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## NCAB APPROVES MAJOR REVISIONS IN PROGRAM PROJECT GUIDELINES; SMALLER, TIGHTLY FOCUSED GRANTS SEEN

The National Cancer Advisory Board last week approved major revisions in program project guidelines which are intended to streamline P01 grant applications and improve their review. One result probably will be future program projects which are somewhat smaller and more tightly focused than those of the present.

Maureen Henderson, who chaired the NCAB committee which has been reviewing program project guidelines for nearly a year, presented the committee's report to the Board, including a series of recommendations. She asked for Board action only on the recommendation calling

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*In Brief*

### O'CONOR NAMED NCI LIAISON TO IARC, SAUNDERS ACTING IA DIRECTOR; SUSAN SIEBER DCCP DEPUTY

**GREGORY O'CONOR**, director of NCI's Office of International Affairs and former director of the Div. of Cancer Cause & Prevention, has left to become NCI's liaison officer to the International Agency for Cancer Research in Lyon. Joseph Saunders, O'Conor's deputy, is acting director of International Affairs. . . . **SUSAN SIEBER** has been appointed deputy director of the Div. of Cancer Cause & Prevention by Director Richard Adamson. Sieber, 41, has been special assistant to Adamson for the past several months. Before that, she was chief of the Pharmacology & Experimental Therapeutics Section in the Div. of Cancer Treatment. She has a PhD in pharmacology from George Washington Univ. and has been at NCI since 1971. . . . **NCI IS SEEKING** a board certified diagnostic radiologist with extensive laboratory and/or clinical research experience to be chief of the Diagnostic Imaging Research Branch in the Radiation Research Program of the Div. of Cancer Treatment. The branch is responsible for planning, development, management and evaluation of grant and contract supported research in all areas of medical imaging research, including conventional radiology, interventional radiology, CT scanning, nuclear medicine, ultrasound, magnetic resonance imaging, photoelectronic radiology, and related disciplines. Salary is $51,353-63,800, plus eligibility for physician's comparability allowance of an additional $10,000 a year. Candidates may submit a personal qualifications statement, CV and bibliography to Cynthia Kauff, Bldg. 31 Rm. 3A32, NCI, Bethesda, Md. 20205, by July 1. . . . **VINCENT CAGGIANO** has been appointed medical director of Sutter Community Cancer Center in Sacramento. Caggiano has been in private practice in hematology and oncology since 1968. The cancer center is part of Sutter Community Hospitals which see 2,000 new cancer patients a year. Sutter is a member of the Northern California Cancer Program.

## NCAB COMMITTEE FINDS P01 SUBPROJECTS MORE THOROUGHLY REVIEWED THAN R01s

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for immediate approval and implementation of the revised guidelines.

Significant changes in the guidelines are:

• Each individual project (subproject) submitted in the application will be considered in the review and will contribute to the grant's overall priority score, *whether approved or not.* Previously, disapproved subprojects have been excluded from the subsequent evaluation of the application. The committee agreed with NCI staff assessments last year that this practice has led to inclusion of many less worthy subprojects, complicating review and leading to inconsistencies in the overall evaluation.

With investigators knowing every proposed subproject will count in determining the priority score, only those they feel are the best and which contribute most to the project's goals will be included. The result should be tighter, better, and easier to review applications and stronger and more successful program projects.

• More emphasis is placed on the pre-application stage, starting with a letter of intent. Recommendations for content of the letters and nature of subsequent discussions with NCI staff are presented in considerable detail.

• Language has been added emphasizing the importance of a "tightly integrated program of collaborative research."

• Emphasis has been added on the coordination, interrelationship, and synergism among the individual research projects and core components; relationship of the program objectives to the common theme; the program objectives; and the advantages of pursuing the proposed research as a program grant rather than through individual research grants.

• The appropriateness of the size of the program is stressed. It should be small enough to afford effective interaction focused on a specific central theme and large enough to achieve synergy and economies not provided by regular research grants.

Henderson's committee took a close look at review of P01s and of individual grant (R01) applications as well, comparing the two, and came up with an interesting conclusion:

"Each individual project of a program project receives considerably greater discussion and deliberation (averaging more than two hours of site visit team time per project) than occurs in the R01 study section situation (average is about 15 minutes of committee time per application). Furthermore, the discussion of P01 projects is led by individuals who are selected specifically for the review because of their particular expertise rather than the committee members with expertise in that particular area."

So much for the critics who have complained that the program projects mechanism permits less meritorious subprojects to escape the rigorous review applied to R01s.

