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ACCC WILL DEVELOP STANDARDS, PATIENT MANAGEMENT GUIDELINES TO UPGRADE COMMUNITY CANCER PROGRAMS

The Assn. of Community Cancer Centers has undertaken an effort to develop national standards for community cancer centers, including patient management guidelines, which will go beyond any current or previous programs aimed at upgrading cancer treatment and facilities in community hospitals. ACCC members agreed at the organization's annual meeting last week to proceed with the plan worked out by the
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In Brief

AMA OPPOSES BILL TO PERMIT HEROIN USE FOR PAIN CONTROL, SAYS MORPHINE IS EQUALLY AS EFFECTIVE

AMA OPPOSED H.R. 4762, the Compassionate Pain Relief Act, when the House Health Subcommittee held hearings on the bill earlier this month. Kathleen Foley, chief of the pain service at Memorial Sloan-Kettering Cancer Center, presented the American Medical Assn.'s statement on the legislation which would establish a five year program under which heroin would be made available to certain pharmacies for the management of pain in cancer patients. Foley said that some cancer patients do suffer needlessly, "not due to lack of effective analgesic medications but because of ineffective use of such medications." The bill is "laudable in intent," Foley said, but "heroin is no more effective in controlling cancer pain than are currently available analgesic medications including morphine and hydromorphone. AMA is also concerned that passage of the bill could result in an increase in illicit drug diversion".... **PAULA HAWKINS** (R.-Fla.) has assumed chairmanship of the Subcommittee on Alcohol & Drug Abuse of the Senate Labor & Human Resources Committee, replacing Gordon Humphrey (R.-N.H.), who left that committee for a seat on the Banking Committee. Hawkins had chaired the Subcommittee on Investigations, from which her probes of NCI were conducted in 1981-82. That subcommittee has been abolished. Humphrey's seat on Labor & Human Resources was assumed by Strom Thurmond (R.-S.C.).... **AMERICAN COLLEGE** of Epidemiology has joined those demanding one of their own be appointed to the National Cancer Advisory Board. ACE President Dwight Janerich wrote the White House, asking that a "suitable epidemiologist" be appointed from among the "many senior epidemiologists in the United States who are actively involved in many aspects of research on cancer".... **ROLAND WUSSOW**, former staff member with NCI's Office of Cancer Communications and more recently head of corporate communications for MedAmerica Health Systems Corp. and Miami Valley Hospital, has been named vice president for corporate communications of Hospital Corp. of America.

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STANDARDS, GUIDELINES TO BE USED AS CRITERIA FOR ACCC MEMBERSHIP

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Committee on Standards, chaired by Edward Moorhead, director of the Grand Rapids Clinical Oncology Program. Moorhead is ACCC president elect.

ACCC has no plans to attempt to impose standards on all hospital cancer programs, through federal intervention or other means of accreditation. Instead, the standards eventually are intended to become criteria for ACCC membership.

Moorhead presented a description of the program as the committee has so far envisioned it, along with a time schedule for adoption, in a memo to members at the meeting:

"ACCC has decided to develop a group of national standards and guidelines for community cancer centers. This goal can only be achieved if every delegate member institution accepts the responsibility for developing comprehensive drafts of potential standards and guidelines.

"Standards include the organizational components of a community cancer center. The components have been identified by various surveys of community oncology professionals. It is intended that the standards will include two levels:

A. Absolute minimum standards for a community cancer center in 1985.

B. Goals to be achieved by 1990.

"Organization, facilities, patterns of operation, personnel and evaluation will be required of all standards committees. All standards committees will also be asked to make a statement on cost control, cost effectiveness and evaluation of same.

"It is expected that the standards will apply to comprehensive community cancer centers. Smaller hospitals that cannot meet the criteria for comprehensiveness can qualify as community cancer centers if the gaps in their programs are covered by agreement with a larger center, in writing.

"Guidelines follow the traditional pattern of guidelines for patient management that have been developed by outstanding community oncology programs across the country. Each guideline will address cancer prevention, early diagnosis, diagnosis and staging, management based upon staging, common complications, followup, rehabilitation and continuing care.

"Very importantly, each guideline should contain acceptable criteria that is highly recommended for initial patient management.

"Each delegate institution is asked to volunteer for at least one standard and one guideline. The delegate institution is asked to list several standards and guidelines that it feels it could do well.

"The Standards Committee will assign a minimum of one and maximum of two draft reports to each delegate member. Assignments will be made by May 1.

"First rough drafts will be due Sept. 1, 1984. Final drafts will be due Jan. 1, 1985.

"The Standards Committee will utilize five subcommittees to review first and final drafts of delegate institutions.

"The delegate institution may include anyone it wishes on its committee. This includes other ACCC members, nonmembers and consultants. Or the ACCC delegate could choose to do the entire report inhouse."

ACCC "delegate" members are institutions (hospitals), as opposed to the individual membership category.

The committee compiled a list of 36 tasks, at least three of which each delegate member was asked to consider in developing the draft of standards. Most of the tasks are components which would be included in the standards. The tasks were grouped in three columns, and each delegate was asked to select one from each, although it ultimately would be assigned only one overall. They were:

Group A—Administration organ and management, tumor board and quality control, the oncology unit, oncology nursing, medical oncology, surgical oncology, radiation oncology, clinical research, social service including pastoral care, hospice, administrative director, role of the cancer committee, home care.

Group B—Cancer prevention, screening and early detection; pathology, anatomical and clinical; pharmacy, diagnostic radiology, dietetics and nutrition, physical medicine and rehabilitation, psychiatric and psychological services, pain control program, special problems of consortiums, infectious problems in the cancer patient, components of the 75-125 bed hospital.

Group C—Tumor registry/data management, oncology cost control, professional education, public education, outpatient oncology services, financial support from the community, financial management, patient and family self help groups, medical director, evaluation, cancer library, nursing homes.

