THE CANCER LETTER

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

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CORE GRANT GUIDELINE REVISIONS, COMPREHENSIVE CENTER CHARACTERISTICS CHANGES STILL COMING UP

Revisions of cancer center core grant guidelines and changes in characteristics required for comprehensive cancer centers—NCI staff proposals which have flared intermittently into controversy over the past two years—have been on the shelf since NCI became immersed in

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In Brief

PANEL MEETING CANCELED; NEW SENIOR EXECUTIVE SERVICE DRAWS ENTHUSIASTIC RESPONSE AT NCI

PRESIDENT'S CANCER Panel meeting scheduled for July 25 has been canceled because President Carter still has not filled the two vacancies on it. Although Joshua Lederberg, Rockefeller Univ. president, has been selected as Panel chairman, his appointment has not been made official. The Administration wants to announce the other appointment at the same time. The terms of former Chairman Benno Schmidt and Paul Marks have expired; NCI feels there is no point in having any further meetings until those positions have been filled. . . . **ALL BUT ONE** of the approximately 60 NCI senior staff members eligible for the new Senior Executive Service have opted to do so, thus trading the security of their civil service positions for potential pay increases, bonuses and risks of the new service. NIH is drawing up criteria for the new Senior Scientific Service, which will offer scientists the same benefits and risks that SES offers administrators. Since pay increases and bonuses for both will depend on annual evaluations, development of criteria for those evaluations has become a controversial issue, especially for the scientists. . . . **FORMER PRESIDENT** Richard Nixon and Mrs. Nixon sent a check for $100,000 to the American Cancer Society. In a letter to Paul Williams, vice chairman of the ACS national board of directors, Nixon said the contribution was being made in memory of John Wayne, Hubert Humphrey and a number of other public figures who have died of cancer, plus Kate Ryan, Mrs. Nixon's mother, also a cancer victim. . . . **LEON SCHWARTZ**, NIH associate director for administration since 1972, has left that position to become vice chancellor for administration and business services at the Univ. of California (Irvine). . . . **"FOR SOME** time, the Viral Oncology Program has been the whipping post of NCI. It is important to recognize that this has been one of the best programs ever mounted by NCI. It has supported a tremendous amount of extremely high quality biological research around the world. The credit should go to Ray Bryant, Dick Rauscher and John Moloney. I take no credit for it, but I do feel it is my responsibility to defend it"—Gregory O'Conor, director of NCI's Div. of Cancer Cause & Prevention. . . . **VIVIAN HESTON**, who was managing editor of the *Journal of NCI* when she retired in 1975, died last month at age 71.

GUIDELINE CHANGES MAY INCLUDE LIMIT ON AWARDS, SALARIES, TERRY SAYS

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reorganization, but they have not been forgotten.

William Terry, acting director of the Centers Program, told members of the Assn. of American Cancer Institutes at their semi-annual meeting in Madison, Wisc., that his staff is still working on guideline revision and that recommendations on changes in the 10 comprehensive center characteristics will go to the National Cancer Advisory Board Subcommittee on Centers before the Board's next meeting in September.

"Why are the guidelines being revised?" Terry asked, and then quipped, "Because they are there. Perhaps that could be the same answer as to why NCI is being reorganized . . . NCI has been in a state of reorganization ever since I went there in 1962."

NCI proposed major core grant revisions two years ago in an effort to trim the size of grant requests, reduce the workload on staff and review committees, and free more money for investigator initiated grants. Those changes would be accomplished by placing a ceiling on grants, transferring the cost of shared resources to individual grants and contracts, phasing out support for staff investigator salaries and awarding most core grants for five year periods.

AACI members were unanimous in opposing changes in shared resources and salary support and were concerned about the ceilings. NCI agreed to study the proposals further. A hangup developed immediately, on how to arrive at ceilings.

Terry told AACI members that "We're trying to get the guidelines up to date, and apply the lessons we've learned over the last four to five years. We hope to make the guidelines more definitive. . . . We probably will put a limit on the size of grants, more closely relate the grants to research, and deal with the salary problem."

