THE CANCER LETTER

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DEVITA SUGGESTS "OVERLAY CONSORTIUM" AS OUTREACH MECHANISM FOR SOUTHERN CALIFORNIA, OTHER AREAS

NCI Director Vincent DeVita told the National Cancer Advisory Board this week that he feels now the consortium approach to cancer control outreach efforts may be the most appropriate mechanism for cancer centers to consider, at least in some areas of the country. He mentioned specifically Southern California, where a "consortium

(Continued to page 2)

In Brief

CHAIRMEN NAMED FOR NEW ORGAN SYSTEMS WORKING GROUPS; POWERS OUT AS OSP COMMITTEE CHAIRMAN

FIVE CHAIRMEN have been named to head the new Organ Systems Working Groups which will do the state of the art surveys and concept development for the Organ Systems Program. Vay Liang W. Go, Mayo Clinic, will chair the Pancreatic Cancer Working Group; Glenn Steele, Harvard Medical School, will chair the Large Bowel Cancer Working Group; Eleanor Spring-Mills, Syracuse Upstate Medical Center, will chair the Breast Cancer Working Group; Gloria Heppner, Wayne State Univ. and the Michigan Cancer Foundation, will chair the Bladder Cancer Working Group; and Donald Coffey, Johns Hopkins Univ., will chair the Prostatic Cancer Working Group. All had been involved in the task forces of the old Organ Site Program. They will work under the auspices of the Organ Systems Coordinating Center headquartered at Roswell Park. The groups are tentatively scheduled to hold two working sessions each during the next 12 months to generate proposals for research projects to be submitted to NCI boards of scientific counselors for concept approval.... **WILLIAM POWERS**, who has been chairman of the National Cancer Advisory Board's Committee on Organ Systems Programs, will be replaced by Robert Hickey in a shakeup of committee chairmanships initiated by new NCAB Chairman David Korn. An outspoken defender of the program, Powers led the fight to save it and was instrumental in working out the compromise that is now in place. Powers still has two years remaining on his NCAB term.... **DIV. OF CANCER** Prevention & Control is accepting applications for the July 1, 1985, entry into the Cancer Control Science Associates Program. NCI hopes the program will attract qualified individuals from a multiplicity of health science disciplines into the field of cancer control research. Up to five persons may be accepted into the program for three year periods, two to be spent at NCI working on cancer prevention and control projects and a third at one of the NCI supported prevention or control programs around the U.S. For more details, send a postcard only to Nancy Garner, Program Coordinator, CCSAP, NCI, DCPC, Blair Bldg Rm 4A01, Bethesda, Md. 20205, or phone 301-427-8788.

CONSORTIUM "OVERLAY" IN ADDITION TO CENTER CORE GRANTS, DEVITA SAYS

(Continued from page 1)
grant overlay" to include existing centers which may want to participate could be developed to carry on outreach programs.

DeVita told the Board that core grants to the various NCI supported centers in Southern California total about $7 million a year. "Those grants do exactly what they are supposed to do, support research. However, there are no resources help them reach out into the communities."

DeVita and the President's Cancer Panel were very impressed by the Northern California Cancer Program, a consortium center, when they heard presentations on that organization's activities earlier this month. "The Northern California grant is $700,000 a year," DeVita told the NCAB. "It seems to be a better instrument to reach out. The question now is, should we be doing more with consortia? We'll discuss that further at the Seattle meeting (of the Panel) and in Hawaii."

DeVita later told **The Cancer Letter** that his suggestion of an "overlay" grant would not interfere with the existing core grants of those centers involved and would not be financed out of the present centers core grant budget. He said he mentioned Southern California as an example of where such a consortium might be considered, and that there are other areas where it could be tried.

DeVita reminded the NCAB that it had approved the concept of special guidelines for encouraging development of minority cancer centers at its last meeting. The Centers Planning Committee of the Div. of Cancer Prevention & Control supported that approach, with the understanding that the consortia guidelines now being written could be applied to centers organized for regional cancer control purposes as well as to the minority institutions (**The Cancer Letter**, Sept. 21).

