

THE

# CANCER LETTER

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## HOUSE-SENATE CONFERENCE AGREES ON \$1 BILLION FOR NCI, INCREASES FOR ALL NIH ORGANIZATIONS

In a stunning and perhaps unprecedented development, House and Senate conferees accepted the full Senate figure of \$1 billion for NCI's 1980 fiscal year appropriations—\$62.9 million more than NCI is getting in FY 1979; \$63 million more than the President's request for 1980;

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### In Brief

#### HOUSE PASSES BILL EXTENDING SACCHARIN STATUS TO 1981; EXECS NOT ENTHUSIASTIC OVER NEW SES

**SACCHARIN STUDY** bill extending to June 30, 1981, the ban on regulatory action against the artificial sweetener was passed last week by the House with a 394-22 vote. Chairman Henry Waxman of the Health Subcommittee acknowledged the National Academy of Sciences report which said that saccharin was at least a low level carcinogen.

"We know that exposure to a number of carcinogens may have a combined impact much greater than that for any individual substance," Waxman said. But he recommended approval of the extension because of "concerns of diabetics and others on a sugar restricted diet who feel that without this substitute they will face a known health hazard from sugar." FDA had not proposed a total ban but would have permitted sale of saccharin as a table top sweetener; its ban would have applied only to soft drink bottlers and other food processors. . . . **MYTH DE-**

**BUNKED:** "Cancer Program appropriations have driven down appropriations for research on other diseases." Nathaniel Polster, American Cancer Society lobbyist, told members of the Assn. of American Cancer Institutes that "that is not true, but the majority of staff members and elected officials on Capitol Hill believe it is." Polster noted that in the six years before passage of the National Cancer Act in 1971, non-NCI institutes of NIH had a 56% increase in their appropriations. In the six years after 1971, their appropriations increased 65%. "There is no logical way they can show an adverse effect, but they've sold that to Congress. They got their increases without working for them." . . .

**ONCOLOGY PROGRAM** for nurses is the subject of a seminar sponsored by the St. Vincent's Medical Center Cancer Committee in Jacksonville Sept. 15. Preregistration is required: Cancer Education Program, St. Vincent's Medical Center, 1800 Barrs St., Jacksonville, Fla. 32204. . . . **NIH EXECUTIVES** did not all agree to transfer to the Senior Executive Service "with enthusiasm," as stated in *The Cancer Letter* July 13. "We felt we had no other choice," one NCI executive said. "It was made rather clear to us that refusing would have meant we would be locked in where we are, with no further chance for advancement." Many are apprehensive about being moved around to other jobs and agencies and are skeptical of the evaluation systems which will determine promotions and bonuses.

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## CONFERENCE DENIES OBEY RESTRICTIONS IN GIVING NCI FIRST \$1 BILLION YEAR

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and \$38.8 million more than voted by the House.

Senate Appropriations Committee Chairman Warren Magnuson pushed through the higher appropriations for NCI and other increases for NIH totaling \$256 million above the President's budget. He had the solid backing of Sen. Birch Bayh and House conferee Silvio Conte, and most importantly, powerful support of House HEW Appropriations Subcommittee Chairman William Natcher.

In previous years, the more conservative House approved one set of figures for each institute, and the Senate voted higher amounts for each. Conferees would split the differences, usually right down the middle.

The Senate HEW Appropriations Subcommittee this year came up with a different game plan. Urged on by the persistence and eloquence of Bayh with help of the subcommittee's Republicans, led by Richard Schweiker, the subcommittee approved \$1 billion for the Cancer Program. The House figure was \$961.2 million.

The Senate subcommittee then went on to approve lower figures than the House for five other institutes and for the Div. of Research Resources—the first time in this decade and possibly for many years previously that the Senate had cut House NIH appropriations. The subcommittee also asked for appropriations higher than the House figures for three institutes and for the National Library of Medicine. For two institutes—Heart, Lung & Blood and Environmental Health Sciences—and for the Fogarty International Center, the Senate and House had the same figures.