Terry said that his policy of attempting to fully fund grants at their recommended peer review levels, rather than partially funding a greater number appears to be working well. "We're going with quality. . . . The available money is being distributed by peer review, modified by a minimum amount of administrative tampering."

AACI developed its own suggestions for modifying the 10 characteristics. Terry said they were "constructive, better than (NCI staff's) first draft. There are a few issues that are still debatable."

The 10 characteristics were written by the National Cancer Advisory Board shortly after passage of the National Cancer Act of 1971, when the concept of formal recognition by NCI of a center as a "comprehensive" one was implemented. The staff suggestions for modifications were the result of a review, completed in 1978, by the Board of how well the recognized centers were living up to the characteristics.

NCI staff also raised the question of "derecognition" of a comprehensive center if it were found to be lacking in a significant number of the characteristics or were otherwise found deficient. One major deficiency which the staff felt would be sufficient cause for recognition: Failure to keep a core grant.

The NCAB Subcommittee on Centers after studying the staff's recommendations had proposed that failure to get a core grant funded or renewed within two years after losing it would be cause for automatic withdrawal of recognition as comprehensive.

The Board modified that somewhat, agreeing that failure to get a funded core grant within two years after losing one would call for a full review by the NCAB of the center. The Board would then make its recommendation to the NCI director, based on that review, of whether the center should continue to be recognized as comprehensive.

Core grants are more important to some centers than to others, and many center directors feel that losing comprehensive status because of the failure to possess a core grant is not appropriate. Most agreed with the Board, however, that such a failure would "raise a flag" that all might not be well.

AACI went along with that position. If a center has a funded core grant, that demonstrates it has passed an intensive peer review of its overall operation; however, that does not have to be the only peer review upon which comprehensive designation is based.

A draft of AACI's recommendations for modifcation of the characteristics was presented at the Madison meeting. It is being circulated to center directors, with AACI's final position to include their suggestions for presentation to the NCAB Subcommittee on Centers.

The AACI draft:

1. Cancer Center Support and Goals

The cancer center must have a funded cancer center support (core) grant or peer review approval. The cancer center must give evidence of local support, as a concept and fiscally, and must demonstrate its aspiration to attain the national goals of a comprehensive cancer center.

2. Program Activities

Research—The cancer center should support laboratory, clinical and epidemiologic research efforts of the highest quality and should create an environment which fosters cancer-related information exchange, cooperation and collaboration between laboratory scientists of multiple disciplines, clinical scientists, physicians of multiple specialties, and epidemiologists.

Clinical—The cancer center should also engage in regional and/or national clinical trials and should have the personnel and facilities to carry out high quality diagnostic, therapeutic, and rehabilitative procedures in the interdisciplinary setting most suited to the cancers being studied.

Cancer Detection Research—The center should develop an organized cancer detection program or research in cancer detection techniques.

Data and Evaluation—The center must maintain a statistical base for evaluation of the results of its program activities. For this purpose patient records should be developed using standardized disease classification (ICD-09) to enable exchange of information between institutions and sharing of a common nomenclature for staging of cancer, end results reporting of experience of prevention, detection, diagnosis and treatment follow up and rehabilitation of the patients with cancer and precancerous clinical diseases. This establishment of a patient data base and end results reporting compatible with peers in this field and sharing of the data is an essential feature of cancer patient care and a part of the cost of the delivery of health care to these patients.

3. Cancer control activities

The cancer center should serve as a primary focal point for local and regional programs designed to control cancer through research and demonstration activities in prevention, detection, diagnosis, treatment, and rehabilitation. The center should participate in the National Cancer Program by coordinating its efforts with the activities of other centers as an integrated nationwide health resource and make appropriate contributions to the International Cancer Research Data Bank. The center should seek the active participation of the non-academic or non-center professional community in control activities.

4. Training, Education and Information Dissemination

The cancer center should serve as a primary focal point for local and regional information dissemination with professional and lay education programs. The best methods to modify professional and lay behavioral patterns should be determined by experimentation and evaluation.