DeVita noted that the Centers Planning Committee had completed its work and had done "an outstanding job."

DeVita presented the NCAB with a wrap up on the 1984 budget, with the fiscal year to end Sept. 30. The budget was the highest in the Institute's history, at $1.081 billion (one billion, 81 million, 581 thousand). With it, NCI was able to fund 38 per cent of approved competing grants, with paylines of 175 priority score for RO1 grants and 178 for PO1s.

NCI supported a total of 2,839 research projects (grants, cooperative agreements) at a cost of $462.3 million; 59 cancer centers, $79 million; 125 research career program awards, $5.4 million; 88 clinical education program awards, #4.5 million; 271 cooperative clinical research awards, $46.9 million; $1.3 million for task forces, $3 million for minority biomedical support, $3.3 million for other research, $23.8 million for National Research Service Awards, $141.5 million for R & D contracts, $185.8 million for intramural research, $63.1 million for cancer control, $2.1 million for construction, and $59.3 million for research management and support.

NCI also had set aside $4.96 million for the Small Business Innovation Development Program, mandated by Congress two years ago. It appears now that NCI will not be able to award all that money, with the result that any left unobligated will revert to the U.S. Treasury. Worse yet, NCI will have to set aside $8.5 million for FY 1985 for the program, and unless the number of applications increases dramatically, almost the entire amount will have to be returned to the Treasury.

The law requires that federal research agencies set aside a portion of their budgets to stimulate technological innovation by small businesses, increase private sector commercialization through federal funding and increase participation by minorities and disadvantaged groups in technology development. The set aside in 1983 for NCI was .2 per cent of the R & D budget, $1.5 million, all of which was used to pay 29 awards. The set aside increased to .6 per cent in FY 1984, $4.96 million. A total of 58 grants were funded, at a cost of $4.65 million.

The first round of awards supported what the program calls phase 1 grants, to establish technical merit and feasibility of the proposed R & D efforts. They are not to exceed $50,000 and six months. Phase 1 grantees are eligible to compete for phase 2 awards to continue the R & D efforts. These may go as high as $500,000 and two years. After that, the firms are supposed to be able to compete on their own for non federal support.

There was such a paucity of applications that, to spend all the money set aside (all except $310,000), NCI had to pick up some applications assigned to other NIH institutes which could be construed as cancer related and to throw priority score paylines out the window. DeVita said some were funded down past the 400 level.

"Almost all of the $8.5 million we will set aside in 1985 will lapse if there is not an increase in the number of applications," DeVita said.

NCAB Chairman David Korn asked if there were any review, or "are they more or less assured of getting $50,000 if they apply?"

DeVita said the applications are reviewed and that some were disapproved when it was determined their proposals did not have potential commercial application or if they did not include good science.

"That doesn't sit well, to have to distribute money to proposals in the 300 to 500 range," Korn said.

"That's not normal to fund grants up to 500 (the worst possible score in the NIH priority rating system)," DeVita agreed, "but in all fairness, some of those were not so bad. In part, the poor scores were due to this being a new program, and the review groups are not familiar with it."

DeVita said he intended to encourage eligible small businesses to develop proposals for the program. He suggested they should contact either Barbara Bynum, director of the Div. of Extramural Activities, or Vincent Oliverio, DEA assistant director. Their phone numbers are 301-496-5147 and 301-496-9138, respectively.

There are also SBIR contact persons in each of the program divisions: Biology & Diagnosis, Louis Greenberg, 301-496-5307; Cancer Etiology, John Cooper, 301-496-1882; Cancer Treatment, Gregory Curt, 301-496-6711; and Prevention & Control, Richard Costlow, 301-427-8648.

DeVita described the current dilemma NCI faces with 1985 appropriations. With the fiscal year starting Oct. 1, a regular appropriations bill has not yet been sent to the President by Congress (or had not by press time this week).

