THE CANCER LETTER

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CANCER PROGRAM ADVOCATES, SUCCESS OVERCAME POWERFUL NEGATIVE FACTORS TO WIN BUDGET FIGHT

There was a time a few years ago when NCI senior executives decided not to submit a budget request to the White House for the full amount authorized at that time because it would have put the request

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In Brief

CANCER INVESTMENT "DROP IN THE BUCKET," OMB IS THE "SECOND GREATEST KILLER," PEPPER SAYS

COMMENTS RELEVANT to the first $1 billion appropriation in NCI's history, and which may have reflected the mood of Congress which resulted in that figure: **CLAUDE PEPPER**, chairman of the House Select Committee on Aging—"This [the Cancer Program] is a good investment, with a fantastic return to the government, not even considering the value of saving lives. The government investment in cancer research is a drop in the bucket to what the disease costs. . . . The Cancer Program is a success story so compelling, I don't see how anyone cannot agree. . . . The greatest killer I know other than cancer is OMB [the White House Office of Management & Budget]". . . . **LARRY HOPKINS**, Republican Congressman from Kentucky—"We've heard from some people that there is waste in the Cancer Program. Well, we ought to waste some money to conquer this disease. I would give up foreign aid and the space shuttle to conquer cancer" . . . . **HENRY KAPLAN**, Stanford Univ.—"I'm concerned that there have been in the past strong and urgent pleas to Congress to add funds to research for some particular form of cancer. The response sometimes has been no additional money, just a redeployment. Scientists all want to cure cancer, and we feel that peer review will determine where the money is best spent" . . . . **DANIEL RUBIN**, who has been special assistant for scientific coordination to Div. of Cancer Treatment Director Vincent DeVita since 1976, has moved to the National Heart, Lung & Blood Institute where he is chief of the Planning & Coordination Branch. He has been at NCI since 1967; as research planning officer in 1973 he helped draw up the National Cancer Program Strategic Plan. . . . **EORTC SYMPOSIUM** on advances in cancer chemotherapy will include presentations on cis-platinum Oct. 18-19 and free communications Oct. 19-20 to be selected from abstracts submitted by Aug. 31. Abstracts should be sent to M. Rozencweig, EORTC Data Center, Institut Jules Bordet, 1 rue Heger-Bordet, 1000 Brussels; registration ($100) to same address. . . . **PACIFIC ENDOCURIETHERAPY** Society winter meeting will be Dec. 5-7 in Mazatlan. Contact J. Smith, 637 S. Lucas, Los Angeles 90017, phone 213-481-1500. . . . **SAMUEL SCHWARTZ** is the new associate director for scientific review of the NIH Div. of Research Grants. He has been chief of review for the NHLBI's Div. of Extramural Affairs since 1973.

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MAGNUSON, NATCHER LEADERSHIP GAVE NCI ITS FIRST $1 BILLION BUDGET

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over $1 billion. They reasoned that one billion was a psychological barrier and to exceed it would have been counterproductive with the Office of Management & Budget and Congress.

A billion dollars isn't what it used to be, and there was no reluctance to ask the White House last year for the full one billion, thirty million that was authorized for NCI for the fiscal year which starts next Oct. 1, even if no one really expected to end up with anything close to that amount.

The $1 billion now approved by Congress not only represents near total victory, it also was a total surprise. Never before—at least not since the Cancer Act of 1971—has NCI come so close to getting an appropriation only $30 million less than originally requested, only $30 million less than authorized—not even in the glory years of 1972-75, when NCI's budget tripled.

