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NCI GETS LONG LIST OF CONSORTIUM CENTER NEEDS, INCLUDING NEW GUIDELINES, REVIEW, MORE "GLUE"

NCI had asked for a presentation of issues, problems and needs, particularly those related to a consortium center, at the President's Cancer Panel meeting in San Francisco last week. Northern California

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In Brief

SUSAN HUBBARD NAMED DIRECTOR OF INTERNATIONAL CANCER INFORMATION CENTER; INCLUDES ICRDB, PDQ

SUSAN HUBBARD, who has been chief of the Scientific Information Branch in NCI's Office of International Affairs, has been appointed to the new position of director of the International Cancer Information Center, Ihor Masnyk, acting OIA director, announced. The Center includes the International Cancer Research Data Bank Branch, which provides a comprehensive range of technical information services including Cancergrams and PDQ; the Computer Communications Branch, which operates and maintains support for the centralized scientific and medical information services of NCI; and the Publications Branch, responsible for editing and production of "Cancer Treatment Reports," "Journal of NCI," and "Cancer Treatment Symposia." Hubbard is acting chief of the ICRDB Branch while recruiting for a permanent chief; Robert Esterhay is acting chief of CCB while recruitment proceeds; and recruiting has just started for a Publications Branch chief.... **NATIONAL CANCER** Advisory Board meeting Sept. 24-26 will include presentations on the White House and health science policy, by Bernadine Bulkley, deputy director of the Office of Science & Technology Policy and the White House ex officio representative on the Board; an update on new NCI funding mechanisms, by Barbara Bynum, director of the Div. of Extramural Activities; a discussion of the NIH peer review appeals system by William Raub, NIH deputy director for extramural research and training; and reports by Chairman Gale Katterhagen of the NCAB Committee on Cancer Control & the Community and Chairman Ed Calhoon of the Committee on Innovations in surgical oncology.... **SOUTHEASTERN CANCER** Study Group has had no association with the West Virginia CCOP, as incorrectly stated in **The Cancer Letter** Aug. 25. "Moreover," writes George Omura, SEG chairman, "the problems which the Tri-State CCOP (in Cincinnati, which was not funded for the second year of the program and which had SEG as one of its research bases) has had have been local ones and in no way reflect on the activities of SEG. We regret that the Tri-State CCOP has not been successful, but perhaps something can be learned from that experience by examining what the local problems were rather than looking for explanations that are not relevant."

CONSORTIUM CENTERS NEED TOTALLY REVISED GUIDELINES, ROSENBERG SAYS

(Continued from page 1)

Cancer Program representatives complied and perhaps came up with more than NCI executives wanted to hear.

Saul Rosenberg, chairman of the Div. of Oncology at Stanford and NCCP director, led off the third in the Panel's series of meetings on cancer centers with this list:

*Consortium cancer centers require "totally revised" core grant guidelines and "totally different" review committees from those presently applied to all center core grants.

"Efforts to understand consortium centers are insufficient and deficient, particularly in understanding the director"s authorities and responsibilities," Rosenberg said. "There must be an acknowledgement of the strong programs in member institutions."

*Core support must be available to support "mini-institutions which are members of the center. Rosenberg was referring primarily to the Integrated Service Areas as developed by NCCP. "The NCCP ISA concept is a successful one but cannot totally depend on local financial and volunteer support."

NCCP had organized nine ISAs which would have required $125,000 support from NCI. The request was cut to $50,000, which supported four ISAs. That amount since has dropped to $30,000, resulting in only two ISAs being funded. Rosenberg said the ISAs need about $30,000-$40,000 a year each for a viable operation.

ISAs were developed to deal with the fact that NCCP covers the large and diversified area of Northern California and Northern Nevada. Each serves an identified "catchment area." They provide local leadership in addressing local needs and constitute bases for collaboration on NCCP's programs.

*NCI must recognize the potential conflict between such national programs as the Community Clinical Oncology Program and the "unique strengths of a regional cooperative group outreach program, such as that of the Northern California Oncology Group." NCOG, organized and sponsored by NCCP, is an NCI supported regional cooperative group and has had one of the contracts with NCI's Div. of Cancer Prevention and Control for a community outreach program.

*The Panel and NCI should tolerate, "indeed encourage," diversity and local program growth and development. "Regional conditions, needs, resources and relationships differ nationally, even differ within the NCCP region. I am not suggesting anarchy or lack of responsiveness and cooperation, but a balance between the direction of a centralized cancer program with potentially worthwhile individualized approaches."

