THE CANCER LETTER
RESEARCH
EDUCATION
CONTROL

Vol. 3 No. 30

July 29, 1977

P.O. BOX 2370 RESTON, VIRGINIA TELEPHONE 703-620-4646

Subscription $100 per year

CANCER CONTROL EMPHASIS SHIFT TO PREVENTION PROJECTED FOR FY 1978; ADVISORS SEEK MORE

NCI's Cancer Control Program will undergo a major change in emphasis within the next two years, moving an increasing share of the Div. of Cancer Control & Rehabilitation budget into grant and contract

(Continued to page 2)

In Brief

NCI GETS $867 MILLION FROM CONFEREES; GRANTS TO BE FUNDED AT 41-42% INCLUDING SOME HOLDOVERS

HOUSE-SENATE conferees agreed on $867 million for NCI in the FY 1978 appropriations bill. This was 40% of the difference between the House figure of $831.9 million and the Senate's $920 million. This will enable NCI to fund 41-42% of approved traditional grants, considerable improvement over the 30% funded in fiscal 1977. So many excellent grants went unfunded this year that NCI will carry over $14 million worth for funding in 1978. Cancer Control will get $63.5 million in the 1978 budget. . . . **SEN. EDWARD BROOKE** (R.-Mass.) carried the ball for NCI in the conference. Rep. David Obey (D.-Wisc.) wanted the conference to hold NCI to $838 million, and Joseph Early (D.-Mass.) offered a motion to give NCI $851 million. Early said HEW Secretary Joseph Califano claimed NCI could spend effectively only $850 million. The Early motion appeared to be heading for approval when Brooke said that if it were adopted, he would recommend to the Senate against approving the entire conference report. Sen. Warren Magnuson (D.-Wash.) agreed with Brooke, and then the other senators lined up with them, killing Early's motion. Rep. Neal Smith (D.-Iowa) suggested the compromise at 40% and it sailed through. Earlier, Rep. Silvio Conte (R.-Mass.) tried to give NCI $875 million, 50% of the difference, but his motion was defeated. . . . **RESEARCH DEVELOPMENT** Program Grants, the American Cancer Society's new rapid-funding short-term grants program, "is coming along very well," according to Frank Rauscher, ACS senior VP for research. Sixty applications have been submitted and 14 funded, with 20 more being processed. Peer review was accomplished in 60 days, compared with the nine to 16 month review cycles required for other ACS grants and for most NCI grants and contracts. Rauscher said the review groups have had no difficulty in reviewing for scientific merit but have had some trouble in determining the need for urgency, a prime requirement for the program. ACS has budgeted $5.6 million for the program, which will award up to $50,000 (most will not exceed $15,000) for periods of up to a year (***The Cancer Letter,*** April 15). . . . **NATIONAL CANCER** Advisory Board meeting Sept. 19-20 will include a report by Board member William Powers on computerized tomography for diagnostic radiology and a report on special training programs for epidemiologists by Marvin Schneiderman, who heads NCI's Field Studies & Statistics Branch.

NEW NURSING, CLINICAL PROGRAMS AXED AS EMPHASIS SHIFTS TO PREVENTION

(Continued from page 1)

supported projects in prevention.

DCCR Director Diane Fink told the division's advisory committee at its special budget planning meeting that staff projections called for increasing the prevention share of the budget from 13% in the current fiscal year (1977) to 25% in fiscal 1979.

When the committee completed going through the staff suggestions for top priority new projects to be funded in fiscal 1978, however, members noted that most of the emphasis was still in treatment, rehabilitation and diagnosis.

"If five-sixths of our free dollars are being put into new treatment programs and those other than prevention, then we're not really making the shift," commented committee member Joseph Painter.

"All of this has to be of lower priority than prevention and detection," agreed committee member Hamblin Letton.

"If our mission is cancer control, prevention has to have first priority," said committee vice chairman Oliver Beahrs.

Fink had asked the committee for advice on how to spend the $4.7 million in "free" money DCCR expects to have in FY 1978. That figure was based on an appropriation of $64 million for the division; a few days later, House and Senate conferees agreed on $63.5 million, which presumably will cut the "free" total to $4.2 million.

Fink said staff has estimated that as much as another $1.4 million might be reprogrammed from existing projects, bringing the total of uncommitted money available for new programs to $5.5-6 million. The staff's projection for new high priority prevention programs in FY 1978 would commit about $1 million of that amount. "If the committee feels that we should have an additional amount, then we'll need another meeting for more suggestions," Fink said.

