

THE

# CANCER

RESEARCH  
EDUCATION  
CONTROL

# LETTER

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

Vol. 3 No. 47

Nov. 25, 1977

Subscription \$100 per year

## WHITE HOUSE FY 1979 BUDGET PROBABLY WILL GIVE NCI \$900 MILLION; NCAB OBJECTS TO '78 ALLOCATIONS

President Carter's budget request for the 1979 fiscal year that will go to Congress in January probably will ask \$900 million for NCI—\$136 million less than NCI has requested and \$20 million less than needed to keep up with a 6% inflation rate over the \$867 million NCI will receive in the current (1978) fiscal year.

(Continued to page 2)

### *In Brief*

#### LESS HAZARDOUS CIGARETTE ONLY HOPE TO REDUCE SMOKING HEALTH PROBLEMS, CARTER ADVISOR SAYS

PETER BOURNE, White House health advisor, told an American Cancer Society meeting that development of a less hazardous cigarette was the only feasible approach to reducing significantly the harmful effects of cigarette smoking. He feels antismoking educational efforts have not succeeded. NCI more or less reached the same conclusion about five years ago and initiated its Smoking & Health Program, headed by Gio Gori, aimed primarily at designing a low tar, low nicotine cigarette that would be acceptable to smokers. Tobacco industry representatives participated in the program. The result: the plethora of new low tar brands that have been introduced in the last two years. The program has cost NCI a total of about \$25 million, and is being phased downward. Gori wants to continue epidemiological studies to monitor the effects of the new cigarettes and to complete animal inhalation studies which are looking at the effects of nicotine and carbon monoxide. NCI has been criticized for spending research money on commercial products (the tobacco industry claims it has spent a lot more to develop the new cigarettes). It would be money well spent if the big drop in average tar content that is under way now is accompanied by a corresponding drop in lung cancer incidence. . . . CIBA-GEIGY Drew Award in biomedical research went to Robert Gallo, chief of NCI's Laboratory of Tumor Cell Biology, and Fred Rapp, Pennsylvania State Univ.—Hershey Medical Center. Gallo's award was for studies on the cellular and molecular pathogenesis of the leukemias, while Rapp was cited for his work on the role of herpes viruses in transforming normal cells to tumor cells. . . . "A SYNOPSIS Of Cancer Chemotherapy", by Richard Silver, R. David Lauper, and Charles Jarowski, New York Hospital-Cornell Medical Center, gives data on structure, mechanism of action, pharmacokinetics, toxicity, therapy and availability for both commercial and investigational drugs. Yorke Medical Books, 666 Fifth Ave., NYC 10019, \$16. . . . ONCOLOGY NURSING Society third annual meeting is scheduled April 5-7 at the Sheraton Park Hotel in Washington D.C. Contact Susan Baird, Norris Cotton Cancer Center, Hanover, N.H. 03755.

1978, '79 Budget  
Projections By  
Research Programs  
. . . Pages 4-5

Community Based  
Organizing Nearly  
Complete; Conn.  
Still Planning  
. . . Page 6

Rabson's Group  
Hears Suggestions  
On Carcinogenesis  
. . . Page 6

Only Seven Of 66  
"Benign" Breast  
Cancers Turn Out  
To Be Doubtful  
. . . Page 7

NCI Advisory Group,  
Other Cancer Meetings  
. . . Page 8

## NCAB FEELS ITS RECOMMENDATIONS ON '78 FUNDS DISTRIBUTION WAS IGNORED BY NCI

(Continued from page 1)

A \$20 million decrease in "constant" dollars would create further disruptions in the National Cancer Program but still would not be as severe as it would if NIH had its way with the NCI budget. NIH has recommended that NCI be held to \$876 million in FY 1979—no one need look any further to justify the independent budget authority granted NCI by the National Cancer Act permitting it to bypass NIH and HEW in submitting its budget requests to the White House.

Earle Browning, chief of NCI's Financial Management Branch, told the National Cancer Advisory Board last week that the White House Office of Management & Budget indicated after hearing the Cancer Program presentation that the 1979 budget "will be lean."

NCAB Chairman Jonathan Rhoads said, "I'm very reluctant to accept \$900 million. . . . I think we should ask for a minimum of \$925 million. Our budget request was \$1.036 billion, an optimistic request, but it would be used wisely."

Board member William Powers suggested that a presentation to Congress for Cancer Program funds be based on the actual cost of caring for cancer patients—from \$16-\$20 billion a year. "We're asking for \$1 billion, which is 6% of the actual cost of treating cancer patients. Six per cent is not a great component for research and development."