Rosenberg said that although the term "consortium" is used by others across the country and by NCI in various documents and cancer center guidelines, "there is little real appreciation of the true nature, needs and potentials of a consortium cancer center."

NCI Director Vincent DeVita, in his opening remarks, referred to the Georgetown Univ.-Howard Univ. Comprehensive Cancer in Washington D.C. and the Illinois Cancer Council Comprehensive Cancer Center as other examples of consortia. Rosenberg suggested that those were not consortia centers, at least in the sense that NCCP is, particularly the one in Washington.

Rosenberg said NCI's Cancer Control Program, which provided core support to centers for cancer control efforts, greatly aided organization of ISAs. He noted that NCCP's problems in supporting ISAs became critical when NCI phased out that mechanism.

NCCP's core grant is about $500,000, approximately 10 per cent of its $5-6 million annual budget. Rosenberg estimated that NCI supported cancer research in the NCCP region totals $50 million. Among NCCP activities cited by Rosenberg are:

—Operation of the SEER (Surveillance, Epidemiology & End Results) registry under contract with NCI for the five Bay Area counties included in the national SEER network, "a significant resource for NCCP and anyone else who would like to use it."

—The clinical research efforts through NCOG and the Community Outreach Program which have entered about 4,000 patients on protocols since 1977. NCCP also serves as the research base for the San Joaquin Valley CCOP. There has been "great cooperation" on the part of community physicians with the program, Rosenberg said.

—Epidemiology studies "are beginning to take off" based on SEER data.

—More difficult to analyze is NCCP's impact on basic science. "Centerness is not seen as necessary," Rosenberg said, but collaboration among scientists at the member institutions has been growing. NCCP's aims in the area of laboratory research are threefold—to foster communication among scientists engaged in basic, applied and clinical cancer research; to catalyze the creation of innovative multidisciplinary, multi-institutional programs and projects; and to provide an organizational framework to develop and administratively manage multi-institutional projects administratively

—Cancer control activities initiated by NCCP have declined since the demise of the funding mechanism. The current NCCP annual report states,

"Cancer control is in a state of transition at NCCP, in part as a result of changing emphasis at the national level. These efforts are moving us from a combination of service and demonstration projects to more rigorous research into new methods of achieving cancer control. More nonfederal funds are needed if we are to continue to apply proven cancer control methods in our region."

Rosenberg summarized NCCP's history: "It's worked."

DeVita asked the presenters at the meeting to "be frank" in their assessment of NCCP and the consortium concept.

The existing consortium centers seem less expensive to operate than single institution centers, DeVita said. "But if they do not get the job done, perhaps we should consider replacing them with single institution centers. If they do work, and they do cost less, maybe we should go for more of them."

As he did at the Los Angeles meeting of the Panel, DeVita cited a number of cancer sites in which the incidence and/or mortality in the NCCP region is higher than the national average. These include the overall incidence in whites and blacks which exceed the national average; the incidence among Orientals in the region exceeds that of Orientals in Hawaii, although the incidence among Japanese and Filipinos in the region is lower than that of Hawaii.

"I think we can explain those differences, and they are exploitable," DeVita said. He noted that cancer mortality in 12 counties covered by NCCP is higher than the national average, despite the fact that the region has a higher percentage of physicians than the average. "Does that mean we do better when we have fewer doctors?" he asked, to the delight of the 150 persons who packed the meeting room, most of them physicians.

Stanley Parry, NCCP deputy director, although not disputing Rosenberg's call for different guidelines for core grants, pointed out that a consortium center does fit the present guidelines in many ways, including leadership, encouragement of new and innovative research, and provision of shared resources. The role of the consortium is particularly important in the coalescing of activities at the individual member institutions.

NCCP member institutions are the American Cancer Society Calif. Div., Bay Area Tumor Institute, California Medical Assn., California Dept. of Health, Central California Cancer Council, Claire Zellerbach Saroni Tumor Institute of Mt. Zion Hospital & Medical Center, Greater Contra Costa County Cancer Program, Greater Sacramento Cancer Council, Hospital Council of Northern California, Kaiser-Permanente Medical Care Program, Northern Nevada Cancer Council, Palo Alto Medical Foundation, San Francisco Regional Cancer Foundation, Stanford Univ., Sutter Community Hospitals, Univ. of California (Berkeley), Univ. of California (Davis), Univ. of California (San Francisco), Univ. of Nevada (Reno), Veterans Administration Hospitals Region 27, and West Coast Cancer Foundation.

