THE CANCER LETTER

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NCAB SUBCOMMITTEE URGES NEW CENTERS CATEGORIES, RECOGNITION OF MORE NEW COMPREHENSIVE CENTERS

Establishment of new categories of cancer centers that are neither comprehensive nor specialized, along with the continued development of new comprehensive centers was recommended to the National Cancer Advisory Board by its Subcommittee on Centers.

Denman Hammond, chairman of the subcommittee and director of the comprehensive center at the Univ. of Southern California, reported those recommendations and others to the Board last week.

The subcommittee also asked for improved guidelines and procedures

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In Brief

OMB TELLS NCI TO MISLEAD CONGRESS, REFUSES HIGHER BUDGET; FORD SAYS HE SUPPORTS PROGRAM

OMB HAS ordered NCI to tell Congress in the fiscal 1976 budget presentation that NCI will get the 1,975 positions the institute feels is the absolute minimum it must have. But *The Cancer Letter* has learned that OMB also has said NCI will not get more than 1,818. OMB has, in effect, told NCI to lie to Congress. To illustrate how the position freeze is hurting the cancer program, Director Frank Rauscher pointed out to the National Cancer Advisory Board that although there is a congressional mandate for a nutrition program, "we weren't given one body" to help run it. . . . **THE ADMINISTRATION** plans to stick with its request for only $605 million for NCI in FY 1976, despite the fact that when Congress killed the President's request to chop $123 million from the 1975 appropriations, that meant NCI will get $691 million in the current fiscal year. Rauscher said he still hopes that OMB will add $123 million to the request, but it isn't likely to happen. As usual, Congress will have to establish a realistic figure on its own initiative. The authorized figure for 1976 is $898.5 million, including $68.5 million for cancer control. . . . **BENNO SCHMIDT** reported to the NCAB that, when President Ford reappointed him chairman of the Cancer Panel, the President assured him he was a "staunch supporter" of the cancer program. Perhaps someone should point that out to OMB. If NCI doesn't get more than $605 million, it not only would severely limit any new initiatives, but would have to cancel a substantial number of existing grants and contracts. . . . **CONGRESS FORCED** the Administration to drop travel restrictions that had threatened to halt NCI site visits and other necessary travel by adding a provision to a bill needed to help save bankrupt railroads. The Administration supported the bill and had to accept the provision, which decrees that each agency can determine its own travel needs. Asked one NCI executive: "Does that mean we have to do our traveling by train?" . . . **RAUSCHER** and Vince DeVita, director of the Div. of Cancer Treatment, will appear on the CBS program, *"Face The Nation,"* Easter Sunday.

SUBCOMMITTEE SAYS SELECTION PROCESS NEEDS BETTER GUIDELINES, PROCEDURES

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in identifying and recognizing centers, including a more active role by the Board itself.

Hammond said the subcommittee agreed that there should be "respectable" new categories for centers that are not clearly specialized or comprehensive. Suggestions included categories for multidisciplinary cancer centers, coordinated cancer centers, community cancer centers, and consortiums of multiple institutions.

The subcommittee urged that NCI continue to support development of new comprehensive centers while not neglecting to strengthen existing ones. New centers should not be located where they would "dilute the effectiveness of existing centers," Hammond said, with distribution on a geographical basis.

Eight recommendations were submitted to the Board:

1. Program Objectives and Program Plan—A more clear statement of the objectives of the centers program and a long-range program plan should be formulated by NCI staff, assisted by the subcommittee, for consideration by the Board.

2. Characteristics and Criteria for Centers—NCI staff, assisted by the subcommittee, should improve, update, revise and extend the NCAB list of "characteristics" and "general considerations" concerning centers to develop criteria which will permit the evaluation of progress of individual centers and the centers program. It was noted that the present list of characteristics are useful for purposes of recognizing centers which have developed programs justifying their recognition as comprehensive or nearly so, but are not sufficiently specific to permit evaluation of progress.

3. Use of Cancer Centers as a Program Resource for all NCI Divisions—All NCI divisions and offices should be asked to examine their missions and programs which may be especially relevant to cancer centers and to develop divisional and inter-divisional plans to use cancer centers wherever appropriate as a resource for accomplishing their missions within the National Cancer Plan.

4. Orientation and Coordination of Review Committees—A joint meeting be arranged of the three cancer center review groups and members of the Board for orientation to the objectives of the centers program and, further, that a handbook be developed for orientation and guidance of new members of review groups and ad-hoc site visitors, in order to provide more consistent evaluation and review of applications for the Cancer Centers Program. There was general discussion of the desirability of NCAB site visits for the purpose of evaluating emerging comprehensive centers, both prior to their recognition and at re-evaluation points.

5. Procedure for Identification and Recognition of Comprehensive Centers—Procedures should be adopted for the identification of centers which have developed sufficiently to qualify for consideration as comprehensive cancer centers and for the Board to make recommendations to the NCI director for their recognition as such, following review by the Subcommittee on Cancer Centers and site visits by members of the Board and appropriate ad-hoc consultants.