Forty two tumor sites, which Moorhead said covers about 98 percent of cancers community hospitals are likely to see, were grouped into three categories, with members asked to choose one or more from each, although they will be assigned only one to work on. They are:

Group A—Primary brain, head and neck except larynx, skin except melanoma, breast, small cell lung, metastatic liver, stomach, colon/rectum, prostate, Hodgkin's, acute adult leukemia, mesothelioma, pain management, and cancer prevention.

Group B—Metastatic brain, larynx, endocrine other than thyroid, sarcomas, non small cell lung, esophagus, adult kidney, testicle, non Hodgkin's lymphoma, chronic adult leukemia, childhood solid tumors, management of depression, early detection.

Group C—Malignant melanoma, thyroid, bone tumors, myelomas, metastatic lung, pancreas, small bowel including carcinoid, bladder, gynecological, leukemia/lymphoma in children, Wilm's tumor, familial tumors, management of infection, access to developmental therapy.

Moorhead chaired ACCC's committee which collaborated with NCI in developing the Community Clinical Oncology Program, an effort that required an intense year of effort in drawing up the community positions and some tough bargaining sessions with NCI.

"This time, the workload is much more overwhelming," Moorhead said. "But if each delegate institution and the Standards Committee do their part, by 1985 we will be well on the way to detailing ACCC's standards for community cancer centers."

Moorhead called the task "vital to the future quality and reimbursement of community cancer cancers."

The committee recognized that some of its members could not now and probably never could implement a sufficient number of the proposed standards to rate being considered in the same category with those that can or will. Thus, the term, "comprehensive community cancer center." ACCC President John Yarbro suggested that before 1990, the standards adopted next year be considered voluntary; after that, a hospital which desires to be considered for ACCC membership as a comprehensive community cancer center would have to comply, essentially, with all of the standards. A minimum requirement of standards would apply to the smaller hospital programs, with the provision that other other requirements would be met through affiliation with another center.

Moorhead pictured the ultimate results:

"At the end of this process, ACCC will have national standards regarding the organization and operation of community cancer centers that can be used as criteria for membership, as a basis for negotiation with third party payers, and/or for accreditation purposes.

"These ACCC national standards will consist of two parts. Part A will include standards for the organization and operation elements of a community cancer center along with a plan for evaluation.

"Part B will include patient management guidelines for almost all types of cancer. These guidelines will then be updated regularly.

"The real winner in this process is the cancer patient, most of whom (85 percent) obtain their treatment in the community hospitals of America. We believe that these standards will both upgrade care and organization in the community hospitals. With significant grass roots involvement, they will also reflect the high quality of cancer programs and cancer care available in community hospitals. This is the most important and far reaching project ever undertaken by ACCC. Oncologists have established a brilliant record in both patient care and clinical research. We can assure that cancer patients and their families will continue to find the highest possible quality of care available in their home communities."

Moorhead said that in developing standards, ACCC "will be building on the base established by the American College of Surgeons. That program has been very good. It has resulted in real improvement in the quality of community cancer care." ACOS through its accreditation program has approved currently a total of more than 1,000 cancer programs in hospitals around the U.S. The ACCC standards probably will include all the elements required by ACOS, and substantially more.

Moorhead said he believes that patient management guidelines will be needed "to fight the battles of DRGs and PROs, and will be useful guides to local oncologists in dealing with other third party payers." Nationally reviewed and approved guidelines should be very helpful, and may be essential, in convincing the government that certain procedures required for high quality care should be reimbursible, he said.

The committee will meet in Colorado Springs in September, one day prior to the annual ACCC Leadership Conference, to consider the first drafts of the standards and guidelines. Another meeting will be held prior to the January meeting of the ACCC Board to consider the revised drafts, and a final draft will be presented to members at the annual meeting in March, 1985.

Barbara McCann, hospice project director for the Joint Commission on Accreditation of Hospitals, warned of problems ACCC will face in developing and implementing standards, including possible antitrust actions. She suggested that antitrust attorneys be consulted "every step of the way" and doubted that the time schedule established by Moorhead's committee could be met.

Members of the Standards Committee are, in addition to Moorhead, Thomas Tucker, Kalamazoo; Dianne Van Ostenberg, Grand Rapids; Nancy Agee, Roanoke; Robert Enck, Binghamton, N.Y.; Herbert Kerman, Daytona Beach; Yarbro, Columbia, Mo.; Paul Anderson, Colorado Springs; Bruce Briggs, Fargo, N.D.; James Bonorris, Los Angeles; Ronald Keel,

Kansas City, Kan.; John Bruner, Phoenix; Donna Minnick, Indianapolis; William Dugan, Indianapolis; C.L. Murray, Minneapolis; Lee Mortenson, Washington D.C.; and Barry Sakulsky, Los Angeles.

HOLLAND ON NEXT 10 YEARS: PROGRESS IN PREVENTION, DIAGNOSIS, THERAPY

The Assn. of Community Cancer Centers, observing its 10th anniversary at last week's annual meeting, called upon one of the country's foremost clinical investigators to make some predictions on what the next 10 years have in store.

James Holland, chairman of the Dept. of Neoplastic Disease at Mt. Sinai School of Medicine and one of the first clinicians to demonstrate that some cancers can be cured with drugs, addressed the meeting on "Future Development in Cancer Management: The Next 10 years." Progress which is possible and which "will come true, in whole or in part, in the next 10 years," include developments in (as excerpted):

*Etiology. We may learn a great deal in the next 10 years but that won't be essential (to improved management of cancer). Cesar drained the swamps around Rome 2,000 years ago and eliminated malaria without understanding the disease. If we could eliminate cigarettes, cancer would substantially decline without our understanding any more about cancer than we do now. We eliminated small pox without knowledge of molecular biology. It's been our good fortune that (Robert) Gallo and his colleagues isolated HTLV. We have learned that it is not confined to leukemia but is associated with lymphomas and certain other diseases among populations from Africa. There is a strong suspicion that cervical cancer, devastating to female populations in most parts of the world, is a viral disease. We surely can learn something about the etiology of carcinoma of the cervix in the next 10 years.

