THE CANCER LETTER

Vol. 10 No. 14
April 6, 1984

Subscription $150 year North America
$175 year elsewhere

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FIRST PANEL MEETING ON CENTERS GENERATES POSSIBLE RECOMMENDATIONS FOR CORE GRANT GUIDELINE CHANGES

The President's Cancer Panel has had only the first of its series of meetings which over a one to two year period will look at the Cancer Centers Program throughout the country, but already NCI

(Continued to page 2)

In Brief

REDUCING DOSES CUTS CURE RATE EVERY TIME, DEVITA SAYS; HYPERTHERMIA USE IN CANCER BEING ASSESSED

"REDUCING DOSES, and reductions made by extending the schedule, reduces the cure rate. There are no exceptions to this:" NCI Director Vincent DeVita, in remarks opening the Fourth International Conference on the Adjuvant Therapy of Cancer last month in Tucson.... **SAFETY, EFFECTIVENESS,** and indications for use of hyperthermia in the treatment of malignancies is being addressed by the National Center for Health Services Research, which is coordinating an assessment of the modality. The assessment will include hyperthermia alone, with chemotherapy and with radiation therapy. Those wishing to provide information may contact, by May 14, Bette Lemperle, NCHSR, Office of Health Technology Assessment, Park Bldg Rm 3-10, 5600 Fishers Lane, Rockville, Md. 20857.... **CANCER STUDY** tour of China is being organized by the AMC Cancer Research Center under auspices of the International Assn. for Breast Cancer Research. The tour will leave Sept. 29, return Oct. 17, with stops in Japan, Beijing, Xian, Shanghai, Hangzhou, Guilin, Guangzhou and Hong Kong. Contact Dr. Jean Hager, AMC, 6401 W. Colfax Ave., Lakewood, Colo. 80214.... **JOHN YARBRO,** president of the Assn. of Community Cancer Centers, on impact of DRG reimbursement: "Extra lab tests or x-rays beyond a bare minimum will not be encouraged. In these days of computers the physician who spends more will be quickly identified. In the past such physicians were called thorough; in the future they will be called profligate. A colleague who chairs pathology in a New Jersey hospital where DRG has operated on a trial basis told me his department was once the fiscal savior of the hospital, but with DRG, he became merely a large cost center... The pattern of medical practice will change just as surely and just as dramatically as it changed with Medicare in 1965. We are headed back to a two tier health care system".... **GERALD MURPHY,** director of Roswell Park Memorial Institute, has received the State Univ. of Buffalo Alumni Assn. annual public service award.... **TEXAS LEGISLATIVE** Task Force on Cancer has called on Congress and the White House to oppose reduction of the federal tax on cigarettes from 16 to 12 cents per pack, as proposed by the House Ways & Means Committee. The group contends that increasing the tax in the past has led to "an important decrease in smoking in the U.S."

Cancer Survival Now May Be Well Over 50 Percent, ACS President Says; Cigarette Consumption Drops ... Page 8

NEW GUIDELINES TO ENCOURAGE MINORITY CENTERS MAY BE RECOMMENDED TO NCAB

(Continued from page 1)

Director Vincent DeVita has in mind some recommendations he may make to the National Cancer Advisory Board in May on significant changes in the program.

In particular, DeVita indicated at the Panel's meeting last month in Birmingham, he is considering asking the NCAB to develop changes in cancer center core grant guidelines to make it more feasible for minority institutions to qualify for those grants. Also, changes may be recommended which would help emerging centers in regions not now served by cancer centers.

Finally, DeVita agreed with Albert LoBuglio, director of the Univ. of Alabama Comprehensive Cancer Center, that "centers do not need to be all things to all people" and that the designation "comprehensive" may not mean as much now as it once did.

Panel Chairman Armand Hammer opened the Birmingham meeting by describing what the Panel intends to do in its extensive survey of centers.

"We want to explore as many aspects of the centers as possible," Hammer said. "We want to hear from the center directors and staff of their needs, their problems, their plans for the future, their ideas for improving the system. We also want to look closely at the roles of the cancer centers in their communities. What roles do they play? What would be the ideal role for a center to play in the future? The answers to these questions will probably differ in various sections of the country, but a great many of the problems the centers face will probably be quite similar.

"We plan to involve not only the cancer centers themselves, but others from the communities they serve so as to get a perspective on the needs of the entire community."