Donald Austin, director of the NCCP SEER Program, said "NCCP is a unique grass roots organization but we need a little more glue to increase our capacity to accomplish our goals. We need a wider program in data analysis. Now in NCCP we can only scratch the surface. It is not sufficient to rely on RO1 grants. We should spend an equal amount on analyzing data that we do on collecting it. We need wider cancer reporting and a mechanism for formal linkage of the providers of health care with the implementers of cancer control and their institutions."

"I take it you are suggesting we need more consortia," DeVita commented. He asked why such a small amount of money was taken from the core grant for ISAs. "That could be the additional glue you need."

Rosenberg responded with the information cited above, that funds for ISAs were cut in the review.

"I know you are looking for a director," DeVita said, referring to the search going on since Rosenberg decided to give up that position several months ago. "You're having difficulty getting one. Is it difficult because you have a different recruiting pitch to make, or that the director has no authority over the member institutions?"

"We are close to identifying a very good one," Rosenberg said, but admitted that some prospects were concerned about the lack of security. "That has been a major hangup."

DeVita, noting that NCOG puts on protocols about 30 per cent of the eligible patients in the region, said that the radiotherapy protocols have been a success, "but not so much for chemotherapy. Thirty per cent is low."

"I would have thought that 30 per cent is excellent," Rosenberg said. "I think 30 per cent means we're doing as well as anyone, although it would be desirable to put on more."

"SEER is one of the best investments NCI has ever made," DeVita said to extended applause, with a number of SEER staff members in the audience. He asked again why the mortality rate was higher than the average considering the number of physicians in the area.

"The cause of mortality varies quite a bit county by county," Austin replied. As one example, he said that in one county, the death rate from coronary

disease is high because that is how the coroner signs out all nursing home deaths.

DeVita asked if the advent of CCOPs has damaged NCCP's clinical research efforts, with the two CCOPs in the region competing for patients which might otherwise go onto NCOG protocols.

Rosenberg said that the CCOPs use NCCP but "we have to be careful. They could drain off patients from the potentially weaker NCOG outreach program."

On whether there should be more consortium centers, Rosenberg said "It would take an unusual relationship. We deal with hospitals, institutions, and individuals. But it should be tried elsewhere."

DeVita suggested that Southern California, with seven cancer centers, might be a prospect for another consortium.

Rosenberg said that NCCP meets regularly with representatives of the Southern California centers. Among the items being discussed is whether to expand NCOG into a statewide group.

Peter Greenwald, director of NCI's Div. of Cancer Prevention & Control, commented on the need expressed by Rosenberg and others for greater core support for ISAs. "A problem in cancer control is an absence of a good, critical data set demonstrating the needs. How can we get that information to help us base our decisions on expenditures?"

Parry responded that cancer control and cancer control research needs should be evaluated as resources. "ISAs should be evaluated as resources. We should expand SEER, to obtain more data and analysis."

Greenwald told **The Cancer Letter** after the meeting that NCI might consider changing the core grant guidelines to permit award of more money for consortia to support ISAs and similar activities. That could be among the items being discussed at the Cancer Center Planning Committee meetings this week.

Jerome Yates, who heads the Centers & Community Oncology Program in DCPC, said that "part of the reason the core grant has done so well is that it is tied to the RO1 and PO1 base. We have to look at excellence. Do you have any idea how an objective, fair review should be done, tied to existing RO1-PO1 support as we have now? It sounds as if the cancer control effort here has been very successful. That is not true everywhere else. Should we go back to entitlement?"

"I would not tie core support to RO1s and PO1s in the institutions or to those in the consortium itself," Rosenberg responded. "Both would be wrong. There should be somewhere in between. You can't answer that simply. It would help if individuals doing the review had some appreciation of consortia and how they work, and of the opportunities they offer."

DeVita pointed out that the National Cancer Advisory Board has approved revision of core grant guidelines to permit basing some core grants on cancer control research, not necessarily RO1s and PO1s.