It was even more surprising considering the factors that were working against anything but a token increase over the 1979 budget:

- The state of the economy and President Carter's decision to try to hold most agencies to 1979 spending.
- Growing criticism of the Cancer Program, some generated by persons with their own interests in mind, some by the well meaning but misinformed.
- The lingering effects of Proposition 13.
- The fact that Warren Magnuson, who had been free to vigorously support NCI since his bill created the institute in 1937, became chairman of the full Senate Appropriations Committee last year. Although he retained chairmanship of the Labor-HEW Subcommittee, Magnuson's responsibilities were broadened. In years past, he would invariably comment during one of the hearings, "We can afford to give cancer another $100 million. They spill that much every day over at the Pentagon." Now he must accept some of the responsibility for spillage, at the Pentagon and everywhere else.
- The demise of Daniel Flood as chairman of the House Labor-HEW Appropriations Subcommittee. Flood has considered himself a strong supporter of the Cancer Program, although his subcommittee had left it up to the Seante to make substantial increases for NCI in the last three to four years. But he was a known quantity, and there was concern that his successor, Kentuckian William Natcher, would impose an even more conservative approach on the subcommittee.
- Edward Brooke, the Massachusetts Republican, was defeated for reelection and was not around to continue his role as the Senate's strongest backer of the Cancer Program, other than Magnuson.
- Finally, there was the continuing hostility of Congressman David Obey, an outspoken member of the Natcher subcommittee and an increasingly powerful member of the House.

So how did NCI get $1 billion in the face of all those negative situations?

Foremost among the factors influencing the outcome was the demonstration that not only are advocates of the National Cancer Program still a powerful influence around the country, their clout is growing. It may not be a coincidence that during this past year, membership in the Assn. of Community Cancer Centers doubled. Now there is an ACCC member practicing oncologist in a majority of congressional districts, and ACCC has aggressively enrolled them in a lobbying effort supporting the Cancer Program. The American Cancer Society and its Washington lobbyist, Nathaniel Polster, argued effectively for the Cancer Program at every opportunity, with the support of thousands of ACS volunteers.

Mary Lasker, whose influence on national health programs is perhaps unprecedented for a lay person, probably has spent more time in Washington during the past few months than in her New York home. A key contribution was encouraging the hearings on cancer by Claude Pepper's House Select Committee on Aging, which recruited a whole new corps of Cancer Program backers.

One factor not to be overlooked, and perhaps the most important one, is the success of the Cancer Program itself and the effectiveness of the scientists and NCI Director Arthur Upton and his staff in presenting evidence of that success to Congress. Despite the best efforts of the detractors, it is now apparent that Congress is convinced the Cancer Program is working, has made remarkable progress since 1971 and is saving thousands of additional lives a year, and that the benefits of the program are just beginning to arrive.

All the lobbying and effective arguments would have been to little avail, however, without the leadership of key individuals in Congress:

★ Magnuson demonstrated that, broader responsibilities or not, when the chips are down he will still back the Cancer Program as aggressively as ever. At the House-Senate conference, it was obvious he had lined up his conferees solidly for the increases for all of NIH; there was not one word of opposition from any of the Senate conferees.

★ Natcher has taken hold of his subcommittee with a firm but fair hand, will listen to the facts and displays as much concern for the nation's health as anyone even when it means putting his job on the line. When the appropriation for HEW's smoking and health program came up in conference, Natcher said, "I gave them every dollar they asked for. I've got 20 counties in my district, and they grow tobacco in every one of those 20 counties. There are some people at home who want to talk to me about that."

★ Sen. Richard Schweiker turned out to be every bit as effective as Brooke in rallying the support of

Republicans to the Cancer Program. Every GOP member of the subcommittee enthusiastically backed the increase for NCI.

★ Birch Bayh was the only Democrat other than Magnuson on the subcommittee to press for increased cancer funding, although Maggie had his side lined up by conference time. Bayh never mentioned his late wife's name either at the subcommittee markup or conference, but he conveyed a determination and depth of feeling that would not be denied. His victory may be the memorial Marvella Bayh would have liked the best.

★ Two Massachusetts congressmen—Democrat Joseph Early and Republican Silvio Conte—came through again as being among the strongest allies the Cancer Program has. A welcome new ally, one who demonstrated intense concern for all health programs, is New Mexico Republican senator and former astronaut Harrison Schmitt.

Lest there be dancing in the streets at cancer centers and premature celebrations in the ranks of Cooperative Groups, it should be noted that except in four specific areas, NCI's budget will be exactly as proposed in the President's request for all programs—essentially a level budget with little if any increases over FY 1979.