The Senate Appropriations Committee has approved $1.188 billion for NCI. This includes money for cancer control, research training and construction, three programs which require the special authorization included in the National Cancer Act. Since the authorization bill is still hung up in the Senate, the House declined to put the money for those programs into its bill.

A continuing resolution, the stop gap measure which Congress uses to provide funds for agencies not funded with a regular appropriations bill, has been prepared which continues authorizations for control, construction and training. However, it would hold spending for those programs at the 1984 level, which DeVita said would leave cancer control, at least, "in a little financial difficulty."

The Senate figure would give NCI an increase of 9.8 per cent over the 1984 budget and 7.8 per cent more than requested in the President's budget. It would be right at the total requested by NCI and the NCAB in the 1985 bypass budget.

If the House figure prevails, and if spending for the three unauthorized programs is held at 1984 totals, NCI's appropriation would be $1.174 billion, an increase of 8.6 per cent over 1984. DeVita said he expected the final amount to be somewhere between the two figures.

NCI expects to fund all grants at recommended levels in 1985, following the usual practice of negotiating reductions of one to three per cent. There will not be any "funding plan" which pays grants at substantially lower than recommended levels in order to support more grants, a practice banned by both congressional appropriations committee and one which NCI did not particularly like when it was forced into it by restricted budgets of the early 1980s. Center core grants and cooperative groups also will be funded at recommended levels.

The Senate bill includes $13.1 million for construction, a healthy increase over the $1-2 million of the last few years. That includes $4.5 million written in and earmarked specifically for a new cancer center at West Virginia Univ. Senate minority leader Robert Byrd of West Virginia is responsible for that move as a tribute to his retiring colleague, Jennings Randolph. The House probably will go along with that plan, making available about $8.5 million for other construction and renovation.

DeVita announced that NCI has completed negotiation of its first contract with a vendor for PDQ (Physician Data Query), the system that allows medical personnel to access through office computers information on state of the art treatment, active clinical research protocols, physicians who spend a majority of their time treating cancer patients, and names and addresses of cancer centers and members of professional cancer societies. The vendor, BRS/Saunders of New York, will provide the data base information for a fee only to physicians and other medical personnel, DeVita said.

Negotiations are still being carried on with other vendors, but some of them are not as enthusiastic as they would be if they could offer the service to the public, DeVita said. The NCAB had previously settled that controversial issue, agreeing that it should not be promoted to the public.

DeVita noted that the American Medical Assn. House of Delegates had voted earlier this year to oppose listing of institutions and release of lists of physicians with special expertise in cancer care. DeVita said he thought there was some confusion among AMA delegates who were reacting to referral information sometimes provided by the Cancer Information Service offices around the country and not to PDQ.

Richard Bloch, NCAB member who originated the idea of PDQ and who put up a substantial amount of money for the building in which it is located, has not been happy about limiting it to physicians. He feels that public access could help pressure physicians into becoming better acquainted with state of the art treatment and available research

protocols. He suggested that "to pacify AMA and provide this service to people with cancer, a happy compromise would be to separate out the list of physicians and make it available only to physicians, and make the balance of the information available to everyone else."

"Some physicians may not agree that patients should have protocols and state of the art information," DeVita said. PDQ is up and operating, and I do not think it would be wise to take parts out."

"I think we should show AMA how it works," Board member Geza Jako said. "It seems to be working well."

"Many doctors do not understand PDQ," Board member Victor Breren said. "A great deal more needs to be done. Perhaps AMA might devote a portion of a future issue of "JAMA" to explaining what PDQ is. There is tremendous confusion about it."

Board member William Powers suggested that Bloch's approach might be the best to take, but DeVita said, "The directory file is the most popular part of PDQ among those who have been using it."

DeVita said NCI has received queries from organizations other than those whose members are listed in PDQ, asking that they be included.

NCI LOOKING AT "APPROPRIATE EARLY DECISION MAKING" IN CONCEPT PROPOSAL

A research effort aimed at "facilitating appropriate early decision making in cancer patient management" with an estimated cost of $1.5 million a year is oozing from the creative juices of NCI's Div. of Cancer Prevention & Control. A committee of the division's board of scientific counselors did not like the staff's first effort in writing a concept, however, and it was sent back for "complete rewriting."