Meanwhile, final allocation of the 1978 appropriation still has to be done. The Board was critical of some aspects of NCI staff's latest proposals for splitting up the \$867 million among programs and funding mechanisms.

Last May when the 1978 projections were presented to the Board, the staff based proposed allocations on an optimistic figure of \$905 million. However, the House had voted only \$831 million; Board members recommended that when the final figure was established, the allocations they approved at \$905 million be adjusted downward on a prorated basis, with each program or research area reduced proportionately.

The figures presented to the Board last week included some deviations from that strict prorated redistribution, and some members were upset about it. The deviations included:

—Program project grants (P01s). The prorated level would have been \$150 million; the latest staff proposal set the figure at \$85.3 million, nearly \$5 million more than program projects received in 1977 but still \$2.6 million less than the Board had asked.

—Regular research grants (R01s). The prorated level would have been \$150 million; the latest proposal is \$152.3 million, up from \$135.5 million.

—Clinical Cooperative Groups. The prorated level was \$29.7 million; the figure in the latest allocation was \$28 million. However, the Div. of Cancer Treatment has decided that the groups will get only \$27.1 million, the same amount they received in 1977.

—Cancer centers core support. The prorated figure was \$59,892,000; the staff proposal trimmed that to \$59 million. Core support totaled \$56.7 million in 1977.

—Cancer research emphasis grants. The prorated figure was \$8.8 million; the latest figure is \$9.5 million. CREGs received \$7.5 million in 1977.

—Research contracts. The prorated level was \$113.8 million; the latest estimate is \$119.4 million. Research contracts received \$109.5 million in 1977.

—Research support contracts. The prorated level was \$96.3 million; the latest estimate \$89 million. NCI paid \$92.5 million to research support contracts in 1977.

Board members were upset over what they perceived as two major points they had stressed last May and which they felt had been ignored by staff. First, the total amount now allocated for investigator initiated grants—R01s, P01s, cooperative groups, radiation development, manpower training, task forces, and centers core support—was only \$377.6 million, \$2.8 million less than it would have been had their recommendations for prorating been strictly followed.

Second, members were disturbed by the \$5.6 million increase in research contracts over their prorating recommendation. They have been pressing NCI to reduce research funding through contracts and increase support for investigator initiated grants.

Board member Denman Hammond also was upset by the reductions imposed on centers core support—the \$892,000 lopped off by staff as well as the May recommendation to cut \$1 million from the original \$64 million allocated to core. Prorated, those cuts "will be harmful," Hammond said. "I think we should look again at the wisdom of singling out the centers budget to fund these highly desirable new investigator initiated grants."

The Board's Subcommittee on Planning & Budget earlier approved a motion objecting to the deviations from the Board's recommendations. But when the budget came up at the Board meeting, the discussion wandered around other issues and no action was taken on the subcommittee motion.

Rhoads pointed out that the distribution of 1978 funds as proposed by staff would increase the percentage of NCI's budget going to investigator initiated research from 58.1 in 1977 to 59.4 in 1978. "This is directly in line with what the Board has recommended," Rhoads said. "That we increase the amount going to investigator initiated research on the order of 1 to 1½% a year."

Rhoads also noted that while research contracts increased by \$10 million, there was a substantial

decrease in research support contracts.

Browning later explained how some of the deviations from the Board's recommendations had come about. Prorating was done by NCI division; division directors had the primary responsibility for distributing their allocations among their programs.

DCT reallocations accounted for some of the changes in mechanism totals that disturbed the Board, although members did not seem concerned about the specific changes initiated by the division. Reductions in funds for the cooperative groups and DCT support contracts—the latter primarily in drug development—and shifting some of that money to treatment research contracts did not draw much attention from Board members.

The Div. of Cancer Research Resources & Centers, which funds most of the grants, incurred most of the other changes. Some were policy decisions by division director Thomas King, but it turned out that the primary culprit was the practice of "rounding off" the prorated allocations to divisions.

"We were .2% off in money allocated to DCRRC," Browning said. "That division could have received another \$1 million on a purely prorated basis, if we hadn't rounded off the figures."

Another problem affecting funds available to DCRRC was that the staff had underestimated the cost of the division's support contracts by \$ million when the first allocation was drawn up last spring. When the actual costs became known, that amount had to come out of the funds allocated to the grants programs.

