THE CANCER LETTER

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COOPERATIVE GROUP COMPETING RENEWALS MAY BE FUNDED ONLY AT 70-80% OF AMOUNTS RECOMMENDED BY CCIRC

The prospect of a level budget for the Cooperative Group Program and what that would mean in funding of individual groups in the current fiscal year was presented to group chairmen at their December meeting. The outlook: Those groups competing for renewal in FY 1981

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In Brief

PHIL AMORUSO WILL BE THE NEW NCI EXECUTIVE OFFICER; DRCCA BOARD OKAYS CCN EXTENSION

PHILIP AMORUSO, who was administrative officer of NCI's Div. of Cancer Treatment while Vincent DeVita was its director, will rejoin his old boss starting next week as NCI executive officer. Amoruso, 38, left NCI in 1979 to become executive officer of the National Library of Medicine after five years in DCT. He had been with NCI since 1969. He replaces Calvin Baldwin, now NIH exec officer. Robert Namovicz, Baldwin's deputy, has been acting executive officer since last July, and will stay on as Amoruso's deputy. The delay in filling the vacancy had been blamed by ***The Cancer Letter*** and others, unfairly as it turns out, on the usual bureaucratic hangups at HHS headquarters. What happened was that the Office of Personnel Management (formerly the Civil Service Commission) had dismantled its Senior Executive Service review mechanism after the election, figuring no further SES appointments would be made until the new Administration takes over. They had to reassemble that machinery when Amoruso's appointment came through, and that took some time. . . . **CANCER COMMUNICATIONS** Network program conducted by the Div. of Resources, Centers & Community Activities was approved for three more years by the division's Board of Scientific Counselors in a mail vote. Board members had indicated at their meeting last September that they had some reservations about the program (***The Cancer Letter,*** Sept. 26). NCI had asked for a five year extension of the contracts with the comprehensive cancer centers and the Univ. of Hawaii. Board members asked for more emphasis on evaluation of the effectiveness of the effort to provide patients and family members with quick access to information. The Board rejected DRCCA staff request for concept approval of a new program for support of cytopathology training at eight to 10 medical schools. . . . **ALEXANDER CAPRON**, member of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, will be the guest speaker at the meeting of the Assn. of American Cancer Institutes Jan. 25. His likely topic will be the commission's stand on compensation for subjects injured in research. The AACI meeting, Jan. 25-27, will be at the Bethesda Holiday Inn.

GROUP CHAIRMEN ASK FOR SELECTIVE CUTS IF NEEDED, NOT "MEAT CLEAVER"

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may be funded only at 70-80 percent of recommended levels; to do even that well, NCI will have to add nearly $3 million to the budgeted amount.

Cooperative Groups received a total of $34.3 million in 1980, not counting $2.6 million in "one shot" special purpose money (including laetrile studies conducted by some group members). NCI has budgeted $34.5 million for the 1981 fiscal year, and the Div. of Cancer Treatment added another $1 million which it does not have at the moment but expects to find later out of reprogrammed funds.

The first round of competing renewals already has been funded at 80 percent of recommended levels. If the second and third round grants are funded at 75 percent of amounts recommended, the total needed would be $37.34 million, still leaving a deficit of almost $1.9 million.

To fund at recommended levels, the groups would need $43.3 million. That amount seems to be out of the question with NCI apparently not getting any increase in its total appropriation over 1980 and DCT taking a cut of nine percent.

Those groups not competing this year are scheduled to receive $16 million, the total of amounts negotiated when the awards were made. It includes cost of living increases of about seven percent (this $16 million is included in the $37.34 million total).

The chairmen objected to imposing the burden of the budget problems on the groups coming in for renewal this year, while the others receive increases.

"Some groups are outperforming their grants," James Holland, Cancer and Leukemia Group B chairman, commented. "There must be some selective waste. If cuts have to be made, we should do it selectively. The selective scalpel is better than a meat cleaver."

The chairmen approved Holland's motion asking DCT staff "to seek in concert with group chairmen ways to reprogram funds at the minimum extent necessary to fulfill budget requirements, through on site visits and review of individual performance."

The vote was not unanimous. Charles Moertel, chairman of the North Central Cancer Treatment Group, and George Lewis, chairman of the Gynecologic Oncology Group, voted against it.