DeVita said that the Cancer Centers Program is the "lynchpin" of the national network developed as a result of the National Cancer Act of 1971 to get the results of research "out to the public in a fairly organized way... A series of programs that go from the bench to the bedside."

DeVita noted that relative survival of cancer patients has increased, from the 1960s to the present, from about 37 percent to 50 percent. He described NCI's goal of achieving a 50 percent increase in survival by the year 2000 and said that timing was important to achieve that goal. "You have to have programs in place by 1990 in order for us to be successful by the year 2000."

Discussing one possible area of progress in how colon cancer may be prevented, DeVita referred to results of a U.S.-Canadian study. "Recently, one of our investigators supported under a contract from NCI—I always find it kind of cute when something like this is discovered under a contract—at Virginia Polytechnic Institute, along with Dr. Robert Bruce in Canada supported by Canadian funds, have found a chemical reduced by bacteroides in the colon that is a very potent mutagen, as potent as benzapyrene, and it may provide an explanation as to why the colon gets a lot of cancer where the small bowel doesn't.

"The small bowel is sterile; the colon has bacteroides bacteria. The interesting point was that many of the experiments that were being done to isolate this chemical were ruined when the patients decided that what we were saying about fiber made good sense and they went out and put more fiber back in their diet, and the bacteria stopped producing the very potent mutagen. We think we now have a sensible explanation for why fat and fiber are interrelating with something that may be produced by a normal occupant of the colon. It increases our optimism a great deal."

DeVita noted that the Panel's review of centers is one of three presently going on. An ad hoc committee under the auspices of the Div. of Cancer Prevention & Control has had one meeting and will have another April 23 at NIH, and will report to the division's Board of Scientific Counselors at its May meeting. "They will ask some of the same questions we're asking here and also use the input from these Panel meetings to help answer some of the questions we will pose to you," DeVita said.

The other is an administrative review by NCI's Grants Administration Branch, "looking at how we interact with each other on a financial basis."

DeVita listed a series of questions he said the center reviews would ask:

"First, what is the role of cancer centers in this network we've described? What's the profile of each cancer center, basic research, clinical research, particularly in terms of reaching goals? What is the demographic profile of the cancer center? What are the unique problems that certain kinds of cancer centers face in terms of the community they serve? How have they gone about identifying these problems? How do they plan to solve these problems? What are some of the unique opportunities that are offered by some centers.

"Some centers, like in Utah, have a very interesting opportunity to study the Mormon population, for example, which has a very low incidence of cancer for a variety of reasons, one of which I've alreay alluded to. They consume a lot of fiber.

"How many centers do we really need? If you look at the map, you can see big gaping areas of the country where the population is not dense. Should

cancer centers, as was implied in the National Cancer Act, have a certain geographic distribution? If you look, these dense areas on the East and the West Coasts really did not occur by planning. They occurred because that is where the major universities are.

"What about basic research centers? Of the 59 centers, we have 17 that are basic research centers. We normally use instruments like RO1 and PO1 grants to support basic research, but in these cases we're using core grants. There is some question as to whether or not we ought to use a different instrument to support the basic research centers than a core grant.

"What about centers without walls? We have three centers without walls. In Chicago, the Illinois Cancer Council is one umbrella for two institutions. On the West Coast, the Northern California Cancer Program is the umbrella for Stanford and the Univ. of California at San Francisco, Berkeley, Davis, and other institutions. In Washington D.C., we have one umbrella center for two institutions, and they have problems because there is sometimes difficulty working close together in a city. Sometimes it's more difficult than working with someone in an institution further away.

"What about comprehensive cancer centers? We haven't named any center comprehensive in a long time. Does it mean something to be a comprehensive cancer center? Does it mean something different to be a comprehensive center than just a center that does both clinical and basic research?

"And we have one particular problem that we're addressing for the first time here and that is, if the survival figures I quoted to you are correct, they have a down side. That is that for the black population of this country, the relative survival rate overall for all cancers is 37 percent, while the overall relative survival for whites is 49 percent. The good news is that for each disease the relative survival rate is improving in parallel with the white populations, but it is starting from a lower base.

"We're asking the question here for the first time. Should we develop cancer centers in areas that serve large minority populations specifically so that there is a focus of the state of the art, not to take over medical care, but a focus of the state of the art so that it can be delivered more readily to the black population?