6. Policies for Award of Construction Grants—The draft document "Policy Considerations on Award of Construction Grants" will be reviewed by Subcommittee members and considered for future action at a subsequent meeting. (See below.) There was discussion of the need for more effective coordination between cancer center review groups including the possible appointment of liaison members from one review group to another during meetings and possibly at site visits.

7. Liaison Among Centers Program Review Groups—Appropriate liaison should be established among the review groups of the cancer centers program and between the Subcommittee on Cancer Centers and review groups.

8. Meeting of Comprehensive Center Directors—At the next meeting of center directors, a half day should be spent in identifying the problems which people in the field are having in trying to develop centers, especially new comprehensive centers.

Hammond said subcommittee members were concerned about the absence of a clear statement of objectives and goals and an organized plan for cancer centers. Expectations of the program might be different if viewed from the different standpoints of Congress, NCAB, Office of Management & Budget, review committees, universities, the basic science community, clinical scientists, practicing health professionals and the public, Hammond said.

NCI Director Frank Rauscher had indicated to the subcommittee that he could use some help in the pressure-packed task of identifying new comprehensive centers. It was his suggestion that NCAB be more active in the selection process.

Rauscher said a mechanism should be established to ensure that recommendations for the recognition of comprehensive cancer centers would be based always on scientific merit but also on geographic location and on program requirements to avoid decisions influenced by pressures from institutions, OMB, members of Congress, the public and other parties interested in the National Cancer Program.

OMB remains adamant in its determination to prevent Rauscher from carrying out his legislative mandate to establish as many comprehensive cancer centers as he and the Board determine are necessary to meet the requirements of the National Cancer Program. OMB wants no more than 20 or 21; Rauscher feels 30 eventually will be needed.

There are 17 comprehensive centers now. Three or

four others are going through various stages of organization now and probably could be recognized this year by NCI. Rauscher may elect to hold back on two or three, to give them more time to get their programs in order and to delay with showdown with OMB.

When that showdown does come, OMB will be the winner, at least temporarily, since it is a White House staff office and acts in the name of and with the consent of the President. But a direct refusal by OMB, or the President, to permit Rauscher to announce that a specific center should have comprehensive status would open the way for that center to seek relief in the courts. The law is clear in giving the NCI director sole authority to establish comprehensive centers, and Congress specifically refused the Administration's request to limit the number of such centers when it extended the National Cancer Act last year.

The Board accepted the subcommittee's report, but reserved the right to further consider the recommendations.

SUBCOMMITTEE LOOKS AT CONSTRUCTION GRANT POLICY; NEW RULES PROPOSED

The list of policy considerations for the award of construction grants which the Subcommittee on Centers will take up at a future meeting includes the following points:

* Geography—is there a regional need?
* Credible dedication to cancer by top institutional officials.
* Evidence of local support—institutional, community, budget, staff, program, other facilities related to cancer, other resources related to cancer.
* Administrative organization—status, authority, stability, effectiveness, efficiency.
* Comprehensive center potential—is it there?
* Strong academic relationships.
* Impact of proposed construction on existing cancer program and existing cancer facilities.
* Fulfillment of characteristics and guidelines established by the National Cancer Advisory Board.
* Merit review of site visitors and priority score assigned by reviewers.

Hammond's presentation to the Board, which included this list, coincided with publication in the *Federal Register* (March 17, page 12092) of proposed rules for NCI construction grants.

Technically, the new rules implement the authority of the NCI director to award grants for new construction of basic research facilities in addition to clinical cancer research centers.

NCI was given construction authority in the 1971 National Cancer Act. This was interpreted as being restriction to clinical research facilities, so in the 1974 amendments to the Act, specific authority was given for basic biomedical research and for biohazard control facilities.

Ironically, the proposed rules explicitly provide for NCI support of new construction, as well as for alterations and renovations. The Office of Management & Budget has refused to permit grants for new construction, except when such construction can be construed as filling in "shell space", and in the case of the new cancer center at Einstein in New York.

Donald Fox, chief of NCI's research facilities construction branch, said the proposed rules will not substantially change existing procedures. One new provision is the rule requiring compliance with the health planning act Congress passed last year, which limits development of health facilities to those approved by state health planning agencies.

Those who wish to comment on the proposed regulations may send them to NCI, Bldg 31, Room A-52, Bethesda, Md. 20014.

AACI TASKS FOR COOPERATIVE ACTION, COMMON PRACTICES" OUTLINED TO NCAB

A "comprehensive plan for developing cooperative action and common practices among cancer institutes" has been drawn up and approved by members of the Assn. of American Cancer Institutes.

R. Lee Clark, AACI president (also president of the Univ. of Texas System Cancer Center which includes M.D. Anderson, and member of the President's Cancer Panel), outlined the comprehensive plan for the National Cancer Advisory Board.