"The oversight involved in contracts is odious," Moertel said. "Here we are asking for the same type of thing over and above peer review. I challenge whether any one man or two running around the country looking at all the individual grants can perform an adequate analysis. That is too much to ask of DCT staff. This would be a major change in what a grant supported group should be. I'm frightened by it."

Denman Hammond, chairman of the Children's Cancer Study Group, said he agreed with Moertel. "It would be a bad precedent to assume staff could improve on peer review," Hammond said. "On the other hand, any group chairman knows who the performers are and where cuts can be made. That is a responsibility I'm willing to exercise. Overturning peer review is an awesome responsibility."

Paul Carbone, chairman of the Eastern Cooperative Oncology Group, summarized the sense of the motion. "Major cuts are looked upon as flexible. Some of the groups (not competing for renewal) will not get the seven percent increase, some will get it after a delay. Deficits will not be taken out entirely of the groups coming up for renewal this year, but will be spread across the entire program. The current deficit is the entire program's responsibility."

"I understand some of Chuck Moertel's point of view," Holland said. "But I don't believe in a meat cleaver approach. The CCIRC (Clinical Cancer Investigation Review Committee, which reviews Cooperative Group grants) is a policy making body remote from today's crisis."

John MacDonald, director of DCT's Cancer Therapy Evaluation Program, later told ***The Cancer Letter*** that he is still considering the chairmen's request and may attempt to make cuts selectively rather than across the board.

It does not seem likely, however, that reductions will be made in continuing grants. NIH policy long has been that once grants have been awarded, they will be paid according to terms negotiated. "That's not chiseled in stone. We could deviate from that policy if we really insisted on it," MacDonald said.

Complicating any attempt to reduce continuing grants, for this year at least, is the fact that two-thirds of them have already been paid. Asking grantees to return money is almost unprecedented.

MacDonald is still hoping that additional money can be found to alleviate the situation without requiring drastic cuts. The chairmen had some suggestions along that line.

One suggestion was in the form of a motion asking staff to request the DCT Board of Scientific Counselors to reconsider its concept approval for three new regional groups. The Board gave that approval at its October meeting and agreed that $1.5 million reprogrammed from contracts be offered in the request for applications as the amount available for the new groups in the first year.

The chairmen argued that with the severe budget restrictions, this is not the time to encourage new groups and not appropriate to shelter them from cuts being applied to existing groups. DCT Acting Director Saul Schepartz responded that DCT would not be obligated to spend the entire $1.5 million on new groups and that their funding would depend on peer review.

MacDonald later said that while the issue might be brought back to the Board at its February meeting, the decision had been made after three years of consideration to support new regional groups. He does not feel that decision will be changed, although start up might be delayed for another year.

The DCT Board approved the regional group concept after accepting the report from the subcommittee chaired by Board member Sydney Salmon on the Board's review of clinical trials. Holland pointed out that the subcommittee did not recommend support for new regional groups and that the subcommittee members had voted against concept approval.

The chairmen also approved a motion calling for continuation of the $3.6 million a year outreach program supported by the Cancer Control Program in the Div. of Resources, Centers & Community Activities. This program supports efforts by several groups to extend clinical trials into community hospitals.

"What is the forecast for that program?" Holland asked. "Will it be continued but at a lower amount? It has become an essential mechanism for things we try to do."

DRCCA Acting Director William Terry said the new division "is still undergoing the process of establishing what its objectives and goals will be. I would expect that cancer control money will be directed through Cooperative Groups, regional groups, and centers to assist in increasing the flow of cancer patients to research."

Carbone pointed out that the cancer control contracts with the groups all expire in April 1982. "Between then and now the Cancer Control Program staff has to make up its mind if those will be continued. . . . Saul and Bill need a message from us."

Moertel offered another suggestion on a source of help for the groups. "The organ site programs have so much money they are looking around for ways to spend it." He suggested that some clinical research supported by the organ site and cancer control programs could be redirected to the Cooperative Groups.

MacDonald responded that those programs involved DRCCA and that any immediate help probably could come only from DCT. Schepartz added, "It is not productive for a group in trouble financially to look around and see where it can get money from other programs."

SCHMITT WILL BE CHAIRMAN OF SENATE HEALTH APPROPRIATIONS SUBCOMMITTEE

Harrison Schmitt, the New Mexico Republican and former astronaut who is starting his fifth year in the Senate, will be the new chairman of the Labor-HEW Appropriations Subcommittee.