The biggest slice of the $62.9 million increase will be the $23 million for carcinogenesis testing. NCI will not even be the final judge on how that is spent, since it will go, with the $22 million originally requested, to the National Toxicology Program, a joint effort of four HEW agencies. Which chemicals will be tested and how they will be tested will be up to NTP advisors, including Upton.

Next is the $18.2 million earmarked for investigator initiated research. That brought the total for research projects, predominantly R01s and P01s, to $300,974,000, and lifted the percentage of approved competing renewals and new grants which will be funded from 24 to 31.

Another portion of the increase, $13.5 million, will go for studies of biological response modifiers, including interferon. Most if not all of that will go into the Div. of Cancer Treatment budget; plans on how it will be spent have not been developed.

Finally, $6.7 million will be used to increase the stipends of NCI training grant recipients, with the balance paying increased NCI overhead costs.

DAVID OBEY—AN OUTSTANDING YOUNG CONGRESSMAN, WITH ONE BLIND SPOT

David Obey is considered by many of his colleagues to be one of the oustanding young members of the House of Representatives. Although only 40, the Wisconsin Democrat has been in Congress 10 years since winning a special election to fill the vacancy created when President Nixon named Mel Laird Secretary of Defense.

(Harold Rusch, retired director of the Univ. of Wisconsin Cancer Center, feels it is ironic that Laird's successor has turned out to be one of the Cancer Program's severest critics in Congress. Rusch had sold Laird on increasing support for NCI back in the 1960s, and Laird remained a strong proponent of the program throughout his public career.)

Obey has displayed courage and statesmanship in leading the fight in the House for ethics reform, health and safety improvements in the workplace, and environmental concerns. Despite liberal inclinations, he has demonstrated leadership in budget responsibility.

He *almost* always talks and acts on the basis of facts. His one blind spot appears to be NCI.

Obey was not entirely negative this year. He went along with the House increase of $25 million over the President's budget for NCI, and agreed that $18.2 million should be added to investigator initiated research. But he nearly undid much of the benefit of those increases by demanding that an increase of $23 million for carcinogenesis testing be financed partially by transferring $17 million out of construction and cancer control.

Obey first took his arguments supporting the reprogramming to the floor of the House, contending that support for construction could be cut because the House had turned down funds for a building for the National Institute of Child Health & Development; that cancer control should be cut because grants supported by the Div. of Cancer Control & Rehabilitation would be funded at lower priority scores than other NIH programs; that control also should be cut because DCCR was paying $15 for Pap smears while Medicaid was paying only $10; and that the Louisville vinylchloride and Tyler asbestos contracts were "lousy" and the Tyler contract was being renewed anyway.

Later, in the House-Senate conference on the appropriations bill, Obey repeated those arguments, except that he justified cutting at least $2 million from construction by saying it should come from the construction budget for Frederick Cancer Research Center. "I don't know of anyone in the Cancer Program who has ever had anything good to say about the way Litton has run Frederick," he said.

Obey obviously hasn't been talking with any members of the various review committees who have subjected every phase of FCRC to careful review over the last four years. In almost every instance, FCRC programs have passed with flying colors.

There undoubtedly have been instances in which Litton Bionetics could have improved on its operation of the center, which it does under contract with NCI. The House Appropriations Committee staff conducted an investigation last year and came up with several deficiencies, none of which outweigh the excellent work being done there and most of which have been or already were corrected.

But Obey's attack on construction at Frederick,

like his original justification for cutting the construction budget, demonstrated a glaring lack of information. Either way—slashing funds for construction grants or eliminating construction at FCRC—it would have severely damaged programs Obey supports the strongest—carcinogenesis research and testing.

Most NCI construction grants are going into improvements for biohazard and chemohazard containment, and for improving animal facilities, vitally important to carcinogenesis research.

The No. 1 construction priority at FCRC in the 1980 fiscal year is one approved by several review groups to renovate an existing building to become a "state of the art" barrier animal holding facility. It is designed to be the standard for biological and chemical hazard containment in accommodating animals for chronic, long term chemical testing. The cost will be $1.1 million.