5. Administration

The cancer center should have a formal commitment of support from the parent institution or organization manifested by the following: a) primary control of laboratory, space and equipment, b) final (with governance agent) control over professional appointments and staff to enable the center director to effectively direct the center and assure accomplishment of its mission, and c) grouped beds and ambulatory care facilities for cancer research and treatment under the primary control of the cancer center director. In addition, the center must have an administrative structure that will assure program formulation and implementation, long-term viability, efficiency of operation and sound financial practices, including control of its own budget and the use of its income.

6. Geographic Impact

The geographic location of the cancer center should increase the national capability to carry out regional clinical trials, regional cancer control programs and regional training, education and information dissemination activities with the professional, volunteer, and governmental health organizations in that region. The location of other comprehensive centers and the size of the regional population will be important considerations.

AACI's recommendation on administration characteristics represents a tougher stance than NCAB took in its original requirements. The AACI position calls for a more definite commitment of resources, more control by the center director and more assurance that the center is a permanent part of the institution. That could be the most controversial of the recommendations; some of the existing 21 comprehensive centers do not meet those requirements and may never do so.

Terry told AACI members he feels that "there has been a certain amount of divisiveness" among the Cancer Program's various constituencies. NCI reorganization (particularly, placing the Centers and Cancer Control Programs in the same division) "may be an opportunity to step back and adopt different approaches. The constituencies represented by AACI, the Assn. of Community Cancer Centers and the American Cancer Society have an immense amount to be gained by working together, defining common goals, and not pulling off in different directions. I hope that the reorganization might provide the basis for the leadership of those organizations to do that. Failure to do so might be destructive to the National Cancer Program. We have seen that in (Congressman David) Obey's effort (cutting $17 million from construction and cancer control). This is the result of different constituencies playing one against the other. I urge you to avoid allowing anyone to take advantage of perceived deficiencies."

COLORADO VULNERABLE TO CORE GRANT REQUIREMENT; NEW APPLICATION DELAYED

The comprehensive cancer center most vulnerable at the moment to any effort to make core grants a mandatory requirement for comprehensive recognition is the Colorado Regional Cancer Center.

CRCC is a consortium which includes the Univ. of Colorado. Last year, just after the NCAB review of comprehensive centers found what it considered a number of serious weaknesses in CRCC's organization and programs, the center was dealt a serious blow when the Cancer Center Support Grant Review Committee did not approve its application for renewal of its core grant. It was the first time a comprehensive center had lost its core grant, and that prompted NCI staff and NCAB to consider adding the core grant as a requirement.

Such a consideration, of course, increased the pressure on CRCC. The Board had determined that it would conduct another review for comprehensiveness at CRCC within two years, which means it probably

will be done in the spring of 1980. If the core grant requirement stands, CRCC will have to successfully compete for another one by that time. And even if the requirement is not enforced, the grant is vital to CRCC, which depends on it for a major portion of its funding.

The center has not rushed in with another application, however. CRCC Director Steven Silverberg told *The Cancer Letter* this week that he does not intend to submit another application until the university has completed an evaluation of its position in relation to the Cancer Program. The chancellor has appointed a "blue ribbon" committee to determine the future of oncology programs at the university.

Roy Schwartz, who has just been named dean of the medical school, has not yet assumed that position (he is at the Univ. of Washington). Silverberg feels that any increased commitment to cancer and to CRCC will depend on Schwartz' assessment to a large degree.

Silverberg said that if he submits a new core grant application, it will have to go through the university, rather than independently from the cancer center. Before that could be effective, the university would have to strengthen certain areas, particularly its clinical oncology program.

While it would be very difficult politically to withdraw comprehensive recognition from a center, NCI staff, the NCAB and most cancer center directors feel it is something that may have to be done eventually, if recognition as a comprehensive center is to have any value.