With the differences split up among the institutes rather than merely high-low levels for each, the bargaining this time took a different tack. Magnuson opened discussion of the NIH section, after the conferees had quickly disposed of the Dept. of Labor and other health programs included in the bills, by suggesting "we accept the higher figure for each of the institutes."

It was a ploy that the House conferees readily accepted, although not without some argument from Congressman David Obey.

Natcher countered Magnuson by accepting the high figures for all institutes except NCI, since the difference there was far greater than the others. Natcher suggested adding only \$20 million to the House amount.

"You're taking all of the add ons except cancer. Why are you excepting cancer?" Bayh asked.

The conference was interrupted at that point so House members could respond to a vote being taken on the House floor. After they returned, Magnuson said, "We made an offer."

"You want to hold to the \$38 million for cancer," Natcher said. "What do you say on this side?" he asked his House colleagues.

Only Obey objected. He argued that \$2 million should be cut from NCI construction funds, contending that should be cut from renovation work at Frederick Cancer Research Center under the contract with Litton Bionetics.

Obey also brought up his arguments that cancer control grants would be funded at lower priorities than the rest of NIH if the control grants budget was not cut; that the Cancer Control Program contract with state health departments for Pap smears among low income women cost \$5 more than Medicare and Medicaid pay for the same service; and that 10% of cancer control contracts "are terminated in mid-stream" when NCI reviewers have determined them inadequate.

Obey asked that \$2 million be cut from the construction budget of \$15.9 million and that the budget of the Div. of Cancer Control & Rehabilitation of \$66.4 million be reduced by \$6 million.

"They ought to be complimented for canceling those contracts that aren't working out," Magnuson said.

Bayh argued, "Dave, if you can find someone getting reimbursed for Pap smears out of Medicare, you're better than I am. Medicare doesn't reimburse for Pap tests."

"How do you defend a program when their own reviewers say it's lousy and yet they renew it?" Obey asked.

"The only ones like that are in underserved areas," Bayh answered.

"Not the one in Tyler, Texas," Obey said, referring to the DCCR contract there dealing with the asbestos problem. "You can't tell me it would injure the Cancer Program if you would take \$6 million out of cancer control and \$2 million from construction."

"I can too say that," Bayh answered. "I've talked with people at NCI and there's no way we can cut \$6 million without hurting community programs."

Obey said he had agreed that no money should be cut from community programs. Since he had written into the House report that no cuts should be made from cancer control prevention or education programs, cuts would have had to be made by early termination of contracts and grants.

Conte suggested that the entire \$1 billion figure for NCI be approved but with the stipulation that \$2 million be moved from construction to other program areas. Natcher accepted that proposal, but then Magnuson stipulated, after the conferees agreed to the \$1 billion, that "there will be no language" restricting use of the funds. Natcher agreed, "No language."

NCI had its first \$1 billion budget.

NCI executives analyze the reports of the House and Senate Appropriations Committees which accompany their bills in making their determinations on



how they will spend the money. They had concluded prior to the conference that if they received the entire \$1 billion (which none of them at that point thought they would get), they would allocate the \$62.9 million above the budget request this way:

- They would go along with Obey and put an additional \$23 million into carcinogenesis testing, which means it would go to the National Toxicology Program along with the \$22 million budgeted.

- \$18.2 million would be added to funds budgeted for investigator initiated research permitting funding of approved new and renewal grants to a pay line of 212.

- \$13.5 million would be allocated for development and studies of biological response modifiers, including interferon.

- \$6.7 million would be used to maintain the same number of full time equivalent training grants as were supported in 1979 but at the higher stipends ordered by NIH.

- The balance of the increase would go into the management fund for increased overhead costs.

In its original request to the White House, NCI had asked for the full authorized amount of \$1.03 billion. But when the Office of Management & Budget slashed that to \$936.9 million, NCI executives felt they would be fortunate to come out with \$980 million. They were disheartened by Obey's attempts to gut cancer control and construction, although the House figure was higher than they had anticipated. Even when the Senate came through with \$1 billion, few Cancer Program advocates expected more than the usual 50-50 split, which would have placed the final figure at \$980 million.

Landing the entire \$1 billion while removing the Obey restrictions was a smashing victory for Cancer Program lobbyists, both those working behind the scenes as well as the campaign generated by the Assn. of Community Cancer Centers.