"It is appropriate that we increase the emphasis on prevention, and it deserves a greater expenditure than $1 million," Beahrs said.

"Provided we get good project proposals," added committee member Harold Rusch.

Existing DCCR projects and those proposed new ones were suggested to the committee at its spring meeting (*The Cancer Letter*, May 13). The discussion at the July meeting was centered around those proposals.

Here are the top priority projects in prevention:

★ Chemical carcinogen control program. Stanford Research Institute has been working on a contract which expires this year, to survey exposure to chemical carcinogens and recommend control and intervention programs, at a cost of $600,000 in FY 1977. DCCR proposed recompeting this project, in two sections—the scientific portion, and one to develop community strategies for handling carcinogens. Total cost would be about the same, around $500,000 for the two.

SRI developed dossiers on 148 chemicals. Twenty were selected for development of control or intervention measures to limit human exposure.

"It's one thing to find out what's dangerous, and another to recommend what to do about it," said committee member Harold Mendelsohn. "The only thing I can think of is to get away from them."

"From chemicals in general?" asked committee Chairman William Shingleton. "Yes," Mendelsohn said.

★ A $500,000 grant program to help communities study their environmental carcinogenesis problems. "There's a lot of interest in communities that are red dots on the (cancer incidence) maps," Fink said. The grants might be made through cancer centers and state health departments.

Committee member Diane Komp, who has served on groups conducting merit review of DCCR contracts, commented that review had found "money has disappeared into state health departments. . . . Unless pressured by Congress, I certainly wouldn't recommend going that way again." The contracts were for cervical cancer screening.

John Goldschmidt, who is chairman of the Cancer Control Community Activities Review Committee, criticized antismoking education efforts aimed at high school students. "Someone has said we would be better off if we put our money into traditional education, so students could read 'No Smoking' signs," Goldschmidt said.

Some of the projects suggested by staff were—implementation of a model type cancer prevention program in a comprehensive cancer center; implementation of a model type cancer prevention program in a community based cancer control effort; development and implementation of prevention programs to serve specific needs of a community served by a comprehensive cancer center; implementation of smoking cessation programs in community based cancer control efforts and in cancer centers; and implementation of a program to encourage innovative community level public education projects on smoking.

The staff had suggested that those organizations which had competed successfully for the community based cancer control contracts could be offered opportunities to increase their prevention emphasis. However, Fink said that those programs already have sufficient emphasis on prevention and probably would not be considered for additional funding.

★ Radiation physics centers. Fink called this "an excellent program" which will continue to receive high priority. Six regional centers received a total of $987,000 in FY 1977 to review and monitor physics capabilities for DCCR diagnostic and therapeutic

programs. This includes monitoring calibration of radiotherapy units and establishing protocols. The cost will go up to $1.2 million in fiscal 1978 plus another $250,000 to the American Assn. of Physicists to coordinate the program.

The asbestos and vinyl chloride workers surveillance programs will be continued in 1978 but the contracts will be negotiated downward. Fink said no new surveillance efforts nor major new screening programs will be undertaken until results of the existing ones can be analyzed and their value assessed.

The increased emphasis on prevention will be accomplished by a decrease in emphasis in other DCCR intervention areas—treatment, rehabilitation and continuing care; and detection, diagnosis and pretreatment evaluation.

The new treatment projects suggested by the DCCR staff would use up about $5 million of the 1978 money available for new programs, which prompted Painter's remark. But three of them were eliminated when they first were relegated to a lesser priority by the committee in weighing them against other new treatment programs and then written off altogether by the decision to upgrade prevention.

Those knocked off the list, for 1978 at least, were proposals to support development of master's level nurse oncology programs, start a new community clinical oncology program, and to expand DCCR's support of the Clinical Cooperative Groups.

The nurse program was estimated to cost $600,000, and the new community clinical oncology program $1.5 million. No estimate was given on the cooperative group expansion, but eliminating the three would save in excess of $2 million.

DCCR has supported an oncology nurses training program, costing $572,000 in FY 1977, which is coming to an end. The existing community clinical oncology program involves seven contracts with community hospitals totaling $1 million a year. It will continue through next year at about the same level. DCCR funds an effort by the cooperative groups (which are primarily supported by grants through the Div. of Cancer Treatment) to expand their activities into community hospitals at $1 million a year. The new program would have added additional cooperative groups to the project.