Comments by others attending the meeting, including members of three discussion panels, and responses follow:

Donald Lyman, head of public health in California—A decentralized approach as represented by NCCP is needed to help achieve NCI's goal of reducing cancer mortality 50 per cent by the year 2000. In each of the great public health accomplishments which has eradicated a disease, it was accomplished by local people with a consortium to coordinate the various efforts. Some consensus is needed by the academic community and elsewhere, including NCI, that a project is doable. We do not need hard and fast documentation to move, but a consensus by the professional community that it can be done. Finally, we need marketing tools—information devices and the paraphernalia to sell prevention efforts. Part of the marketing effort is the glue that has been talked about here. I encourage you (the Panel and NCI) to provide it. You may say, "California is a rich state. Why can't you do it yourself?" To a large extent, we have. Some other states cannot do it themselves.

Victor Levin, associate director for laboratory sciences of NCCP and professor of of neuro-oncology at UCSF—NCCP has achieved the formidable goal of bringing together scientists from different institutions, creating a dialogue, learning each other's terminology, understanding each other's problems, preventing common frustration. Many informal contacts nurtured by NCCP have led to new research efforts. Those include collaborative drug development efforts and successful competition for one of the new National Drug Discovery Group awards from NCI's Div. of Cancer Treatment. The current core grant guidelines were established with single institutions in mind. It would be helpful if they were modified for consortia. We need flexible support for new programs.

Edwin Cadman, director of the UCSF Cancer Research Institute—NCOG works. The excitement generated 10 years ago when it was organized persists.

Joseph Castro, director of the Radiotherapy Dept. at Lawrence Berkeley Laboratories—The strength of NCOG is important. Further efforts to promote interaction between basic and clinical scientists is critical. We must increase the participation of surgeons. There is a growing number of surgical oncologists in the region, but we need the support and participation of community surgeons. We need to reevaluate the guidelines for consortium centers.

It is time for a change in our name. There is confusion about what a Northern California Cancer Program is. Northern California Cancer Center, perhaps.

Carol D'Onofrio, NCCP vice chairman who is with the School of Public Health at UCB—If we succeed in reducing mortality 50 per cent by 2000 AD we need more effort in rehabilitation. We can't talk about saving lives without doing something about the quality of life. That is not unrelated to mortality reduction. People will seek treatment and undergo screening earlier if they are confident they will maintain their quality of life. We need evaluation. Cancer control programs in the past were specifically marked not for research, then were criticized for not having evaluation. We need money for program development. We have the capacity to do many more sophisticated innovations, but it takes time, organization, and glue. We need more room to experiment with different forms of organizations, such as ISAs. We need to learn how to develop local funds to help support them. We need research on the process of organizing the community, developing programs and implementing them. We need general overall efforts to help communities develop programs in primary prevention.

DeVita—You are absolutely right. In the early 1970s, a lot of people did not know what cancer cancer is. It was a major mistake not to permit research. But those things have changed. Some of the things you suggest are happening.

Cadman—The CCOP idea is a good one, but we could accrue more patients if the power were given to the consortium center.

DeVita—One of the reasons for CCOP was that community physicians did not like relating with centers. They do not like going to centers to be rewarded. CCOP gives the community physicians incentives and some control. I do not feel we should force all of them to go to NCOG.

Castro—I'm all for strengthening ISAs. Their contribution has been great. It seems to me the CCOP approach is what is needed to increase the number of patients on clinical trials.

Roger Miercort, chairman of the Radiation Therapy Dept. at Washoe Medical Center in Reno—ISAs are a unique concept. Our ISA is the main repository for all publications on cancer care in our area. It coordinates all NCCP programs in our area. We initiated training oncology nurses and paraprofessionals. Through NCOG, we have placed 150 patients on protocols. We need a stable and adequate source of funds, from $50-60,000 for each ISA.

Robert Carlson, NCOG executive officer and head of the NCCP Community Outreach Program—The current outreach program is drastically underfunded. Community participants in NCOG outreach are full members of the group, and equal partners. It is a rich resource with a broad range for cancer prevention, control and research activities. Funding continues to be the single most significant problem. Increased reporting requirements for phase 1 and 2 studies is a problem. The high cost of living in California is not reflected in the awards. The NCI review process (of protocols) sometimes takes six months. The review of each arm of our Kaposi's protocol took longer than the trial. It is difficult for NCOG to respond to a serious local health problem. NCCP and NCOG function very well, with a spirit of cooperation instead of competition. Current and anticipated problems are surmountable with the joint efforts of NCCP and NCI.