Even Obey can claim at least a partial victory, more than doubling support for carcinogenesis testing.

Congress was planning to take a month vacation starting this week. Leaders of both houses thought there might be a slim chance of getting final action on the Labor-HEW appropriations bill before the recess. House conferees accepted the Senate version of restrictions on Medicaid funding of abortions; the question now is whether the full House will go along.

#### **TASK FORCE SUBMITS RECOMMENDATIONS FOR CENTERS-CONTROL-RESOURCES DIV.**

The task force established to advise NCI Director Arthur Upton on the content of a proposed new division which would include cancer control, centers and other activities agreed that:

- Most of the existing programs in the Div. of

Cancer Control & Rehabilitation should be in the new division.

- Some of DCCR's activities in prevention should be moved into the proposed new Div. of Cancer Prevention, if it is in fact established.

- The cancer centers, construction, organ site and education and training programs should be in the new division (suggested name: Div. of Cancer Centers, Community Activities & Resources).

- The Office of Cancer Communications and the Journal of NCI should remain in the Office of the Director.

- The International Cancer Research Data Bank, presently in the Office of the Director, should be moved into the Div. of Cancer Cause & Prevention.

William Terry, chairman of the task force and acting director of DCCR, said in his report to Upton that if all proposed components as recommended by the task force are located in the new division, it would have a budget of about \$195 million and a staff of 80-85.

Four major program areas were considered—resources, research programs, treatment/control, and prevention/control. The report follows (new division, or ND, refers to the Div. of Cancer Centers, Community Activities & Resources):

#### **I. RESOURCES**

##### **A. Construction**

The task force recommends that this program be transferred in its entirety to the new division (ND). There was no alternative proposal. Vote: 14 for, none against.

##### **B. Information Dissemination**

1. Journal of the National Cancer Institute—The task force recommends that JNCI remain in the Office of Director, NCI. An alternative proposal, that JNCI be transferred to the ND, was discussed and supported by a minority of the task force. It was concluded by the majority, however, that as a journal of international stature, it would be inappropriate for JNCI to be located in any operating division where the policies or content of the journal might be subject to parochial interests. Vote: 9 for, 4 against, 1 undecided.

2. Office of Cancer Communications—The task force recommends that all components of OCC remain in the Office of the Director, but that a close working relationship should be established between OCC and the ND. Transfer of some portions of OCC to the ND was discussed, but the task force concluded that it would be more efficient and productive to retain a centralized office with a critical mass of communications expertise. This office should collaborate closely with the ND to accomplish information dissemination functions of relevance to that division. Vote: 13-0-1.

3. International Cancer Research Data Bank

(ICRDB)—The task force recommends, by split vote, that ICRDB be transferred to the Div. of Cancer Cause & Prevention for a trial period of two years, with review at that time for appropriateness of program location. The task force considered, and rejected by an 8-5 vote, an alternative proposal to move ICRDB to the ND. The minority supported the idea that ICRDB was both a resource and information dissemination activity and, for these reasons, should be moved to the ND. The majority, however, supported the argument that ICRDB was working well, that the support and participation of Gregory O'Connor (DCCP director and former ICRDB chief) was an important element, and that it would be desirable to move ICRDB to the division of which he is director in order to assure this continued working relationship. Vote: 8-5-1.

4. Div. of Cancer Control & Rehabilitation Information Activities—The task force recommends the transfer of all DCCR information activities to the ND. There was no alternative proposal. It was further recommended that the organization of these activities be restructured in the ND, both to assure close collaboration with OCC and to take advantage of the organizational relocation of the Centers Program. 12-0-2.

#### C. Education and Training

The task force recommends that all programs supporting professional and paraprofessional clinical education, research training and continuing education currently carried out in the Div. of Cancer Research Resources & Centers and the Div. of Cancer Control & Rehabilitation be transferred to the ND. There was no alternative proposal. It was suggested that this education and training program should develop and maintain a critical mass of personnel expert in education and education evaluation and serve as an NCI resource. Vote: 12-0-2.