Schmitt will take over the position held for so many years by defeated Democrat Warren Magnuson of Washington. Magnuson was a powerful figure in the growth of the Cancer Program, invariably supporting major increases for NCI. In his relatively brief time on the subcommittee, Schmitt has gone along with those increases and has indicated he will continue to back cancer research funding.

Charles Mathias, the liberal Maryland Republican who had been the top ranking minority member of the subcommittee, could have assumed the chairmanship with the GOP gaining control of the Senate. Mathias chose instead to become chairman of the Senate Rules Committee, and he decided to leave the Appropriations Committee for a seat on the Foreign Relations Committee.

Terry Lierman, staff director of the Labor-HEW Appropriations Subcommittee for several years and a Magnuson appointee, will move over temporarily to the staff of Oregon Sen. Mark Hatfield, who is the new chairman of the Appropriations Committee. Lierman will work on health issues for Hatfield, and plans to leave Capitol Hill in May.

When Robert Michel, the Illinois Republican, was elected House minority leader, that removed him from the House Appropriations Committee and his top ranking position on the House Labor-HEW Subcommittee. Silvio Conte of Massachusetts remains as the ranking Republican on the parent Appropriations Committee. He could assume that role on the Labor-HEW Subcommittee but probably will not, since he already has that designation on another subcommittee.

Committees in the House and Senate probably will be organized next week, with assignments to the various subcommittees made then.

The Senate Labor & Human Resources Committee is considering eliminating the Subcommittee on Health & Scientific Research, the group which has been involved in writing all health legislation for the last 10 years under Sen. Edward Kennedy. If it is dropped, health related bills would be written by the full committee if they are not appropriate for assignment to another subcommittee.

UICC FELLOWSHIP PROGRAM FOR STUDY ABROAD ANNOUNCED; APPLY BY OCT. 1

The International Union Against Cancer, with funds provided by the Cancer Research Campaign of the United Kingdom, will award fellowships for research on cancer. These are designed to enable investigators to work abroad for a period of time to gain new experience in clinical or basic research in cancer. These fellowships are also open to investigators in the behavioral or social sciences relevant to cancer.

Fellowships will be granted only to persons on the staffs of universities, teaching hospitals, research laboratories or similar institutions.

A fellowship will not be granted to a person who wishes primarily to perfect his training or who wishes to visit briefly several institutions abroad. The duration of the fellowships ordinarily will be one year but

this period may be longer or shorter in special circumstances.

The stipend will be fixed on the basis of £9,000 per annum adjusted to the cost of living in the host country. Travel of the fellow will be equivalent to tourist/economy class air fare. Should a fellow remain abroad for more than six months a round trip ticket will be provided for his spouse.

Deadline for receiving applications and supporting documents is Oct. 1. Successful applicants may begin their fellowships at any time during the 12 month period beginning June 1.

Application forms and additional information may be obtained from International Union Against Cancer, rue du Conseil-General, 3, 1205 Geneva, Switzerland.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR JAN., FEB., FUTURE

Gynecologic Oncology Group—Jan. 8-10, Miami, semiannual national business meeting.

President's Commission for the Study of Ethical Problems in Medicine & Biomedical & Behavioral Research—Jan. 9-10, Hay Adams Hotel, Washington, 9 a.m.

Div. of Resources, Centers & Community Activities Board of Scientific Counselors Cancer Centers Grant Guidelines Working Group—Jan. 9, International Hotel, O'Hare Airport, Chicago, 9 a.m.

National Toxicology Program Board of Scientific Counselors—Jan. 15-16, NIEHS, Research Triangle Park, Bldg 18 conference room, open Jan. 15, 9 a.m.—adjournment.

Molecular Basis of Carcinogenesis—Jan. 21, MCV/VCU Cancer Center, Richmond, Baruch Auditorium, 1 p.m., no registration required.

Current Concepts in Cancer Diagnosis & Management—Jan. 22-24, Century Plaza Hotel, Los Angeles, sponsored by UCLA.

NAC/NRC Nitrites Committee—Jan. 22, National Academy of Sciences, 2100 C St NW, Washington, 10 a.m.-3 p.m.

UCLA Jonsson Comprehensive Cancer Center Inaugural Scientific Symposium—Jan. 24, UCLA.

Assn. of American Cancer Institutes—Jan. 25-27, Bethesda Holiday Inn.

Mechanism of Metastasis—Jan. 28, Thomas Jefferson Medical College.