Second on FCRC's priority is the upgrading of the ventilation system in which major recombinant DNA research is being conducted. This research includes efficacy studies and monitoring of the recombinant DNA research guidelines. The improvement, at a cost of $600,000, is vital to building this facility as the key to continued development of recombinant DNA research in this country.

Third in priority is installation of a solvent recovery system for the chemotherapy fermentation lab. This lab produces all of the daunomycin, an important new anticancer agent, which NCI uses in its clinical trials and which it supplies to investigators around the U.S. Production at FCRC is done at an enormous saving to the government—a cost of $100,000 per kilogram compared with $300,000 NCI was paying previously. The lab also is producing interferon and is becoming recognized as the world's leading technical center for interferon production.

At a cost of from $160,000 to $200,000, the solvent recovery system will recover 85-90% of the solvent used by the lab. Without the system, the lab now must get rid of 100% of the waste solvent by disposing of it, at considerable and increasing cost, in distant burial sites.

FCRC plans to spend, as a fourth construction priority, $100,000 on energy saving equipment and management systems for temperature control in its animal facilities.

NCI's total budget for FCRC through the Litton contract is $23.7 million, which supports a strong basic research program, an outstanding effort in carcinogenesis testing, and the production of resources, including viruses and animals, distributed free to investigators throughout the U.S.

Here are the facts on the cancer control programs criticized by Obey:

After reading Obey's comments about the cost of Pap tests, DCCR checked with several states and found only one that claimed it was reimbursing through Medicaid at $10 per test.

The cervical cancer screening program DCCR supports through contracts with state and territorial health departments pays physicians from $8 to $25 or or $30 for Pap tests. Average cost per test, based on the total cost of the program and the number of tests conducted each year, is $15. Obey was right on that point, but apparently was not aware that this includes costs of the program which the Medicaid reimbursements do not have to support.

The DCCR-state programs are designed to reach the "hard to reach" and high risk women. It involves an outreach effort that adds considerably to costs. It also includes cost of evaluation, required of the contractors to determine which methods have been most successful in reaching target groups. Contracts were for three years, and most will expire by the end of 1979, with only two active after that. States are expected to pick up costs of programs continued after NCI funding stops. The contracts were included in DCCR merit review, and five were terminated early because of inadequate performance.

Obey was not correct when he said that the Tyler asbestos program contract was going to be renewed. The contract with the West Texas Chest Foundation expired in June, but is being recompeted, not renewed. Two new RFPs were issued, one to develop a community approach in dealing with broad exposure to a carcinogen, the other to coordinate a program in Tyler to meet the asbestos problem. It is possible that neither of those programs will be implemented, depending on the review of proposals.

Merit reviewers of the Tyler contract found that the program was hampered by the fact that not much can be done at the present for persons who have been exposed to asbestos, other than urge them to stop smoking and get regular examinations.

The contract with the Univ. of Louisville on the vinylchloride problem terminated in November 1978, and was not renewed. Obey had charged that not only was the contract ineffective but that it had increased the danger for some workers.

DCCR staff members could not understand how the program could have increased the danger to anyone, although it had been criticized by some for allegedly not reaching former vinylchloride workers.

The anticipated number of angiosarcomas did not materialize in the study, which found only five or six among the exposed workers. Investigators concluded that biochemical tests may not be effective in predicting angiosarcoma, and that even when precursor lesions were found, there was not much that could be done.

FLORIDA LEGISLATURE PASSES BILL CREATING CANCER CONTROL PROGRAM

The Florida legislature has passed and the governor has signed the Florida Cancer Control & Research Act which will create a cancer control and research

fund and provides a mechanism for awarding grants and contracts to carry out the authorized programs.

A 25 member Florida Cancer Control & Research Advisory Board will oversee the program, recommend plans to the Dept. of Health and advise the secretary of the department on the award of grants and contracts.

Herbert Kerman, chairman of the Florida Cancer Council, said the act "will give us a starting point for a better cancer control program in Florida. As with most bills, it has some good and bad features, but on balance I think it is a very positive approach."