## II. RESEARCH PROGRAMS

### A. Cancer Centers Program

The task force recommends that the Centers Program, including the centralized cancer patient data system (CCPDS) grants and the statistical analysis and quality control contract be transferred to the ND. There was no alternative proposal. Coordination of CCPDS with related activities in the Field Studies & Statistics Program was suggested. Vote: 14-0-0.

### B. Organ Site Programs

1. Urinary Bladder, Large Bowel, Pancreas and Prostate—The task force recommends that these four organ site programs, currently administered by DCRRC, be transferred to the ND. There was no alternative proposal. Vote: 14-0-0.

2. New organ site activities—The task force recommends that activation of dormant organ site programs (such as the lung program) or development of any new organ site programs should be a function of the ND. There was no alternative proposal. Vote: 13-0-1.

3. Breast Cancer Task Force (BCTF)—The task force recommends that administration of the BCTF

be retained in the Div. of Cancer Biology & Diagnosis but that this matter be reviewed in two years. The alternative proposal, that the BCTF be transferred to the ND and become part of the Organ Site Program was discussed. Arguments supporting this transfer were that (1) breast is an organ site and should be handled like the others, (2) it might be advantageous to have the BCTF and the Breast Cancer Detection & Demonstration Programs located in the same administrative unit. (This arrangement presumes that the Breast Cancer Detection & Demonstration Programs would indeed be located in the ND.) The task force is persuaded by the counterarguments that (1) the BCTF program is working well in DCBD, (2) BCTF is managed directly by NCI staff, whereas the other Organ Site Programs are managed extramurally and therefore are operationally different, and (3) recent separation of BCTF program from review has been disruptive and more changes at this time would be demoralizing to NCI staff. The task force therefore did not support this proposal. Vote: 12-1-1.

## III. TREATMENT/CONTROL

The task force recommends that all activities currently carried out by the Treatment, Rehabilitation & Continuing Care Programs as well as the Community Special Projects Programs of DCCR be transferred to the ND. There were varying degrees of agreement on these recommendations and comments about the specific programs will therefore be presented separately.

### A. Centers Outreach Program

The task force recommends transfer to the ND. There was no alternative proposal, but it is suggested that attention be paid to the administrative relationship of this program to the Centers Program and consideration be given to integrating these two activities. Vote: 12-0-2.

### B. Clinical Oncology Program

The task force recommends transfer to the ND. There was no alternative proposal. It was noted, however, that there seemed to be considerable overlap between the Oncology Program and other clinical activities within DCCR. It was recommended, therefore, that there should be a thorough examination of the goals of each program within the ND. Vote: 13-0-1.

### C. Community Based Control Program

The task force recommends transfer to the ND. The task force, however, considers this program to be unwieldy, not evaluable and probably unworkable and recommends that the director of the ND carefully review the recommendations of the next merit review and consider termination of at least some portions of this program. Vote: 12-0-2.

### D. Oncology Nursing Program

The task force recommends transfer to the ND. The task force suggests that the educational aspects of this program be integrated with the other professional educational activities of the ND. Vote: 13-0-1.

#### E. Patterns of Care Program

The task force recommends transfer to the ND. The task force discussed the possibility of transferring this program to the Div. of Cancer Treatment on the grounds that this is an activity of the Radiation Therapy Oncology Group, a Cooperative Group that is administered by DCT. The majority of the task force, however, was persuaded by the argument that this type of program, encompassing evaluation of delivery of cancer care and modification of the delivery of cancer care, is significantly different from the research activities of concern to DCT and therefore that location in the ND would be advantageous. Vote: 12-1-1.

#### F. Clinical Cooperative Program

The task force recommends transfer to the ND. A large minority of the task force supported the idea that this activity is really an extension of the Cooperative Group Program run by the Cancer Therapy Evaluation Program of DCT, and should be transferred to DCT to provide better administration and program review. A majority of the committee, however, considered that although there needs to be administrative interaction and cooperation between DCT and the ND, these outreach programs are sufficiently different from the mission of DCT that they most appropriately belong in a division concerned with cancer at the community level and that the program therefore should be located in the ND. Vote: 8-6-0.