Phyllis Mowry, principal investigator for the San Joaquin Valley CCOP headquartered in Fresno—Kern County has just been added to our CCOP. Cooperation between NCOG and our physicians has been excellent. How can NCI help us put more patients on protocol? We need to educate the public on the benefits. We need more support for data collection and analysis. We are in a good position to do cancer control research. There is a high content of selenium in the soil in our area, and we are talking with Dr. (William) DeWys (director of DCPC's Prevention Program) about a selenium project. We are considering responding to the RFA for studies of low fat diets for breast cancer patients. We could test for the anticancer effects of betacarotene. We can consider such ambitious projects because of the outstanding scientists affiliated with NCCP. We need to protect our programs against the ravages of the DRG system.

Jonas Richmond, of the UCB Dept. of Nutrition—The East Bay (Oakland, Berkeley) death rate from prostate cancer among blacks is twice that of whites. We need to look at dietary and other factors in the environment.

Gerald Hanks, director of radiation therapy at the Radiation Oncology Center in Sacramento—Eighty per cent funding of group trials is an existing policy that must be changed if you want to retain private sector patients. In a few years, they will disappear unless you pay more of the costs. We need immediate funding of carefully screened initial involvement private groups, at a cost of $10-15,000 each to bring in more private facilities. If they are screened carefully, three quarters of them will be long term producers. There is a vast untapped resource of patients in community private practice. The level of government funding will play an important role in tapping this resource.

DeVita, to Mowry—I liked everything you said, particularly prevention trials by CCOPs. We have felt that CCOPs, once set up, could be a nidus for implementing prevention trials. How would you react

to the suggestion that you use only NCOG protocols?

Mowry—I haven't thought about it. I suppose that if there were good reasons presented, we would consider it. I don't see why that would be necessary. I think we enjoy our participation with NSABP and RTOG (in addition to NCOG).

DeVita—You made an important point on educating the public about clinical trials. NCI has to play a major role in getting the public to understand that clinical trials are the best way to get standard treatment plus something that may be better.

DeVita to Carlson—Are NCOG protocols realistic, and are the prime protocols at the base institutions? Are standard protocols used by NCOG?

Carlson—Protocols are identified at both the universities and in the communities. Protocols for early studies with toxicity problems are done only at the institutions, although I would feel comfortable with many physicians in communities performing those protocols. If anything, community physicians do a better job following protocols than university physicians.

DeVita—On funding at the 80 per cent level, I agree. We never like to fund less than recommended. We are no longer going to do that, depending on how generous Congress is.

(DeVita earlier had stated that NCI grants in the 1984 fiscal year would be funded in the 1984 fiscal year at or close to recommended levels. NCI will pay 35 per cent of approved competing grants, to a priority score of 175. NCI intends to fund centers and cooperative groups at full recommended levels in FY 1985).

Carlson—We expect, on the best time schedule possible, for protocols to be reviewed by NCI in five to six weeks. We have found it can take six months, even when only minimal changes are made. The problem seems to be that relatively junior staff people at NCI are doing the review of protocols written by senior investigators. The junior people don't always understand them, and the problem has to be straightened out with discussions (Carlson admitted that with the Kaposi's protocol, NCI review was completed in three months, while the NCOG review required twice as long).

DeVita—The average time of review (by NCI) is two months. I have told our Cancer Therapy Evaluation Program people that if they don't approve a protocol in two months, I'll approve it myself without further review. The Kaposi's protocol had serious problems. It took five months to come back to us after our comments. We would rather do this than FDA. I assure you it is faster this way. It is a serious concern, but the delays usually are not at NCI.

Hanks, on competition between groups—When we got involved with NCOG, it was not very interested in radiotherapy questions. We were (and therefore most patients entered into trials from his center were enrolled in RTOG studies). My impression is that there has been a significant change. There are now a fair number of joint trials with both groups doing the studies.

Carlson—NCOG has joined NSABP to work jointly on a number of protocols, specifically not to dilute the number of patients.

Sidney Saltzstein, president of the ACS California Div. and professor of surgical pathology at Univ. of California (San Diego), on DRG reimbursement—To restrict payment for care to a mean determined in the past is unrealistic. It imposes a burden on institutions that is not justified.