HOUSE CUTS IN CONSTRUCTION, CONTROL BUDGETS ANALYZED; COMMUNITIES HURT

Congressman David Obey (D.-Wisc.), in explaining the Appropriations Committee's intent in reprogramming $23 million of NCI's FY 1980 budget (*The Cancer Letter*, July 6), made several comments which require clarification.

• Obey said the committee was justified in cutting $8 million out of the construction budget of $16 million because Congress had just rejected an appropriation for a building to house the National Institute of Child Health & Human Development at NIH. "We decided to hold down spending on construction in order to more fully fund research," Obey said.

The NICHD building would have been constructed entirely with federal funds. In the NCI budget, $11 million had been earmarked for grants, which require at least 50-50 matching by the grantee institutions. In practice, NCI construction funding has generated local support at the rate of two dollars for every federal dollar spent.

At least half of the grants would be used to upgrade animal facilities and to improve biohazard and chemohazard containment in research laboratories. These would be to bring institutions into compliance with federal regulations—regulations arising directly from laws enacted by Congress.

A careful study of construction needs around the country in labs performing NCI supported research, conducted by the National Cancer Advisory Board, determined that NCI should support construction at the rate of $25 million a year for six years in order to meet those needs. The Board asked NCI Director Arthur Upton to reprogram funds from other NCI areas (excluding investigator initiated research) if Congress does not appropriate that much each year.

The other $5 million in the construction budget would be used for (1) NCI's share of the expansion of the NIH clinical center; (2) renovation for animal facilities and bio-chemohazard containment at Frederick Cancer Research Center, including controls to permit recombinant DNA research.

• Obey said the committee felt it was not fair that cancer control grants, with an appropriation of $20 million, would be funded to a lesser priority score level than the NIH and NCI average. By cutting control grants $3.7 million, "it put cancer control on the same footing as everybody else within NCI and within NIH at a payline of around 212," Obey said.

As the budget now stands, NCI grants would be funded to priority scores of about 235; the unfairness would be reversed, if cancer control grants are held to a 212 level.

Existing cancer control and rehabilitation grants, which have to be funded if NCI honors its moral commitment, will require $11 million. That would leave $5 million for new grants and for competitive renewals if the House figure stands, instead of $9 million as proposed in the budget request.

Included among the grants coming up for renewal in the 1980 fiscal year are all of the cancer center outreach grants, totaling $5.4 million. Those grants support programs at comprehensive centers in prevention, public and professional education, and collaborative efforts with community hospitals and physicians.

Also competing for renewal will be other grants which support activities essentially in community settings totaling $3.6 million.

Obey said it was not his intention nor the committee's to cut funding for cancer control community activities (specifically, he referred to funding for "community cancer centers." Actually, NCI does not have a funding category for community centers. Obey may have been referring to the Community Based Cancer Control Program, to the Community Oncology Program, and to other activities which support directly or indirectly community demonstration and education programs).

Yet, much if not all of the reduction in money for grants would have to come out of community related programs.

• Obey said the committee felt that cutting $5.3 millionfrom Cancer Control Program contracts could be done "simply by improving efficiency and im-

proving selection of their projects." He cited the poor results found in the Div. of Cancer Control & Rehabilitation's merit review of the vinyl chloride contract in Louisville, and the asbestos workers contract in Tyler, Tex. He also criticized cervical cancer screening of low income women conducted through contracts with state health departments.

Criticism of those contract supported programs is valid, up to a point. However, the vinyl chloride contract has been terminated, and there are some very persuasive arguments for continuing the others.

The DCCR budget request for 1980 included $48.5 million for contracts, including existing commitments and new initiatives. Of that amount, 45% is in prevention and education programs, 24% in treatment, rehabilitation and continuing care, and 31% in direct support of community activities—primarily, the Community Based Cancer Control Program and the Community Oncology Program.