#### G. Network Programs

The task force recommends transfer to the ND. There was no alternative proposal. These programs are close to termination and the remaining activities concern evaluation. The task force suggests, therefore, that there be close interaction with the Biometry Branch, DCCP, during the evaluation phase. Vote: 14-0-0.

#### H. Hospice and Terminal Care Activities

The task force recommends transfer to the ND. There was discussion concerning the advisability of transferring these programs to other government agencies, but this suggestion was not supported. There was also discussion of establishing a link with the National Institute of Mental Health in order to obtain assistance in the development and management of psychological programs. No specific recommendation is made. It was suggested that this was an area requiring special emphasis. Vote: 12-1-1.

#### I. Pain Program

The task force recommends transfer to the ND. There was discussion of the advisability of transferring this program to DCT on the grounds that DCT has the mission of sponsoring development of new drugs and is prepared to support toxicity and efficacy studies of new pharmacologic agents. The task force decided, however, that pain was an area that needed special emphasis and recommends that a full program, including support for relevant studies in neurobiolo-

gy and neuropharmacology, as well as clinical studies and technology transfer, should be located in the ND. Vote: 11-2-1.

#### J. Rehabilitation Programs

The task force recommends transfer to the ND. Again, it was the sense of the task force that this should be a special emphasis program, extending from basic research through technology transfer and evaluation. Vote: 12-0-2.

#### K. Diethylstilbesterol (DES) Program

The task force recommends transfer to the ND, with subsequent transfer to the Prevention Division when it is established. This long-term study of the offspring of women exposed to DES during pregnancy would be appropriate for inclusion in a division devoted to cancer prevention. It was recommended, however, that until that division is created and functioning, it would be disruptive to move the DES Program elsewhere within NCI on an interim basis. Inclusion in the ND would, therefore, be most practical. Vote: 12-1-1.

### IV. PREVENTION/CONTROL

Consideration of prevention-related activities was quite difficult for two reasons: (1) the Prevention Division does not yet exist and it is not clear what the mandate of that division will be. This makes it difficult to determine precisely which activities belong where; (2) the concept of a Prevention Division encompassing all prevention activities runs counter to the general pattern that is being established with other program areas. For example, in the area of treatment, basic research and early levels of applied research are in the province of the Div. of Cancer Treatment, while technology transfer, evaluation of quality care, behavior modification and other activities related to treatment would be located in the ND. It was not clear to the task force that the organization of prevention activities should be different from the organization of treatment activities and the discussion and recommendations were based upon that concept.

The task force considered only the programs currently in DCCR.

#### A. Smoking & Health, Occupationally Associated Cancer, Carcinogens Related to Public Health

The task force recommends transfer to the Prevention Division following a discussion between the directors of the ND and the Prevention Division as to the best location for each program at the time of the discussion. The task force decided there were too many variables and unknowns to make a more definite recommendation. Vote: 13-0-1.

#### B. Breast Cancer Detection Demonstration Projects and Female Pelvic Cancer Detection Project

The task force recommends transfer to the ND and that these programs be transferred to the Prevention Division when it is established. A consensus could not be reached on this issue. The subcommittee that addressed detection and diagnosis proposed that detec-

tion/diagnosis activities be considered to have three phases: (1) basic research which would be carried out in the Div. of Cancer Biology & Diagnosis; (2) screening trials, to determine if tests used in asymptomatic populations are predictive of cancer susceptibility or early cancer, to be carried out in the Prevention Division; and (3) detection and screening demonstration activities to implement tests and methodologies shown previously to be effective in defined situations and to determine or confirm usefulness, feasibility and cost acceptability in a more general population, to be carried out in the ND. BCDDP and pelvic cancer detection projects were considered to be examples of such activities. Extensive discussion of this concept did not lead to a consensus, nor did it lead to a clear indication of where BCDDP and pelvic detection projects belong now, nor, if they were just being initiated, which division should most properly assume responsibility. Vote: 6-5-3.

#### C. Centers for Radiologic Physics

The task force recommends transfer to the ND if BCDDP is to be located in the ND. If not, the appropriate allocation of these resources would have to be explored further. Vote: 12-1-1.