Oncogenes, which in mammalian species can transform benign cells to malignant cells, normally are not active, it now appears. In the next 10 years it should be possible to learn much more about how oncogenes are activated.

We may learn much more about the repair process. DNA may be repetitively injured and repaired. Carcinogens active in one species may not be active in another, one with an elegant repair mechanism. We are learning more about the pathogenesis of the disease. Dysplasia is increasingly recognized as the forerunner of the malignant state. In marrow disease and bronchogenic carcinoma, the process can be reversed before onset of malignancy. Investigators will pay more attention to premalignant conditions prior to invasive cancer.

*Diagnosis. I believe we are on the threshold of blood testing for cancer. Information is available

on radiolabeled antibodies, monoclonal or polyclonal in origin. They are not yet as useful as we would like them to be. In the next 10 years we will see stable antibodies, monoclonal and polyclonal, with a little more specificity.

A few years ago I looked with amusement on economists who worried about over use and increasing cost of medical care represented by the advent of computer tomography, and they said it ought not be used. Now, with a better analysis of the economics, every institution will have one. It is an extremely valuable tool. NMR is even more expensive, and we may be in danger of investing millions which could be better spent on other things, particularly on personnel. Every cancer center has a computer and the capability of connecting them with modems to an NMR installation somewhere else. The facility then could be utilized 24 hours a day, perhaps, on a regional basis. An oncologist could view on his screen the reading from an NMR 500 or 1,000 miles away, quicker than he could walk down the hall and look at films. A network of computers with an NMR could be established with a modest investment.

*Prevention. This implies a governmental role. The Environmental Protection Agency and Occupational Safety & Health Administration have concerned themselves with pesticide exposures and such workplace chemicals as benzene. Another agency, a eunuch, which is supposed to be concerned with environmental pollution, is the Food & Drug Administration. FDA has no authority over tobacco which, as a pollutant with adverse health effects, exceeds all others. It has been over 200 years since Potts discovered that carcinoma of the scrotum in chimney sweeps came from the residue of burning. We know full well that combustion products cause bronchogenic carcinoma, bladder carcinoma, oral carcinoma, and others. It is a scandal that tobacco land value prevents us from stopping this, because tobacco is a high profit crop. I suggest that we find a high profit crop to replace it. Orchids, or shrimp culture. Retirement communities do well in areas temperate enough to grow tobacco, and they seem to be very profitable. We must educate children to not start smoking. It seems easier to educate men to stop smoking as they approach age 40. It is not as easy to educate women. I have suggested many times that a federal tax of one cent per pack per milligram of tar be imposed, and print on the package that this money will be used for the health care of smokers.

Next to air, our principal interaction with the environment is the diet. There seems to be a consensus on the value of fiber and bulk, but I don't as yet see any basis for fadism in diet. There might be a supravitamin effect, but that is a topic for research.

*Therapy. We have seen a stepwise increase in survival over the past 20 years, but the steps have become smaller. An increasing number of patients in a clinical trial is required to get smaller increases in improved results. We need research. Fifty percent of children with leukemia are still dying. This organization (ACCC), the community cancer centers, could take the money that might be spent on NMR and develop the kind of tie in network that is needed to get some answers.

We must bring science into therapy ahead of time using mathematical models. We need organized treatment and should not treat patients as if we knew what was best. None of us know what is best.

Surgery will be utilized more effectively for staging. There will be more X-ray therapy. And I'm not certain we won't make progress in sensitization and protection.

There will be more presurgical chemotherapy, and chemotherapy will be more intense and shorter in duration. We need a great deal more emphasis on ambulatory chemotherapy. There will be progress against diseases that are now refractory to chemotherapy.

There will be a resurgence in activity and interest in immunotherapy, and restoration of immune competence. There will be need for more intensive support services. We will see more autologous bone marrow transplants, with marrow sterilized by monoclonal antibodies, and possibly with marrow grown in vitro and returned.

*Socio-economic factors. We should not forget that we are already successful, and that should be emphasized to the American people. The cancer death rate for those under 60 has reached a plateau. If we subtract deaths caused by tobacco, we would see a major improvement for those over 60. The curve down starts at about 1970, when the National Cancer Program was started, when it was recognized that if we applied what we knew to the communities, we could have an impact. With more oncologists trained and going into the communities, that became a reality.

The next 10 years will see greater appreciation of health as a commodity. There will be an increasing aversion to nuclear insanity. As we turn to more reasonable undertakings, there will be an increasing public awareness of cancer. We will see an increasing insurability of cancer patients, and greater acceptance of them in the workplace. I believe we need greater public participation in clinical research. The public will be more interested in participating now that the no treatment option is not so widely used.

Networking needs to be set up among the communities and regional or national groups and centers. It is unwise to assume that all wisdom is

concentrated in Bethesda. It would be useful for a community cancer center to adopt a sister city elsewhere in the world. That would create more goodwill than anything else this country could do. Cancer is a problem in all parts of the world. If we had sister community cancer centers in the Soviet Union, China, Zaire, it would go a long way toward developing a constructive interchange that would put us ahead in the next 10 years.

NCI/NTP FOUND EDB CARCINOGENIC, BUT HUMAN RISK ASSESSMENT NOT CONCLUSIVE

Since the concern over ethylene dibromide (EDB) in certain food supplies became intensified a few weeks ago, NCI has been swamped with congressional and press calls about it. Richard Adamson, director of the Div. of Cancer Etiology, related the history of NCI and National Toxicology Program testing of the compound and the results at the meeting earlier this month of the division's Board of Scientific Counselors.

"This compound has been used primarily as a lead scavenger in tetra-alkyl lead gasoline and antiknock preparations," Adamson said, "but as you know, it has also been used as a soil and grain and fruit fumigant pesticide. In addition, NCI conducted a bioassay on this compound, using gavage as the route of administration. Preliminary results were reported in December 1973 and complete bioassay results in 1978. Under the conditions of this bioassay, EDB was carcinogenic to Osborne-Mendel rats and B6C3F1 mice. The compound induced squamous cell carcinomas of the forestomach in rats of both sexes, hepatocellular carcinomas in female rats, and hemangiosarcomas in male rats. In mice of both sexes the compound induced squamous cell carcinomas of the forestomach and alveolar/bronchiolar adenomas.