Highest on the priority for treatment, rehabilitation and continuing care was a grant program for studies in cancer pain and pain control. Staff estimated these would cost about $500,000. Other programs with high priority include patterns of care in surgery, $300,000, grants; miscellaneous rehabilitation grants, $400,000; psychosocial rehabilitation grants, $400,000; and reimbursement studies for home health care and outpatient drugs, $50,000, contracts.

Fink noted that "we can't turn down grant applications, no matter what priorities we establish." She said the grant money for the entire division "will be in one pool." Applications will be reviewed and given priority scores and will be funded by priority. Thus, the adivosry committee's thrust toward prevention could be thwarted by the failure of applicants for prevention grants to compete effectively with others.

DCCR funded grants in the 100-250 priority score range in 1977 and expects to do the same in 1978.

Existing treatment/rehab projects that will continue with high priority are the breast cancer networks, $4.3 million; head & neck cancer networks, $2.7 million; hospice concept demonstration, $900,000; at home rehabilitation, $325,000; and enterostomal therapy training, $400,000. These are in addition to the community clinical and cooperative group programs.

The division funded 42 rehabilitation research grants in 1977, totaling $3.3 million; they will cost $1.1 million in 1978, with a substantial number of the grants expiring.

Fink said DCCR is considering extending the networks past the three-five year periods included in the original contracts.

The only major new initiative in detection, diagnosis and pretreatment evaluation suggested by staff was development of nine pathology reference centers, at a cost of $1.5 million in 1978. The committee shot that down, but Fink later said it would be brought back at the committee's October meeting, when further discussions on new programs will be held.

Painter suggested that the money budgeted for pathology centers could be better spent elsewhere. "It would be more prudent to make references available on an ad hoc basis than fund nine centers." Letton commented, "The pathologist who will ask for help is already getting it. Those who don't, won't, no matter what."

The thermography technologists training program, costing $30,000 a year, was knocked out after Letton observed, "This training is useless considering the state of the art. . . . They get less than 58% positives of cancer found."

One of DCCR's top priorities this year will be core support grants to cancer centers with community outreach programs. Although designed primarily for the comprehensive cancer centers, which are required to have outreach programs, they will be available to other centers with such programs.

Staff had planned for the core grants to be a maximum of $300,000, but Shingleton said he thought $200,000 would be sufficient for basic staff, public education, planning and evaluation that would be covered by the grants. Fink agreed to the $200,000 limit.

Here's how the DCCR FY 1978 budget "best guess" breakdown is at this point:

$63.5 million total, up from $59 million in 1977.

Overhead—staff salaries, travel, committee costs, maintenance, etc.—$4.1 million.

Extramural (grants and contracts)—$59.4 million.

Committed to existing grants and contracts–$55.1 million ($42.5 million contracts, $12.5 million grants).

UPTON APPOINTMENT STILL NOT OFFICIAL; WHITE HOUSE SAYS "COUPLE OF WEEKS"

Arthur Upton had hoped to start work as director of NCI last Monday. That day came and went, however, and the White House still had not announced the appointment.

Rumors started circulating that (A) HEW Secretary Joseph Califano was still sitting on the recommendation and had not sent Upton's name to the White House, and (B) that President Carter may not have been satisfied with the recommendation and was having some second thoughts about it.

The White House personnel office laid the first rumor to rest. A spokesperson told ***The Cancer Letter*** that Califano's recommendation had been received and was still being processed. The spokesperson said that the announcement probably would not be made "for a couple of weeks."

One HEW official observed that Califano was a product of the Johnson Administration. "When LBJ was getting ready to make an appointment, if the name of the person was leaked before Johnson could make the announcement, as Upton's was in this case, LBJ frequently withdrew it and named someone else. No one was going to upstage him."

It apparently is out of Califano's hands now, and Carter is not a Johnson alumnus. Most of his other appointments have been leaked; those that did not go through were withdrawn either because of congressional pressures or at the request of the appointees themselves.

NEW MAMMOGRAPHY GUIDELINES CUT USE BY WOMEN UNDER 50 FROM 75 TO 25%

The interim guidelines for mammography in the Breast Cancer Detection Demonstration Project issued by NCI last year, aimed at reducing the number of asymptomatic women in the project under age 50 receiving mammography, did not have as much impact as desired. Six months later, 75% of those women were still receiving mammography.

The Cancer Control & Rehabilitation Advisory Committee last May recommended further restrictions, this time limiting mammography for asymptomatic women under 50 to two high risk groups–those with a previous history of breast cancer, and those whose mothers or sisters had had the disease.