#### CONCLUSION

This task force was given a well defined task and has by and large limited its deliberations to specifics. Accordingly, it has made recommendations about the future location of (1) all programs of DCCR, (2) all programs requiring relocation due to the first phase of the reorganization (the Centers, Organ Site, Education and Training and Construction Programs), and (3) selected other programs or activities suggested for inclusion in the ND (the Breast Cancer Task Force, the International Cancer Research Data Bank, the Journal of the National Cancer Institute and portions of the Office of Cancer Communications). It is important to note that the task force did not address the advisability of creating a Div. of Prevention. It carried out its deliberations in the expectation that there will be a Prevention Division. If a Prevention Division is not created, some of these recommendations will have to be reconsidered. On an interim basis, all programs that are recommended for transfer to the Prevention Division should be located in the ND, since this will be least disruptive of current activities.

Members of the task force in addition to Terry were Richard Costlow and Margaret Sloan, DCCR; Margaret Edwards, Sam Price and Donald Fox, DCRRC; Joseph Fraumeni and Earl Pollack, DCCP; Jane Henney and Brian Lewis, DCT; Robert McIntire and Jane Taylor, DCBD; John Schneider, ICRDB; Paul Van Nevel, OCC; and Paul Schaffer, executive secretary.

#### NIH HIT WITH TOTAL HIRING FREEZE; NCI, STILL OVER LIMIT, IS HURTING

A total freeze on hiring has been imposed by NIH

Director Donald Fredrickson in order to reduce the number of employees to the September 1977 level, as required by the so called Leach amendment to the Civil Service Reform Act.

Fredrickson previously had ordered that no advisory groups could meet from Aug. 26-Sept. 22 to keep part time (as advisors are listed on the rolls) from the payroll during the period when they would be counted at the end of the fiscal year (*The Cancer Letter*, July 20).

NIH also had been limited since last June to filling only one of every three vacancies that occur. The new freeze prohibits any replacement.

NCI had been given a position ceiling of 2,057 by Congress for fiscal 1979. However, the Administration slashed that to 1,935, and then again in June to 1,915. There are about 1,975 on the NCI rolls now.

The freeze could severely hamper some programs. For instance, the International Cancer Research Data Bank has eight professional positions, but presently has only three of those filled. Director John Schneider has recruited persons for those jobs but can't hire them. The Carcinogenesis Testing Program is authorized 52 positions, is losing significant numbers and can't replace them. The program also needs more clerical help, and is faced with the task of phasing out the prime contractor, as demanded by critics of the program. One potential result: Backlog II.

The Leach Amendment was sponsored by Congressman James Leach (D-La.), who may soon be off the federal payroll himself. He was indicted recently on vote buying charges.

#### GOLDENBERG TELLS GOVERNORS STATES SHOULD INCREASE CANCER EFFORTS

An appeal for increased participation by state governments in cancer programs was made by David Goldenberg, executive director of the Ephraim McDowell Community Cancer Network in Kentucky at the recent National Governors' Conference in Louisville.

"The investment of state governments in cancer programs has been minimal, although there have been some noteworthy efforts in Texas, New York and most recently here in Kentucky," Goldenberg told the governors. "State and local governments contribute only about 9% of the total national budget for cancer programs. And yet, about 85% of cancer patients are first seen and diagnosed at the community level, outside the major medical and cancer centers.

"It is here where the opportunities for using the latest advances of knowledge in cancer detection, diagnosis and treatment lie, and where a major impact on cancer can be made. By just applying the knowledge and methods we have today more rapidly and effectively, we should be able to save an additional 10 to 17% of Americans afflicted with cancer, or between 70,000 and 119,000 lives each year.

"The Kentucky General Assembly in 1978 appropriated \$1 million per year for statewide, community oriented cancer detection, screening, education and documentation programs. Governor Carroll and our legislature thus accepted this challenge and responsibility to join the federal government in the effort to control cancer.

"The federal government, through the National Cancer Institute, should support fundamental and applied research on cancer, while the states should be prepared to invest in and develop local public health programs with cancer as the main strategy. An effective cancer control program, that is, the proper and rapid transfer of new technology and knowledge to the practice of medicine, must reach those who need attention most, at the local, community level. This can be done best by the states and the local communities themselves.