"NCI/NTP also conducted an inhalation bioassay of EDB by exposing groups of 50 F344 rats and B6C3F1 mice of each sex by inhalation to concentrations of 10 or 40 ppm of the compound for 78-103 weeks. Untreated controls consisted of 50 rats and 50 mice of each sex exposed in chambers to ambient air.

"Under the conditions of this bioassay, EDB was carcinogenic for F344 rats, causing increased incidences of carcinomas, adenocarcinomas, adenomas of the nasal cavity, and hemangiosarcomas of the circulatory system in males and females; mesotheliomas of the tunica vaginalis and adenomatous polyps of the nasal cavity in males; and fibroadenomas of the mammary gland and alveolar/bronchiolar adenomas and carcinomas (combined) in females. EDB was carcinogenic for B6C3F1 mice, causing alveolar/bronchiolar carcinomas and adenomas in males and females; and hemangiosarcomas of the circulatory system, fibrosarcomas in the subcutaneous tissue, carcinomas of the nasal

cavity, and adenocarcinomas of the mammary gland in females.

"Thus, there is no doubt that EDB is carcinogenic under the conditions of these bioassays. However, there were some limitations to both these bioassays in using them for quantitative risk assessments. The NCI EDB gavage study had a number of specific problems: (1) the administered doses were changed several times during the course of the experiment due to early death, effectively resulting in a one dose study; (2) the study was terminated well short of the usual rodent lifespan; and (3) the doses used were so high that the resulting response was near 100 percent causing serious problems in making inferences as to the shape and the slope of the dose response curve.

"Although the NCI/NTP inhalation study had fewer problems than the gavage study, the resulting responses of nasal cavity tumors were so pronounced that the study was effectively reduced once again to a one dose study. This study also had substantial differences in survival between the high dose group and the low dose/control groups.

"NCI considers EDB to be a carcinogen in animals and a potential carcinogen for humans. However, the dosage to which humans are being exposed are parts per billion compared to the parts per million used in the bioassays."

Adamson related several organizational changes made recently in DCE.

The Field Studies & Statistics Program, directed by Joseph Fraumeni, is now the Epidemiology & Biostatistics Program. The division is now organized into three programs—EBP, Biological Carcinogenesis, and Chemical & Physical Carcinogenesis.

The Laboratory of Carcinogen Metabolism, in the Chemical & Physical Carcinogenesis Program, has been renamed the Laboratory of Experimental Carcinogenesis, which Adamson said more accurately reflects the research areas of that lab.

A new branch, the Radiation Epidemiology Branch, has been established within the Epidemiology & Biostatistics Program. John Boice has been appointed chief of that branch. The new branch was created, Adamson said, "because of the clearly demarcated research within the Radiation Studies Section, the size and complexity of the epidemiology program and the extremely good reviews this section received in the recent site visit."

Adamson, who was stung last year when SEER was moved from his division to the Div. of Cancer Prevention & Control, may be the beneficiary of another organizational change. He has initiated discussions with the Div. of Cancer Treatment to move the Low Level Radiation Effects Branch, part of DCT's Radiation Research Program, to DCE. "At the

present time there are no problems of interaction between the two divisions concerning extramural activities in that branch which are concerned primarily with effects of low level radiation in animals and in vitro effects of radiation damage in cells and repair of this damage," Adamson said. "However, it is an issue for discussion."

DEVITA: KAPLAN WAS ONE OF CENTURY'S OUTSTANDING SCIENTISTS IN CANCER

Henry Kaplan, internationally renowned radiologist and cancer scientist who died last month, was "one of this century's outstanding scientists," NCI Director Vincent DeVita said before attending a memorial service at Stanford, where Kaplan spent 36 years in the forefront of cancer research.

Kaplan's accomplishments in cancer research included "major advances in both clinical and basic science," DeVita said. "Not only did he pioneer innovative and improved methods of cancer treatment, but he also made fundamental contributions toward understanding the biological causes of cancer. He is probably best known for his contributions to clinical medicine, starting with the development of the first clinical linear accelerator in the Western hemisphere. Dr. Kaplan, along with Stanford physicists led by Dr. Edward Ginzton, helped adapt the cumbersome machine into a useful medical tool, and performed the first experiments that set the standards for its use. Today, medical linear accelerators are the cornerstone of radiation therapy; the instruments are found in cancer treatment centers and hospitals throughout the world.

"Dr. Kaplan's pioneering work in radiation therapy has led to notable gains in treating a wide variety of cancers," DeVita continued. "In no form of cancer have the gains been more dramatic, however, than in Hodgkin's disease. Working with several colleagues, he devised an aggressive diagnosis and treatment program combining radiation, chemotherapy and surgery. This multipronged approach has helped transform Hodgkin's disease from a fatal illness to one that is 90 percent curable in its early stages.

"His vast array of scientific contributions also include impressive discoveries in cancer biology. In 1959, by demonstrating that viruses cause lymphoma in animals, he stimulated the search for a viral cause of cancer in humans. In 1980, Dr. Kaplan's research group was responsible for another major advance: the first reported production of human monoclonal antibodies in the laboratory. Today, cancer researchers around the world are attempting to turn these tiny components of the immune system into potent cancer fighting agents."

DeVita said that Kaplan's work at Stanford

"brought innovation and acclaim to the school's department of radiology, not only through his clinical and scientific work but in teaching practices as well."

MOUSE STRAINS AVAILABLE FROM NCI FOR RESEARCH ON RETROVIRUSES

NCI's Laboratory of Cellular & Molecular Biology in the Div. of Cancer Etiology has been using the following mouse strains for its retroviral studies, obtained under a contract with the California Dept. of Health Services. The Division's Board of Scientific Counselors recently gave concept approval to continuation of the contract, after expressing some reservations about whether their availability to investigators had been adequately promoted.