DCCR Director Diane Fink told the committee at its July meeting that the new guidelines were taking effect–the number of women under 50 receiving mammography in the project dropped from 75% to 25% in May, and the number in June was less than 25%.

Committee vice chairman Oliver Beahrs, head of general surgery at Mayo Clinic, is chairman of the group commissioned to study the results of BCDDP. He said the committee "has a reasonable chance to reach a consensus on most issues" this month and can then start writing its final report. The committee plans to have all of its recommendations ready by the "consensus meeting" NIH will hold Sept. 14-16 on the issue of mammography screening.

Fink said NIH Director Donald Fredrickson is lining up a "panel of experts" in oncology, general medicine, law, theology, epidemiology, radiology, and radiation biology as well as some lay persons. The panel will review data from the HIP study, the Upton, Breslow and Thomas reports which were sponsored by NCI to study the benefits and dangers of mammography, and the report of the Beahrs group. It will hear from the critics of mammography, the diagnostic radiologic aspects of mammography and how the techniques have changed since the HIP study, and from the BCDDP project directors. Four hours will be reserved for the public, with each speaker allowed 10 minutes.

Beahrs commented that he hopes the panel will "come to a firm position after the meeting. . . . It will be unfortunate if action by the panel is delayed. That would confuse the public. The panel needs to act immediately."

National Cancer Advisory Board Chairman Jonathan Rhoads noted that clearances of the report by NCI, NIH and HEW would take two to three months. Fink said that probably would be the case, but that she hoped a verbal report could be available immediately.

Beahrs said the report of his group would be available to the panel members two weeks before the meeting.

NEW SEER RFP SEEKS CHEAPER COLLECTION OF DATA, BETTER INFORMATION SOURCES

NCI's Sources Sought announcement of a proposed study of alternative methods for gathering data in its $5 million a year SEER program (***The Cancer Letter***, July 22) did not reflect dissatisfaction with that program, according to Marvin Schneiderman, associate director for Field Studies & Statistics in the Div. of Cancer Cause & Prevention.

Schneiderman said that he had become concerned with two factors in SEER (Surveillance, Epidemiology & End Results Reporting): "First, gathering of survival data is very expensive. Maybe we can accomplish the same thing with sampling. Do we really have to follow every breast cancer case (in the population centers covered by SEER), or will samples give us just as good survival data?

"Second, we are looking for potential sources other than population based registries. Those registries aren't necessarily representative of the population, but only where there are people capable of doing them. They are okay on trends, but may not

be truly representative."

The RFP (NCI-Cp-FS-71047-55) will be issued to organizations qualified to assess the present SEER program on adequacy of its population coverage and to evaluate data acquisition procedures. The contractor will be asked to suggest alternative sampling methods and differing or supplemental sources of data, and to design feasibility studies for the field testing and evaluation of proposals for any methods suggested.

Any alternatives or changes will have to be consistent with the present objectives of SEER: Collection of data necessary to assess the trends in cancer incidence, the utilization and outcomes of different therapeutic modalities, and the survival of cancer patients.

Resumes of capabilities should be sent to Fred Shaw, contract specialist, Viral Oncology & Field Studies, NCI, Landow Bldg, Bethesda, Md. 20014, phone 301-496-1781.

QUESTIONS RAISED BY COMMITTEE KILLS, MERGERS ARE STILL NOT RESOLVED

The demise of four major NCI advisory groups (*The Cancer Letter,* July 22) has left one question unresolved: What provision will be made for peer review of intramural scientists working on two major programs in the Div. of Cancer Cause & Prevention—Viral Oncology and Carcinogenesis?

One of the primary missions of both the Carcinogenesis and Virus Cancer Scientific Advisory Committees, both now dead, was to conduct periodic peer review of intramural research in those areas. The committees also were charged with developing advice on extramural research—that function now is expected to be performed with the help of workshops, at least in Carcinogenesis.

The Virus Cancer Program was subjected to a flood of criticism in the early 1970s which led to appointment of a group of non-government scientists headed by Norton Zinder to study the program and offer suggestions for improvement. The committee recommended, among other things, that the intramural and extramural aspects of the program be separated, and that an advisory committee be established to provide an overview of the program and to conduct peer review of intramural research.

NCI complied with those recommendations, but that committee is now out of business.