"All segments of the public are rightfully impatient and demanding that money breed results, indeed, rapid returns, as measured by important 'breakthroughs' and instant 'cures.' And the journalistic and political forces are easily persuaded that anything less than such accomplishments are failures on the part of science and medicine to fulfill the expectation that we win the so-called 'war' on cancer. The scientist approaches the complexity of cancer with the realization that it will take a long, sustained stepwise effort to bring the more than 100 forms of cancer under control.

"The patients and their families are slowly learning that cancer is not a hopeless scourge imbued in secrecy and shame. Physicians no longer dread to diagnose cancer, but work hard to find a tumor, act faster when it is found, and teach their patients to practice self examination where it is appropriate. Now is the time for the governors of our nation to seek to understand the full meaning of the cancer problem—medically, socially and economically—and to set the fiscal priorities needed at the level of state government to better cope with the most feared disease of our time."

Goldenberg briefly described progress of the Cancer Program and defended its costs as relatively modest when compared with accomplishments and with costs of other national efforts.

"If we look at the federal budget for fiscal year 1980, the National Cancer Institute is to receive the equivalent of \$4.16 per person in the U.S., while a similar calculation places the amount per person at \$41.46 for federal highways and airline subsidies, \$18.97 for space programs, and \$628.18 for defense programs. And yet, each year cancer takes more lives in this country than we lost in the Second World War.

"Although I cannot assure you that any amount of money in a single year will permit us to eradicate this dread disease, the National Cancer Program, although a modest effort in monetary terms, has had an impressive record of accomplishment. Advances in

cancer detection, diagnosis and therapy have had an important effect in reducing the mortality rate in a few kinds of cancer, such as the lymphomas, particularly Hodgkin's disease, childhood leukemia, thyroid cancer, bone cancer, testicular cancer, bladder cancer, and cancer of the uterus. In 1950, we were able to save 25% of cancer patients; today, over 41%. The American Cancer Society estimates that three million people in the U.S. are alive today although they have had cancer. The best example of eradicating a cancer by improved early detection is that of cancer of the uterine cervix. The Pap test is capable of detecting not only early stages of cancer, but abnormal changes in the cervix 5 to 10 years before it may turn into cancer. Similar research is in progress for the early detection of other cancers, but under the current budget only a fraction of the research deemed acceptable by scientific review can be funded; a fraction that was two-fifths of approved grants in 1978. I remind you that this is what has been termed a 'war on cancer.' Since establishment of the National Cancer Institute in 1937, about \$8 billion have been invested in cancer research. For the 3 million Americans we have been able to save, we compute that each life saved cost us only \$2,667.

"How does this compare to the costs of each new cancer death? What is the impact of cancer on our nation's economy? The cost of all diseases in the U.S. has been estimated at \$245 billion, which includes hospital and physician and other direct costs, as well as indirect—although very real—expenses such as lost earning power and productivity due to premature death. Cancer makes up about 9% of this total cost, amounting to about \$30 billion a year. Dividing this amount by the relative cancer occurrence figures for each state, the cancer economic burden by state in 1978 comes to \$2.7 billion for California, \$1.5 billion for Florida, Texas or Illinois, \$1.2 billion for New Jersey, \$3 billion for New York, \$1.8 billion for Pennsylvania, and \$510 million for Kentucky. These are not exaggerations.

"Although 1,120 cancer patients die daily in the U.S., we are achieving a savings of 797 lives each day. This comes to 291,000 Americans being cured each year, which is 41.6% of the 700,000 new cases diagnosed annually. These lives saved each year are enough to populate such cities as Tampa, Spokane, and Lexington in Kentucky. Since it has been imputed that each premature death due to cancer costs between \$41,000 and \$69,000, the lives saved each year are returning to the economy in the form of productive work, earnings, and taxes between \$11 and \$20 billion, or more than has been spent on the entire federal cancer program since the establishment of the National Cancer Institute in 1937.