Warren Winkelstein, professor in the School of Public Health at UCB—The charge to us at NCCP is to increase our efforts in education, particulary on lifestyle. If we are to be effective at the local level, we must end this silly policy of a mule with two heads. It has been known for 20 years that cigarettes may cause death from cancer in men, and now we know that it also kills women. Government must present a consistent and rational policy and cease the subsidizing of tobacco growing. It is encouraging that in the last 10 years, there has been a 20 per cent decline in cancer among men under age 50. The decrease is small, but it is just a beginning. You in Washington have to be more outspoken, even if it costs you your jobs as it did Secretary Califano (when he implemented a strong antismoking campaign while HEW secretary in the Carter Administration).

DeVita—Is that director's job still open (laughter). I couldn't agree more. We'll do the best we can. It is up to Congress (to halt tobacco subsidies, increase cigarette taxes, control advertising. See following article). I'm encouraged. Antismoking campaigns are popping up everywhere. Smoking is on the decline. One of our goals for the year 2000 is to decrease smoking 50 per cent by 1990. I have been encouraged by the reaction to prevention efforts. People do want information. They are enthusiastic. The food industry is taking up the cudgel. It is planning a large advertising program and is seeking ways to modify products to make them less likely to cause cancer. The reception is not uniformly negative, except for the cigarette industry. I have not heard from them any suggestions for reducing smoking. To the contrary, the industry is making an effort to attract children by making chewing tobacco look like bubble gum. They are doing this because their older customers are dying of lung cancer and heart disease, and they need young people as replacements. If we reduce tobacco subsidies, it could make cigarettes cheaper, and we should not permit that. The difference should be made up for by

increasing cigarette taxes and making sure that all that money goes to cancer research and prevention.

Rose Kushner, member of the National Cancer Advisory Board—There are 25,000 physicians in Northern California and 10 million people. There is intense competition for medical dollars. How many of the 25,000 actively participate in protocols? What challenge is there to encourage patients to get attention immediately? Radiotherapists must have a machine, whereas any physician with a pad can treat a cancer patient until he is untreatable. Do you have that here?

Carlson—We have no figures on participation. I suspect that is from 300 to 500. NCOG doesn't have any documents to tell physicians how to administer state of the art treatment outside of a research setting. NCOG has no funds to support education programs.

Kushner—The problem is that community physicians do not refer patients to specialists until the disease is advanced.

Carlson—I don't know about that. But we're impressed by the quality of care in the communities. I suspect that many cancer patients are treated by primary care physicians.

Raymond Weisberg, chairman of the Cancer Planning Coalition—It is standard practice in San Francisco to refer cancer patients to oncologists.

DeVita, responding to a statement from the audience, that if he really believes primary prevention will account for half of the 50 per cent reduction in mortality by 2000, "you will allocate your resources accordingly, and put your money where your mouth is"—About one third of the DCCP budget goes into primary prevention. We're frequently asked, if 80 per cent of cancer is environmentally caused, why not put 80 per cent of the budget in that area? The answer is, we'll put every nickel we can in prevention when good studies are proposed.

Panel Chairman Armand Hammer said the full house turnout for the meeting "is very encouraging." Referring to the year 2000 goal, he said that even if it is met, "five million people will die of cancer from now until then, at a cost of $16 billion. That is intolerable. We should aim higher, for greater reduction, and sooner. Even when you increase survival to 95 per cent, for the other five per cent, it is 100 per cent fatal."

The Panel's next meeting will be Oct. 1 in Seattle, at Fred Hutchinson Cancer Research Center, Stuart Auditorium. Robert Day, director of the center, will be the host.

The final meeting of the Panel's western swing in its review of cancer centers is scheduled for Nov. 9 in Honolulu. Lawrence Piette, director of the Cancer Center of Hawaii, will be the host.

HOUSE PASSES COMPROMISE BILL ON NEW CIGARETT LABELING; SENATE IN DOUBT

A compromise bill acceptable both to health groups and the tobacco industry—that in itself an amazing feat—passed the House of Representatives this week, a measure that would replace the 13 year old health warning on cigarette packages. The new warnings consist of four alternating messages about the dangers of cigarette smoking.

The bill was passed unanimously by voice vote, with only a handful of members present. Its fate is now up to the Senate, where it may have been acted upon by the end of this week unless blocked by tobacco state senators.

The warning which would be replaced states simply, "Warning: The Surgeon General has determined that cigarette smoking is dangerous to the health."

The new warnings each begin with the statement, "Surgeon General's Warning," followed with:

*"Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy."