A recent survey of RO1 grantees seeking expressions of interest in the material evoked no responses. They are still available, however.

These colonies are maintained in a closed system of isolation pods which limits their exposure to pathogens and thus permits long term tests in nude and other fragile mouse strains. Because of these advantages, they are available to the scientific community involved in research on retroviruses.

Currently, breeding programs and pathogenicity tests are available on the following euthymic (immunologically normal) and athymic nude (immunodeficient) mice strains:

*129J +/+ (inbred)

129 +/nu and 129 nu/nu (outbred, from 129J stock)

NFR +/nu and NFR nu/nu (inbred NIH Swiss N II +/nu and N II nu/nu (outbred, NIH Swiss and CBA xid)

NSW +/+ (outbred NIH Swiss)

*+/+ = homozygous euthymic

+/nu = heterozygous euthymic/athymic (phenotype = euthymic)

nu/nu = homozygous athymic (phenotype=athymic)

For reasons of space conservation and economy, only sufficient animals are produced to fulfill services contracted for. It requires four to six months in lead time to handle new orders for mice and services. NCI will supply a list of cost estimates. Actual costs would depend upon numbers of animals and tests, and complexity of procedures.

Those interested in use of these facilities and services may contact Garrett Keefer, PhD, Program Director, RNA Virus Studies I, Biological Carcinogenesis Branch, Div. of Cancer Etiology, Bethesda, Md. 20205, phone 301-496-9734.

NEW PUBLICATIONS

"Alternatives: New Developments in the War on Breast Cancer," by Rose Kushner. This is an update from Kushner's "Why Me?", offering 1984

information on possible preventions, diagnostic procedures and treatments. The Kensington Press, P.O. Box 643, Cambridge, Mass. 02139, \$12.95, 50% discount on orders of 10 or more, \$1.50 more per book if paid by check, phone 800-227-3800 for information on credit card purchases.

"Trends for Cancer Deaths by County, 1950-1979," by the Environmental Protection Agency in collaboration with NCI. The new reference on trends by county shows that overall cancer death rates would have declined over the years 1950-1979 for most of the male population of the U.S. if it were not for increases in lung and other smoking related cancers. Overall rates for females decreased in spite of a large increase in lung cancer. Supt. of Documents, U.S. Government Printing Office, Washington D.C. 20402, order number 055-000-00234-7, \$45.

"International Journal of Cell Cloning," published six times a year, edited by Martin Murphy. AlphaMed Press, 3525 Southern Blvd., Dayton, Ohio 45429, \$50 year individuals, \$100 institutions.

"Cancer Treatment Symposia: Proceedings of the Workshop on Patterns of Failure after Cancer Treatment," edited by Robert Wittes. Available from the U.S. GPO, address above, \$15.

"Malignant Melanoma and Nevocellular Nevi," by Erberhard Paul. Thieme-Stratton Inc., 381 Park Ave. South, New York 10016, phone 212-683-5088, \$25 in paperback.

The following are available from Raven Press, 1140 Ave. of the Americas, New York 10036, phone 212-575-0335:

"Controlled Clinical Trials in Urologic Oncology," edited by Louis Denis, Gerald Murphy, George Prout and Fritz Schroder. \$49.

"Environmental Influences in the Pathogenesis of Leukemias and Lymphomas," edited by Ian Magrath, Gregory O'Connor and Bracha Ramot. \$69.

"Cancer and the Cardiopulmonary System," by Khalil Ali and Michael Ewer. \$45.

"Cancer Invasion and Metastasis: Biologic and Therapeutic Aspects," edited by Garth Nicolson and Luka Milas. \$65.

"Radiation Carcinogenesis: Epidemiology and Biological Significance," edited by John Boice and Joseph Fraumeni. \$75.

"Cancer Rehabilitation," edited by Albert Gunn. \$38.

"Biochemical Basis of Chemical Carcinogenesis," by Helmut Greim, Reinhard Jung, Martin Kramer, Hans Marguardt and Franz Oesch, \$55.

PHS TO HOLD CONFERENCE FOR SMALL, DISADVANTAGED BUSINESSES APRIL 4

A conference for small and disadvantaged businesses selling to the Public Health Service, including NCI, will be held April 4 at the

Uniformed University of the Health Sciences, Bethesda Naval Medical Center.

The conference is being sponsored by PHS and is designed to provide guidance to small businesses which are potential 8(a) contractors on the procedures for writing technical proposals, developing cost proposals, and improving marketing techniques.

For additional information, contact Nat Lindsey, 301-496-4637 or Willie Gibson, 301-443-6630.

STUDY FINDS BREAST CANCER PATIENTS WHO PRACTICED BSE LIVED LONGER

Women who practiced breast self examination, even at intervals of less than the recommended once a month, fared better than those who had never practiced BSE in a seven year study of 1,004 breast cancer patients, the American Cancer Society has reported. Breast cancers were discovered earlier in the women who practiced BSE, and those women lived longer.

The report, by Roger Foster and Michael Costanza of the Univ. of Vermont, was published in "Cancer" (Feb. 15 issue). It is based on analysis of the records of 15 of the 16 general hospitals in Vermont, which maintains a state wide breast cancer registry.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

SOURCES SOUGHT

Epidemiologic studies to address emergent cancer issues ologic studies to address emergent cancer
Deadline: June 15 for statement of capabilities

The Epidemiology & Biostatistics Program of the Div. of Cancer Etiology, NCI, is frequently called upon, often by congressional or executive mandate, to provide data to respond to questions concerning the possible carcinogenicity to humans of various environmental substances. Typically the issues are of national visibility and importance, with exposures generally affecting very large numbers of

individuals. A recent example involved the concern over saccharin, resulting in a request to NCI to conduct a large nationwide case control study of bladder cancer to evaluate the role of artificial sweeteners in the origins of cancer.