"I have taken this effort to itemize the costs of cancer to you, and to show what the investment in cancer research at the federal level returns to our nation's economy because the public and its leaders

need such information in order to make rational decisions regarding budget priorities. What government programs can show such high returns, not only in dollars but in the lives of members of two-thirds of all our families? As you well know, a cancer victim in one's family imparts an entirely different view of this disease from all the statistics, calculations, and logic one expresses."

### RFPs AVAILABLE

*Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute, unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP, citing the RFP number. Some listings will show the phone number of the Contract Specialist, who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Address requests to the contract officer or specialist named, NCI Research Contracts Branch, the appropriate section, as follows:*

*Biology & Diagnosis Section and Biological Carcinogenesis & Field Studies Section—Landow Building, Bethesda, Md. 20205; Control & Rehabilitation Section, Chemical & Physical Carcinogenesis Section, Treatment Section, Office of the Director Section—Blair Building, Silver Spring, Md. 20910. Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.*

### SOURCES SOUGHT

**Title:** *Large scale tissue culture virus production for cancer research*

**Deadline:** *Soon as possible for submission of resumes*

NCI knows of only one organization capable of producing, purifying, characterizing and distributing a variety of different type-C retroviruses and selected tissue culture cell lines. This effort is currently being performed under Contract No. N01 CP 91001, by Electro-Nucleonics Laboratories Inc. Interested organizations must have the following capabilities:

1. The contractor will be required to produce 4-5 different type-C retroviruses on a continuing but flexible basis at a level of 110 liters of virus-containing tissue culture fluid per week. The RNA viruses to be produced and purified may include, but not be limited to, growth of AKR murine leukemia virus in the AKR mouse embryo fibroblast cell line with varying times of harvest and methods of processing tissue culture fluids to obtain AKR virus that would favor the subsequent isolation of either structural proteins, high molecular weight viral RNA or viral glycoproteins; NZB murine leukemia virus (NZB ME C1 35) in the New Zealand black mouse embryo cell line; Kirsten murine sarcoma virus pseudotype of either NZB murine leukemia virus (NZB-MuLV, BC 232) or NIH murine leukemia virus (NIH-MuLV, BC 232), both grown in the human rhabdomyosarcoma

cell line (A673); NIH murine leukemia virus (ATS-124) in the RD human rhabdomyosarcoma cell line; BALB virus-1 in Swiss mouse embryo cells (NIH 3T3); BALB virus-2 (BC-144) in the A673 cell line; Gross leukemia virus, passage A, in the NIH 3T3 cell line; and Moloney leukemia virus (SNE 31) in the NIH 3T3 cell line.

Additionally, the contractor will be required, from time to time, to provide to laboratory investigators gram quantities of a variety of noninfected and infected cell cultures.

2. Production of the RNA viruses should take place in cell systems and with production processes so that final yields of virus, both qualitative and quantitative, are consistent with the latest state-of-the-art. Final preparations should contain appropriate virus particle counts and acceptable levels of high molecular weight nucleic acid, reverse transcriptase enzyme activity, and selected structural proteins.

3. The contractor will also be required to process authorizations from NCI for the distribution of purified viruses and tissue culture cell lines and have the capability to ship these materials to laboratories throughout the world. Associated activities include the completion of internal records and repositories for the accountability of operations.

4. The contractor's facilities should provide air flow systems of defined specification in determining the number of air changes, particle counts, direction of air flow, and description of filter systems. Since the quantities of viruses to be produced represent a moderate risk biological level, attention should be directed in the response to this aspect.

5. The availability of contractor furnished equipment for this effort is desirable. The government reserves the right not to accept offers limited to subsection, smaller elements or portions of the overall work.

Fifteen copies of the resume of capability and experience must be submitted.

**Contracting Officer:** Fred Shaw  
Biological Carcinogenesis &  
Field Studies  
301-496-1781

### NCI CONTRACT AWARDS

**Title:** Demonstration for reimbursement in cancer control, one year renewal

**Contractor:** Blue Cross Assn., \$222,630.

**Title:** Studies of normal, premalignant and malignant epithelial tissues of the human

**Contractor:** Univ. of Maryland (Baltimore), \$686,842.

### The Cancer Letter — Editor Jerry D. Boyd

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