"If so, it would require a reversal of our guidelines. Our current guidelines require, in order to become (eligible for a core grant), you have to have a certain amount of basic research support from NCI, $750,000 in grants. Many of the historically black colleges do not have this kind of basic research support. Do we reverse the guidelines, bring in a nidus of clinical research in order to have a focus of state of the art and see if that doesn't draw in the basic research? That will engender a good deal of heated debate in the scientific community which feels already that the centers program is drawing on the resources of basic research."

Excerpts from other presentations made to the Panel, and from NCI responses, follow:

Philip Cole, director of epidemiology for the Univ. of Alabama Cancer Center—The South is sparsely populated, its education level is not up to that of the national average, the poverty level is higher than the national average, and some cancer rates—namely malignant melanoma and cervical cancer, are considerably higher than the national average. "If there is a malignant disease that can be called the Southern disease, it is malignant melanoma in white people, particularly white men." Also, white men have an excess of cancer of the lung. Black men have no special problems, compared with the national rates, although like black men everywhere they do have high rates of cancer of the prostate and esophagus. Black women have a high rate of cancer of the cervix.

These problems are "barriers to cancer control in the South. The sparse population making it difficult to reach people, making it difficult for people in turn to reach the facilities that they will need; the poor education which makes them unreceptive to health messages, particularly those related to prevention; and the impoverishment which again makes it difficult for them to access medical care, to pay for it, and makes it difficult to justify the construction of sophisticated facilities."

LoBuglio—(After relating the history of the development of his cancer center, crediting the response of Alabama citizens after the death of Gov. Lurlene Wallace from cervical cancer, and the efforts of the first director of the center, John Durant). One of the programs impacting the delivery of care throughout the state is the center's Medical Information System. Physicians in the state and the region have a phone number they can call "that directly brings them into our university and immediately directs them to conversations with physicians with specific expertise. We have 6,000 calls of this type, of a physician with a patient in his own office or a patient in his hospital bed calling to talk to me, to the head of surgical oncology, to the head of Gyn oncology specifically about his patient's current situation, what's new, what should we do, does it need referral, and this kind of personal interface. With about 6,000 incidents per year, adding to the 2,500 new cases we see gives us a considerable input into the total cancer problem of the state."

James Pittman, dean of the Univ. of Alabama School of Medicine—Describing the organization of the center, it is "not a department as medicine or surgery or pediatrics. On the other hand, its main thrust is to be interdisciplinary and to bring people together from all the clinical and basic science departments. Organizationally, the center director is equivalent to a department chairman, reports directly to the dean and deals with the dean regarding allocation of resources, money and space. The appointments in centers are parallel to the appointments in primary departments. Virtually everybody who has an appointment in the center has a primary academic appointment in a traditional department and an appointment as a senior scientist, scientist, or associate scientist in the center. You don't have your primary appointment in a center, you have it in a department. On occasion, however, there will be some individual who will be very valuable to a center and each department will say, 'Well, he's not really in my discipline.' So it is technically possible and has been done in a few cases to give an individual what we call a schoolwide appointment. In some institutions, this is a little bit of an unstable state. The centers tend either to grow or wither and one has to work at keeping this matrix organization going. In some places it has tended to drift into being a formal department of oncology. We've considered that off and on here."

Howard Skipper, president emeritus of Southern Research Institute—"Some of our clinical associates across the country say that our work has been helpful to them in developing treatments which are now curing 40,000 to 50,000 patients a year with disseminated cancer in this country alone. (Ed. note: An understatement if there ever was one. It was Skipper's work which laid the foundation for cancer chemotherapy).

"Let me mention only one of my own goals for the future of the National Cancer Program. It is continued improvement at an accelerated pace in cure of disseminated cancers using systemic treatment plus surgery and radiotherapy. It doesn't seem unreasonable to me to postulate by the year 2000 the cure rate for disseminated cancers can be increased from, say, 40,000 to 50,000 a year to, say, 100,000 a year or greater. This would require application of what we know today and perhaps a few new classes of effective anticancer drugs. I'm aware that some are wondering if the majority of what can be achieved with drugs today has already been achieved. I can't agree with that pessimistic view for very simple reasons.