The committee agreed with NCI Director Vincent DeVita's concern, that the practice of scoring an application after removal of disapproved subprojects "promotes the inclusion of low quality and irrelevant projects with the end result that the programs proposed are not tightly integrated, collaborative, synergistic efforts. . . . Members of the committee expressed the belief that the review committees currently do take into account the presence of projects in an application which merit disapproval when they award the overall priority score, although perhaps to varying degrees."

The committee also discussed at length the process by which a person or a committee develops a priority score which reflects that person's or committee's assessment of the individual projects and/or ultimately the program project as an integrated whole. "The committee believes that an assessment of the extent to which each of these factors constitutes a major element in the mind of the reviewer as he/she develops a priority score is needed. The committee recommends that an experiment be undertaken to measure the extent to which each of these factors is taken into account in the course of the assessment of merit of both the individual projects and of the program as a whole. This behavioral parameter of the peer review process has never been systematically investigated but should be. The results of such a study may be helpful in providing guidance to reviewers in the future which can bring greater meaning and uniformity to the evaluation process."

**Summarizing its report,** the committee said, "Available data support the following conclusions:

—NCI program project grants are supporting unique basic science and unique clinical research, research that would not be readily supported by other existing mechanisms.

—Good P01 research subprojects are not only integrated but synergistic.

—It is reasonable to expect the output of a P01 to be more than the sum of the outputs of the individual subprojects.

—Program projects and all subprojects usually have more extensive peer review than a majority of R01 applications.

—All three standing NCI P01 review committees use similar criteria to evaluate program project grant applications.

—The number of disapproved subprojects is currently being taken into account to a greater or lesser extent when P01 priority scores are awarded.

—Review committees intuitively distinguish between subprojects that are disapproved on the basis of scientific merit and those that are disapproved

because they are inappropriate for inclusion in the overall program. Priority scores are worse if subprojects are disapproved on the basis of scientific merit. Most subproject disapprovals are based on the lack of scientific merit.

—The quality of P01 review can be hampered by the inclusion of too many reviewers with limited experience of research management and administration.

—The quality of P01 review can be threatened by the absolute size of a program project proposal. This statement applies both to the number and complexity of subprojects and to the overall budget.

—There are a few unavoidable and appropriate differences in the review of basic sciences and clinical program project grants but both stand to benefit from more explicit and standardized procedures and criteria.

—Patient care costs are difficult to describe to nonclinical reviewers which, if misunderstood, can have an inappropriate influence on review decisions.

—Innovativeness, expected scientific performance, percentage of science that is not reiterative, track record of the investigators, relatedness of the project to the entire program, feasibility of achieving project goals, and the budget are major criteria used by all three review committees when they assess subprojects.

—Major criteria being used by all three committees for review of the program project as a whole include: the PI's leadership ability; the program's potential for synergistic interactions; its cost effectiveness; its scope and its likely impact on the scientific and technological state of the art.

—Two levels of review provide the best assurance that all individual subprojects and the entire program are thoroughly reviewed and appropriately weighed.

—There are very few data anywhere in the scientific community to distinguish the particular factors that make a grant proposal fundable. An effort to identify and quantify these factors would be a value to the scientific community at large and should therefore be undertaken very carefully and judiciously.

The subcommittee reaffirmed the directives that:

—Each P01 subproject be judged on its integration and on its synergistic potential within the program as well as its scientific merit.

—Every review committee include the results of review of every subproject in the development of a final priority score for a P01.

—The core be recognized as an administrative support component whose review does not contribute to the overall priority score. The committee recognizes however that the cost of the core would be considered and taken into account by the reviewers in the overall budget assessment.

The committee suggested that the following responsibilities be emphasized:

—Principal investigators are responsible and accountable for the scientific merit and the integrative and synergistic qualities of every subproject included in a P01.

—Program staff and standing review committees are responsible for limiting P01 support to research programs that meet its stated goals and requirements.

The committee also encouraged NCI's Div. of Extramural Activities to:

—Use two levels of peer review whenever possible.

—Make every effort to recruit appropriately experienced reviewers.

—Make the review criteria and procedures more explicit to site visit teams and standing review committees.

The specific recommendations to the NCAB are:

1. To approve the revised guidelines and put them into effect immediately.
2. To consider an objective and scientifically sound study of factors contributing to P01 peer review decisions.

In the meantime, the committee recommends that DEA:

—Give clear instructions to reviewers to use agreed upon criteria to judge each subproject and to assess the program as a whole.

—Transmit all review data from site visit teams to parent review committees together with its recommendation but without any numerical values.