SENATE LABOR-HEW APPROPRIATIONS SUBCOMMITTEE

Congressman	Address	Telephone	Staff Member
DEMOCRATS		(A.C. 202)	
Warren G. Magnuson, Chmn. (Wash.)	127 RSOB	224-2621	Featherstone Reid (224-0226)
Robert C. Byrd (W.Va.)	133 RSOB	224-3954	Gary Curran
William Proxmire (Wis.)	5241 DSOB	224-5653	Larry Patton
Daniel K. Inouye (Hawaii)	105 RSOB	224-3934	Dr. Patrick DeLeon
Ernest F. Hollings (S.C.)	115 RSOB	224-6121	James Feely (224-7298)
Birch Bayh (Ind.)	363 RSOB	224-5623	Abby Reed (224-8750)
Thomas F. Eagleton (Mo.)	1209 DSOB	224-5721	Marcia McCord
Lawton Chiles (Fla.)	437 RSOB	224-5274	George Patten
Quentin N. Burdick (N.Dak.)	451 RSOB	224-2551	Ann Humphrey (224-1184)
REPUBLICANS			
Richard S. Schweiker (Pa.)	253 RSOB	224-4254	David Winston (224-4062)
Mark O. Hatfield (Oreg.)	463 RSOB	224-3753	Ms. Riki Poster
Charles McC. Mathias, Jr. (Md.)	358 RSOB	224-4654	Jill Porter
Lowell P. Weicker, Jr. (Conn.)	313 RSOB	224-4041	Peter Goldfarb (224-9042)
Harrison H. Schmitt (N.Mex.)	248 RSOB	224-5521	Frances Draper
L-HEW SUBCOMMITTEE STAFF			**RESPONSIBILITY**
Maj: Terry Lierman	1108 DSOB	224-7283	L-HEW and Health
Jim Sourwine	1108 DSOB	224-7256	Dev. Disabil. & Rehab.
Sam Hunt	1109 DSOB	224-7208	Education
James P. Moran	1108 DSOB	224-7291	Welfare
Min: Gar Kaganowich	1239 DSOB	224-7231	
Jim Painter	1239 DSOB	224-7238	

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DSOB, Dirksen Senate Office Building, Washington, D.C. 20510

another $6 million to be reprogrammed from other unspecified areas of NCI under the House Appropriations Committee plan. The $23 million would be added to the $22 million budgeted for the Carcinogenesis Testing Program.

Obey said that with the $22 million, the same amount the testing program is getting in FY 1979, the program not only would not be able to put any additional chemicals on test, but it would have to pull off 70 of the 195 compounds which are already on test.

Obey was basically correct on that position, although the actual number of tests which would have to be stopped would be closer to 42 than to 70. As with nearly every other program, level funding from one year to the next means that, because of inflation and increased costs, something has to be cut. Other programs frequently include contracts or grants which are up for renewal or have been completed,

HOUSE LABOR-HEW APPROPRIATIONS SUBCOMMITTEE

Congressman	Address	Telephone	Staff Member
DEMOCRATS			
William H. Natcher, Chmn. (Ky.)	2233 RHOB	225-3501	None
Daniel J. Flood (Pa.)	108 CHOB	225-6511	Richard Altman
Neal Smith (Iowa)	2373 RHOB	225-4426	Tom Dawson
Edward J. Patten (N.J.)	2332 RHOB	225-6301	Susan Mannina
David R. Obey (Wis.)	2230 RHOB	225-3365	Cathy Reed
Edward R. Roybal (Calif.)	2211 RHOB	225-6235	Harry Pachon
Louis Stokes (Ohio)	2465 RHOB	225-7032	None
Joseph D. Early (Mass.)	1032 LHOB	225-6101	Fred Fedeli
Jamie L. Whitten, Ex Officio (Miss.)	2314 RHOB	225-4306	Buddy Bishop or Hal DeCell
REPUBLICANS			
Robert H. Michel (Ill.)	2112 RHOB	225-6201	David Kehl (225-0197, 1622 LHOB)
Silvio O. Conte (Mass.)	2300 RHOB	225-5335	Peter Michaelson
George M. O'Brien (Ill.)	2439 RHOB	225-3635	Patrick Barkauskas
Carl D. Pursell (Mich.)	1414 LHOB	225-4401	Gary Russell
L-HEW SUBCOMMITTEE STAFF			**RESPONSIBILITY**
Maj: Henry Neil	2358 RHOB	225-3508	(L-HEW)
Fred Pfluger	2358 RHOB	225-3508	(Education Programs)
Mike Stevens	2358 RHOB	225-3508	(Health/Welfare/Social Services)
Min: Jim Fairchild	1016 LHOB	225-3481	

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LHOB, Longworth House Office Building, Washington, D.C. 20515

leaving room for new awards.

