THE CANCER NEWSLETTER

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CENTERS ELIGIBLE FOR COMPREHENSIVE IDENTIFICATION NAMED; RAUSCHER TO PICK FOUR NOW, TWO MORE LATER

The four new comprehensive cancer centers that will be "identified" by NCI Director Frank Rauscher within the next month will be selected from the following center, *The Cancer Newsletter* has learned:

Yale; Howard and Georgetown Universities in a cooperative program; the Colorado Regional Cancer Center in Denver; Univ. of California at San Francisco; UCLA; the Hawaii Cancer Center, a non-profit corporation in the process of organization to include the Univ. of Hawaii and others; a yet-to-be-defined organization in Philadelphia to include the Univ. of Pennsylvania and others; the Illinois Cancer Council which includes the Univ. of Chicago and Northwestern among others; and Ohio State.

There are other centers in varying stages of organization that were tentatively approved by the committee for eventual core support as

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In Brief

CANCER CONTROL TO PUSH ENVIRONMENTAL RESEARCH OCCUPATIONAL HAZARDS; BAILAR TO JOURNAL POST

CANCER CONTROL programs will include a heavy emphasis on efforts involving environmental and occupational hazards during the 1975 fiscal year, NCI Director Frank Rauscher told Sen. Warren Magnuson and his Appropriations subcommittee. Control also will stress attempts to reduce the lung cancer incidence and to make earlier detection of cancer of the cervix and colon. . . .**JOHN BAILAR**, who headed Cancer Control in the first few months of the new program's existence, has been appointed editor in chief of the *Journal of the National Cancer Institute.* He replaces Mearl Stanton, who returns full time to NCI's Laboratory of Pathology. . . .**NORRIS COTTON**, retiring senator from New Hampshire, frankly admits that getting a cancer center established at Dartmouth , with a boost from federal funds, was a sprinkling of the "sugar" one might expect after long service on the Appropriations Committee. The facility, named for Cotton, will include a diagnostic center, and Cotton suggested to Magnuson that an appropriate farewell gift would be for the diagnostic center money to be included in the 1975 appropriations bill. . . .**ONLY** 30% of approved grants will be funded in 1975 if NCI does not get more than the $600 million requested by President Nixon. . . .**RECRUITING** to fill key positions at NCI goes on. Rauscher now is hunting for someone to replace Palmer Saunders as director of the Div. of Research Resources & Centers, the division that controls awards for grants and centers. Saunders will retire June 30. He also needs a clinical director when Alfred Ketcham retires Sept. 1. Harvard's Steve Rosenberg will take Ketcham's other job as chief of surgery. And Rauscher is still narrowing down the list of candidates for the job of basic research director at Frederick. . . .

FORMER COMPETITORS WORK TOGETHER TO ACHIEVE COMPREHENSIVE STATUS

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comprehensive centers. But the four to be named by Rauscher before the June meeting of the National Cancer Advisory Board almost certainly will come from the nine named above.

Speculation on the four to be immediately identified centered on Yale, Denver, San Francisco and Chicago. However, it is possible that Rauscher hasn't entirely made up his mind yet. He could name six, since the congressional mandate requires that 18 comprehensive centers be established, and so far NCI has tabbed only 12.

The new cancer act will lift the limit of 18, and Rauscher hopes that eventually as many as 30 comprehensive centers will be so identified. But few if any of the aspiring centers are far enough along in their organizational work to rate the comprehensive title; even those already selected still have certain problems to be overcome. That is why Rauscher intends to pick only four right now, with two more to come as centers struggle to meet the NCI guidelines for comprehensive status.

The effort to meet those requirements has caused some former competitors to conclude that the best way is to work together. Johns Hopkins, one of the nine identified by Rauscher last year as having comprehensive standing, is taking in the Univ. of Maryland as a partner.

The Hawaii organization is being developed to form a structure that will accomodate the academic institutions with those in the private sector (although Hawaii is on the approved list, the organization there is not far enough along to be included among the next four, but will be in line for future consideration).

The Denver Regional Center includes the Univ. of Colorado, Colorado State and a number of hospitals and other institutions.

SURGICAL ONCOLOGY PLANNERS DEVELOP NCPP RESEARCH APPROACHES, PROJECTS

The "paucity of well-trained cancer surgeons" and the need for carefully controlled clinical research in the role of surgical therapy in the treatment of cancer were among the problems pointed out at the Surgical Oncology Research Planning Conference convened to develop approaches and projects related to the National Cancer Program Plan.

The participants drafted 37 approach elements, 240 project areas and 90 pages of narrative materials. The rough draft of this work is undergoing review before incorporation into the updated NCPP.