DRCCA Board of Scientific Counselors Subcommittee on Chemoprevention—Jan. 28, NIH Bldg 31 Rm 8, 9 a.m.

DRCCA Board of Scientific Counselors—Jan. 29-30, Blair Bldg Rm 110, 8:30 a.m. both days.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors—Jan. 29-31, Frederick Cancer Research Center, Bldg 539 1st floor, open Jan. 29 and 30, 9 a.m.

National Cancer Advisory Board—Feb. 2-4, NIH Bldg 31 Rm 6, open Feb. 2, 8:30 a.m.—3 p.m. and Feb. 4, 8:30 a.m.—adjournment. (Schedule of subcommittee meetings will appear in the Jan. 30 issue of *The Cancer Letter.*)

Advances in Gynecologic Oncology—Feb. 5, Roswell Park continuing education in oncology. Contact Gayle Bersani, Cancer Control Coordinator.

Div. of Cancer Treatment Board of Scientific Counselors—Feb. 12-13, NIH Bldg 31 Rm 10, open Feb. 12, 8:30—10:30 a.m. and 1:30 p.m.—adjournment, open Feb. 13, 8:30 a.m.—adjournment.

Breast Cancer Task Force—Feb. 23-24, NIH Lister Hill Aduitorium, 9 a.m. both days.

Clinical Cancer Education Committee—Feb. 25-26, NIH Bldg 31 Rm 4, open Feb. 25, 8:30—9:30 a.m.

15th Annual Clinical Symposium—Feb. 27-28, St. Jude Children's Research Hospital, Memphis.

Recent Advances in Cancer Diagnosis—Feb. 28-March 1, UCLA Jonsson Comprehensive Cancer Center.

FUTURE MEETINGS

4th Annual Symposium on Patient Education—March 12-15, Holiday Inn-Golden Gateway, San Francisco. Univ. of California (San Francisco) continuing education in health sciences. Current issues in the study and practice of patient education will be presented. Credit is available. Fee is $150, $70 for full time students. For registration information, contact Univ. of California, Continuing Education in Health Sciences, 1308 3rd Ave., San Francisco 94143, phone 415-666-2894.

Clinical Cytopathology for Pathologists—March 22-April 3, Johns Hopkins Univ. School of Medicine, Baltimore. The program is designed for pathologists certified or qualified by the American Board of Pathology or their international equivalents. It will provide an intensive refresher in all aspects of the field of clinical cytopathology, with time devoted to newer techniques, special problems and recent applications. Topics will be covered in lectures, small information conferences, and in discussions over the microscope with faculty. Self instructional material will be available, and a loan set of slides with text will be sent to each participant for home study during February and March. Application deadline is Jan. 28. Write to John Frost, MD, 610 Pathology Bldg., Johns Hopkins Hospital, Baltimore 21205.

12th International Congress of Chemotherapy—July 19-24, Florence, Palazzo dei Congressi and the Centro degli Affari. The scientific program, divided into symposia and free paper and poster sessions, will cover antimicrobial, anticancer and antiviral chemotherapy as well as immunology and immunotherapy. Deadline for receipt of abstracts is Feb. 15 and for advance registration at reduced fees, $175 for members and $200 for nonmembers, is March 15. Add $50 after that date. Contact Congress Secretariat, 12th International Congress of Chemotherapy, Via della Scala 10, Florence 50123, Italy.

Contemporary Issues in Hodgkin's Disease: Biology, Staging & Treatment—Sept. 9-12, San Francisco Hilton, sponsored by NCI and the Cancer Clinical Investigation Review Committee. Emphasis in this multidisciplinary international symposium will be on controversial issues in clinical management. Clara Bloomfield, Stephen Jones and Bruce Peterson are members of the organizing committee. Registration, at $50, is open to all physicians and allied health personnel. Deadline for receipt of abstracts is March 1. Contact Lili Zubar, Box 277 University Hospitals, Univ. of Minnesota, Minneapolis 55455.

