the best mechanism of treatment for carcinoma of the pancreas with the Dept. of Medicine, Div. of Gastroenterology.

"We were also participants in the RTOG and the Acute Leukemia Group B national study groups. Furthermore, we had intradepartmental studies involving cancer of the lung, ovary, the various lymphomas, and primary brain tumors. His department was one of the forerunners in the countfy with computer assisted treatment planning and the use of transverse axial tomography for tumor localization and treatment planning.

"From my point of view, the department was quite strong and was a forerunner in the country. We were utilizing techniques in a controlled fashion which were not being utilized to any great extent throughout this country.

"Although patient accrual to single institutional protocols may be a problem and lead to a prolonged time for patient accession, I feel that quality control as far as patient selection for the various protocols is superior to the multi-institutional national cancer study groups. If you were to assess the patient attrition from the various national protocols, you would find that many departments would deviate from protocol standards. This I think would diminish credibility of these studies," Balfour concluded.

ADVISORY GROUP, OTHER CANCER MEETINGS FOR JULY, AUGUST

3rd Congress of International Rehabilitation Medicine Assn.– July 2-8, Basel, Switzerland.

Cancer & Nutrition Scientific Review Committee– July 10-12, NIH Bldg 31 Room 9, open 8:30–9 a.m. each day.

Cancer Control & Rehabilitation Advisory Committee– July 12-13, NIH Bldg 31 Room 6, 9 a.m. both days, all open.

Committee on Cancer Immunotherapy– July 13, NIH Bldg 10 Room 4B14, open 1:30–2 p.m.

National Pancreatic Cancer Committee– July 13, New Orleans La Salle Bldg., open 8:30–9 a.m.

General Oncology– July 17, Roswell Park continuing education in oncology, contact Claudia Lee.

Clearinghouse on Environmental Carcinogens Executive Subgroup– July 19, NIH Bldg 31 Room 6, 8:30 a.m., open.

Virus Cancer Program Scientific Review Committee– July 20-21, Landow Room 4C18, open 9–9:30 a.m.

Cancer Center Support Review Committee– July 20-21, NIH Bldg 31 Room 6, open July 20 8:30–10 a.m.

Advances in Medicine– July 23-28, London.

President's Cancer Panel– July 25, NIH Bldg 31 Room 7, 9:30 a.m., open.

Clinical Cancer Program Project Review Committee– July 31-Aug. 2, NIH Bldg 31 Room 6, open July 31 8:30–10:30 a.m.

9th International Conference on Electron Microscopy– Aug. 1-9, Toronto.

Diagnostic Research Advisory Group– Aug. 2, NIH Bldg 31 Room 10, open 11 a.m.–adjournment.

Developmental Therapeutics Committee– Aug. 3, Blair Room 110, open 9–9:30 a.m.

President's Cancer Panel– Aug. 22, NIH Bldg 31 Room 7, 9:30 a.m., open.

General Oncology– Aug. 25, Roswell Park continuing education in oncology.

7th International Tutorial on Clinical Oncology–Aug. 26–Sept. 3, Vienna.

2nd European Council on Smoking and Society– Aug. 28-31, Rotterdam.

International Conference on Cell Differentiation & Neoplasia–Aug. 28-Sept. 1, Minneapolis.

Clearinghouse Chemical Selection Subgroup–Aug. 29, NIH Bldg 31 Room 6, 9 a.m., open.

4th International Congress for Virology–Aug. 30-Sept. 6, The Hague.

Clearinghouse Experimental Design Subgroup– Aug. 30, NIH Bldg 31 Room 6, 9 a.m., open.

Clearinghouse Data Evaluation/Risk Assessment Subgroup– Aug. 31, NIH Bldg 31 Room 6, 9 a.m., open.

NCI-EORTC Symposium on New Drugs in Cancer Therapy–Sept. 7-8, Brussells.

National Conference on Care of the Child with Cancer–Sept. 11-13, Boston.

Clinical Oncology Study Course–Sept. 12-16, London.

16th Meeting of the Nuclear Medicine Society–Sept. 13-16, Madrid.

2nd International Conference on Nuclear Medicine & Biology–Sept. 17-21, Washington D.C.

NCI Conference on Cis Platinum & Testicular Cancer–Sept. 21-22, Washington D.C. Shoreham, contact Franco Muggia, NCI-DCT, Bldg 31 Room 6A17, Bethesda Md. 20014, phone 301-496-6138.

5th UICC Training Course in Cancer Research–Sept. 21-Oct. 3, Sao Paulo, Brazil.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute, unless otherwise noted. Write to the Contracting Officer of Contract Specialist for copies of the RFP, citing the RFP number. Some listings will show the phone number of the Contract Specialist, who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Their addresses, all followed by Bethesda, Md. 20014, are:
Biology & Diagnosis Section – Landow Building
Viral Oncology & Field Studies Section – Landow Building
Control & Rehabilitation Section – Blair Building
Carcinogenesis Section – Blair Building
Treatment Section – Blair Building
Office of the Director Section – Blair Building
Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NO1-CP-85644-62

Title: *Survey of compounds which have been tested for carcinogenicity–1978 supplement*
Deadline: *July 24*

The Carcinogenesis Bioassay Testing Program of NCI is interested in acquiring a resource to prepare the 1978 supplement of PHS Publication No. 149, presented entitled "Compounds Which Have Been Tested for Carcinogenic Activity."

The project is to be divied into three tasks: (1) Searching the scientific literature. (2) Extracting specific data from these documents and indexing the documents with respect to selected items of the extracted data. (3) Generating a computer-readable tape of the indices with record format.

The government estimates that approximately four to five professional man-years of effort for one year is required for this project.

Contract Specialist: Dorothy Britton
Carcinogenesis
301-427-7574

RFP ECI-SHP-78-134

Title: *Study in a migrant group*
Deadline: *July 7*

A two-year case-control study of male lung cancer cases in the Cuban migrant population of Miami/-Dade County, Fla. The study will call for identification of most of the lung cancer cases in this population in the two-year period in order to achieve a sufficient sample size for reliable findings. It is anticipated that neighborhood controls will be used for this study. The capability statement of an offering organization must include:

Previous experience in epidemiological studies, especially case-control studies of tobacco-related diseases, discussion of the unique characteristics of the Cuban migrant population and possible problems or obstacles in performing a study in this population, as seen by the offeror, and demonstrated ability to collaborate with the primary health care migrant population who would be identifying the cases.

Respondents should submit the above information, the qualifications and relevant experience of their employees, and describe their facilities.

G. Hall, Contracts Administration
Enviro Control Inc.
One Central Plaza, 11300 Rockville Pike
Rockville, Md. 20852

NCI CONTRACT AWARDS

Title: Diagnosis of human leukemias
Contractor: Univ. of Massachusetts, $79,250.

Title: Immunogenicity of 'spontaneous' animal tumors, continuation
Contractor: Pennsylvania State Univ., $64,903.

Title: Immunotherapy of C_3H murine mammary carcinoma, continuation
Contractor: Univ. of Pittsburgh, $80.929.

The Cancer Letter –*Editor* JERRY D. BOYD

Published fifty times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090.