This Master Agreement Announcement (MAA) seeks technical proposals from organizations capable of providing the necessary managerial, data collection, and data processing support (resource) services to assist NCI and its collaborators in the conduct of epidemiologic studies to address new or emergent cancer issues that require rapid evaluation. Although the studies which will actually be conducted cannot be specified in advance, it is anticipated that they will often be national in scope, conducted in multiple locations throughout the country in collaboration with scientists in the local areas, and will involve identifying and interviewing large numbers of cancer patients and controls, or the assembly and evaluation of information on environmental or occupational exposures of large groups of individuals.

A Master Agreement shall be issued as a result of this MAA. Eight Master Agreements have already been issued as a result of a solicitation issued last year. It is anticipated that several more may be awarded this year as a result of this announcement.

A series of Master Agreement Orders (MAOs) may be issued during the tenure of this agreement. Contractors receiving an MAO award will be selected from among those with an M/A who compete for the MAO based on technical merit and budgetary considerations for the specific tasks involved.

A more detailed description (including the evaluation criteria) of the services required is available from the individual named below. This description involves specifics on personnel, experience and facilities that is too large to place in this announcement. All requests for this additional information should be in writing and addressed as shown below.

This MAA will solicit a pool of organizations with pertinent successful experience and capabilities to carry out certain tasks. A Master Agreement will be signed with each selected organization, which will then compete for MAOs to follow.

No government personnel may be contacted in connection with this announcement except for the individual named below. A statement of capabilities detailing your organization's capabilities in this area should be delivered to the address below by 4 p.m. (local time of addressee) on the date shown above.

Contract Specialist: Patrick Williams
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The Cancer Letter — Editor Jerry D. Boyd

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HECKLER, NCI KICK OFF CANCER PREVENTION AWARENESS CAMPAIGN

NCI launched its new "Cancer Prevention Awareness Program" this month, with HHS Secretary Margaret Heckler promoting it as a major initiative of her department. The program will consist of two phases—a general information campaign, beginning immediately and culminating in a nationwide media effort during the first week in June; and a second phase targeting cancer prevention information on those most at risk.

NCI will work with physicians and other health professionals, as well as private companies and local organizations, in making cancer prevention information available.

Six hundred thousand copies of a booklet, "Cancer Prevention," have been printed and will be distributed free. Copies may be requested from NCI, Office of Cancer Communications, Bethesda, Md. 20205, or by calling the toll free number 1-800-4-CANCER.

The new campaign places NCI, and the federal government, squarely in the position of making dietary recommendations for the first time. These recommendations have been developing in the last few years and are not startling. The fact that a cabinet

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ACS Recommendations

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SCIENCE, GOVERNMENT, ACS REACH NEAR CONSENSUS: U.S. READY FOR MAJOR NEW EFFORT ON CANCER PREVENTION

*Evidence on the role dietary factors play in the causation of cancer has accumulated to the point where few scientists doubt its importance. The federal government, in an unprecedented move, has officially and firmly advised Americans on dietary recommendations to help prevent cancer. The American Cancer Society, also for the first time, has added its prestigious voice by issuing a set of nutritional guidelines which it says may help reduce the chance of getting cancer. In another vital area of cancer prevention, the Secretary of the U.S. Dept. of Health & Human Services, ignoring the fact that one of her predecessors lost his job when he took a similar stand, placed the department and the government solidly behind the National Cancer Institute's antismoking education campaign. Finally, one of the world's foremost leaders in the area of cancer prevention has called on oncologists in cancer centers and private practices to provide the leadership for a concentrated health promotion effort. With these developments coalescing within the past few weeks, **The Cancer Letter** and **The Clinical Cancer Letter** felt it was appropriate to compile summaries of these events and reports in a special supplement for our readers.*

CANCER CENTERS, ONCOLOGISTS URGED TO ASSUME STRONG LEADERSHIP ROLE IN NATIONAL PREVENTION EFFORTS

Ernst Wynder, president of the American Health Foundation, wrote the following Letter to the Editor in the February 1984 issue of the "Journal of the National Cancer Institute."

Life style factors and cancer incidence have been unquestionably linked by epidemiologic, clinical, and experimental research. Their relationship is well known among most health professionals and to the general public. Despite this knowledge, there have been only isolated instances of broad societal trends toward the adoption of more healthful behavioral patterns. When such changes have occurred, they have been observed primarily among selected populations. For example, cigarette smoking is clearly associated with cancer. Yet only among white males has there been a sharp reduction of smoking. Among women and black males smoking has actually increased. Rising incidence rates of lung cancer among this group provide tragic confirmation of a fact that behavioral scientists have long been aware of: Increased knowledge does not necessarily lead to changes in behavior.

Other such examples abound. For instance, dietary fat is considered an important risk factor in the etiology of a number of cancers, including cancers of the colon, breast, and prostate gland. Yet, despite this knowledge, most Americans continue to consume diets that are not only high in fat, but also low in fiber, a dietary component putatively correlated with a decreased incidence of colon cancer.

Why then have these habits persisted? And why, when presented with the facts, do most people ignore them and resist the opportunity to prevent a devastating and life threatening illness? The answer, I suggest, is posits that health promotion today lacks certain critical ingredients. Perhaps the most important of these is the enthusiasm of the medical profession as a whole to acknowledge behavior change as a significant factor in the prevention of cancer. Cancer prevention through health promotion remains low in the hierarchy of medical practice. Of course, the obstacles to health promotion confronting

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WYNDER: HEALTH PROFESSIONALS NEED INCENTIVES FOR PREVENTION EFFORTS

(Continued from page 1)

health providers are both many and well known (For the individual: Illusion of mortality, lack of social and peer support, sense of powerlessness, satisfaction today vs. future benefits. For the health professional: Insufficient financial incentives, lack of evident academic reward, lack of support from the medical care and insurance system). Only when academic rewards and adequate remuneration for health promotion are provided will cancer prevention programs be established in our offices and clinical centers.