Browning said that NCI Director Arthur Upton may want to consider restoring the \$1 million DCRRC should have received on the prorating. If so, it would have to come from the other divisions and could be put into the programs King felt most need additional money.

Even without any extra money, regular research grants are in much better shape than last year, when only about 35% of approved new and competing renewal grants were funded. Browning estimated that the \$152.3 million allocated for R01s would fund 42% of approved grants this year.

Upton also has said he will take another look at the \$10 million increase for research contracts, with the prospect that some of that could be reprogrammed.

Here's how the division 1978 allocations stand for now, compared with 1977: (in millions)

	1977	1978
DCRRC	\$351.5	\$373.6
Biology & Diagnosis	61.6	64.5
Treatment	127.3	132.9
Cause & Prevention	144.2	155.
Control & Rehabilitation	60.5	64.5
Office of Director	42.9	44.7
NIH management fund	27.1	32.
Totals (rounded off)	\$814.9	\$867.1

Hammond presented three charts he had made which show the growth of NCI's budget by various mechanisms from 1970 to 1977. R01s went on a steady climb from \$39.6 million to \$135.5 million; P01s went from \$21 million to a peak of \$83.5 million in 1975, dropped to \$77.8 million and then back up to \$80.7 million; and core support went from \$4.6 million to \$56.7 million.

Research contracts and CREGs climbed almost 700% in the seven years; investigator initiated grants went up 310%; inhouse research, management and support went up 287%; and research support contracts 216%.

Browning presented another set of figures to the Board which elicited strong criticism from Hammond—an analysis of all NCI funds going to institutions with cancer centers. It was headed "1977 Estimated Support to All Cancer Centers," and then footnoted, "Represents total NCI dollars to institutions where centers are located."

The analysis showed that more than \$306 million in R01s, P01s, core, training, control, contract and other funding mechanisms go to 70 such institutions. Thirty-two of the institutions are components of or affiliated with the 20 comprehensive cancer centers, the rest with specialized centers. Those with comprehensive centers receive \$192.4 million, the others \$114.4 million.

There was no attempt to show amounts going strictly to the centers or to investigators within the centers. Such figures are not available now but will be when the Cancer Centers Profile being compiled and analyzed by Centers Program staff has been completed.

"I strongly object to figures that seem to show that all this money is going to centers," Hammond said. He referred to a similar chart prepared by NCI staff two years ago which created some confusion about the definition of centers and amount of money they received from NCI.

"What this really says," Hammond contended, "is that a major segment of the biomedical community which competes successfully for NCI support also has centers. It says they are important to centers. It says that centers are able to attract people capable of competing successfully."

Hammond pointed out that much of the \$11.4 million the analysis listed as going to his institution, the Univ. of Southern California, supports investigators in other parts of the university which have "absolutely no connection with the cancer center" which Hammond heads.

Interestingly enough, the institution shown with the greatest amount of support, \$21.7 million, is Sloan-Kettering Cancer Institute. All of those funds are going to a cancer center.

Browning said the analysis was made because NCI is constantly being asked, "How much money goes to

(Continued to page 6)