With the testing program, there will not be enough

The committee directed that none of the cuts could come from prevention and education, and Obey stated on the House floor that none of the cuts should come from community activities. That leaves the $12 million budgeted for treatment, rehabilitation and continuing care contracts which would have to absorb much of the $5.3 million cut in contracts.

The stickler is that about two-thirds of the treatment, rehabilitation and continuing care contracts are in communities—again, an area Obey agreed should not be cut.

DCCR was planning to initiate a number of new contract programs, including the Community Hospital Oncology Program, $1.5 million in the first year; rehabilitation projects, $900,000; and prevention, $200,000. All of those would be jeopardized by the House's cuts.

• The $17 million reprogrammed from construction and cancer control would be supplemented by chemicals coming off test in FY 1980 to make up for increased costs; some existing tests therefore would have to be stopped before completion.

Obey is fully justified in his exasperation. Cutting off tests before they have been finished would be every bit as wasteful as prematurely canceling other projects. Given the interest in chemical carcinogenesis Obey and Congress in general are known to have, it was shortsighted of NCI not to have provided some additional funds for the testing program in the budget.

The best solution, of course, would be for Congress to add $23 million, or whatever it deems necessary, to the appropriation for carcinogenesis testing, in addition to the add-ons already made for investigator initiated research and for interferon. To that end, the Assn. of Community Cancer Centers, primarily concerned over cuts which would affect community programs, is urging its members to step up contacts with their senators and representatives. The Senate Appropriations Committee will mark up its bill some time after the middle of July, and it could reach the Senate floor before the August recess. The House-Senate conference probably will not be scheduled before Congress reconvenes in September, so there is still time for contacts to have an impact.

Those whose senators and/or representatives are members of the Labor-HEW Appropriations Subcommittees might be even more helpful at this stage. Most if not all of those subcommittee members will be appointed to the conference.

The subcommittee members, addresses and staff members are listed on page 5. Note that Jamie Whitten (D.-Miss.), who is listed as an ex-officio member of the House subcommittee, is the chairman of the full Appropriations Committee. Warren Magnuson (D.-Wash.) is chairman of both the full Senate committee and the subcommittee.

AACI HEARS PROPOSAL FOR COMPUTERIZED CANCER PATIENT MEDICAL HISTORY SYSTEM

John Schweppe, chairman of the Northwestern Univ. Cancer Center Education Committee, has developed with others a proposal for transcribing and encoding medical records of cancer patients using central computer facilities. The proposal was presented to the Assn. of American Cancer Institutes at its meeting last month:

"We are proposing that a summary of a patient's entire medical history be encoded on microfichette or stand in a central computer facility, with terminals in hospitals, clinics, or registries. Elderly patients, in particular, are unable to give an accurate account of their previous medical problems or the current therapy being utilized. Under the proposed method, the patient would carry a plastic card with his number on it. This access number would enable a physician or treatment center to retrieve the patient's entire medical history, a history which could be easily updated every three months.

"Correspondence has been going on with government agencies and learned societies, such as the National Institutes of Health, the biostatistical division of the National Center for Health Services, the American College of Physicians, and the Institute of Medicine of the National Academy of Sciences. I have not heard of any objections to this plan, but rather compliments from all societies contacted. The proposal has also been discussed at length with Dr. Nathaniel Berlin, director of the Northwestern Univ. Cancer Center. Dr. David Hamburg of the National Academy of Sciences has given helpful comments. The Illinois Medical Society and the American Cancer Society have been contacted, and are at present reviewing the possibilities of such a program.