"Only recently, it's become clear why chemotherapy will cure greater than 50 percent of patients bearing various rapidly growing cancers after they are widely disseminated, but rarely cures some slowly growing cancers such as colon cancer or melanoma even after surgical removal of the primary tumor. The phenomenon primarily responsible for the failure of cancer chemotherapy is mutant drug resistant cancer cells. The problem is the drugs we use today often leave these cells and the slowly growing cancers that we're having so much trouble with have much higher percentage proportions of drug resistant cells at a given size than the rapid ones which are curable at really quite significant rates today.

"For this reason, the method of delivery of combinations of non-cross resistant drugs after local treatment must be reconsidered and redesigned for many of the slowly growing cancers. Special attention must be given to redesigning in a way that we can eradicate the drug resistant cells as well as the sensitive cells.

"The critical variables that must be taken into consideration in this approach already have been identified by years of research in metastatic animal cancers. In my opinion, this approach almost surely will result in a stepwise increase of the cure rate of disseminated cancers which today, in 1984, are generally considered incurable."

Max Cooper, director of the immunology program at the Univ. of Alabama—Immunological approaches to the cancer problem, including use of monoclonal antibodies, "is clearly going to require a concerted, coordinated approach that cancer centers are more ideally suited to provide than any other mode that I can think of."

DeVita—"The compromises that are made in the delivery of medical care usually result in the lower survival rates. So, when you have a practicing oncologist calling in on the MIS System and talking to an associate professor, is that a blessing of a halfway technology that is being given in a compromised way so that the patient is supposedly getting the modern therapy but the survival is not impacted becase the doses are cut in half, the schedule is altered? Or is that, in fact, a delivery of the state of the art therapy as it has been described?"

LoBuglio—"That's a mixed blessing, I would guess, because I would guess all of the national averages are a mixture of optimal and suboptimal therapy."

Pittman—"At least one fourth of the cancer patients (in the state) we are seeing somewhat later (initially), but given the stage that the are in, we are doing as well as or better than the country as a whole. For the other three quarters of the cancer patients in the state, I have no information."

DeVita—"This again bears on the issue of what the role of a comprehensive cancer center is vis a vis other kinds of cancer centers. 'Comprehensive'

implies that you will do everything. It's a big mission. One might take from that, if three quarters of the patients with cervical cancer are not being treated at your center or not being diagnosed at an earlier stage, that one of the major problems that would be facing a comprehensive cancer center in the state of Alabama would be to develop some sort of plan to reach the rest of the population so that you could have earlier diagnosis and then worry about the delivery of therapy at an earlier stage."

Cole—"We're trying. There's no doubt we can do more, more different kinds of things, but we are making efforts to address the problems that you point to."

LoBuglio—(After Devita restated his question on whether MIS results in delivering halfway technology) "Dr. DeVita's question is a good one and a tough one. Our approach has been that the important role that we have to play is to try to help the physician in his own community understand and have the feel to some extent what status there is for approaching and treating a patient... The major role we play... is for a physician to call and say, 'I have a patient that has such and such right now. What is it that I should do? Should this patient be seen at a comprehensive center? Does this patient need special diagnostic tests? Are there programs available for this stage of disease? What sorts of things should I be doing to give my patient the best that I can?'

"We don't sit on the phone and say, 'Well, the thing to do is give 37 milligrams of such and such and get a blood count in a week.' We try to provide them advice on expertise that exists in their own area, in terms of radiation therapy, medical oncology, surgical colleagues that interact with us on a regular basis, an idea about what the state of the art is in evaluation and staging for that particular disease and most of the time or much of the time they don't have the data. They don't know enough about the disease to even know whether this a stage 2 or stage 3 because they're not familiar enough, and by telling them the importance of those sorts of things you can generally get either the patient referred to an appropriate place or appropriate studies accomplished so that some decision making can be done. It often involves transfer to the institution, but just as often not. I think it's that kind of trying to deal with the practical realities of the family physician who, in fact, bumps into the cancer patients that we think is one strategy to try to solve the problem."

DeVita—"I'm curious as to what you would consider the area served by the Univ. of Alabama. There is no center in Mississippi and there's no center in Georgia. Does that make any difference? (And on the organization of centers) Somebody once joked about the structure of a center—it wasn't yours—where the dean could sit in his office and have a little box on his desk and press one of two buttons that said, 'Center On' or 'Center Off,' depending on who came in. The center was made up of people who were all resting nicely in their own departments and therefore, if it lost the core grant, that's all it would lose and there would be no difference. Part of the intent of the National Cancer Act was that centers would have life of their own. I think you said that would happen here. I believe it. But what is the area served? We don't know the answer for the numbers of centers, but we do have a sneaking suspicion that geography is important if there are problems like people who die from cervix cancer who shouldn't and somehow you've got to get those people someplace where the state of the art therapy is either being preached or delivered."