The plan consists of 12 tasks which all member institutions are committed to implement through NCI contracts. Each task area is assigned to a lead institution for planning and coordination, with team members from other institutions participating.

The tasks are grouped into six areas:

- Business management—Task 1, financial profiles; task 2, data management; task 6, organization and management.
- Information management—Task 3, nomenclature; task 4, registries; task 5, biostatistics systems; task 7, literature systems.
- Research management—Task 9, research management; task 10, clinical research.
- Patient management, task 8.
- Education, task 11.
- Cancer control, task 12.

Much of the work is already in progress, and has been gathered into the AACI planning effort. Contracts for tasks 1, 3, 4 and 5 were awarded last year; the rest will be implemented this year, according to the plan.

Chairmen and lead agencies for each task are:

Task 1, Robert Goehle, Roswell Park; task 2, Stuart Zimmerman, M.D. Anderson; tasks 3, 4 and 5, Robert Hickey, M.D. Anderson; task 6, H. Donald Putney, Fox Chase; task 7, Marie Harvin, M.D. Anderson; task 8, David Carr, Mayo; task 9, Henry Pitot, Univ. of Wisconsin; task 10, Gordon Zubrod, Univ. of Miami; task 11, John Spratt Jr., Cancer Research

Under this program, the contractor will provide in-patient bed space, space for out-patient visits, laboratories and offices. The contractor will also provide doctors, nurses, nurses aides, technicians, laboratory personnel and other such personnel necessary for staffing and operating a gastrointestinal program.

Areas of research to be included in the program are as follows:

1. De velopment of methods for early detection of GI malignancies.
2. Evaluating the role of staging in management of patients.
3. Systematic investigation of new and established agents in GI cancer.
4. Development of new combinations and multi-disciplinary approaches in GI cancer.
5. Detailed pharmacologic evaluation of single and combined agents in GI cancer.
6. Biochemical and immunochemical evaluation of markers of tumor cell number.
7. Training of health professionals in GI cancer.

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RFP NCI-CM-63810

Title: *Hematology support care project*
Deadline: *May 2*

The Experimental Hematology Section of the Medical Oncology Program, DCT, has an extensive histocompatibility capability. This histocompatibility competence has greatly enhanced the selection of histocompatible platelet transfusion donors. In order to select compatible leukocyte transfusion donors, it is important that all recipient serum available be tested against leukocyte donors. The assays for leukoagglutination are time dependent in that leukocyte samples cannot travel great distances without interfering with the reproducibility of results.

The contractor will supply the following services:

a. Conduct a variety of leukoagglutination assays of prospective human recipient sera against prospective donor peripheral leukocytes, in an effort to ascertain the optimal recipient-donor combinations to be employed for supportive clinical cell transfusions. (Microleukoagglutination Capillary Migration.)

b. Conduct micro-lymphocytotoxicity assays on serum samples from patients, in an effort to ascertain the presence, level and specificity of humoral antibody directed against specific and random donor lymphocytes in these individuals following supportative clinical transfusions and/or bone marrow transplantations.

Volume of work in items a and b will not exceed, on a daily (weekday) basis, 12 serum-call interactions of any combination of assays, and on weekends or holidays that amount of work which be accomplished by one technician.

c. Ascertain the granulocyte phenotype of patients and prospective donors, employing reference granulocyte typing sera in a modified micro-lymphocytotoxixity type of procedure, in an effort to ascertain the optimal recipient-donor combinations to be employed for supportive clinical cell transfusions.

d. Conduct micro-granulocyte cytotoxicity screening assays and absorption studies on serum samples from patients, in an effort to ascertain the presence, level and specificity of humoral antibody directed against specific and random donor granulocytes, in these patients following supportive clinical cell transfusions and/or bone marrow transplantations.

e. Maintain a systematic frozen repository of all serum and/or plasma samples obtained from the patients, relatives, and normal donors under study in this program.

f. Arrange for the routine pick-up each morning and/or afternoon of the blood samples for assay or storage and for the routine delivery of the completed and evaluated assay results.

g. Arrange, when necessary for the pick-up of blood samples, performance of the required assays and reporting of the test results and evaluations.

h. Perform other histocompatibility assays, evaluations and service or modifications of the proposed techniques, as requested by the Project Officer.

i. Arrange to have the capability for performing leukocyte compatibility assays on a seven-day-a-week basis.

j. Provide reporting forms which will clearly depict the results of the compatibility studies and recording systems which will permit accurate storage and retrieval of pertinent serial laboratory studies for individual patients and potential blood donors.

k. When technical personnel are not committed to human blood studies they will conduct a variety of leukoagglutination and micro-lymphocytotoxicity assays between combinations of animal sera and cells, as part of the experimental preclinical transfusion program.

Because the assays for leukoagglutination are time dependent, it is necessary that any contractor have a local capability for testing of the preformed anti-leukocyte antibodies.

The government estimates that performance of these services will entail approximately four man-years of effort per year.

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