Present Status and Future of the Anthracycline Antiobiotics in Cancer—Sept. 16-18, New York Univ. Postgraduate School. Sponsored by Farmitalia—Carlo Erba and contributions from Adria Laboratories and Bristol-Myers. Franco Muggia, NYU; Charles Young, Memorial Sloan-Kettering Cancer Center; and Stephen Carter, Northern California Cancer Program, are the scientific program committee. The program, a decade after the first international symposium on doxorubicin, will consist of presentations and panel discussions on biological effects, mechanism of action, drug development, cardiotoxicity, new clinical investigations and related compounds. Frederick Philips, Memorial Sloan-Kettering, will present the keynote address on "Selectivity of Antitumor Agents—A Reality in Search of Explanation." Aurelio DeMarco of Milan will be honored for his pioneering efforts in identifying this group of anticancer drugs.

Cancer 1981/Cancer 2001—An International Colloquium—Nov. 10-14, Shamrock Hilton Hotel, Houston, scheduled in lieu of the M.D. Anderson annual clinical conference. On the 10th anniversary of the National Cancer Program, authorities will take a hard look at the directions cancer research and

treatment should take in the near future. Presentations will focus on promising avenues of cancer research and likely developments in fields such as imaging, artificial intelligence and monitoring. Impact on cancer patient care and probable status of that care by the year 2001 will be discussed. Contact C. Stratton Hill Jr., Conference Coordinator, Rm 115, UT M.D. Anderson, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

SOLOMON GARB'S QUESTIONS AND ANSWERS ABOUT THE NATIONAL CANCER PROGRAM

Publication of questions and answers frequently asked of and answered by Solomon Garb, chairman of the Citizens' Committee for the Conquest of Cancer, continues.

COSTS AND FINANCES (Continued)

115. Why should cancer be emphasized more than any other disease?

Because the American people fear it more than any other disease, and with good reason. In a democracy, their feelings should have weight.

116. Doesn't the Cancer Program take funds from other programs?

No. In the six years preceeding the inauguration of the Cancer Act in 1972, the other institutes in the National Institutes of Health received a 56 percent increase in funding. In the six years after the Cancer Act, they received a 65 percent increase in funding. A superficial glance at the figures for some institutes may not show this, since several institutes were split into two.

117. Doesn't the NCI spend most of its money on a search for cures?

No. NCI originally estimated that 15 percent of its budget went to direct clinical treatment research and about 13 percent to preclinical studies designed to find newer and better medicines. That would have been 28 percent which is hardly an excessive proportion. It now appears that 26 percent is a more accurate estimate.

118. Doesn't cancer research get too much money?

No. It receives much less than is needed and could be wisely and effectively spent.

119. Wouldn't more funds for NCI lead to inflation?

Hardly. The amount of taxpayer funds wasted and stolen each year in other government agencies is many times more than the total spent to fight cancer.

120. Doesn't the National Cancer Institute have some wasteful and inefficient programs?

Yes. No program is perfect. Still the productive and efficient parts of the NCI program have been so successful that the overall average is high.

121. The government is faced with many serious problems. Why do you want to divert energies and funds to fighting cancer?

How many of the other problems facing the nation kill over 1,000 Americans every day?

122. How much do you think NCI should receive each year?

In 1971, the National Panel of Consultants on the Conquest of Cancer recommended a level of $800 million to $1 billion by 1976. They meant, of course, 1971 dollars, since they could not anticipate the inflation rate since 1971. When we consider the drop in the purchasing power of the dollar, it becomes evident that for fiscal 1980, the Cancer Program should receive at least $1.4 billion to do the job assigned to it.

123. How much do you think should be spent to find better treatments for cancer?

At minimum, for fiscal 1980, the Div. of Cancer Treatment of NCI needs $400 million to move ahead at an accelerated pace. This should increase to $500 million in fiscal 1981, $600 million in fiscal 1982, and $700 million in fiscal 1983. These are the amounts needed for reasonable progress. If there were more funds, there would be more progress.

124. If still more money were available, how much faster could newer, better anticancer drugs be developed?

If the nation were to use fully the abilities of all cancer research scientists who for reasons of inadequate funding are not doing all the research they can do and want to do, it should be possible to double the number of new anticancer drugs found each year. However, it would take at least two to three years before the first of the new drugs reaches clinical trials. If the nation were to utilize fully the abilities of all other capable scientists who want to do cancer research, but who are not formally considered cancer scientists, we should be able in about three to four years to multiply by three to four times the number of new, useful anticancer medicines found each year. This refers to scientists such as organic chemists, biochemists, clinical pharmacists, pharmacologists, botanists, veterinary pathologists and others who would join research teams and increase their efficiency and productivity.