*"Quitting smoking now greatly reduces serious risks to your health."

*"Smoking by pregnant women may result in fetal injury, premature birth and low birth weight."

*"Cigarette smoking contains carbon monoxide."

Congressman Henry Waxman, chairman of the House Health Subcommittee and chief sponsor of the bill, said the "current warning label hasn't been revised in over 13 years and does not adequately reflect the extent of adverse health effects caused by smoking." The proposed new warnings would be about 50 per cent larger than the old.

The compromise was worked out last spring by Congressman Albert Gore (D.-Tenn.) and other House members with representativefs of the Tobacco Institute and the Coalition on Smoking or Health, which represents the American Cancer Society, American Heart Assn. and American Lung Assn., among other groups.

The compromise maintained the concept of new, more specific warnings advocated by the health groups, but was made more acceptable to the industry by omitting references to addiction, death and miscarriage that raised product liability fears. The labels also will be less visible than originally proposed.

House Energy & Commerce Committee Chairman John Dingell said he had assurances from Sen. Orrin Hatch, long a champion of the bill, as well as from Sen. Jesse Helms, who had been blocking its consideration, that the bill would be acted upon swiftly by the Senate. However, Sen. Paul Trible of Virginia and others had placed a hold on it. Congress is due to adjourn early in October, and failure to act on the bill by then would kill it.

CONGRESS CLOSE TO PASSING FY 1985 MONEY BILL; AUTHORIZATION DOUBTFUL

Congress is close to passing the 1985 fiscal year appropriations bill for the Dept. of Health & Human Services, which includes NCI's funding. But reauthorization of the National Cancer Act appears farther away than ever, with prospects of approval before adjournment next month growing dimmer by the day.

The House has passed its version of the HHS-Labor-Education appropriations bill, calling for $1.084.9 billion for NCI in the fiscal year which starts Oct. 1. This amount does not include money for cancer control, construction, or research training. Those activities were specifically authorized in the National Cancer Act of 1971 and its subsequent renewals and are not mentioned in Section 301 of the Public Health Service Act, the blanket authority for NIH. The Senate ignored the fact that reauthorization had not yet been completed, since when similar situations have come up in recent years, authority for specific programs has been extended by continuing resolutions.

The House Appropriations Committee decided not to include those items, primarily because of some concern about the construction issue. For one thing, there is no consistency at NIH, with some institutes, including NCI, having authority to award construction grants, while others do not.

The Senate bill, as approved by its Appropriations Committee, would give NCI $1.188 billion next year, approximately $13 million more than the House would have been with control, construction and training including, depending on the final figures for those categories. Action by the full Senate is imminent. How the differences will be resolved, considering the authorization issue, remains to be seen.

That problem could be resolved if the Senate would pass its version of the authorization bill. That is not likely to happen, despite the smooth move by Henry Waxman, chairman of the House Health Subcommittee, to circumvent the roadblock thrown up in the Senate by fetal research issue.

So called pro-life senators have prevented Sen. Orrin Hatch's reauthorization bill from reaching the floor, but they permitted the Senate to pass another Hatch bill authorizing a new National Arthritis Institute. When that bill came to the House, Waxman moved to substitute his biomedical research authorization bill, which had been approved by the House, for the Senate measure. The House concurred, which means that the differences could be worked out in conference and a revised version presented to the Senate. However, Hatch has not appointed the Senate conferees and is not likely to unless an agreement can be reached with the pro-life senators. Meanwhile, Hatch's committee has 11 other conferences lined up with the House, and time is running out.

HHS attorneys feel that a case can be made that cancer control, at least, is authorized under Section 301. If House conferees on the appropriations bill can be convinced of that, cancer control funds could be included without a new authorization. In any case, a continuing resolution will be approved to keep construction, research training and, if necessary, cancer control going.

NEW PUBLICATIONS

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

"Gene Transfer and Cancer," edited by Mark Pearson and Nat Sternberg, $58.

"Mechanisms of Neoplastic Transformation at the Cellular Level," edited by George Klein, $79.

"Hormones and Cancer 2: Proceedings of the Second International Congress," edited by Francesco Bresciani, Roger King, Marc Lippman, Moise Namer, and Jean-Pierre Raynaud, $95.

"Icosanoids and Cancer," edited by Helene Thaler-Dao, Andre Crastes de Paulet, and Rodolfo Paoletti, $48.

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