—Clearly instruct each parent review committee to take every disapproved project into account in the assignment of the priority scores.

## FIFTY-NINE CCOP AWARDS MADE, PAYLINE SET AT 250, SIX FUNDED AS EXCEPTIONS

Fifty-nine Community Clinical Oncology Program awards were approved for funding by the National Cancer Advisory Board last week, and the prospect remains that an additional 10-15 may be funded after NCI learns more definitely how much it will be paying for indirect costs and research base expenses.

The priority score payline was established at 250. Every proposal scoring 250 or below (down to a best possible score of 100) was funded, a total of 53 CCOPs.

Six CCOPs scoring above the 250 payline were approved for funding as exceptions, for the most part to achieve a somewhat better geographic distribution.

NCI estimated that the 59 awards, with indirect costs and the payments to the research bases, will require $8 million. A total of $10 million had been committed to the program, and more awards definitely will be made to meet that commitment.

Despite the priority scores running somewhat higher than those for other NIH reviews, NCI staff in general agreed that the quality of applications was

very good, and that a number of good ones were not funded. There were enough good, viable proposals to fund as many as 100, if the money were available (probably at least $3 million more, for a total of $13 million).

Eleven of 14 Community Hospital Oncology Program contractors won CCOP awards, indicating that those with strong, established oncology units scored well. One of two Community Oncology Program hospitals was funded. This has led some NCI staff to speculate that before another CCOP round is established, more CHOPs should be funded.

Another element believes, however, that the hospitals with the stronger programs don't need the help as much as do the weaker ones. "I would like to take the 10 worst CCOP applicants, fund them, and see what happens," one staff member said.

The complete list of awards was not made available by NCI.

## NCAB APPROVES, NCI ACCEPTS POWERS' VERSION OF OSP RECOMMENDATIONS

NCI leadership retreated gracefully from the confrontation with the National Cancer Advisory Board's Committee on the Organ Systems Program and its chairman, William Powers, accepting in full the committee's recommendations on the new program including the revisions demanded by Powers.

The new version of the recommendations is consistent with the one Powers said was drawn up by the committee at its two day meeting last January and submitted then to the full Board. It includes provisions Powers said had been agreed upon by the Board but which were dropped when NCI staff compiled its report of the Board's action.

Powers and Board member Rose Kushner objected to the omissions, but NCI Director Vincent DeVita stood firm. An exchange of letters between DeVita, Powers, and President's Cancer Panel Chairman Armand Hammer ensued, including a letter DeVita disseminated throughout the scientific community, with neither side giving ground (all of which was published in various issues of ***The Cancer Letter***).

When the committee met May 15 prior to last week's NCAB meeting, however, NCI raised no objections to the revisions. "Most of the modifications are reasonable," Div. of Resources, Centers & Community Activities Director Peter Greenwald said.

Committee member Janet Rowley had been defending NCI's version of the recommendations. She commented that some of the committee provisions were "trying to be more directive to NCI than is appropriate. . . and were not acceptable to some Board members. . . . We as a Board don't have to legislate how (NCI staff) interacts with the (organ systems) working groups."

But after Greenwald's conciliatory remarks, committee member Robert Hickey said, "If they don't have a problem, you don't have a problem, Janet." Rowley then joined the committee in voting unanimously for the Powers version, and it was approved by the full Board by unanimous vote later in the week.

The main points in contention were:

- Powers insisted that the committee's original report called for planning to begin immediately on establishing new working groups for cancers of the upper respiratory tract and central nervous system. The full Board had added the words, "as feasible." But the NCI version added the words, "with consideration of need."

"That was not the intent of the committee," Powers said. "To change it was provocative and unnecessary. This committee and Board are capable of making recommendations and writing them and voting on them."

- The NCI version omitted a reference to the working groups in the new program which noted that they "are already chartered committees." That was clearly referring to the four existing working groups (prostate, bladder, bowel, pancreas) and could be interpreted as a mandate to use those charters and continue those groups.

The request for applications for the new headquarters grant which will replace the four existing programs, however, does not include a reference to the existing working groups. Greenwald, during the Board's discussion of Powers' report, asked if the committee was satisfied with the RFA as it had been written. Powers said that it was.

- The NCI version, in the provision referring to funding was vague in the matter of providing funds for any new groups which might be established. Kushner argued that it could be interpreted that adding new groups would not bring with it additional money and that it would just dilute funds available to the entire program. Powers and Kushner insisted the committee's original report called for NCI to "adjust OSP funding, as available, to provide for additional working groups that may be established in the future."