125. How much extra would that cost?

The nation now spends about $¼ billion per year in both direct and indirect costs to find better treatments for cancer. A full-scale effort, using all scientists who want to contribute and who are qualified to do the job would cost about $1 to $1½ billion per year—if indirect costs do not increase. That is just the amount needed by the Div. of Cancer Treatment. That means that the NCI would need $2 to $2.5 billion per year.

126. Is that a reasonable amount to expect?

It depends on whom you ask. The people we speak to think it quite reasonable to ask that finding cures and controls for cancer receive at least half as much per year as the space program. We don't expect that much, but we do expect and intend to seek the amounts listed in question 123.

127. Are there scientists who are capable of doing productive cancer research who are not doing it?

Yes, hundreds.

128. Why not?

There isn't enough money to pay for the costs of their research.

129. Why should the cancer research program be treated differently than all other government programs? If other programs are held back because of inflation, why shouldn't the cancer program?

The Cancer Program starts out grossly underfunded compared to others, such as the space program. Cancer is the most dreaded disease, it will strike over 25 percent of all Americans directly and will strike almost every family.

130. How much is the government spending on cancer prevention and cancer prevention research?

That is extremely difficult to answer because there are so many government agencies involved in these areas and because many activities involve preventing cancer, and at the same time preventing other illnesses and accidents. One can only estimate. Based on information obtained from several federal agencies, but not all, our estimates suggest that about $½ to $1 billion are spent annually by the federal government on cancer prevention research and cancer prevention, including regulatory and enforcement costs.

131. How much is spent on research to find better treatments for cancer?

Only one federal agency, the National Cancer Institute, spends significant amounts trying to find better treatments for cancer. The total for fiscal 1979 was just under $¼ billion. For fiscal 1980 it is just over $¼ billion but because of inflation, slightly less than before in purchasing power.

132. If $¼ billion is spent on treatment research, and $½ billion to $1 billion is spent on cancer prevention activities, prevention seems to be favored. Isn't that correct?

It's hard to tell. The figures aren't fully comparable.

133. Does that mean that supporters of increased cancer treatment research will not ask for funds to be reallocated from prevention activities to treatment research?

Correct. We believe that both prevention and treatment need to be strengthened and improved.

134. Some people claim that even if cancer were completely conquered, the average American life expectancy would only go up two years. Therefore, they question the wisdom of spending lots of money on cancer research. How do you respond?

Their claim is based on statistical juggling and a series of unjustified assumptions. If cancer were conquered, the average American life expectancy would go up much more, but in fact there are no accurate methods for predicting how much more. Still, let us, for the sake of argument use the low estimate of two years of added life per American. How much is each year of added life without cancer worth? Surely it is worth at least $10,000. Therefore, two years would be worth $20,000 per person. Since there are 220 million Americans, $20,000 each comes to a total of $4,400 billion. That's how much, conservatively, an added two years of happy, healthy productive life would be worth to Americans. We are only spending about $1 billion per year to conquer cancer. One part in 4,400. How can any reasonable person call that too much? If we spent $10 billion per year to conquer cancer, it would not be excessive.

135. What is the economic impact of successful cancer therapy?

Let's assume that the average citizen earns $10,000 per year. Based on that assumption, and other conservative assumptions, the lives saved each year by chemotherapy for Hodgkin's disease are worth over $700 million to the nation, the lives saved from non-Hodgkin's lymphoma are worth over $110 million, the lives saved from acute lymphocytic leukemia of childhood are worth over $1.8 billion, the lives saved from premenopausal breast cancer are worth over $100 million. The total saved for the nation each year just in these five cancers is about $3.6 billion. The cost of treatment for these individuals is less than $600 million. Therefore, the nation's economy is already saving over $3 billion per year from the cancer program in which it has invested less than $1 billion per year.

136. Can more money really produce better treatments for cancer?

It already has.

137. Doesn't an increase in funds for cancer research mean less funds for other research?

No. This nation can easily afford effective research programs to conquer all serious diseases. All of the National Institutes of Health together receive far less money than the Space Program.

138. Why do you continually compare medical research to the space program?

As citizens and taxpayers we disagree with the present research and development priorities. The President has asked Congress to appropriate $5.7 billion for the space program while pressuring them to keep the Cancer Research Program at $1 billion, and all health research at $3.6 billion. We don't believe that this reflects the wishes of the American people.

139. Why should cancer get the lion's share of the biomedical research appropriations?

Because of all the diseases that afflict the people of the United States, cancer causes the lion's share of agony, suffering, despair, anxiety, and fear.