According to the draft, "The most widely used surgical techniques—those of ablative excision of cancers, their organs of origin and their regional and distant metastases—are now known, with a high level of precision, but further refinement of the applicability of these techniques to specific cancers is needed.

"An intregal part of the improvement in cancer management must be the provision for producing surgical oncologists and upgrading post-graduate instruction in surgical oncology for surgeons in practice," the draft says. "Studies to improve surgical curricula must coincide with studies to improve public education in order to make earlier detection and proven methods of treatment acceptable to the patient.

"At a time of increasing need, surgical oncologists capable of improving cancer treatment, performing research, and teaching their colleagues are in short supply. The paucity of well-trained cancer surgeons and their concentration in large centers has led to a wide gap between the quality of cancer surgery as practiced in community hospitals and the optimum management available in large cancer centers. In addition, there has been a serious deficit in the emphasis placed on surgical oncology in the surgical departments of our medical schools so that surgeons as a group have shown little interest in devoting themselves to the study of cancer as a clinical or scientific problem.

Recommendations included in the draft:

—I. To evaluate the effect of improved detection, diagnosis and staging of cancer on surgical treatment for cure and palliation.

Since surgical therapy is most successful when the primary neoplasm is small and localized, more sensitive detection which will permit earlier, initial diagnosis of cancer, and more accurate staging of the extent of the disease must be developed. These detection methods should be capable of detecting microfoci of tumor cells and should be serially applicable, e.g., before, after, and during therapy."

A. To investigate new or improved methods of detecting primary cancer at various sites as related to surgical treatment.

B. To evaluate new methods for detecting regional spread of cancer as related to curative surgery.

C. To evaluate new methods in the detection of distant metastases as related to curative and palliative surgery.

D. To evaluate new methods in the detection of recurrent cancer as related to curative or palliative surgical treatment.

E. To develop new instrumentation for improving detection diagnosis and staging of cancers related to surgical treatment.

F. To identify patients who are at high risk to develop cancers (including patient with premalignant lesion) amenable to subsequent prophylactic or curative surgical treatment.

G. To develop methods of intra-operative detection of local and regional spread of cancer. At operation, careful appraisal of extent of disease is difficult and important if the proper operation is to be done. New methods would be helpful.

H. To develop methods of intra-operative detection of incidental or coincidental cancers.

I. To investigate the influence of host factors in the detection, diagnosis and staging of cancers related to surgery.

J. To investigate the relationship between the biologic characteristics of the tumor and detection, diagnosis and staging of cancer related to surgery.

K. To determine the relation between stage of disease at time of detection and the prognosis of surgically treated neoplasms.

–II. To evaluate and improve current surgical therapeutic approaches in the prevention, cure, and palliation of cancer.

Surgical treatment will prove adequate treatment by itself in certain groups of patients which must be carefully defined. Other patients may respond to the proper forms of surgical treatment combined with radiotherapy, chemotherapy, and/or immunotherapy. Newer surgical techniques should be designed and older ones evaluated to treat the cancer directly, to formally affect the host response to the tumor, and to minimize the morbidity and mortality of operations. Certain biological characteristics of host and tumor must be understood in the design of newer therapeutic approaches.

A. To identify high risk groups of patients including patients with premalignant lesions which might benefit from surgical prophylactic treatment.

B. To conduct clinical trials to determine those types of cancer amenable to cure by surgical therapy without adjuvant therapy.

C. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancer combined with systemic chemotherapy.

D. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancer combined with local infusion or perfusion chemotherapy.

E. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancer combined with radiotherapy.

F. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancers combined with treatment designed to increase the antitumor defenses of the host.

G. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancer combined with several other tumor reductive modalities.

H. To compare the therapeutic effects of conventional surgical excision with other methods of local tumor destruction.

I. To evaluate the therapeutic effect of primary surgical treatment of local or regional cancer combined with treatment designed to alter the tumor cell.

J. To evaluate the therapeutic effect of the surgical reduction of tumor bulk combined with adjuvant.

K. To evaluate the therapeutic effect of surgical treatment of metastatic disease or suspected metastitic disease after control of the primary tumor.

L. To evaluate biological characteristics of the host which influence the prognosis of cancer treated by surgical means.

M. To evaluate those tumor characteristics which influence the prognosis of cancer treated by surgical means.

N. To evaluate the effect of para-surgical events in the prognosis of cancer treated by surgical means.

O. To evaluate palliative surgery which is not directed toward the reduction of the tumor bulk, (e.g., colostomy, ileostomy).

P. To evaluate methods of reducing the incidence of intra-operative implantation or distant dissemination of cancer.

Q. To evaluate regional arterial chemotherapy with potentially favorable drugs or drug combinations for regional cancer.

R. To evaluate the effect of surgical procedures designed to alter the host response to the tumor (e.g., endocrine ablation).