- The NCI version said that the working groups would be kept informed on NCI supported research in their respective areas. Powers said the committee's intent had been that the groups would be kept informed "concerning all research in their respective areas."

Powers, at the request of committee member Victor Braren (who missed last week's meetings because he was in China), added a phrase calling for "participatory involvement" of the working groups in their respective programs. This was in part, at least, a response to complaints from the Breast Cancer Task Force that it had not played a role in developing the concepts for the breast cancer diet studies before

they were presented to the DRCCA Board of Scientific Counselors.

Grantees of the old Organ Site Program feared, with some justification it turned out, that review by the NIH study sections would not be fair to them. Only three of 34 grants were funded in the first round reviewed by Div. of Research Grants study sections after the review was removed from the four working groups.

They fared considerably better in the round just awarded by the NCAB last week. Of 37 grants submitted, 32 were approved, and 12 were funded, as follows:

—Prostate, 16 submitted, 12 approved, four funded.

—Pancreas, two submitted, two approved, two funded.

—Bladder, six submitted, six approved, two funded.

—Bowel, 13 submitted, 12 approved, four funded.

That funding was achieved through a decision by NCI, with NCAB concurrence, to fund below the R01 payline (about 195) so that a minimum of 30 percent of the approved grants could be paid. R01 funding also will be at least 30 percent this year.

## DRCCA BOARD APPROVES FOUR CONCEPTS, REJECTS ONE, TABLES TWO OTHERS

The Div. of Resources, Centers & Community Activities Board of Scientific Counselors approved four additional concepts presented at its recent meeting, including a diet modification study that would result in three to six cooperative agreement awards at a total cost of $500,000 a year.

The other concepts were for a contract to develop an international food data system, a master agreement/task order contract for a national occupational cancer control network, and a 15 month extension of the coordinating center for the Centers for Radiological Physics.

**Modification of eating behavior and cancer prevention.** Three to six awards, three years each, total cost $500,000 a year.

Based on animal data and international, epidemiological evidence, both dietary fat reduction and the addition of dietary fiber appear to play some role in prevention of breast, endometrial, prostatic, and colon cancers. There is suggestive but weaker evidence for the role of other macronutrients such as elevated protein consumption related to increased cancer risk.

As NCI prepares to develop large scale intervention trials in order to test hypotheses related to diet modification and the reduction of cancer risk, methods of altering eating behavior in large human populations need further study. Although there have been some recent attempts at large scale interventions in order to reduce multiple risk factors associated with disease, few large scale studies have been carried out specifically on diet modification and disease prevention. Few have been carried out within cancer-relevant populations, attempting to modify dietary constituents of interest to the NCI.

The preponderance of behavioral intervention studies in the area of diet modification have focused on the reduction of total caloric intake within obese populations. A few have attempted to modify specific categories of food consumption such as dietary lipids. However, most of the studies carried out to date have been conducted with small, clinical groups; the change in overall dietary behavior is in many cases minimal, and the effects achieved are usually of short duration.

However, authors of recent methodological reviews on diet modifications suggested promising directions for outcome research in this area. In addition to the potential effectiveness of multiple component behavioral treatment packages, there is recent evidence for the effectiveness of social support, and spouse or couples training in altering eating behavior. But whether a technique—or specific combination of techniques—would be equally effective in both the initial behavior change, and in the maintenance of dietary behavioral patterns, requires further investigation.

Within a clinical trial framework, special problems exist which are not present within small scale, experimental, or quasi-experimental studies. Since the trial is designed to test the effect of an intervention precision of intake and compliance to protocol are of utmost importance to the conduct of the trial and interpretation of trial outcome. In addition, for future trials in the area of dietary fat reduction and fiber intake, significant alterations in eating behavior must be achieved and maintained in large population samples over long periods of time. Therefore, not only must precision of intake and ideal levels of compliance be maintained over lengthy periods of time, but these behavioral or life style modifications will be carried out in settings where constant scrutiny and control are not possible.

For the purpose of this initiative, interdisciplinary behavorial and nutritional investigations will utilize between-groups designs to develop and test methods of altering dietary behavior relevant to cancer control within noncancer populations, age- and SES-matched to population subgroups identified at the highest risk for colon and breast cancer. The behavioral endpoint in these studies will be reduction of dietary fat consumption and increase of dietary fiber consumption to predetermined levels.

Because the aim is to develop valid, reliable and cost effective methods for altering such eating behaviors within large sample clinical trials, some form of comparative research strategy must be adopted. Component parts of multifaceted treatment packages must be tested for their individual contribution to eating behavior variance in order to insure the most effective method at minimal cost to future trials.