140. Penicillin was discovered by accident by a single scientist, Dr. Alexander Fleming. Wouldn't it be best to support just the scientists like Dr. Fleming and wait until they make the needed discoveries?

There are several reasons why that alone would not work. First of all, how can we identify the future Dr. Flemings? Second, how long must we wait? It might be hundreds of years before another Dr. Fleming comes along. The history of penicillin itself indicates why we cannot rely on this approach alone. Dr. Fleming discovered penicillin in 1928. His colleagues considered it an interesting oddity, but did not recognize its potential value. Dr. Fleming did, but he could not make enough penicillin to treat a patient or even animals. For 12 years, penicillin remained a minor curiosity. The onset of World War II spurred the British government to seek better ways of treating infection, and other scientists were brought in to help Dr. Fleming. Penicillin was not available for use in the United States for civilian patients until 1944, 16 years after its discovery.

We certainly should support those scientists who are like Dr. Fleming when we can identify them. However, when they have made a vital discovery, we must be ready to carry it forward to clinical use without excessive delay. This requires the cooperative efforts of many scientists. That is precisely what the National Cancer Program is doing.

ACS SAYS 41 PERCENT ARE SURVIVING FIVE YEARS, COULD BE UP TO 50 PERCENT

The American Cancer Society has accepted the survival figures which NCI Director Vincent DeVita reported last year—that 41 percent of cancer patients are surviving five years after treatment.

NCI's figures were based on data accumulated by the SEER Program and utilized five year survival information for patients whose treatment began in 1973 or earlier. DeVita has estimated that with improvements in therapy since 1973, survival may be considerably higher now, perhaps as high as 50 percent.

In the 1981 edition of ACS' annual publication, *Cancer Facts and Figures,* the Society asserts that about 268,000 Americans—one-third of all who will get cancer this year—will survive for five years or more. When normal life expectancy is taken into consideration (factors such as dying of heart disease, accidents and diseases of old age) 41 percent of cancer patients will survive.

The Society adds that many more people could be saved. "About 134,000 people with cancer will probably die in 1981 who might have been saved by earlier diagnosis and prompt treatment," says *Facts & Figures.* This means that with our present knowledge of the disease, as many as one-half of cancer patients could be cured.

According to the Society, more than three million living Americans have survived cancer, two-thirds of them having been diagnosed five or more years ago. Most cancer patients who have gone that long without recurrence are considered to have the same life expectancy as persons who never had the disease. But *Facts & Figures* points out that "the decision as to when a patient may be considered cured is one that

must be made by the physician after examining the individual patient."

Despite the progress against cancer since the early part of this century, the total numbers of new cases each year continues to rise. "In the 70s," the publication states, "there were an estimated 3.5 million cancer deaths, over 6.5 million new cancer cases, and more than 10 million people under medical care for cancer."

The most optimistic trends continue to be in the area of diagnosis and treatment. Because of this, the Society's education program focuses on six priority sites: lung, colon-rectum, breast, uterus, oral cavity and skin. The program explains how people can help protect themselves against cancer and stresses the importance of careful attention to possible warning signs of the disease through self-examination techniques and regular medical examinations.

The report also describes 14 cancers which used to be considered largely incurable. It states that "today they are being cured in many cases, predominantly because of chemotherapy advances," and lists the following as examples of this progress: acute lymphocytic leukemia, adult myelogenous leukemia, Hodgkin's disease, histiocytic lymphoma, Burkitt's lymphoma, nodular mixed lymphoma, Ewing's sarcoma, Wilms' tumor, rhabdomyosarcoma, choriocarcinoma, testicular cancer, ovarian cancer, breast cancer and osteogenic sarcoma.

Facts & Figures is available from ACS, 777 Third Ave., New York 10017, and from local ACS offices.

RFPs AVAILABLE

physical examination, including initial observations, microscopic examination for parasites; viral serological testing; histopathological examination of all major organs and organ systems; bacterial culturing and examination for pathogenic microbes; examination for ectoparasites; and examination for endoparasites.

The above includes the monitoring of all areas of the animal production and utilization program as designated by the government representatives. A second area will be concerned with emergency performance when clinical disease outbreaks occur within the program. While animal disease problems are expected to occur with decreasing frequency throughout the general program, certain areas will remain of critical importance, e.g. nude mouse production and testing life time bioassay experiments and biological modifier program mice.