RESEARCH PROGRAMS (Dollars in Thousands)	FY 1977	FY 1978	FY 1979
<b>1. Epidemiology</b>			
Epidemiology – DCCP	\$ 4,367	\$ 4,798	\$ 6,461
Biometry – DCCP	13,099	14,394	17,034
Epidemiology – DCRRC	9,628	10,527	14,358
Breast Cancer Task Force – DCBD	1,000	1,100	1,200
Prostate Cancer Project – DCRRC	287	243	444
Bladder Cancer Project – DCRRC	188	138	318
Pancreatic Cancer Project – DCRRC	199	103	222
Large Bowel Project – DCRRC	28	0	0
Management and Support	3,217	3,748	4,372
<b>Total</b>	<b>\$32,013</b>	<b>\$35,051</b>	<b>\$44,409</b>
<b>2. Carcinogenesis (Physical &amp; Chemical)</b>			
Carcinogenesis – DCCP	55,769	63,946	78,980
Smoking & Health – DCCP	6,600	6,600	7,100
Carcinogenesis – DCRRC	22,878	28,823	39,593
Viral Oncology – DCCP	2,215	3,000	3,801
Radiation Biology & Phys. – DCRRC	257	506	1,046
Large Bowel Project – DCRRC	1,640	1,804	2,185
Prostate Cancer Project – DCRRC	159	178	280
Bladder Cancer Project – DCRRC	643	671	864
Pancreatic Cancer Project – DCRRC	736	770	969
Clinical Oncology – DCRRC	78	83	152
Drug Development and Pharm. – DCT	0	0	250
Management and Support	5,641	6,322	7,915
<b>Total</b>	<b>\$96,616</b>	<b>\$112,703</b>	<b>\$143,135</b>
<b>3. Viral Oncology</b>			
Viral Oncology – DCCP	58,710	58,410	59,887
Viral Oncology – DCRRC	32,399	32,158	35,610
Biological Studies – DCT	1,357	1,292	1,330
Prostate Cancer Project – DCRRC	497	547	619
Bladder Cancer Project – DCRRC	134	148	130
Management and Support	6,370	6,883	7,478
<b>Total</b>	<b>\$99,467</b>	<b>\$99,438</b>	<b>\$105,054</b>
<b>4. Nutrition</b>			
Diet and Nutrition – DCCP	3,475	3,866	6,407
Carcinogenesis – DCRRC	451	1,206	1,643
Tumor Biology – DCRRC	611	800	989
Nutrition – DCT	875	1,251	1,651
Clinical Oncology – DCRRC	423	683	877
Management and Support	1,675	1,662	2,159
<b>Total</b>	<b>\$ 7,510</b>	<b>\$ 9,468</b>	<b>\$13,726</b>
<b>5. Immunology</b>			
Immunology – DCBD	24,268	23,834	27,891
Immunobiology	(11,145)	(10,948)	(13,118)
Immunodiagnosis	( 6,023)	( 6,232)	( 7,173)
Immunotherapy	( 7,100)	( 6,654)	( 7,600)
Immunology – DCRRC	36,648	40,457	48,664
Immunobiology	(22,935)	(25,560)	(30,966)
Immunodiagnosis	( 3,098)	( 3,463)	( 4,147)
Immunotherapy	(10,615)	(11,434)	(13,551)
Radiation Biology & Phys. – DCRRC	173	113	258
Radiation Oncology – DCRRC	392	590	874
Large Bowel Project – DCRRC	1,494	1,476	1,943
Prostate Cancer Project – DCRRC	639	388	536
Bladder Cancer Project – DCRRC	978	1,202	1,356
Pancreatic Cancer Project – DCRRC	394	634	852
Clinical Oncology – DCRRC	209	228	295
Management and Support	8,668	9,769	11,250
<b>Total</b>	<b>\$73,863</b>	<b>\$78,691</b>	<b>\$93,919</b>