Board member Barbara Hulka suggested that "We should get into this (RFA) the notion that people are very susceptible to diet modification, if it is made easier for them. We need a strong factor in addition to motivation, some practical considerations."

"This might be better done in smaller communities, where all the schools, the entire community, could be brought into the program," Ernst Wynder said. "This requires tremendous involvement."

Board member Laurence Kolonel said, "The level of knowledge in this area is primitive. This concept may be one step beyond our knowledge. There is a need to explore why people eat the way they do."

William DeWys, head of DRCCA's Prevention Program, pointed out that the RFA would provide for investigator initiated proposals, and "they can propose studies they feel are needed. I don't think we

would look kindly on three years for inquiries only, but it could start with that, then do the tests."

Board member Christine McGuire suggested another strategy would be to develop convenience foods that fit the intervention categories. "Go to General Foods and ask them to put out packaged low fat meals."

Wynder added that fast food chains look for products that "are tasty and profitable. If we could develop products that are tasty, profitable, and healthy, then we've got something. They would use their advertising power to promote it."

**National occupational cancer control clinical research network.** Approximately 15 awards for master contracts are anticipated as a result of the initial solicitation. Additional awards are anticipated as a result of a requirement for annual resolicitation. Anticipated cost depends on the number of tasks issued; staff estimated $800,000 in the first year; $1.5 million in the second; and $2.5 million a year for years three to five.

Since the late 1970s, clinical units in occupational medicine affiliated with medical schools have begun to emerge in several locations across the nation. These clinics provide specialized patient evaluation, evaluate potential workplace hazards, and form a base for research in occupational medicine.

To capitalize on this development, and to take advantage of the research potential in cancer control in occupational populations, two obstacles need to be surmounted:

1. While the level of cancer risk occupational cohorts in many cases may be very high, the number of workers in each plant is usually too small to achieve meaningful results. It therefore is essential to aggregate similar work forces from different locations for the purpose of generating a cohort of sufficient size to produce study results with a high degree of validity.

2. While the aggregation of populations implies the need for multicenter cooperative studies, units with clinical and analytical expertise in occupational medicine are still few in number. Among those that do exist, at present there is little in the way of standardized approaches to either medical or exposure history taking, or to data management.

This proposed network provides for standardization of protocols for clinical management and reporting of results. Such standardization is intended to offer the opportunity to aggregate data on incident cases based on medical findings and exposure history.

Each unit included in this network will have the following key characteristics: 1) a history of effective clinical management; 2) established patterns of patient referral and specialist consultation (including ties to the most proximate cancer center); and 3) evidence of strong support from unions and industries. It is intended that the complete network will cover most of the nation. The DRCCA Biometrics Branch will be responsible for data management for these cooperative studies.

Tasks in the initial RFP might include:

Task 1: Procedures for standardization. All approved applicants will be expected to participate in working meetings during the first six months of the contract to develop procedures for an operations manual for the conduct of cooperative studies, and to upgrade and standardize data management systems, forms and procedures.

Task 2: Asbestos exposure. To identify and register high risk asbestos exposed populations for inclusion in a chemoprevention trial to reduce lung cancer. Such populations should be well defined in terms of denominators and past exposures to allow for estimation of expected numerators, and thus sample size.

Task 3: Roofing exposure. Evaluate mechanisms to reduce risk for lung and skin cancers associated with exposure to polycyclic aromatic hydrocarbons (benzo(a)pyrene) from coal tar pitch aggrevated by burns, ultraviolet radiation in sunlight, and cigarette smoking. This study will focus on the reduction of airborne emission levels, smoking patterns, and skin burns, photosensitivity and conjunctivitis.

Task 4: Aromatic amine exposure. To identify and register populations exposed to aromatic amines as dye intermediaries at high risk of bladder cancer for inclusion in a study to evaluate the effectiveness of different detection methods in the reduction of bladder cancer mortality. The populations should be well defined in terms of denominators and past exposures.

This network will be funded through a master agreement/-task order mechanism. The RFP will seek qualified applicants to be master agreement contractors to NCI. Funding is committed only when a task order is issued by NCI to a unit that holds a master agreement contract. The task orders will be designed by DRCCA staff. Although the data collected will be provided to DRCCA for processing all evaluation is intended to be collaborative. Results will be disseminated through the network. The RFP for the master contract will include four initial task orders to be funded as part of the approval of the applicants' proposals. All subsequent task orders will be competed among the contractors, and both science and cost will be considered.