Jerome Yates, director of the Centers & Community Oncology Program, presented what he insisted was only an "evolving" concept at the committee's meeting earlier this month. Committee members agreed for the most part that the problem of inappropriate management decisions for new cancer patients is one which NCI should address, but they disagreed with much of the approach suggested in the proposed concept.

The proposal stated as its major objectives:

—To develop an effective system aimed at improving early peridiagnostic (prior to and during) early hospitalization management for cancer patients leading to improved cancer care and an overall reduction in cost.

—To provide an optimal climate for those patients with cancer where early treatment decisions affect outcome (both disease free survival and survival).

—To assess the program costs, patient care costs and institutional impact.

—To determine the role of computerized and noncomputerized educational aids (i.e. guidelines and PDQ) for both health professionals and the patients and their families in improving management during the early course of their disease.

As justification for the concept, the staff proposal said:

"NCI his presently engaged in an effort to reduce cancer mortality by 50 per cent by the year 2000. Optimal therapy for most cancers includes appropriate diagnostic and treatment choices made at the time the new cancer patient is initially seen. There is little chance of decreasing mortality of curable cancers if appropriate decisions are not made early in the course of the disease. Late corrections in management seldom improve curability. Multidisciplinary efforts are not only desirable but usually necessary to ensure appropriate early management for patients with cancer. The stress of possibly having cancer for patients and their families, coupled with unsympathetic physicians, often results in premature decision making. Information about treatment options and outcomes is often incompletely communicated. The availability of unbiased information for health professionals, patients, and families, using guidelines developed by multidisciplinary efforts, to help determine the workup of patients and the involvement of the appropriate treatment disciplines in the early recommendations for treatment could eliminate mismanagement for many patients.

"Physicians are reluctant to surrender their autonomy to other health professionals, regulatory agencies, or even in some instances to their own peers. They often justifiably claim that their training and understanding of patients they know provide them with the best platform to make judgments regarding the patient management. However, available data would suggest that other factors, including an individual physician's own training and biases, may result in inappropriate decisions for some patients. The development of an acceptable alternative assuring little interference with most physicians but safeguarding against errors in judgment on the part of the responsible physician(s) and patients would be desirable. PROs mandated by the DRG legislation are likely to require some preadmission review with the goal of avoiding mismanagement and extra costs rather than optimal care. The above would provide optimal review, not just a regulatory exercise."

The proposal calls for a "health professional experienced in oncology working with a hospital cancer committee" who would be available to review plans of admitting physicians for patients suspected of having cancer prior to admission.

Yates suggested that the health professional would be a "nurse facilitator."

For those whose clues to the diagnosis occurred after admission, or for urgent or emergency admission, postadmission review would be possible. Local guidelines, locally approved protocols, and/or PDQ would be used to assure acceptability on the part of managing physicians, the concept proposal stated.

"Problems identified through the guidelines would be brought to the attention of attending physician(s). Streamlined access to information systems (PDQ, protocols, guidelines, etc.) would be available. Multidisciplinary tumor board type of recommendations could be arranged for prior to, or shortly after, admission before initiating primary therapy. The patient could be followed for evaluation during the course of workup, treatment, and continuing care. It is expected that a high quality peridiagnostic educational/review system would benefit patient, family, physician and hospital and might avoid some of the after the fact peer review necessary for monitoring quality of care and reduce inhospital workups and hospital management costs.

"A quasiexperimental design looking at specific cancers in hospitals with and without educators/review/facilitators could be expected to yield comparative results."

Yates said the intention was to focus the project on breast cancer, head and neck cancer and pediatric malignancies.

Staff anticipated that 12-18 hospital awards would be made, with a total cost of $1.2 million a year, plus another award for a statistical center to cost $300,000 a year. The awards would be cooperative agreements.