The opportunities in health promotion, including those afforded by the establishment of outpatient prevention clinics in each clinical cancer center, warrant our effort to overcome all obstacles (These include, for the individual: School health promotion, parental health education, community wide health education, organized religions. For the health professional: Increasing public awareness of benefits of preventive health care, outpatient preventive care services, organizing work site programs, and influencing insurance policies covering preventive health care services). Certainly, the spiraling disease care costs, the unnecessary pain and suffering, loss of income, and loss of life due to avoidable illness should provide the more than sufficient incentive to adopt a preventive approach.

Solutions involve finding strategies whereby preventive services provided within the confines of clinical cancer centers could play an important role. The establishment of such preventive services in a clinical setting could have dramatic medical and social impact not only on hospitalized patients, but also on all who come in contact with the hospital. With a minimum investment, outpatient clinics could establish smoking cessation and nutrition clinics, provide counseling on occupational safety, and organize a network for disseminating cancer detection information. Once in operation, such services should become economically self sustaining through cost reimbursement fees, although initially they could be staffed from within by those already involved and experienced in disease prevention.

A concentrated health promotion effort across the country with continuing research into the behavioral components of health—i.e., how health and illness associated habits are established, maintained, and reshaped—could have a broad public health impact, especially if society follows the other opportunities listed above with equal energy.

Who will provide the leadership for this effort?

HECKLER IGNORES POLITICS, BACKS NCI ANTISMOKING EFFORT, DIET GUIDELINES

(Continued from page 2)

secretary has made it an initiative of the Administration, in an election year yet, is somewhat remarkable.

Even more remarkable, considering political sensitivities, is that the campaign stresses the dangers of the use of tobacco products. The last time an HHS secretary took on the tobacco industry (Joe Califano in the Carter Administration), he became a political liability in the tobacco states and was forced to resign. Carter wound up losing most of those states anyway.

"Recently our research has come together compellingly to show how closely cancer is associated with our lifestyle choices," Heckler said at the press conference kicking off the campaign. "We know that fully 80 percent of cancer cases are linked to lifestyle and environmental factors. And we know that the most important causes of cancer are the ones we can control or influence. We are not always at the mercy of our environment."

Heckler referred to a survey by NCI which shows that "perceptions about cancer have failed to keep pace with the progress of medical science." About 49 percent of respondents in the survey failed to identify individual prevention as a way to reduce cancer risk.

Here is NCI's recommendation for a "well balanced diet" that is included in the booklet: "Eat a variety of foods every day. Include fresh fruits and vegetables, especially those high in vitamins A and C such as oranges, grapefruit, nectarines, peaches, strawberries, cantaloup, and honeydew melons. Choose leafy green and yellow-orange vegetables like spinach, kale, sweet potatoes, and carrots, as well as cabbage, cauliflower, broccoli, and brussels sprouts. Keep your intake of fats low, both saturated and unsaturated fats. Choose lean red meats, fish, and poultry. Trim fat from steaks, roasts, and chops, and skin poultry before cooking. Try broiling, roasting or baking meats and fish, or simmering them in their own juices, rather than frying them. Limit your use of

We appeal to the oncological community which knows so well the price of cancer, both in terms of human suffering and economic terms, to examine the opportunities afforded by health promotion and to act upon them in their own cancer centers or individual practices. It is incumbent upon each of us in the health professions who deals with the complex issues of cancer in our everyday lives to be in the "business" of preventive care.

butter, margarine, cream, shortening, and vegetable oils. Avoid hidden fats in dressings and snack foods like potato chips. Choose lowfat or skim milk, lowfat cheeses, and dairy desserts. Choose fruit instead of high fat desserts. Eat foods with fiber, such as whole grain breads and cereals; a variety of raw fruits and vegetables, especially if eaten with the skin; beans, peas, and seeds."

In answer to the question, "Does cigarette smoking cause cancer," the booklet says:

"Yes. People who smoke have a 10 times greater chance of getting cancer than people who don't smoke. Overall, smoking causes 30 percent of all cancer deaths. The risk of getting lung cancer from cigarettes increases with the number you smoke, how long you have been smoking, and how deeply you inhale. Smoking also has been linked to cancers of the larynx, esophagus, pancreas, bladder, kidney, and mouth. Although stopping is better, switching to low tar, low nicotine cigarettes may reduce somewhat your risk of developing lung cancer if you do not inhale more deeply, take more puffs, or smoke more cigarettes than you did before you switched. However, switching to low tar, low nicotine cigarettes will not reduce your risks of developing other cancers and diseases, such as heart disease. Once you quit smoking, your risks begin to decrease at once. The only way to eliminate your cancer risks due to smoking is not to smoke at all."

The booklet also includes warnings against excessive amounts of alcohol; repeated exposure to sunlight; and unnecessary exposure to X-rays. It recommends following workplace health and safety rules, and suggests that women discuss estrogen use with their doctors and use only as long as needed.

The booklet discusses other questions related to cancer risks and causes.

ACS OFFERS ITS RECOMMENDATIONS FOR REDUCING CANCER RISKS THROUGH DIET

The American Cancer Society has been in the forefront of antismoking efforts for years. Last month, the Society's Board of Directors launched an effort to help make Americans more aware of the role nutrition plays in the etiology and prevention of cancer. The Board approved a set of nutritional guidelines which ACS said "may help reduce one's chance of getting cancer."

1. Avoid obesity. The suggestion that weight reduction may help to lower cancer risk is based in part on findings of the Society's own 12 year study (1960-72) of nearly a million Americans, which uncovered higher cancer risks among men and women who are overweight, particularly those who were 40 percent or more overweight. The study found "a markedly increased incidence of cancers of the

uterus, gallbladder, kidney, stomach, colon and breast associated with obesity." Women 40 percent or more overweight had a 55 percent greater risk, and men a 33 percent greater risk of cancer than those of normal weight.

2. Cut down on total fat intake. Moderation in the use of fatty foods not only reduces chances of getting cancers of the breast, colon or prostate but is an effective way to reduce daily calorie consumption. Americans consume about 40 percent of total calories as fat. A decrease in that amount to 30 percent has been suggested by the National Academy of Sciences. "For most people, this should mean a simple change in food habits, readily achieved by moderation in the consumption of fats, oils, and foods rich in fats," ACS said.