**International food composition data system.** One award, $300,000 first year, $500,000 second and thir years, $300,000 final year.

The goal of this procurement is the development of a data system which will encompass all available certified data on the nutrient composition of foods. Such a data system would facilitate international research involving nutrient consumption and would enhance the completeness of the food data base within each country. The major objectives of this procurement include 1) a review and certification of analytic methods, 2) the compilation of an inventory and description of available data bases on nutrient composition, 3) the development of a thesaurus of food items, 4) the completion of a survey of potential users of this system, 5) the development of a data base management plan, and 6) the activation of a functioning data system.

There is a need for a data system of international scope providing detailed information on the nutrient and nonnutrient composition of foods. This data system would clarify interpretation of studies involving comparisons between countries, would facilitate collaborations between scientists in different countries and would enhance the data base available for use within each country. An international data system exists for animal feeds and has facilitated international research.

A series of tasks will be required to develop this international data system. A brief description of each task follows:

1. Review and certification of anayltic methods of nutrient and nonnutrient composition of foods. At the present time different laboratories in different countries use different methods to assay for a given substance with little effort to standardize the methods between laboratories. Obviously, before data can be combined, the comparability of data must be known.

2. Compilation of an inventory and description of available data bases on nutrient composition. Every effort should be made to make this international system as comprehensive as possible. Each description should include data on sampling procedures, analytic methods and data format.

3. Development of a thesaurus of food items. Laboratories in different countries currently classify and name foods differ-

ently. For example in one country American cheese and cheddar cheese are lumped together as processed cheese while in another country several varieties of each are analyzed separately. A standardized nomenclature will be needed for an international system.

4. Survey of users and uses of the data system. The uses of the system may be important for the organization of the data base management system.

5. Development of a data base management plan. Based on items 1-4 above, a plan must be developed to receive and organize the data into a usable format.

6. Activation of a functioning data system. This system should be responsive to the needs of its sponsors and contributors on a no charge and first priority basis. Other users will be expected to pay for use and will be assigned second priority.

The Board approved the concept with the condition that other NIH institutes and appropriate agencies outside NIH which might use information from this program be brought into the funding.

Extension of the contract with the American Assn. of Physicists in Medicine for coordinating activities of the six Centers for Radiological Physics will cost $225,000.

**The Board rejected one concept, a contract to support a prostate tissue collection center, and tabled two others.**

Prostate tissue collection has been carried out by the National Prostatic Cancer Project with funds provided through its grant. Reduction in funds from NCI for the Organ Site Program and the impending change to the new Organ Systems Program made it necessary to support the tissue collection with a contract.

The concept was brought to the Board at its previous meeting and deferred with the request that staff determine if investigators still needed the service. Andrew Chiarodo, chief of the Organ Systems Branch, reported that 31 of 37 investigators queried said they did need it. Of 25 active NCI grants using prostatic tissue, 17 obtained it from this source.

The Prostate Tissue Center was established at the Univ. of Miami in 1973, and the concept proposal was to continue it for five years, at $175,000 a year. Chiarodo said that "without this facility, accessibility to human prostate tissue for research would be sharply curtailed."

Board members did not agree.

"I prefer to vote against this concept," Jerome DeCosse said. "It's an idea that has outlived its time. There are hundreds of hospitals which have urology units and the basic competence to supply this need."

"The way the bank operates, they don't just take out a gland and separate it," Chiarodo said. "The bank provides or has access to material on a continuous and routine basis, and supplies it under the conditions required for research."

"To me, this seems like a little bit of a ripoff," Board member Harry Eagle said.

"This seems terribly expensive," Board member Charles Moertel said. "Many other institutions are doing work in this area."

The vote to reject the concept was unanimous.

The Board tabled a concept for cooperative large bowel intervention studies, in which persons in certain groups at high risk for carcinoma of the large bowel, and patients with resection for favorable Dukes stage of the disease would be monitored closely for polyps or recurrence. The five year study would cost an estimated $800,000 for the first year to $1.3 million for the second.

Board members concluded that the staff proposal was not well enough defined and directed that it be rewritten and resubmitted.

The Board also tabled a concept for two to four cooperative agreements to design, implement and evaluate specific interventions whose purpose is to meet the specific needs of cancer patients and their families. Cost was estimated at $600,000 a year for three years.

Board members in general liked the idea of the concept. "It is appropriate for the National Cancer Program to meet human needs of cancer patients," Moertel said.