"This is about as global and all inclusive a program as one could envision," committee Chairman Virgil Loeb commented. "It is so global that it is mind boggling. You could involve every facet of NCI and still not cover it all. It will take an awful lot of thought, discussion and feedback to you before we can present any recommendations to the Board. Why not zero in on the things we do well, and let the others fall by the wayside? Look around the country, ask where are the areas where head and neck cancer is best treated."

Committee member Charles Smart agreed that a problem exists. "Everyone says he's doing as well as anyone else, until you point out with the data that that isn't the case. There is a need to break out of the lethargy that exists in a lot of places."

Cancer Centers Branch Chief Lucius Sinks said that the effort could focus on individual diseases. Referring to a study comparing treatment of medulla blastoma at university centers with that at community hospitals, Sinks said a two fold difference was found in favor of the universities. "Perhaps a study could identify the reasons. It is obvious that no general surgeon should operate on this tumor."

"You're identifying strengths," Loeb said.

"Strengths show the best way to go," Sinks answered. "If you look at lung cancer, you'll never get anywhere."

Committee member John Ultmann suggested that it would be "irrelevant to make the point with each disease. In the first 20 years of the study, some breakthrough might come which would make your data useless. If you demonstrate a minor edge, you've identified nothing." The study should concentrate on a case study approach looking at the large cure rates that are possible but not being achieved everywhere, those with 100 per cent cures down to 50 per cent, Ultmann said. "Any lower than that, you're wasting your time. But if you want to improve (results with) stage 1 and 2 Hodgkin's disease, you would need 900 cases, and the difference is not worth doing. If you want to be realistic, narrow it down."

"This is just the first step in priority setting, the first cut. Then we'll look at where we can have the biggest bang for the buck," Yates said.

Ultmann said that the federal government "has missed an opportunity. With DRGs, everything points to the fact that we are containing costs, and we are going to pay a terrible price. There are better ways to do it. The DRG system has been accepted. But we know that chemotherapists now have to fight with hospital administrators. We have to show that there are ways to do better, and that they cost less. Patients now won't get effective treatment because of cost containment. We should use that tool (reimbursement) to reward outcome efficiency. The government should say, 'If you cure more people, we'll pay you more.'"

"How do you get the medical profession to change its ways without being coercive or punitive?" Smart asked. "There is a lot of suboptimal treatment going on because the doctor doesn't know any better. Take breast cancer. We all have our prejudices, that a lumpectomy is just as good as a mastectomy or not, without radiotherapy while others say you need radiotherapy. Even though I'm in the field, I'm not aware of many things. PDQ and patient management guidelines could help, if we are able to effectively disseminate that information."

Committee member Robert Cooper said, "The problem is the psychology of acceptance. There are some inadequate physicians. One of the problems is consensus development. NIH consensus conferences are too long, too complicated, and when published, inadequately disseminated. There is also the problem

of referring. When one doctor in a community refers to us and sees his patients doing better, others in that community begin referring to us and become part of our center."

Cooper and others disagreed with the plan to use a "nurse facilitator" as described in the concept proposal. "A long term nurse-doctor team relationship is necessary," Cooper said. "Having the nurse screen patients and telling the doctors what's available (in treatment) is not a good idea. One untapped resource that might be used here are the retired physicians, not intellectually too old but past the mandatory retirement age. Or perhaps some senior member of the hospital medical staff could serve in this role. Many hospitals don't permit their surgeons to operate after age 65, 67, or whatever. They might be more acceptable to the medical staff than nurses. I know the nurse facilitator would not work in our institution."

The committee discussed two other evolving concepts presented by staff:

*Crico-pharyngeal mytomy with speech and swallowing followup. This would involve one award for a two year study to cost an estimated $40,000 a year for a randomized trial of crico-pharyngeal myotomy in patients undergoing surgical resection for supraglottic and laryngeal carcinomas. Standardized measures of speech and swallowing would be employed in patient followup.

Yates said a goal would be to find out "how to get radiotherapists and surgeons to look at morbidity."