Pittman—"I guess the best answer to that is that there is no line. It's a gradient or spectrum, and the farther you get away from the center the less likely it is to be served by it."

Lemone Yielding, chairman of the Dept. of Anatomy, Univ. of South Alabama—"Every investigator cannot work in a cancer center. Not all of the talent in cancer research and cancer management and perhaps not even the major talent nor majority of talent in cancer research and cancer management exists within cancer centers. This Panel really does have to address the question of how do cancer centers impact on the efforts in cancer in other institutions. The institution I work in obviously will not achieve the size to command a major cancer center, and yet the quality of the research is apparent... It is important for people in smaller institutions to have the stimulation and interaction with larger centers... I think there are three areas that we really have to get together. First of all, we really do need collaboration between smaller institutions and the cancer center in the area of cancer education... I think we need interaction at the research level between the cancer center and other institutions... The third area where we really need help is in the identification of new and existing areas of research, what I would call venture efforts, venture capital... I think NCI would do well to address the possibility that cancer centers could participate on a regional basis in pilot projects, and these, of course, would have to be subjected to the same intense peer review as those within the cancer center."

Arthur Bacon, chairman of the Div. of Natural Science at Talladega College—"Historically black institutions represent a significant reservoir of scientific potential which, despite some commend-

able strides made in the last decade, remains largely untapped. It seems that, given the proportionately higher incidences of cancer among minorities, particularly blacks, the involvement of black institutions in the prevention, detection and cure of cancer would be a natural. . .

"I am convinced that minority institutions can play the following roles for cancer centers:

"One, conduct cancer research through collaboration with cancer centers and also independently.

"Train undergraduates and graduates to pursue careers in biomedical research.

"Alert the community to potential cancer hazards through awareness and outreach programs based at minority institutions.

"Assist in assuring the accessibility of state of the art treatment.

"Cancer centers can be of great help to minority institutions by duplicating or complementing the efforts of NCI and the MARC and MBRS programs. That is, by providing training for faculty and students through summer and academic year activities, research consultation, research resources, research collaboration, and support for cancer outreach and awareness projects."

Hugh Shingleton, director of the Div. of Gynecologic Oncology at the Univ. of Alabama--The center developed a program to teach colposcopy in the state, which was funded by NCI's Cancer Control Program, helping gynecologists and pathologists improve efforts to detect cervical cancer. "Another program funded by Cancer Control which unfortunately has now died after 12 years was a nurse practitioner program... We have trained around a hundred nurses. They were taught to do detection for breast cancer, abdominal masses, ovarian cancer, GI tract cancer, cervical cancer and endometrial cancer. At least 40 of the 60 counties in the state have nurses who have been trained to do these techniques."

Charles Huguley, Emory Univ., Atlanta—"We developed a cancer center in the mid 70s. We were awarded a core grant. This was not renewed because we failed to achieve sufficient administrative backing, money and slots and because we did not build an adequate bench research base.

"We apologize. We are trying to do better. We have a new administration. We have new money. We're moving into a new building before the end of the year and we are committed to developing a fully competitive cancer center.

"Now I've had a lot of experience. I was director of that cancer center and I've had a lot of experience with networks and interrelations. It's hard for me to say much about basic research interrelationships. We did try. We did work with some of the neighboring institutions, especially Georgia Tech, but we didn't have a lot of research going and the other institutions had even less facilities. So, there wasn't a lot of collaborative bench research.

"On the other hand, in clinical research, we have had a different record. We have been a major patient contributor to the Southeastern Cancer Study Group and to the Pediatric Oncology Group, and we've contributed a lot of the leadership of those groups.

"More recently, we have developed the Nutrition Oncology Research Cooperative Agreement with four institutions. So we represent three cooperative groups.

"These are some of the things you can do without having a center. We have also been active in educational activities without having a center, although we did have federal support for developing programs like oncology nursing. We graduate about eight master degrees a year, enterostomy nursing and so on.

"In terms of what you can do with a center that you can't do without, I can tell you that from the time we applied for a planning grant until the end of our core grant funding our grant funds—some of it was training—went up five fold in five years. In the succeeding three years they fell by half. So it does make a difference in research."