**RESEARCH PROGRAMS (Dollars in Thousands)**

	FY 1977	FY 1978	FY 1979
<b>6. Tumor Biology</b>			
Tumor Biology – DCBD	\$17,454	\$19,682	\$22,238
Tumor Biology – DCRRC	31,953	35,414	42,398
Radiation Biology & Phys. – DCRRC	4,373	4,764	5,380
Clinical Oncology – DCRRC	626	599	530
Tumor Biology – OD (Frederick)	3,350	3,660	3,700
Management and Support	11,219	12,698	14,417
<b>Total</b>	<b>\$68,975</b>	<b>\$76,817</b>	<b>\$88,663</b>
<b>7. Diagnostic Research</b>			
Tumor Biology – DCRRC	170	220	300
Detection & Diagnosis – DCBD	16,240	17,204	20,197
Radiation Biol. and Phys. – DCRRC	345	0	0
Large Bowel Project – DCRRC	723	708	854
Bladder Cancer Project – DCRRC	801	856	1,039
Pancreatic Cancer Project – DCRRC	590	484	749
Multidisciplinary Research – DCRRC	775	827	1,846
Clinical Oncology – DCRRC	227	234	384
Radiation Oncology – DCRRC	0	463	725
Management and Support	6,239	7,060	7,803
<b>Total</b>	<b>\$29,491</b>	<b>\$31,933</b>	<b>\$39,285</b>
<b>8. Preclinical Treatment Research</b>			
Biological Studies – DCT	6,226	6,556	6,916
Radiation Biology & Physiology – DCT	1,100	1,243	1,750
Radiation Development – DCRRC	3,081	4,150	6,000
Drug Development and Pharm. – DCT	52,787	54,538	60,467
Drug Development and Pharm. – DCRRC	23,802	23,333	27,266
Radiation Oncology – DCRRC	6,165	6,432	7,751
Large Bowel Project – DCRRC	989	967	1,177
Prostate Cancer Project – DCRRC	422	780	1,063
Bladder Cancer Project – DCRRC	464	510	859
Pancreatic Cancer Project – DCRRC	0	0	108
Clinical Oncology – DCRRC	181	233	307
Management and Support	11,407	11,935	13,166
<b>Total</b>	<b>\$106,624</b>	<b>\$110,677</b>	<b>\$126,830</b>
<b>9. Clinical Treatment Research</b>			
Surgery – DCT	1,843	2,640	3,969
Radiation Oncology – DCT	3,867	4,183	5,498
Radiation Oncology – DCRRC	16,990	18,078	21,968
Chemotherapy – DCT	27,680	27,056	31,153
Immunology (therapy) – DCT	2,221	2,387	2,768
Combined Modality – DCT	15,686	18,697	22,832
Supportive Care Research – DCT	6,191	5,647	7,436
Breast Cancer Task Force – DCBD	2,600	2,701	3,200
Large Bowel Project – DCRRC	399	540	641
Prostate Cancer Project – DCRRC	1,028	945	1,130
Bladder Cancer Project – DCRRC	720	520	884
Multidisciplinary Research – DCRRC	19,087	22,599	25,936
Clinical Oncology – DCRRC	4,577	4,918	6,318
Clinical Trials Support – DCT	7,434	7,394	7,924
Management and Support	10,868	13,103	15,416
<b>Total</b>	<b>\$121,191</b>	<b>\$131,408</b>	<b>\$157,073</b>
<b>10. Rehabilitation Research – DCCR</b>	<b>3,425</b>	<b>3,485</b>	<b>7,270</b>
Management and Support	20	20	49
<b>Total</b>	<b>\$3,445</b>	<b>\$3,505</b>	<b>\$7,319</b>
<b>Total NCI Research Programs</b>	<b>\$639,195</b>	<b>\$689,691</b>	<b>\$819,413</b>
Resource Development	117,226	114,805	142,055
Cancer Control	58,516	62,640	74,532
<b>Total NCI</b>	<b>\$814,937</b>	<b>\$867,136</b>	<b>\$1,036,000</b>

(Continued from page 3)

centers, or to a specific center. We weren't trying to mislead anyone. We did footnote it."

It's still misleading," Rhoads said. "Congress has been misled in the past. Many up there think centers are overfunded."

Benno Schmidt, chairman of the President's Cancer Panel, said, "I have never worked with any government agency where you can get figures better, faster, or more understandable than we get from Cal Baldwin (who heads NCI's Office of Administrative Management) or Earle Browning." But Schmidt suggested that future budget analyses be developed with the advice of appropriate supervisory people.

The breakdown of the 1978 allocations provided a variety of ways to look at how the money will be spent—by division, funding mechanism, and research programs. The breakdown by research programs, showing the division in which they are located and comparing amounts for 1977, 1978 and 1979 (the last based on the ultimate \$1.036 billion appropriation) offer the most detailed picture of NCI's spending plans. This breakdown is shown on pages 4 and 5.

#### **COMMUNITY PROGRAM ORGANIZING ALMOST COMPLETE; CONNECTICUT STILL PLANNING**

NCI's Div. of Cancer Control & Rehabilitation has all but wrapped up the process of awarding contracts in its Community Based Cancer Program with the completion of negotiations for programs in Hawaii, Long Island, Rhode Island and Los Angeles.

Programs in New Mexico and Detroit have been under way for more than a year. Of those agencies which received planning contracts, only the Connecticut group has not either received a contract or been dropped from the program.

All awards are for five years, incrementally funded. The program calls for concentrated, coordinated efforts by public and private agencies within the communities to determine if a significant impact can be achieved on morbidity and mortality in specific types of cancer.

Los Angeles will receive \$7.4 million with emphasis on breast, lung and cervical cancer. Principal investigators are Lester Breslow, Robert McKenna, Ruth Pick, and Ralph Sachs. Helene Brown is the program director.

Rhode Island will receive \$6.5 million, emphasizing breast, cervical, lung and colorectal cancer. Fiorindo Simeone is the principal investigator and Robert Schilling the program director.

Long Island will receive \$6.5 million, emphasizing breast, cervical, colorectal and prostatic cancer. Ray Crampton and Raj Prosad are the principal investigators, and Prosad also is the program director.

Hawaii will receive \$6.6 million, with emphasis on breast, lung, cervical and colorectal cancer. Lawrence Piette is the principal investigator and Robert Hasterlick the program director.