Florida thus becomes one of the few states which has formally accepted responsibility for funding cancer control programs through the state government. The act did not authorize a specific amount. Kerman said that requests for funding each year would be made to the legislature based on objectives the Board would seek in its annual plan.

The act says the board will:

—Approve each year a program for cancer control and research to be known as the "Florida Cancer Plan" which shall be consistent with the state health plan developed by the state health coordinating council and integrated and coordinated with existing programs in the state.

—Formulate and recommend to the secretary of the Dept. of Health & Rehabilitative Services a plan for the care and treatment of persons suffering from cancer and recommend the establishment of standard requirements for the organization, equipment and conduct of cancer units or departments in hospitals and clinics in Florida. The board may recommend to the secretary the designation of cancer units following a survey of the needs and facilities for treatment of cancer in the various localities throughout the state. The secretary shall consider the plan in developing departmental priorities and funding priorities and standards under chapter 395, Florida Statutes.

—Be responsible for including in the Florida Cancer Plan recommendations for coordination and integration of medical, nursing, paramedical, lay, and other plans concerned with cancer control and research. Committees shall be formed by the board so that the following areas will be established as entities for actions:

(a) Cancer plan evaluation: tumor registry, data retrieval systems, and epidemiology of cancer in the state of Florida and its relation to other areas.

(b) Cancer prevention.

(c) Cancer detection.

(d) Cancer patient management: treatment, rehabilitation, terminal care, and other patient-oriented activities.

(e) Cancer education: lay and professional.

(f) Unproven methods of cancer therapy: quackery and unordodox therapies.

(g) Investigator initiated project research.

"In order to implement in whole or in part the Florida Cancer Plan, the board shall recommend to the secretary the awarding of grants and contracts to qualified profit or nonprofit associations or governmental agencies in order to plan, establish, or conduct programs in cancer control or prevention, cancer education and training, and cancer research.

"The board shall have the responsibility to advise the secretary on methods of enforcing and implementing laws already enacted and concerned with cancer control, research, and education.

"The board may recommend to the secretary rules not inconsistent with law as it may deem necessary for the performance of its duties and the proper administration of this act.

"The board shall formulate and put into effect a continuing educational program for the prevention of cancer and its early diagnosis, and disseminate information concerning its proper treatment to hospitals, cancer patients, and the public.

"The secretary, after consultation with the board, shall award grants and contracts to qualified nonprofit associations and governmental agencies in order to plan, establish, or conduct programs in cancer control and prevention, cancer education and training, and cancer research.

"The secretary, after consultation with the board, shall make rules specifying to what extent and on what terms and conditions cancer patients of the state may receive financial aid for the diagnosis and treatment of cancer in any hospital or clinic selected. The department may furnish financial aid to citizens of Florida afflicted with cancer to the extent of the appropriation provided for that purpose in a manner which in its opinion will afford the greatest benefit to those afflicted and make arrangements with hospitals, laboratories or clinics to afford proper care and treatment for cancer patients in Florida.

"There is hereby created the Florida Cancer Control & Research Fund consisting of funds appropriated therefor from the general revenue fund and any gifts, grants, or funds received from other sources.

"The fund shall be used exclusively for grants and contracts to qualified nonprofit associations or governmental agencies for the purpose of cancer control and prevention, cancer education and training, cancer research, and all expenses incurred in connection with the administration of this act and the programs funded through the grants and contracts authorized by the secretary."

The board will consist of 24 members and a chairperson, all of whom shall be residents of the state. All members except those appointed by the speaker of the House of Representatives and the president of the Senate shall be appointed by the governor. Included will be representatives of the American Cancer Society, Assn. of Florida Tumor Programs Directors, the Florida Tumor Registrars Assn., the Comprehensive Cancer Center of the State of Florida, the

Dept. of Health & Rehabilitative Services, the Florida Nurses Assn., the Florida Osteopathic Assn., the American College of Surgeons, the School of Medicine of the Univ. of Miami, the College of Medicine of the Univ. of Florida, the College of Medicine of the Univ. of South Florida, the Florida Society of Clinical Oncology, the Florida Medical Assn., the Florida Pediatric Society, the Florida Radiological Society, three members shall be representatives of the general public acting as consumer advocates, a member of the House of Representatives appointed by the speaker, a member of the Senate appointed by the president of the Senate, the Dept. of Education, the Florida Dental Assn., the Florida Hospital Assn., the Assn. of Community Cancer Centers, and the Papanicolaou Cancer Research Institute.