NCI staff members have been meeting to discuss the implications of the committee phaseouts, and the question of peer review of DCCP scientists is a question yet to be resolved. The other two NCI divisions with intramural research programs—Biology & Diagnosis and Cancer Treatment—have boards of scientific counselors who perform that task. Those boards were left untouched.

One suggestion was that the Clearinghouse on Environmental Carcinogens could provide review of carcinogenesis intramural research, and that the virus program technical review committees could add review of intramural virus research to their tasks.

The merger of various technical review committees which review contract proposals apparently can be handled with no serious difficulties. Those are the Carcinogenesis Program Scientific Review Committees A and B; Virus Cancer Program Scientific Review Committees A and B; the Cancer & Nutrition and Diet & Cancer Scientific Review Committees; the Developmental Therapeutics and Drug Development Committees; and Diagnostic Radiology Committee and Diagnostic Research Advisory Group.

Those committees were organized as dual committees with the same areas of expertise and responsibilities to permit committee members (or their institutions) to compete for contracts in their respective fields. If a member of Committee A submitted a contract proposal, it was reviewed by Committee B.

NCI expects that the conflict of interest problem will be handled now simply by requiring the member with a proposal in review to absent himself from that meeting.

The four Breast Cancer Task Force committees—Diagnosis, Epidemiology, Experimental Biology, and Treatment—will be combined into one. Conflicts will be avoided in the same manner. There apparently will be no restrictions preventing the combined committees from creating subcommittees along discipline lines and meeting separately.

NCI insists that the mergers will result in reduction in numbers of committee members over all. This will be accomplished to some extent through attrition, and with that in mind, vacancies on the affected committees have gone unfilled for several months. Some committees will have to be reduced through resignations, "and that could be touchy," one NCI executive said. There are some committee members who are serving only out of a sense of duty and who will not be unhappy at the prospect of leaving the committees and accompanying drain on their time and energies. There are others, however, who feel their committee memberships are prestigious, and/or who like the pay of $100 a day plus expenses (some must turn in that pay to their employers, some do not). Those individuals may resist being put off their committees.

NCI expects the savings will be about $800,000, less the remedial costs of using individual consultants, workshops, etc.

Perhaps the mergers which will be the most difficult to effect will be the organ site working cadre groups—Bladder, Prostatic, Large Bowel and Pancreatic.

The organ site projects are not headquartered at NCI but at four separate, geographically scattered institutions—Bladder at St. Vincent Hospital in Worcester, Mass.; Prostatic at Roswell Park Memorial Institute, Buffalo; Large Bowel at M.D. Anderson,

Houston; and Pancreatic at Louisiana State Univ., New Orleans.

The merger will be applied only to the working cadre, not to the programs themselves. It was proposed as a "two by two" merger—the Bladder and Prostate Cadre in one group, Large Bowel and Pancreas in the other.

At best it will be awkward; at worst, impossible without considerably hindering the entire Organ Site Program.

When the National Cancer Advisory Board decided to back development of an investigator-initiated, grant supported program for concentrated research on the more difficult and deadly cancers, Board members and NCI staff agreed to decentralize program planning and administration, including review of grant applications. It was intended to extend the investigator-initiation concept, place more of the program in the hands of nongovernment scientists, and save personnel slots at NCI.

NCI staff members feel it has worked out very well, "although the degree to which is has is variable," said one. The three older programs—large bowel, prostatic and bladder—have handled the administration and planning "reasonably well, and very well for the most part." The pancreatic project started too recently and its budget has been too limited to make a judgment yet on it.

The program's concept was not universally favored among NCI advisors and other scientists, and as a result, it has been carefully scrutinized from the start. One NCAB review compared priority scores attained by principal investigators receiving organ site grants with the scores the same investigators received on applications in more established review. They compared favorably, convincing NCI and the organ site participants that their review and standards were every bit as good as those of NIH study sections.

One of the main objectives of the organ site program is to bring together clinical and laboratory scientists, primarily through workshops. NCI feels that aspect has been very successful so far, based on the enthusiasm displayed at the workshops and the continuing dialogue developed there between the two groups.

Those involved with the program feel that the working cadre mergers may be workable only if the total membership is not diminished. Each cadre has quite different expertise from the others, and to reduce the numbers would weaken the program. The primary way the merger can bring about any savings, however, is through reduction in numbers of committee members, and NCI feels "when the other shoe drops"—the order to cut numbers—the problems will start.

The other way to save money would be to reduce the number of meetings. If that happens, another of the important unique features of the program would be lost—the ability to move grant applications through the system faster than through the traditional route.