The local agencies will be required to match the NCI funds, in goods, services or hard dollars.

Connecticut received an extension of its planning time and will submit an implementation application in January.

#### **RABSON'S GROUP HEARS SUGGESTIONS ON "WHAT IS NEEDED" IN CARCINOGENESIS**

Alan Rabson, chairman of the committee NCI Director Arthur Upton set up to review the institute's efforts in carcinogenesis, last week asked members of the National Cancer Advisory Board Subcommittee on Environmental Carcinogenesis for their ideas "on what you think is important" in the areas of carcinogenesis research.

Rabson said his committee was "getting a view of the entire program"—what NCI is going in carcinogenesis in research supported by grants, in the organ site program, and contract programs. "We are evaluating the quality of science and science emphasis. What are the main areas of excitement in the carcinogenesis field?"

Subcommittee members responded:

"Short term tests are agreeing with each other," said Bruce Ames. "We hope to get enough of an agreement and enough of an idea of the magnitude of potency so that we can use them to establish priorities for testing. There are not enough pathologists in the world to test everything that should be tested."

"Do the potency in short term tests correspond to potency in animals?" Rabson asked.

"That whole area of cancer potency needs a lot of work," Ames answered.

Rabson committee member Edward Scolnick asked for some suggestions on areas of basic cell biology where increased knowledge would help in carcinogenesis research.

Ames suggested, "DNA repair, enzyme repair. What are the targets? Which genes are important?"

"A lot of this depends on how you want to look at the problem," said subcommittee member Philippe Shubik. "We are faced with an extraordinarily complicated problem and could go off on a tangent that could land us in all sorts of trouble. We are in the midst of an epidemic of lung cancer, and have managed to do absolutely nothing about it. NCI does have the program to develop a so-called safe cigarette. Almost no hospital in the U.S. supports smoking cessation clinics. When we do one at our institution, there is an enormous oversubscription.

"We have seen gastric cancer practically disappear in this country, for no apparent reason," Shubik continued. "It could be better nutrition, better hygiene, diminished levels of nitrite in the diet. There's not enough epidemiological data. There are opportunities for comparative epidemiology, comparative metabolism. It's terribly important to know what these tumor producing (in animals) materials do in man. Low dosage tests in animals need to be much better

than we have done. I'm not ready to say the level of sensitivity in short term tests is definitely established. We need a great deal more to validate them."

**CORRECTION:** *The Cancer Letter* (Nov. 11) reported that Upton had told members of the Clearinghouse on Environmental Carcinogens they should consider all available data in making judgments on risks to humans and not limit themselves to the bioassay reports on chemicals tested by NCI.

That would have enormously increased the scope of the Clearinghouse and its workload, and would require a substantial increase in NCI staff support.

Upton said later that was not the advice he had intended to convey and that extensive literature searches and analysis of other data (except for the NCI bioassays) would be outside the Clearinghouse responsibilities. He suggested that during Clearinghouse deliberations, members should feel free to point out information from the literature with which they are familiar and to offer comments relating to other data.

Upton did ask, as reported, that the Clearinghouse serve as an ex-officio advisory committee for the Carcinogenesis Program.

Richard Griesemer, director of the Carcinogenesis Testing Program, told the NCAB that "the backlog is under control," referring to the test results that had piled up four years ago and are now being reported out. One report a day is being turned out, and the backlog will be eliminated—at least with preliminary reports out—by the end of February.

Meanwhile, new chemicals are going on test. Griesemer said that 76 are scheduled to start and 81 will be completed and reported out in FY 1978.

"We do other kinds of work than testing," Griesemer said. A major part of the program's effort is in developing in vitro tests; efforts are being made to improve assays in animals, develop ways to look at promoters, and develop new animal models.

Gregory O'Connor, acting director of the Div. of Cancer Cause & Prevention, told the Board that the Carcinogenesis Testing Program "is very much on track and extremely well organized." It was a tribute, perhaps unintended, to O'Connor's predecessor, James Peters, under whose direction the program was reorganized with Griesemer at the helm.

### **ONLY SEVEN OF THE 66 "BENIGN" BREAST CANCER CASES TURN OUT TO BE DOUBTFUL**

Those 66 cases of "benign" malignancies which resulted in most of the women having "unnecessary" mastectomies has turned out to be something else.