The Florida legislature also voted an appropriation of $121,154 for 1979-80 and $726,923 for 1980-81 to implement the statewide tumor registry law approved the previous session. The first year money will allow for development and testing of the reporting procedures and accession methods. With total implementation the following year, accession is expected to be 30,000 patient records.

The tumor registry bill provided for reimbursement to the Central Accession Facility and Cancer Biostat Center for 35% of the appropriation, with 65% being available for reimbursement for hospital costs in providing the necessary accession of records and abstracting.

"We estimate this 65% reimbursement will allow the participating hospitals to obtain approximately one half of their costs of operating a tumor registry," Kerman said. "The other half of the hospital's costs will have to come from other sources of income, presumably reimbursement as a patient service. Thus, the implementation for this tumor registry activity in Florida should provide both epidemiological and demographic data as well as provide and maintain the quality control aspects of individual hospital registries."

COOPERATIVE GROUP-CANCER CONTROL PROGRAM CONTINUATION APPROVED

The NCI Div. of Cancer Control & Rehabilitation Advisory Committee unanimously approved continuation of the division's program in which seven Cooperative Groups receive funds to enlarge existing Cooperative Group activities in community hospitals, provide support for data collection and upgrade the quality of cancer care at the participating hospitals.

Six groups are supported in this program with DCCR contracts—Eastern Cooperative Oncology Group, Southwest Oncology Group, Children's Cancer Study Group, National Surgical Adjuvant Breast & Bowel Project, Radiation Therapy Oncology Group and Gynecologic Oncology Group. The Northern California Oncology Group is supported in this program with a grant.

"This has been a successful venture," committee member Harold Rusch commented.

Committee member Gale Katterhagen said, "To do good clinical trials, you need patients. This brings patients to the clinical trials."

"If you accept the premise that the best patient care is in clinical trials, what happens after the program ends?" asked committee member Gussie Higgins. "If the demonstration is a success, what happens to it at the end of the program?"

Harry Handelsman, DCCR project officer for the program, said, "I don't know what will happen. We would expect that a successful program will succeed in lobbying for support from other sources to continue."

"Why is clinical research considered a demonstration?" Katterhagen asked.

"We're not in the business of supporting research," Handelsman said.

"If the primary motive is to improve clinical research, the way to go would be to continue NCI support, possibly from the Div. of Cancer Treatment," said acting DCCR Director William Terry. "If it is considered control, it would be appropriate to fund it out of the cancer control budget. Let me back off a little. Research into ways to control cancer are proper control activities."

Handelsman presented a report from ECOG describing that group's current efforts at evaluating the program and some of the findings.

A self evaluation questionnaire was sent out to participating ECOG members last February. There has been a 68% return, the report said.

Excerpts from the report:

An unexpected, but important result of the Cancer Control Program was the establishment of institutional review boards in the ECOG cancer control institutions. To date 73 institutional review boards have been formed. It is recommended that the creation of institutional review boards be featured in the evaluation.

The educational component of the Cancer Control Program has been emphasized and has helped bring attention to many areas of concern to cancer control participants. To date the ECOG Cancer Control Program has sponsored seven workshops, on the topics psychosocial aspects of cancer care, the role of the nurse oncologist, legal aspects of the diagnosis and management of cancer, education of the cancer professional, nutrition and cancer therapy, heredity and cancer genetics, and pathology staging and grading.

Three workshops are scheduled, on applications of statistics to cancer research, pain control in cancer patients, and informed consent. Consideration is also being given to holding a workshop on cancer and the environment. Other topics suggested are: consideration of psychosocial aspects of cancer care with an emphasis on quality of life factors, extent and nature of insurance coverage and benefits, problems with

Medicare and Medicaid programs, alternate treatment for cancer, a retrospective look at successful cancer control programs and a workshop on determinants of successful and unsuccessful protocol studies.