The cadre have been meeting four times a year, and they can submit grant pink sheets (summaries of the review) to the Board for mail ballot. "If we're cut back to three times a year, we'll be right back on the old schedule," an NCI executive said.

The cosmetic combination of the four groups into two will not pose any substantial problems unless efforts are made to force them to hold their meetings at the same time and place. If the bladder-prostate group can split into a bladder subcommittee and a prostate subcommittee, with the former meeting at St. Vincent and the latter at Roswell Park, then no damage will be done, provided of course the subcommittee membership remains at a level required to do the job.

That might not save any money, but it would let the Administration add two more "agencies" to the number it has "eliminated" in the name of "economy" and "efficiency."

If dollar reductions are attempted by slashing the numbers, any economies would be even more phony. The quality of review and the scientific excellence of the research eventually would be diminished, and NCI and the taxpayers would be getting less for their dollars.

The silliness of this is so obvious that NCI has appealed to NIH to ease up, at least on the organ site cadre mergers. NIH has the authority to permit modifications of the merger plans, provided equivalent (supposed) savings can be obtained elsewhere.

* * * * * * * *

Another merger that some NCI staff feel could compromise peer review is that combining the Clinical Cancer Program Project Review Committee with the Cancer Centers Support (Core) Review Committee.

Those grants invariably involve complicated and extensive site visits. Pressures will be applied to reduce the number of visits and number of people making them. On the other hand, there are those who feel that combining core and program project review would give the reviewers a better overall picture of each center.

ACS-ELEANOR ROOSEVELT FELLOWSHIPS AWARDED TO 18 INVESTIGATORS

The American Cancer Society announced 18 ACS-Eleanor Roosevelt International Cancer Fellowship grants totaling $349,678. These grants will enable six U.S. investigators to pursue cancer research abroad and will allow 12 foreign investigators to work both here and in countries other than their own.

The 1977-78 awards bring the total number of

scientists served by the program to 316 since its inception in 1961. The program is an effort to further international cooperation in the fight against cancer. The fellowship program is funded by ACS but it is administered by the International Union Against Cancer (UICC).

Each fellow will have an opportunity to work with outstanding scientists in leading institutions. At the close of the fellowship period, participants will return to their home institutions to continue research and teaching responsibilities. In their educational roles they will have the chance to share knowledge gained in their time abroad.

The 1977-78 fellows have a wide range of research interests. Among these areas of study are viruses that cause cancer in animals, processes of normal and abnormal cell growth, and the body's immune defense system and its relation to cancer. Specific questions are the influence of hormones on the development of breast cancer and the high rate of stomach cancer in Japan.

The fellows, who were selected by an international committee of cancer researchers, will receive grants ranging from $9,844 to $30,616, depending on the amount of support continued by the fellow's home institution.

These awards will permit scientists from California, Pennsylvania, Connecticut, Rhode Island, Massachusetts and Utah to work abroad. Others from Bulgaria, Czechoslovakia, France, Hungary, Israel, Japan and Switzerland will work in the United States. In addition, an Italian scientist will work in Holland and a Canadian-based scientist, who is an American citizen, will work in Japan.

Following are the 1977-78 fellows:

Cestmir Altaner, (Czechoslovakia) to the McArdle Laboratory for Cancer Research, Univ. of Wisconsin.

Michael Finkelstein, (Hadassah Medical School, Jerusalem) to the Univ. of Louisville Medical School.

Leon Goodman, (Univ. of Rhode Island) to Fondation Curie-Institut du Radium, Paris.

John Furth, (Univ. of Pennsylvania) to Maischal College, Aberdeen, Scotland.

Irving Goldschneider, (Univ. of Connecticut) to Walter and Eliza Hall Institute of Medical Research, Victoria, Australia.

Bernhard Hirt, (Swiss Institute for Experimental Cancer Research, Univ. of Lausanne) to Cold Spring Harbor Laboratory, New York.

Carl John Pfeiffer, (Faculty of Medicine, Univ. of Newfoundland, Canada) to the Kyoto Univ. Medical School, Japan.

Alfonso Colombatti (Laboratory of Experimental Oncology, Padua, Italy) to the Netherlands Cancer Institute, Amsterdam.

Edwin Lowell Cooper, (UCLA) to the Swiss Institute for Experimental Cancer Research, Univ. of Lausanne.

Haim Manor, (Israel Institute of Technology, Haifa) to the California Institute of Technology.