Those were the cases in the Breast Cancer Detection Demonstration Project in which "minimal" (less than 1 centimeter) lesions were found in women participating at some of the 27 project centers. There were 462 such cases which were reviewed by the group headed by Oliver Beahrs.

The Beahrs group pathologists, in their first and

rather hasty review of the slides from the 462 cases, concluded that in 66 of those cases, the lesions were benign. When that news got around the country, after the Beahrs report was released at the mammography consensus meeting in September, it created considerable unrest.

The Beahrs group had only a limited time to review the slides, and the slides were all the data they received on those individual cases. Project directors, in checking it out, found that the wrong slides had been sent in some cases. Diane Fink, director of NCI's Div. of Cancer Control & Rehabilitation, asked the Beahrs group to take another and more careful look at the 66 cases.

Beahrs submitted a supplemental report to Fink this week in which he reported:

—Two of the case reports were distorted by computer error.

—Eleven of the 66 women had only breast biopsies with no further surgery.

—Sixteen of the 66 definitely had cancer, all pathologists agreed.

Taking out the 16 definitely with cancer and the two computer errors, that left 48 cases to be reconsidered. Of those, 11 had biopsies only, leaving 37 who underwent some form of mastectomy.

Beahrs said the group found that in the management of 30 of those 37, the procedure was in two stages—biopsy one day, surgery at a later date. That means that the surgeons and their patients undoubtedly realized that there was at least some question that the lesions were malignant, but proceeded anyway with the mastectomies. Of those 30, in 26 cases the hospital and project pathologists both were asked for opinions. They agreed that the lesions were malignant in 21 cases. The project diagnosis was not known in the other four cases. In the remaining five, either one or the other considered the lesions cancerous.

In only seven cases does it appear that mastectomies were performed needlessly. The Beahrs group intends to review those again, with more information made available.

On this second review, each of the cases was reviewed by the entire Beahrs group, case by case, including clinical data. Pathologist Henry Pitot told the National Cancer Advisory Board last week that the first review, in which only slides were available, "was doing it blind. I don't know how you can make an intelligent diagnosis without the clinical data."

"Based on data in the supplemental report," Beahrs said, "it appears that great care was given in the management of these women with possible breast cancer or significant pathological changes in the breast.

"The treatment in almost all instances, based on information available to the surgeon at the time of management, was consistent with acceptable surgical practice, and those responsible for care of patients

behaved in a proven ethical and professional manner."

The real problem has been the success of the projects in achieving one of the program's major goals—the detection of early breast cancer, while it can be treated before it spreads outside the breast. With the use of mammography (another much debated issue), the projects have found an unusually high number of minimal cancers. Those patients presumably have an extremely good prognosis.

But the very small lesions are very difficult for pathologists to definitively decipher. Even with larger tumors, "diagnosing cell abnormalities can be very complex," Beahrs said, leading to disagreement among pathologists looking at the same slides.

Sidney Wolfe, director of the Nader-affiliated Health Research Group, had demanded under the Freedom of Information Act the locations of the centers in which the 66 women had been participating. After NCI and the Beahrs group had undertaken the second review, Wolfe issued press releases in those regions, criticizing the "unnecessary" mastectomies and lack of supervision by NCI.

"Wolfe set back completion of the second review by two to three weeks," Fink said. "It shook people up in those areas." Some physicians did not want to cooperate with the Beahrs group any further, and it took some persuading to overcome that resistance.

#### **ADVISORY GROUP, OTHER CANCER MEETINGS FOR DECEMBER, JANUARY**

**Assn. of Community Cancer Centers**—Dec. 1-2, Detroit Plaza Hotel, regional meeting on hospice & continuing care at home.

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

**National Large Bowel Cancer Project**—Dec. 1-2, Anderson Mayfair, Houston, open Dec. 1, 7:30 p.m.—8:30 p.m.

**State of the Art Conference on Bladder Cancer Screening**—Dec. 5-7, Dulles Marriott, Washington D.C., sponsored by NCI Div. of Cancer Control & Rehabilitation, 9 a.m.—5 p.m. each day, all open.