ECOG cancer control participants have been asked to describe the nature of their inhouse educational activities, their outreach educational activities and the nature of the evaluation of such activities. The responses of the ECOG cancer control subcontractors show that inhouse seminars, workshops, conferences and rounds are the most popular means of providing continuing education. The subcontractors also hold frequent meetings with network investigators, meetings with community based health personnel, data management workshops, tumor conferences and post graduate courses. Such efforts are evaluated and comments about the nature of the evaluations include the following:

a. Albany Medical College—"Feedback is solicited from attendees...Level of attendance indicates usefulness of program...evaluation cards."

b. Albert Einstein Medical School—"Effectiveness of programs is also evaluated by studying accrual patterns of patients into new protocols, using new drugs and new techniques."

c. Boston Univ. Hospital—"Medical staff assessments of our performance is handed in to the physician-in-chief."

d. Case Western Reserve—"All continuing education is evaluated by a special office developed at the school of medicine that approves, continuously evaluates and grants the credits."

e. Harbor General Hospital of Los Angeles—"Opinions are sampled from participants....We are beginning to develop 'tests' for the participants to evaluate how much of the information is retained."

f. Mayo Clinic—"Activities of participating members and Mayo ECOG-CC project activities are reviewed three times annually at NCCTG meetings and cancer communications personnel directly participate."

g. Roswell Park Institute—"Attendance...evaluation critique by participant...pre and post testing."

h. Rush-Presbyterian-St. Luke's—"The program as well as the speakers are evaluated in writing by each participant. The RPSLMC Office of Continuing Medical Education reviews the program content and speakers and the participant evaluations to monitor quality control."

i. Mt. Sinai Medical Center (Milwaukee)—". . . response cards from participants and attendees."

Both ECOG cancer control subcontractors and affiliates were asked to describe the support services their institutions provided which are in part attributable to the ECOG Cancer Control Program. Such services include but are not limited to data management, nurse oncology, secretarial support, expert consultation, etc. Clearly, the greatest support has been in providing data managers or coordinators to collect data as well as to pass on instruction to individuals responsible for data in community institutions. Expert consultations and telephone referrals are significant aids and include all aspects of oncology, clinical and biochemical pharmacology and tumor immunology, slide review, pathology review, pharmacy support and education regarding new drugs. Important also is the training, support and availability for consultation of experienced nurse oncologists. Secretarial support is frequently needed and available. Psychosocial services are enhanced. Experienced clinicians and established institutions are especially helpful in matters concerning protection of human subjects and interacting with Human Ethics and Studies Committees at community hospitals. Another interesting support service is the providing of staff oncologists to community hospitals when their resident oncologists are away on leave, vacations or at meetings.

ECOG Cancer Control subcontractors and affiliates were asked to describe how information about ECOG protocols, meetings, pertinent publications and analyses circulated in their communities. Responses indicate that the most popular method of dissemination of information is via memoranda, minutes of meetings, reports, specially prepared instructional material and other forms of mailings. Personal contact, either by telephone or during conferences is important as are meetings and workshops held for the institutional networks. Information is also disseminated via tumor boards and conferences, circulation of newsletters, by participation in oncology clinics, support of travel for staff and by posting information on bulletin boards and blackboards.

ECOG cancer control subcontractors and affiliates described the manner in which their data collection is organized. A sampling of quotations includes:

a. "Data managers in satellite institutions submit all data to central office from which all data go to the ECOG Statistics Office."

b. "...an elaborate system for accurate and prompt collection and submission of ECOG-related data... includes working closely with the satellite protocol coordinators."

c. "All patients whether on protocol or not are entered into computerized file, minimal data forms have been developed and coded."

d. "Central office...requires monthly or weekly collection via data person at regional hospital."

e. "Physician with assistance of protocol secretary."

f. "Our data collection is managed through a central protocol office...nurse oncology data managers... submit the required data to the Central Protocol Office...cooperating community physicians are responsible for reviewing and assuring quality control of all data submissions."