S. To develop surgical methods of sampling viable tumor tissue for laboratory study in an effort to improve cancer treatment.

T. To investigate methods of safely extending the anatomical limits of surgical treatment for cure and palliation (including excision of vital organs and organ replacement).

U. To develop and improve the rehabilitation of all categories of cancer patients managed by surgical treatment.

V. To develop models of human cancer in animals suitable for study and treatment.

–III. To develop the manpower and resources for surgical oncology.

Development of programs designed to improve the training of surgical oncologists in order to satisfy the requirements for the specialists in regional centers and in the community.

A. To support the development and testing of curricula for the training of surgical oncologists.

B. To support surveys to evaluate national and regional needs of manpower requirements in surgical oncology.

–IV. To evaluate and improve the public accessibility of surgical diagnostic and treatment services for cancer.

–V. To develop and support standardized programs for processing cancer patient data.

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 or Contract Specialist for copies of the RFP. Some listings will show the phone number of the Contract Specialist, who will respond to questions about the RFP. Contract Sections for the Cause & Prevention and Biology and Diagnosis Divisions are located at: NCI, Landow Bldg. NIH, Bethesda, Md. 20014; for the Treatment and Control Divisions at NCI, Blair Bldg., 8300 Colesville Rd., Silver Spring, Md. 20910. All requests for copies of RFPs should cite the RFP number. The deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CM-53752-18

Title: *Therapy of patients with brain tumors*

Deadline: *July 8, 1974*

The contractor will conduct studies of intensive multidisciplinary therapy of patients with malignant gliomas and other types of intracranial tumors and to determine the efficacy of a number of therapeutic approaches. Possible intrarelationships to morphologic type, extent and clinical stage of disease, changes in roentgenographic findings, alterations in nuclear imaging and pharmacotoxicology of selected agents in certain cases, may be explored within the framework of these therapeutic investigations.

A minimum total of 35 newly operated on and evaluable patients having a microscopically confirmed diagnosis of malignant glioma shall be required. Patients are to be treated three to four weeks following surgery in accordance with the current protocol.

Contract Specialist: Michael M. Del-Colle
Cancer Treatment

RFP NO1 CP-C-55316-68

Title: *Chemical carcinogen testing in the Old World Monkey, Erythrocebus patas*

Deadline: *June 17, 1974*

This contract will involve establishing a breeding facility for the Old World Monkey, Erythrocebus patas, and administering a chemical carcinogen to pregnant animals at a specifically defined time during gestation in order to observe the effect upon the offspring exposed to this chemical agent during fetal life. Non pregnant animals also will receive the compound.

Contract Specialist: S.W. Ranta
Cause & Prevention

CONTRACT AWARDS

Title: Synthesis of cancer chemotherapy compounds
Contractor: Starkes Associates Inc., Buffalo, $1,014,343

Title: Development of parenteral dosage forms for clinical investigation
Contractor: Univ. of Kansas School of Pharmacy, $285,000 (supplemental)

Title: Therapy of patients with testicular carcinoma
Contractor: New York State Dept. of Health & Health Research Inc., $88,410
Contractor: Mayo Foundation, $36,000
Contractor: Memorial Hospital for Cancer & Allied Diseases, NYC, $57,487

Title: Breast cancer detection demonstration project
Contractor: Univ. of Louisville, $158,547(renewal)
Contractor: Good Samaritan Hospital, Portland, Ore., $169,754
Contractor: Cancer Research Center, Columbia, Mo., $174,000

Title: Integrated cancer rehabilitation services
Contractor: Saint Francis Hospital, Honolulu, $378,569

MEETINGS

NCI advisory group meetings frequently are closed, usually for review of contract and grant applications. Times scheduled as open will be shown with each listing, but these sometimes are changed.

Centennial Conference on Laryngeal Cancer, Univ. of Toronto, May 26-31.

International Agency for Research on Cancer, meeting on biostatistics and epidemiology, Lyon, France, May 27-June 8.

Virus Cancer Program Scientific Review Committe, NIH Landow Bldg conference room C418, May 29, open 9-10 a.m.

Fifth International Congress of Cytology, Miami Beach, May 29-June 1.

Cancer Control Education Review Committee, NIH Bldg 31 conference room 3, May 31, open 8:30-9:30 a.m.

Fourth International Convocation on Immunology, Buffalo, June 3-6.

Workshop on the Serologic Protection of Leukemia Associated Antigens, Duke Univ., June 3-11.

Committe on Cancer Immunotherapy, NIH Bldg. 10, room 4B17, open 12-12:30 p.m.

Southwest Oncology Group, Kansas City, Kan., June 5-7.

The Cancer Newsletter—*Editor* JERRY D. BOYD

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