Peter Greenwald, director of NCI's Div. of Cancer Prevention & Control—"Dr. Bacon and Dr. Cole eloquently gave profiles of cancer incidence and mortality...I wonder if you have any information by way of profile on (smoking) exposure? Do you know the smoking rates? Do you know what are effective interventions in the black population? Do you know how many of your public schools have good health education programs and are they effective in smoking prevention?

"I think you displayed quite a good network amongst physicians. To what degree do they take part in smoking intervention? There are data which show that with just two or three minutes, physicians can be quite effective, and if each physician in this state or this region were to get 15 or so people to stop, he or she would have prevented one lung cancer.

"Who is to do the applied research and make the transition? I wonder whether you see it as a role of the centers, as a role of some of the other institutions networking with these groups to get the data and what will really count in in terms of what interventions can have the impact?"

Yielding—"One the question of who's to do the applied versus the other research, I think ideally you'll find a mix within the cancer center and within the outlying institutions, of individuals who might be interested the most. I think it is not a very attractive system to think of farming out the

applied research to outlying institutions because I think ideally we want those faculties to have the same sort of mix as you find within this institution."

Greenwald—If you look at lung cancer mortality rates in the United States over time, they are changing. They are changing so that relatively there is more lung cancer in the black population, there is more lung cancer in blue collar workers, and there is more lung cancer in people who live in this region of the country. I wonder who is to take the responsibility to address that changing pattern of lung cancer and how would you suggest going about it?"

Huguley—"I personally think the responsibility is federal. I mean, the recipients are the public. I think a university's endowment is given in the name of education and it is their responsibility to supply the manpower. But as far as evaluation of the impact, it is just so extraordinarily difficult."

LoBuglio—"I would like to comment on the question of whose responsibility it is. I think it is really important to have this kind of get together to air those kinds of things because my perception is that we are all in this together. I think the National Cancer Institute and its leadership has got to maintain a profile and set priorities and those things are being done.

"The cancer centers and other investigative groups in the country can interact. The physician in practice has a responsibility and the patient and population themselves have a responsibility. I think ... we have to accept that these are very cumbersome things to approach... I'm sure we don't have a glimmer of what the incidence and rate of smoking is in the state of Alabama. I don't think we have a way of knowing. Whether that is a crucial event right now for us to find out or not I think would take a little time and thought."

DeVita—(To Huguley) "You raised a very interesting point that related to the problem I posed earlier. When the cancer centers were first organized, it was felt that the only way to start a cancer center was to have a strong basic research program and then build on top of that the clinical research program, and then you could get a core grant from the Cancer Institute.

"Emory failed in that regard because they didn't have that amount of support ($750,000 in NIH grants, a criteria added in the late 1970s), and yet there is a clinical nucleus there. One can't help but wonder if the guidelines were revised so that, if you had a nucleus for clinical research and some basic research, that the basic research component might have expanded more rapidly. In other words, you might have reached the goal of becoming a full fledged center by anybody's definition by having a core grant, not having been hamstrung by the support of basic research. In that vein, we brought that up particularly because of the historically black colleges, medical colleges, because they have a harder time getting that base of basic research to get a core grant. So, they'll never have core grants and therefore perhaps we won't be able to effectively deal with the more serious problems of cancer in the black population.

"Since Emory had that problem ... in your plans for the center at Emory, do they include the black medical colleges in your region so that the center might become one of the centers without walls, in a sense that it would encompass three institutions instead of one?"

Huguley—"I'm not really involved in that kind of planning, but all I can say is that we have had a long history, as long as the existence of Morehouse, a record of close cooperation and help."

Louis Sullivan, Morehouse School of Medicine—Because significant numbers of future black health professionals are receiving their training in predominantly black schools, "and because of the unique perspective of black health profession schools and black health professionals have on the health problems of black and low income citizens, I believe that all efforts to improve the health status of blacks and to reduce the morbidity and mortality from cancer must involve minority health profession schools and minority health professionals. Such efforts should include more basic research, clinical research, clinical trials, patient education, and public education programs based at minority institutions."

Those efforts should include "the development of comprehensive cancer centers in minority health profession schools."

Robert Hardy, director of medical oncology at Meharry Medical College—Efforts to bring the mortality and morbidity levels of cancer in blacks to that of white Americans "could probably be effected by providing changes commensurate with common cancer care for the general population. The centers, institutions and organizations represented by (black institutions) have or could easily have, with the provision of some basic support, a large role to play in the alleviation of this problem."