ECOG cancer control subcontractors and affiliates were asked to describe how ECOG protocols influ-

ence diagnosis, treatment, patient management, etc. for patients not on protocols. A sampling of responses includes:

a. "Most non-eligible patients receive non-randomized ECOG treatment."

b. "Institutional protocols are devised with future ECOG studies in mind."

c. "Previous study results strongly influence therapy decisions."

d. "All patients are managed as if they were on protocol in terms of data collection, standards of care, diagnosis and treatment."

e. "They (protocols) force greater attention to clinical staging and details of patient care."

f. "Their detail is useful in preventing errors in therapeutic judgment."

g. "These clearly serve as guidelines and models to the latest state of the art in therapy, staging, restaging and diagnostic evaluation of cancer patients."

h. "The patient may get recommended ECOG treatment, not on study, when they return home... in other areas."

i. "The heightened attention to meticulous toxicity, both observation and recording, as well as the rigorous response criteria, improve the organization and acuteness of patient followup and treatment decisions."

j. "Attempts are always made to put patients on protocol. When this is not possible, the protocols are still utilized but the institution does not receive credit for randomization."

k. "Greatest benefit derived from the Cancer Control Program is in patient management....Although not on protocol, therapy is still based on ECOG guidelines."

l. "Protocols and minutes are consulted...as a source of information about the current status of management of particular tumor types, drug doses and scheduling, drug side effects and as a source of current references."

m. "Extra reassurance to patients and referring physicians to knwo that local treatment programs reflect the current state of the art on a national level."

n. "Recognize the necessity of precise staging of disease and accurate histological diagnosis for proper treatment and evaluation."

o. "Has led to a regularly scheduled meeting with radiotherapy, oncology and surgery to discuss modalities of treatment for all cancer patients, not just those on ECOG protocols."

p. "Protocols...often used as a course of the latest information for the treatment of a particular primary."

NOMINATIONS OPEN FOR THIRD ANNUAL BRISTOL-MYERS CANCER RESEARCH AWARDS

Nominations are now being accepted for the third annual Bristol-Myers Award for Distinguished Achievement in Cancer Research, according to Alan Sartorelli, professor and chairman of the Dept. of Pharmacology of the Yale Univ. School of Medicine and chairman of the Award Selection Committee.

The $25,000 award is made annually for outstanding contributions to cancer research.

The award winner is selected by a five-member panel of judges from cancer research centers at Baylor, Chicago, Johns Hopkins, Stanford and Yale Universities. Each of those schools participates in a $2.5 million grant program funded by Bristol-Myers to promote unrestricted, innovative cancer research.

Gertrude and Werner Henle, virologists at the Joseph Stokes Jr. Research Institute of Children's Hospital of Philadelphia, received the second Bristol-Myers Award last spring for their identification of the first virus regularly associated with human cancers.

James and Elizabeth Miller, biochemists at the Univ. of Wisconsin's McArdle Laboratory for Cancer Research, received the first award in 1978 for their pioneering research in chemical carcinogenesis.

Nominations will be accepted from medical schools, free standing hospitals and cancer research centers until Dec. 31, 1979. Only one nomination from each institution will be accepted. For forms and further information, contact Secretary, Awards Committee, Bristol-Myers Co., 345 Park Ave., Room 43-30, New York 10022.

NCI CONTRACT AWARDS

Title: Breast Cancer Detection Demonstration Project, six month phase out
Contractor: Univ. of Kansas, $104,718.

Title: Long term mortality study of Minnesota iron-ore miners
Contractor: Univ. of Minnesota, $46,793.

Title: Immunological and biochemical studies of mammalian viral oncology, continuation
Contractor: Meloy Laboratories, $38,776.

Title: Etiologic studies of cancer in New Jersey, continuation
Contractor: New Jersey Dept of Health, $499,900.

Title: Technical writing and telephone answering services in response to cancer-related inquiries, extension
Contractor: Biospherics Inc., $198,965.

The Cancer Letter _Editor Jerry D. Boyd

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