3. Eat more high fiber foods, such as fruits, vegetables, and whole grain cereals. Fiber is a term used to cover many food components that are not readily digested in the human intestine tract. These substances, abundant in whole grains, fruits and vegetables, consist largely of complex carbohydrates of diverse chemical composition. Agreement on fiber's role in cancer prevention is not universal. Proponents cite a large body of epidemiologic evidence that colon cancer is low in populations which live on a diet of largely unrefined food high in fiber. Other scientists point to data that suggest that since refined diets low in fiber are likely to be high in fat, the latter factor may play a more prominent role in elevating cancer risk than low fiber intake. Even if fiber itself may not prove to have a protective effect against cancer, high fiber containing fruits, vegetables and cereals can be recommended as a wholesome substitute for fatty foods.

4. Include foods rich in vitamins A and C in the daily diet. The Society recommends obtaining vitamins from fruits and vegetables, warning that excessive supplementary use of vitamin A in capsule or tablet form can be toxic. Lab and human population studies point to dark green and deep yellow vegetables rich in carotene, a form of vitamin A, as reducing the incidence of cancers of the larynx, esophagus and lung. Other foods rich in carotene include carrots, tomatoes, spinach, apricots, peaches and cantaloups. Studies also indicate that people whose diets are rich in ascorbic acid (vitamin C) are less likely to get cancer, particularly of the stomach and esophagus. Vitamin C can inhibit the formation of carcinogenic nitrosamines in the stomach.

5. Include cruciferous vegetables such as cabbage, broccoli, Brussels sprouts, kohlrabi and cauliflower in the diet. Some epidemiological research has suggested that vegetables such as those (members of the mustard family) may help to reduce

the risk of cancers of the gastrointestinal and respiratory tracts. Tests in lab animals have revealed that inclusion of cruciferous vegetables in the diet may be highly effective in the prevention of chemically induced cancer.

6. Be moderate in consumption of alcoholic beverages. Heavy drinkers of alcohol, especially those who are also cigarette smokers, are at unusually high risk for cancers of the oral cavity, larynx and esophagus. Alcohol abuse can result in cirrhosis which may sometimes lead to liver cancer. (ACS did not define "moderate" in its guidelines; the NCI definition was one to two drinks day).

7. Be moderate in consumption of salt cured, smoked and nitrite cured foods. The U.S. Dept. of Agriculture and the American meat industry have substantially decreased the amount of nitrite in prepared meats. However, hams, fish and some varieties of sausage which are smoked by traditional methods absorb cancer causing tars. There also is limited inferential evidence from various parts of the world linking salt cured or pickled foods to an increased risk of cancers of the stomach and esophagus.

ACS called attention to seven additional dietary factors for which it made no recommendations at this time:

Food additives—Insufficient knowledge for a recommendation. Those found to cause cancer already are banned; others may protect against cancer.

Vitamin E—No evidence it prevents cancer in humans, although there is some animal evidence that it does.

Selenium—Evidence that it protects against cancer is too limited, and there is danger of selenium poisoning in medically unsupervised use as a food supplement.

Artificial sweeteners—There is no clear evidence that moderate use causes cancer in humans.

Coffee—There is some epidemiologic evidence that heavy coffee drinking is implicated in bladder and pancreas cancers; none that caffeine is a risk factor.

Meat and fish cooked at high temperatures, such as by frying or broiling—There is evidence that this creates mutagens which can induce cancer in animals; further studies are under way.

Cholesterol—Evidence relating both high and low blood cholesterol levels to human cancers is inconclusive.

The ACS recommendations are consistent with those issued by the National Research Council of the National Academy of Sciences in 1982. They go beyond the Academy's recommendations in relation to obesity and fiber.

The report was based on a study carried out for ACS by Sidney Weinhouse, Fels Research Institute.

BURKITT: EAT MORE WHOLE GRAIN BREAD, CEREAL, POTATOES, CUT BACK ON MEATS

Denis Burkitt, the English scientist whose work in Africa gained him international acclaim, has more recently become involved with the study of dietary factors in the cause of cancer. He is an outspoken advocate of increasing fiber in the Western diet. The following is excerpted from his address at the annual Scripps Cancer Symposium last fall:

Fiber provides bulk in food without providing much energy, so one feels much fuller after fiber rich foods than after consuming the same amount of energy in fiber depleted foods. In addition, fiber rich foods take much longer to eat. For these and other reasons, fiber is believed to be protective against obesity. Fiber in food also delays the rate of absorption of energy from the stomach and intestine and this is believed to confer protection against diabetes. Carbohydrate in the form of starch instead of sugar also protects against diabetes.

How would a normal Western diet have to be changed (to improve health)?

Cereal foods retaining their fiber should be increased, for cereal fiber is without doubt our main dietary deficiency. Therefore, breakfast should be predominantly a cereal meal. This means plenty of brown or whole meal bread or a large helping of fiber rich breakfast cereals or oatmeal porridge preferably containing a dessert spoonful of bran per person. The breakfast to avoid except for a treat is bacon and eggs or sausage and on all occasions white bread if possible should be replaced by brown or whole meal.

If I were asked to make one change in Western diets it would be that we should eat three times as much bread but almost never white. The changes to make in the main meal would be to eat four to five times as much potatoes and vegetables as meat, and the potatoes should not be peeled and not cooked or eaten in fat. To reduce fat, fried foods should almost invariably be avoided and meat reduced, since even lean meat as grown today is about 40 percent fat unless it is fish or fowl. There is no need to eat meat more than once a day, and we base our third meal, be it lunch or supper, on whole meal bread with margarine, cheese, jam, honey or peanut butter. Fruit and vegetables can of course be eaten liberally, but it is a fallacy to consider salads as a good source of fiber. It would be a sound policy to refrain from adding salt to food at the table. There is enormously strong evidence such changes would be highly beneficial. Except in unusual circumstances, there is no good evidence they are harmful. The betting odds appear to be "Heads I win, but I am not sure of the stakes, and tails I don't lose."