DeVita—"One can infer that if the linkages are there between the minority medical schools, Morehouse and Meharry and the Univ. of Alabama and Emory and so forth, that they haven't been working very well because we are not doing anywhere near as well as we should. That leaves one to say that we could do a better job in making these linkages work or we could do what we mentioned this morning. That is, change the guidelines to develop a center at minority medical schools.

"The question is, which is preferable? To have a consortium center with the existing centers to get the job done or have individual centers at these two schools that are represented here, or have a consortium center among the minority schools, but independent of the existing centers?

"... We'll have one more Panel meeting before the next National Cancer Advisory Board meeting, and I will address this particular issue to the next Panel meeting, because I'd like to ask the Panel members to come away with a recommendation that we can take back to the NCAB and start to chew on it. We ought to have some better focus as to whether you would prefer a consortium of the minority medical schools linked to existing centers, independent of existing centers, or each separate institution have its own cancer cancer."

Sullivan—"The various options are all feasible. However, I would opt for the minority institutions having their own centers, but in conjunction or in linkages with other centers."

Hardy—"There are definite advantages relative to the consortium among schools such as Morehouse and Meharry."

DeVita—"This issue undoubtedly will be a thorny one at the NCAB, whether it is scientifically wise to start with a center that will focus on applied research and clinical research working its way back to basic research as opposed to the way we've been doing it."

ACS PRESIDENT SAYS PACE IS SPEEDING UP, CIGARETTE CONSUMPTION IS FALLING

The pace of progress against cancer "seems to be quickening," and a recent Gallup Poll commissioned by the American Cancer Society confirms that a significant decrease in the number of persons who smoke has occurred in the past three years, ACS President Gerald Murphy said in opening the annual ACS Science Writers Seminar this week.

"Scientists working under sponsorship of the American Cancer Society, the National Cancer Institute, and scores of comprehensive and community cancer centers around the country have been helping to make possible some material increases in survival rates," Murphy said. "Only a year ago, we reported (in the ACS publication, "1983 Cancer Facts & Figures") an overall relative cancer survival rate of 46 percent. The 1984 edition of "Facts & Figures" shows that this rate has risen to 48 percent. This is a tremendous gain in a single year. In 1979, only five years ago, the survival rate was 41 percent. Keep in mind that this year's 48 percent figure is based on statistics for 1973 through 1979. When records are compiled for the first four years of the 80s, I expect to see further substantial progress. It's my guess that right now, a comfortabale majority of all cancer patients, well over 50 percent, already may be outliving cancer by five years or more."

Murphy revealed that the Gallup survey found that during the past three years, the number of adults who say that they've never smoked has decreased by six percentage points, or a relative drop of approximately 10 percent. "This reflects a growing disinterest in smoking on the part of young adults. The same study showed that in late 1983 only 29 perecent of American adults were still smoking, as compared to 37 percent in 1980. An accelerating trend away from the use of cigarettes is unmistakable. Clearly, it is no longer considered 'smart' to smoke."

Per capita consumption of cigarettes dropped seven percent in 1983, Murphy said. "This was the largest drop ever recorded in a single year. It represented a decline of 31 billion cigarettes smoked during a 12 month period, an average drop of more than 2 1/2 billion cigarettes a month. This was the equivalent of what the tobacco trade would refer to as a 'five percent share' of the total domestic cigarette market as it existed at the end of 1982."

Murphy said, "The American Cancer Society's main thrust always has been, and will continue to be, the ultimate eradication of cancer as a cause of illness and death. No one knows when final victory will be achieved. But let me point out that only a few decades ago there were scientists who firmly believed that the answer to cancer would never be found. You don't hear that kind of talk any more. In order to hasten the day of eventual conquest over this disease, the American Cancer Society continues to invest heavily in basic and clinical research. During its fiscal year which ended on Aug. 31, 1983, the Society processed a total of 2,564 applications for research grants of various kinds. The Society was able to fund better than one fourth of them—668 in all. During the year it allocated more than $57 million for this purpose.

"The battleground for the fight against cancer is constantly widening. We seem to be winning. We're learning how to prevent cancer, we're detecting it earlier, and we're treating it more effectively."

The Cancer Letter _Editor Jerry D. Boyd

Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.