However, some members felt, as David Eddy commented, "This looks like a demonstration project, and we know about those." Chairman Lester Breslow suggested a motion asking the staff to work on the proposal and return it to the Board; the motion was approved unanimously.

## NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR JUNE, JULY, FUTURE

**Interagency Collaboratorive Group on Environmental Carcinogenesis**—June 1, NIH Bldg 31 Rm 4. Contact Dr. Herman Kraybill, phone 301-496-1625.

**Diet, Nutrition & Cancer: Etiologic and Treatment Issues**—June 2-4, New England Deaconess Hospital, Boston. Contact Dept. of Continuing Education, Harvard Medical School, 25 Shattuck St., Boston, Mass. 02115, phone 617-732-1525.

**Third Annual Leukemia-Lymphoma-Myeloma Conference**—June 3-4, Colony Conference Center, Longboat Key, Fla. Sponsored by the American Cancer Society Florida Div. and Univ. of South Florida College of Medicine. Contact Dr. Henry Azar, Laboratory Service, James A. Haley Veterans Hospital, 13000 N. 30th St., Tampa 33612, phone 813-972-2000, ext. 500 or 504.

**International Symposium on Cell Differentiation and the Plasma Membrane**—June 5-8, Noordwijkerhout, The Netherlands. Contact Dr. C.A. Feltkamp, Secretary, The Netherlands Cancer Institute, 121 Plesmanlaan, 1066 CX, Amsterdam.

**American Society of Colon & Rectal Surgeons**—June 5-9, Boston. Contact H. Gibson, American Society of Colon & Rectal Surgeons, 615 Griswold, Suite 516, Detroit, Mich. 48226.

**UICC Postgraduate Course on Clinical Cancer Chemotherapy**–June 6-13, Nurnberg. Contact W. Gallmeier, 5 Medizinische Klinik, Klinikum der Stadt Nurnberg, Flurstr., 17, 8500 Nurnberg, Fed. Rep. of Germany.

**NCI Div. of Cancer Cause & Prevention Board of Scientific Counselors**–June 6-7, NIH Bldg 31 Rm 10, closed June 6, 9-11 a.m., open for the rest of the meeting.

**Cancer Control Grant Review Committee**–June 6-7, Bethesda Holiday Inn, open June 6, 8:30-9 a.m.

**Nutrition & Cancer**–June 8, Biltmore Hotel, Los Angeles. Contact Bonnie VanWaardenburg, Hospital of the Good Samaritan, 616 S. Witmer St., Los Angeles, Calif. 90017, phone 213-977-2345.

**NCI Div. of Cancer Treatment Board of Scientific Counselors**–June 9-10, NIH Bldg 31 Rm 10, 8:30 a.m. Closed June 9, 12 noon-3:30 p.m., open for the rest of the meeting.

**National Surgical Adjuvant Project for Breast & Bowel Cancers**–June 9-11, Copley Plaza Hotel, Boston. 24th semiannual meeting by invitation only. Contact Dr. Bernard Fisher, Dept. of Surgery, Univ. of Pittsburgh, 3550 Terrace St., Pittsburgh, Pa. 15261, phone 412-624-2671.

**UICC Postgraduate Course on Clinical Cancer Chemotherapy**–June 13-18, Ljubljana, Yugoslavia. Contact S. Plesnicar, Onkoloski Institut, Zaloska 2, 6100 Ljubljana.

**Bladder Cancer Review Committee**–June 13-14, Logan Airport Hilton, Boston, Mass. 8:30 a.m., all open.

**Disciplinary Approach to Adolescent Oncology**–June 16, Roswell Park continuing education in oncology.

**8th International Congress of Cytology**–June 19-23, Montreal. Contact Dr. Alexander Meisels, Secretary-General, 8th International Congress of Cytology, 1050 Chemin Sainte-Foy, Montreal, Quebec, Canada G1S 4L8.

**46th Annual Meeting of the Canadian Assn. of Radiologists**–June 19-23, Quebec City, Canada. Contact the Association, 1440 St. Catherine St. W, Suite 806, Montreal H3G 1R8.

**Assn. of American Cancer Institutes**–June 19-21, Hilton Hotel, Denver. Semiannual meeting, starting with Progress in Cancer Control, June 19. Contact Dr. Edwin Mirand, Roswell Park Memorial Institute, 666 Elm St., Buffalo, N.Y. 14263.

**The Contribution of Pediatric Oncology to the Clinical Investigation of Cancer**–June 20, Univ. of Wisconsin Hospital. Denman Hammond, chairman of the Children's Cancer Study Group, speaker.