Toyozo Maeda, (Kyoto Univ., Japan) to Stanford Univ.

Jean Andre, (Univ. of Montpellier, France) to NCI, Bethesda.

Jordon Stoychkov, (Oncological Research Institute, Sofia, Bulgaria) to NCI, Bethesda.

Frank O'Neill, (Univ. of Utah Medical Center) to the Univ. of Erlangen-Nurnberg, Germany.

Lajos Dobrossy, (Oncopathological Research Institute, Budapest, Hungary) to Roswell Park Memorial Institute, Buffalo.

Masamitsu Futai, (Univ. of Tokyo) to Cornell Univ., Ithaca, N.Y.

Hisano Ohkura, (National Cancer Center Hospital, Tokyo) to Massachusetts General Hospital, Boston.

Walter Hughes, (Tufts Univ., Boston) to the Swiss Institute for Experimental Cancer Research, Univ. of Lausanne.

ADVISORY GROUP, OTHER CANCER MEETINGS FOR AUGUST, SEPTEMBER

Clearinghouse on Environmental Carcinogens Executive Subgroup—Aug. 1, NIH Bldg 31 Room 10, 8:30 a.m.—5 p.m., open.

Virus Cancer Program Scientific Review Committee A—Aug. 4, NIH Bldg 37 Room 1B04, open 9—9:30 a.m.

President's Cancer Panel—Aug. 5, NIH Bldg 31 Room 7, 9:30—10:30 a.m., afternoon session if required to start at 2 p.m., open.

Committee on Cancer Immunotherapy—Aug. 18, NIH Bldg 10 Room 4B14, open 1:15—1:45 p.m.

VIIIth International Symposium on Comparative Research on Leukemia & Related Diseases— Aug. 22-26, Amsterdam.

Diet & Cancer Scientific Review Committee—Aug. 23-24, NIH Bldg 31 Room 10, open 8:30—9:15 a.m.

Cancer & Nutrition Scientific Review Committee—Aug. 23-24, NIH Bldg 31 Room 9, open 8:30—9:15 a.m.

Clearinghouse Chemical Selection Subgroup—Aug. 29, NIH Bldg 31 Room 10, 8:30 a.m.—5 p.m., open.

Clearinghouse Experimental Design Subgroup—Aug. 30, NIH Bldg 31 Room 10, 8:30 a.m.—5 p.m., open.

Committee on Cancer Immunobiology—Aug. 31, NIH Bldg 10 Room 4B14, open 2—2:30 p.m.

General Oncology & Hematology—Sept. 1, Roswell Park continuing education in oncology, contact Claudia Lee.

Committee on Cancer Immunodiagnosis—Sept. 2, NIH Bldg 10 Room 4B14, open 1—1:30 p.m.

American Cancer Society Conference on Human Values & Cancer—Sept. 7-9, Palmer House, Chicago.

Current Concepts in Good Lab Animal Practice—Sept. 7-8, Cockeysville, Md., sponsored by National Capital Area Branch of American Assn. for Laboratory Animal Science. Contact Gene New, NCI.

Committee on Cancer Immunotherapy—Sept. 6-8, Landow Bldg Room C418, open Sept. 6, 7:30 p.m.—8 p.m., Sept 7 and 8, 8:30 a.m.—11:30 —11:30 p.m.

Large Bowel Cancer Project Working Cadre—Sept. 8-9, Anderson Mayfair Hotel, Houston, open Sept. 8, 7:30—8:30 p.m.

Cancer Research Manpower Review Committee Subcommittee on Manpower Needs—Sept. 12, NIH Bldg 31 Room 7, open 9 a.m.—3 p.m.

Clearinghouse Executive Subgroup—Sept. 12, NIH Bldg 31 Room 10, open 8:30 a.m.—5 p.m.

Bladder Cancer Project Working Cadre—Sept. 12-13, Logan Hilton, Boston, open 8:30 a.m.—5 p.m.

NIH Consensus Meeting on Mammography—Sept. 14-16, time and place to be determined, all open.

Developmental Therapeutics Contract Review Committee—Sept. 14-16, Blair Bldg Room 110, open Sept. 14, 8:30–9:30 a.m.

Virus Cancer Program Scientific Review Committee B—Sept. 15-16, Landow Bldg Room C418, open Sept. 15, 9–9:30 a.m.

National Cancer Advisory Board Subcommittee on Construction—Sept. 18, 7:30 p.m., NIH Bldg 31 (Room to be assigned), open.