"Originally, the concept was to test out such a program in small regional areas—for example, an HMO area—and then to apply it to large urban, small urban, and rural locales. However, it would be almost impossible to collate the required information because of the time that would have to be spent by individual physicians or hospital personnel. For this reason, it is the conclusion of individuals whom I have contacted that the system should first be tried in the field of oncology, for which accurate records are already available through the cancer registries.

"IBM and other similar companies have the techniques available for miniaturization on a plastic card of all records. However, the hardware for reproducing the information and encoding and decoding is not on line, because there is not as yet sufficient demand.

"There would be no medical/legal aspects to the program by reason of the fact that the card would be under the patient's control. I have discussed this matter with legal counsel, and it would appear that no medical/legal problems could arise in view of the fact that the patient himself would carry the card

and present it to a consultant or another physician. The computer facilities would be under the control of hospital-utilized central facilities. No other person would have the patient's index number other than his physician. Consent forms would probably be necessary.

"Exploration of details pertaining to contents of records: The computerized record or microfichette would contain the following:

1. Background information: name, address, telephone number, names of attending physicians and consultants, and hospital affiliation.

2. Present medical illness, including all primary and secondary diagnoses, and anatomical location, including pathology (type of biopsy, etc.).

3. Past medical illness during lifetime, either associated or unassociated with present condition.

4. Genetic and family information of disease, including abnormal x-ray and laboratory findings.

5. Staging and specific extent of lesion, if metastatic.

6. Specific therapeutic measures undertaken, including surgery, chemotherapy (with dosages and courses), and specific irradiation ports, dosages, and times.

7. Any pertinent miscellaneous information, such as mental status, habits, drug usage. Of importance would be contact with potential carcinogens.

"We suggest the system first be tried in the oncological field in cities subserved by cancer centers.

"Microfiche is a cheap process, and the patient would have his own record with him at all times. The cancer registry and managing physician would have a duplicate. This is the cheapest, simplest system.

"Computer storage, retrieval, and terminal facilities have been developed and are available, but are (to my knowledge) in local use only. To enter current cancer centers would be ideal, but more costly. Quite a few small companies are designing such systems, but not on a national scale.

"The cost of such a program would be borne by the patient and third party insurance."

NCI CONTRACT AWARDS

Title: Program planning, evaluation and related support services for the Div. of Cancer Control & Rehabilitation, modification
Contractor: JRB Associates, $99,743.

Title: Incorporation of seven additional alteration/-renovation/maintenance/upgrading projects at Frederick Cancer Research Center
Contractor: Litton Bionetics, $165,840.

Title: Immunohistochemical studies of tumor associated antigens, continuation
Contractor: Univ. of Kentucky, $145,017.

Title: Purification of human tumor associated antigens, continuation
Contractor: Univ. of Kentucky, $196,177.

Title: Chemoimmunotherapy of acute myelocytic leukemia
Contractor: Mount Sinai School of Medicine, $168,653.

Title: Characterization of antigen-binding T-cell receptors, continuation
Contractor: Univ. of Chicago, $86,883.

Title: BCG immunotherapy of recurrent superficial bladder cancer, continuation
Contractor: Univ. of Texas Health Science Center at San Antonio, $158,189.

Title: Clinical evaluation of immunodiagnostic tests for cancer
Contractor: Kaiser Foundation Research Institute, $40,444.

Title: Prediction of hormone dependency in human breast cancer, continuation
Contractor: Univ. of Chicago, $85,000.

Title: Biological characterization studies of animal mammary tumors, continuation
Contractor: Mason Research Institute, $169,870.

Title: Isolation and tissue culture of human tumor cells
Contractor: Sloan-Kettering Institute, $1,268,063.

Title: Immune stimulants in patients receiving radiation therapy, continuation
Contractor: Emory Univ., $73,218.

Title: Immunoprophylaxis of "cancer eye" in cattle, continuation
Contractor: Utah State Univ., $271,260.