The third area of performance will be that of assisting the project officer in interpreting data from the monitoring services which will include serological, microbiological, histological, and parasitological data supplied by other contractors. A degree of flexibility will be expected between the project officer and the successful offeror regarding both the exact procedures utilized and the number and frequency of animals that should be tested in order to build a profile.

It is estimated that approximately 1500 rodents will be processed per year and that approximately 15,000 viral serodiagnostic titrations will be performed. Animals will be furnished by the government at no charge to the contractor. In addition, approximately 10,000 viral serological tests will be per-

In view of the requirements of the proposed contract, it is essential that the offeror's facilities be readily accessible to the NIH headquarters in Bethesda. This research support effort is to be performed in close collaboration with NCI staff. Therefore, offeror's facilities must be within a 50-mile radius of NIH.

Contract Specialist: Thompkins Weaver Jr.
Biology & Diagnosis
301-427-8877

RFP N01-CM-15737-56

Title: *Provision, maintenance and transfer of tumored laboratory animal models for investigation*

Deadline: *Jan. 29*

Objective of this contract is to provide housing, maintenance, observation and transportation of laboratory animals involved in experimental studies by the various branches of the Clinical Oncology Program at NCI. The contractor must be able to maintain and provide housing at all times for a maximum 5,000 mice, 1,000 rats, 750 hamsters and 50 rabbits.

The contractor must also provide adequate facilities for the maintenance and storage of animals treated with radioactive, carcinogenic or hazardous chemical compounds according to established government requirements. The contractor will deliver and pick up animals from investigators on the NIH reservation on 24 hours notice. Deliveries shall be available Monday through Friday except federal holidays.

The contractor must be able to provide adequate workspace (minimum 200 square feet) for NIH personnel to perform experimental procedures. Such space must be provided with materials necessary to weigh, bleed and innoculate animals. Facilities must be present for suitable handling and disposal of radioactive materials and carcinogenic or hazardous wastes. Refrigerator and freezer, each a minimum of 14 cubic feet and storage for equipment must be provided.

The contractor must have the work overseen by a responsible investigator with experience in laboratory animal maintenance as well as experimental investigations. Veterinary consultation must be available within 24 hours for any health problem related to the stored animals.

The contractor must provide 24 hour access to animals and workspace for the NIH investigators and staff including weekends and holidays. The contractor's facilities must be located within a 35 mile radius of the NIH reservation and must provide parking for NIH investigators and staff.

Contract Specialist: Ann Peale
Cancer Treatment
301-427-8737

RFP NCI-CB-15533-07

Title: *Resource bank(s) and distribution center(s) for cell lines useful in research in tumor immunology*

Deadline: *Feb. 16*

The Div. of Cancer Biology & Diagnosis, NCI, is seeking proposals for provisions of an efficient system for the acquisition, cataloging, storage, and distribution of cell lines capable of long term growth in vitro which are useful in research in tumor immunology. In addition, the selected contractor(s) shall be prepared to offer recipients of cell lines expert advice on the culture and characteristics of all lines shipped.

Cell lines of interest include, but are not limited to, the following major categories:

1. Cell lines useful in the study of B (bursal equivalent derived or bone marrow derived) lymphocyte development and function with particular regard to their role in the immunobiology of tumors.
2. Cell lines useful in the study of T (thymus dependent or thymus derived) lymphocyte development, and function with particular regard to their role in the immunobiology of tumors.
3. Cell lines useful in the study of monocyte/-macrophage development and function with special regard to their role in the immunobiology of tumors.
4. Cell lines useful in the study of immunoglobulin structure, synthesis and secretion and/or useful in somatic cell hubridization including myelomas and their variants.
5. Somatic cell hybrids (hybridomas) useful in tumor immunology with special reference to those producing monoclonal antibody useful in the identification of leucocyte subpopulations and in the identification of tumor associated antigens.
6. Cell lines useful in the study of immune effector mechanisms such as lines of target cells.

While the contractor(s) is/are expected to have available a suitable library of cell lines or specific plans for procurement of suitable cell lines, the final list of specific lines for inclusion in the bank shall be determined by consultation between the project officer and contractor(s) and shall be predicated by usefulness to a broad segment of the immunological research community.

Contract Specialist: Helen Kelly
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The Cancer Letter _Editor Jerry D. Boyd

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