NCAB Subcommittee on Centers—Sept. 19, 8:30–10 a.m., NIH Bldg 31 (Room to be assigned), open.

NCAB Subcommittee on Planning & Budget—Sept. 19, 8:30 a.m., NIH Bldg 31 Room 6, open.

NCAB Subcommittee on Special Actions—Sept. 19, 8 p.m., NIH Bldg 31 (Room to be assigned), open.

National Cancer Advisory Board—Sept. 19-20, NIH Bldg 31 Room 6, open Sept. 19, 1 p.m.–5 p.m., Sept. 20, 9 a.m.–noon.

Diet & Cancer Scientific Review Committee—Sept. 21, NIH Bldg 31 Room 9, open 8:30–9:15 a.m.

Cancer & Nutrition Scientific Review Committee—Sept. 22, NIH Bldg 31 Room 9, open 8:30–9:15 a.m.

The Chronic Leukemias—Sept. 22, Roswell Park continuing education in oncology, contact Claudia Lee.

Committee on Cancer Immunodiagnosis—Sept. 25-26, Landow Bldg Room C418, open Sept. 25, 7–7:30 p.m., Sept. 26, 8:30 a.m.–11:30 p.m.

Clearinghouse Data Evaluation & Risk Assessment Subgroup—Sept. 26, NIH Bldg 31 Room 10, open 8:30 a.m.–5 p.m.

Biometry & Epidemiology Contract Review Committee—Sept. 27-28, Landow Bldg Room C418, open 1–3 p.m.

Committee on Cytology Automation—Sept. 28, NIH Bldg 10 Room 1A21, open 1–1:30 p.m.

Psycho-Sociological Aspects of Diseases of the Breast—Sept. 30-Oct. 2, Strasbourg.

CONTRACT AWARDS

Title: Anorexia in adult and pediatric cancer patients
Contractor: Northwestern Univ., $258,240.

Title: Clinical evaluation of the use of computerized transaxial tomography in the diagnosis of brain tumors, continuation
Contractors: Mayo Foundation, $68,435; and Columbia Univ., $88,140.

Title: Maintain an animal holding facility and provide research services, continuation
Contractor: Pharmacopathics Research Laboratories, $157,098.

Title: Operation of a registry of tumors in lower animal, continuation
Contractor: Smithsonian Institution, $132,000.

Title: Studies of usefulness of carcinoembryonic antigen in diagnosis of bowel carcinoma, continuation
Contractor: Mayo Foundation, $96,030.

Title: Epidemiologic studies of drug induced cancer, continuation
Contractor: Johns Hopkins Univ., $54,500.

Title: Regulation of RNA tumor virus gene expression in mammalian cells, continuation
Contractor: Univ. of Minnesota, $120,392.

Title: Etiologic studies of cancer in New Jersey, continuation
Contractor: New Jersey Dept. of Health, $499,172.

Title: Research on etiology and epidemiology of cancer, continuation
Contractor: Univ. of Southern California, $2,072,773.

Title: Studies of high risk breast cancer families, continuation
Contractor: Michigan Cancer Foundation, $203,944.

Title: Immunological studies on relationship of embryonic antigen to virus-induced tumor antigens, continuation
Contractor: Univ. of Alabama, $42,358.

Title: Cycasin and macrozamin as potential environmental carcinogens
Contractor: Univ. of Hawaii, $36,091.

Title: Isolation, propagation and storage of mutant vertibrate cells
Contractor: Ontario Cancer Institute, $173,133.

Title: Synthesis of polycyclic hydrocarbon derivatives
Contractor: Midwest Research Institute, $41,309.

Title: Study on pulmonary tumors in mice for carcinogenic and co-carcinogenic bioassay
Contractor: Univ. of California (San Diego), $359,031.

Title: Breast Cancer Detection Demonstration Project, renewals
Contractor: Univ. of Louisville, $227,983; and Iowa Lutheran Hospital, $269,853.

Title: Pathology quality control system for breast cancer detection projects, renewal
Contractor: Vanderbilt Univ., $482,214.

Title: Northeast center for radiological physics, renewal
Contractor: Memorial Hospital for Cancer & Allied Diseases, $530,091.

Title: The use of screening techniques for blood in the stool as a means of detecting early cancer of the bowel, continuation
Contractor: Univ. of Minnesota, $609,000.

The Cancer Letter —*Editor* JERRY D. BOYD

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