Title: Investigation of a slit-scan technique as a basis for an automated prescreening system for cancer detection in cytology, continuation
Contractor: Univ. of Rochester, $1,156,325.

Title: Diagnostic use of cross-reacting microbial antigens
Contractor: Univ. of Texas System Cancer Center, $80,005.

Title: Reagents for characterization of human cell subpopulations, continuation
Contractor: Univ. of Chicago, $185,642.

Title: Characterization of antigen binding T-cell receptors
Contractor: Univ. of California (San Francisco), $87,963.

Title: Diagnostic application of monocytes function in cancer patients
Contractor: Duke Univ. Medical Center, $83,302.

Title: Acquire and analyze data and information on chemicals that impact on man and his environment, continuation
Contractor: SRI International, $374,713.

Title: Intratumoral BCG immunotherapy prior to surgery for carcinoma of the lung, continuation
Contractor: Yale Univ., $156,300.

Title: Immunoprophylaxis of bovine lymphosarcoma, continuation
Contractor: Univ. of Pennsylvania, $312,000.

Title: Immunotherapy of disseminated human cancer, continuation
Contractor: M.D. Anderson Hospital, $258,500.

Title: Immunological markers applicable to cytology automation, continuation
Contractor: Johns Hopkins Univ., $90,658.

Title: Cell mediated reactivity of normal persons to human TAA's
Contractor: UCLA, $74,282.

Title: Direct assay for lymphokine
Contractor: Stanford Univ., $155,034.

Title: Hodgkin's disease and other human lymphoma
Contractor: Stanford Univ., $450,000.

Title: Processing laboratory for virus containing fluids, continuation
Contractor: Electro-Nucleonics Laboratories, $400,000.

Title: Role of hormonal factors on the induction of mammary tumors in MPMV infected animals, continuation
Contractor: Mason Research Institute, $412,962.

Title: Search for genetic material in human cancer and studies on mechanism of oncogenesis, continuation
Contractor: St. Louis Univ. School of Medicine, $499,999.

Title: Support services for field studies, continuation
Contractor: Westat Inc., Rockville, $56,525 and $824,787.

Title: San Francisco Bay Area resource for cancer epidemiology, continuation
Contractor: California Dept. of Public Health, $1,422,567.

Title: Immunologic study of RNA (type C) viruses, continuation
Contractor: Scripps Clinic & Research Foundation, $470,000.

Title: Maintenance of chimpanzees for cancer research, continuation
Contractor: Albany Medical College of Union Univ., $170,576.

Title: Population based cancer epidemiology research center in Iowa
Contractor: Univ. of Iowa, $40,754.

Title: Occupational cancer risk in Hawaii, continuation
Contractor: Univ. of Hawaii, $355,303.

Title: Natural occurrence of RNA tumor viruses (genomes), continuation
Contractor: Jackson Laboratory, $458,383.

Title: Clinical Oncology Program, two month extensions
Contractors: Methodist Hospital of Indiana, $32,195 and Allentown Hospital, $14,359.

Title: Radiologic Physics Centers, six month extensions
Contractors: Memorial Hospital, New York, $89,941, Univ. of Texas System Cancer Center, $59,724, Univ. of Colorado, Denver, $86,506, and Allegheny-Singer Research Corp., Pittsburgh, $132,258.

Title: Development of assays for new tumor associated antigens
Contractor: Vanderbilt Univ. School of Medicine, $110,746.

Title: HL-A typing and matching for platelet and leukocyte transfusions
Contractor: UCLA, $1,266,753.

Title: Cancer communications support for minority hard-to-reach audiences program
Contractor: Small Business Administration, $99,283

Title: Data support project for cervical cancer screening
Contractor: SBA (Evaluation Technologies Inc., subcontractor), $237,557.

Title: Breast Cancer Detection Demonstration Project, one-month extension
Contractor: Stella & Charles Guttman Breast Diagnostic Institute, $37,680.

The Cancer Letter _Editor Jerry D. Boyd

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