**Diagnostic Research Advisory Group**—Dec. 6-8, NIH Bldg 31 Room 6, open Dec. 6, 8:30–11 a.m.

**President's Cancer Panel**—Dec. 6, NIH Bldg 31 Room 7, 9:30 a.m., open.

**Adolescent Oncology**—Dec. 8, Roswell Park continuing education in oncology. Contact Claudia Lee.

**National Bladder Cancer Project Working Cadre**—Dec. 8-9, Dulles Marriott, open Dec. 8, 8:30 a.m.—noon.

**Committee on Cancer Immunodiagnosis**—Dec. 12, NIH Bldg 10 Room 4B14, open 1–1:30 p.m.

**Clinical Cancer Program Project Review Committee**—Dec. 12-14, NIH Bldg 31 Room 8, open Dec. 12, 9–10:30 a.m.

**Committee on Cancer Immunobiology**—Dec. 13, NIH Bldg 10 Room 4B14, open 2–2:30 p.m.

**Clinical Cooperative Group Chairmen**—Dec. 14, NIH Bldg 31 Room 7, 8:30 a.m., open.

**National Cancer Advisory Board Subcommittee on National Organ Site Programs**—Dec. 14, NIH Bldg 31 Room 9, open 10:30 a.m.—adjournment.

**Cancer & Nutrition Scientific Review Committee**—Dec. 14, NIH Bldg 31 Room 4, open 8:30–9 a.m.

**Virus Cancer Program Scientific Review Committee**—Dec. 14, Landow Room C418, open 9–9:30 a.m.

**Role of Rehabilitation in Cancer**—Dec. 15, Roswell Park continuing education in oncology.

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

**Clinical Trials Committee**—Dec. 15-16, NIH Bldg 31 Room 8, open 8:30–9 a.m. both days.

**Carcinogenesis Program Scientific Review Committee**—Dec. 15-16, Landow Room C418, open 8:30–9 a.m. both days.

**Clearinghouse on Environmental Carcinogens Chemical Selection Subgroup**—Dec. 19, NIH Bldg 31 Room 6, 8:30 a.m.—5 p.m., open.

**Clearinghouse Experimental Design Subgroup**—Dec. 20, NIH Bldg 31 Room 6, 8:30 a.m.—5 p.m., open.

**National Prostatic Cancer Project Working Cadre**—Jan. 6, NIH Bldg 31 Room 8, open 8:30–9 a.m.

**Div. of Cancer Biology & Diagnosis Board of Scientific Counselors**—Jan. 6-7, NIH Bldg 31 Room 7, open Jan. 6, 9 a.m.—5 p.m.

**Breast Cancer Task Force**—Jan. 10-12, NIH Bldg 1 Wilson Hall, open Jan. 10, 8 a.m.—adjournment, Jan. 11, 8:30 a.m.—adjournment.

**Cancer Control & Rehabilitation Advisory Committee Subcommittee on Community Activities**—Jan. 12, Blair Bldg Room 110, open 8:30 a.m.—adjournment.

**Clearinghouse Data Evaluation/Risk Assessment Subgroup**—Jan. 18, NIH Bldg 31 Room 6, 8:30 a.m.—5 p.m., open.

**Clearinghouse Executive Subgroup**—Jan. 19, NIH Bldg 31 Room 6, 8:30 a.m.—5 p.m., open.

**Cancer Control Community Activities Review Committee**—Jan. 19-20, NIH Bldg 31 Room 10, open both days 8:30 a.m.—adjournment.

**Workshop on Lymphoid Leukemias**—Jan. 20-21, Cedars-Sinai Medical Center, Los Angeles, sponsored by the Amie Karen Cancer Fund for Children and the Leukemia Society of America.

**National Cancer Advisory Board**—Jan. 23-25, NIH Bldg 31 Room 6, schedule of open sessions and subcommittee meetings will be announced later.

**Committee on Cancer Immunotherapy**—Jan. 24, NIH Bldg 10 Room 4B14, open 1:15–1:45 p.m.

**Thyroid Carcinoma: New Concepts and Management**—Jan. 26, Roswell Park continuing education in oncology.

**Developmental Therapeutics Committee**—Jan. 26-27, Blair Bldg Room 110, open 9–9:30 a.m.

**Committee on Cytology Automation**—Jan. 26-27, NIH Bldg 31 Room 9, open 8:30–9 a.m.

**Virus Cancer Program Scientific Review Committee**—Jan. 27, NIH Bldg 37 Room 1B04, open 9–9:30 a.m.

**Assn. of Community Cancer Centers**—Jan. 27-29, Washington D.C. Key Bridge Marriott, annual meeting.

**Assn. of American Cancer Institutes**—Jan. 29-31, USC/Los Angeles County Comprehensive Cancer Center, annual meeting.

### **The Cancer Letter** —Editor JERRY D. BOYD

Published fifty times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. All rights reserved. None of the content of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of the publisher.