**Platinum Coordination Complexes in Cancer Chemotherapy**–June 22-24, Shelburne Farms, Burlington, Vt. Convened by the Norris Cotton Cancer Center and the Vermont Regional Cancer Center. Contact J. MacKenzie, VRCC, 1 South Prospect St., Burlington 05401, phone 802-656-4414.

**1972-1982: A Decade of Achievements and Challenges in Large Bowel Cancer Research**–June 22-23, Four Seasons Hotel, Houston. Contact Jessie Huerta, National Large Bowel Cancer Project, Box 210, Univ. of Texas M.D. Anderson Hospital & Tumor Institute, 6723 Bertner Ave., Houston 77030, phone 713-792-3391.

**Treatment of Advanced Gastrointestinal Cancer**–June 23-24, Padova, Italy. EORTC symposium. Contact D. Eechoudt, Executive Secretary, EORTC Data Center, 1 rue Heger-Bordet, 1000 Brussels, Belgium.

**Fourth International Conference on Automation of Cancer Cytology & Cell Image Analysis**–June 24-25, Montreal. Contact P. Bartels, Chicago Univ., HM 449, 5841 Maryland Ave., Chicago Ill. 60637.

**7th International Congress of Radiation Research**–July 3-8, Amsterdam. Contact Dr. Arthur Upton, Finance & Travel Committee, Institute of Environmental Medicine, NYU Medical Center, 550 First Ave., New York 10016.

**11th International Symposium for Comparative Research on Leukemia and Related Diseases**–July 3-8, Cambridge, England. Contact Dr. David Yohn, Secretary General, Suite 302, 410 W. 12th Ave., Columbus, Ohio 43210.

**First International Symposium on Tumors of the Urinary Bladder**–July 4-6, Intercontinental Hotel, Paris. Contact Saad Khoury, M.D., Clinique Urologique Hopital de la Pitie, 83, Boulevard de l'Hopital, 75634, Paris Cedex 13, France; or James Karr, PhD, Roswell Park Memorial Institute, 666 Elm St., Buffalo, N.Y. 14263.

**Standardization in the Production and Use of Monoclonal Antibodies**–July 6-9, Paris. Contact M. Barme, Institut Pasteur, 25 rue du Roux, 75015 Paris, France.

**5th World Conference on Smoking or Health**–July 10-15, Winnipeg. Contact K. Baumgartner, Canadian Council on Smoking or Health, 725 Churchill Ave., Ottawa, Ontario K1Z 5G7.

**3rd International Conference on Oxygen Radicals in Chemistry & Biology**–July 10-15, Munich. Contact Kongresswesen der GSF, Ingolstadter Landstr. 1, 8042 Neuherberg/Post, Oberschleissheim, Federal Republic of Germany.

**Laboratory Workshop on Affinity Electrophoresis of Glycoconjugates**–July 13-15, Copenhagen. Contact Glycoconjugate Workshop, The Protein Lab, Sigurdsgade 34, DK-2200, Copenhagen N, Denmark.

**Predictive Drug Testing on Human Tumor Cells**–July 20-22, Zurich. Contact Dr. V. Hoffman, Div. of Oncology, Univ. Hospital, 8091 Zurich, Switzerland.

## FUTURE MEETINGS

**Sexuality and the Cancer Patient: Nurse, Where Are You?**–Sept. 24, Widener Univ. School of Nursing, Chester, Pa. Sponsored by the Delaware Valley Chapter of the Oncology Nursing Society. Contact Vivian Middleman, Widener Univ. School of Nursing, Pennsylvania Campus, Chester, Pa. 19013.

**Medical Oncology Review Course**–Oct. 17-22, Honolulu. American College of Physicians course, directed by Thomas Hall. Contact Maxine Topping, Postgraduate Div., American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104, phone 215-243-1200 or 800-523-1546.

**NIH Consensus Development Conference: Precursors to Malignant Melanoma**–Oct. 24-26, Lister Hill Center Auditorium, NIH, Bethesda. Contact Michele Killon, Prospect Associates, Suite 401, 2115 E. Jefferson St., Rockville, Md. 20852, phone 301-468-6555.

**5th National Cancer Communications Conference**–Feb. 15-17, Washington D.C. Updates on cancer research, approaches for effective public information and education on cancer, information on new communications technology, focus on emerging trends in cancer communications. Contact Nancy McCormick-Pickett, Office of Cancer Communications, Bldg. 31 Rm. 4B39, Bethesda, Md. 20205.

**The Cancer Letter** _Editor Jerry D. Boyd

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