Ultmann noted that head and neck cancer patients usually have a long history of heavy alcohol and tobacco use. "They are absolutely the hardest patients to evaluate. Their habits are bad, and they go back to those habits after treatment."

Yates indicated this concept proposal did not have a high priority. "You may or may not see this again," he said.

*Breast cancer and benign breast lesions in diethylstilbesterol treated mothers and in DES exposed daughters. Three or four awards for the three year study were projected, each to cost about $100,000 a year.

The objectives would be to evaluate whether there is an increased incidence of breast cancer and/or benign breast lesions among women who were treated with DES during pregnancy; to determine whether there is an increased incidence of breast cancer and/or benign breast lesions in their daughters or sons; to document the histopathologic types of cancers and benign lesions that have developed; and to define accurately prior or subsequent hormonal profile abnormalities or reproductive difficulties in DES exposed individuals.

Cooper suggested that a study in animal model systems, or at least a review of the data from animal studies, should be made before proceeding with this project. "Give us some time to think about this," he asked.

Yates said he intended to present the concept to the Board at its October meeting "unless you find some reasons to change this substantially."

Bynum, reporting on what she called NCI's "pride and joy," the new Outstanding Investigator Award, said that 100 applications have been received from some of the world's leading investigators. Many of them receive substantial NCI support through other mechanisms, which means that major renegotiation of their funding will be necessary.

The review will be done by mail to about 200 scientists who have agreed to serve as the program's study section. Bynum said review should be completed in time to present the award recommendations to the Board at its January meeting.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR SEPTEMBER, OCTOBER

President's Cancer Panel—Oct. 1, Stuart Auditorium, Fred Hutchinson Cancer Research Center, Seattle, 9 a.m., open.

Urologic Cancer—Oct. 1-3, Boston. Contact Harvard Medical School, Dept. of Continuing Education, Boston 02115, phone 617-732-1525.

Society for Oncodevelopmental Biology & Medicine—Oct. 14, Houston. 12th annual international meeting. Contact Dr. Elliot Alpert, Dept. of Medicine, 533-D, Baylor College of Medicine, Houston 77030, phone 713-790-2171.

10th Annual Frederick Stohlman Memorial Symposium—Oct. 1-5, Boston. Contact Bernadette Stohlman-Trenholm, Dept. of Biomedical Research, Basket 93A, St. Elizabeth's Hospital, 736 Cambridge St., Boston 02135.

Immunocytochemistry Workshop in Tumor Diagnosis—Oct. 3-5, Detroit. Contact Dr. Jose Russo, Dept. of Pathology, Michigan Cancer Foundation, 110 E. Warren Ave., Detroit 48201.

Div. of Cancer Prevention & Control Board of Scientific Counselors—Oct. 4-5, NIH Bldg 31 Rm 6, 8:30 a.m. both days, open.

2nd Fall Cancer Rehabilitation Conference—Oct. 4-5, Univ. of Wisconsin Hospital, Madison. Contact Sarah Aslakson, CME, 465B WARF Bldg, 610 Walnut St., Madison 53705, phone 608-263-2856.

American Society of Therapeutic Radiology & Oncology—Oct. 7-12, Washington Hilton, Washington D.C. Annual meeting.

Testicular Tumors—Oct. 8-10, Hotel George V, Paris. Contact Saad Khoury, Clinique Urologique Hopital de la Pitie 83, Boulevard de l'Hopital, 75634 Paris Cedex 13, France.

Genetics, Cell Differentiation & Cancer—Oct. 8-9, New York. Seventh annual Bristol-Myers Symposium on Cancer Research. Contact Suzanne Emery, Memorial Sloan-Kettering Cancer Center, 425 E.

61st St., New York 10021, phone 212-794-7173.

24th Annual Interscience Conference on Antimicrobial Agents & Chemotherapy—Oct. 8-10, Sheraton and Shoreham hotels, Washington D.C. Contact the American Society for Microbiology, 1913 I St.NW, Washington D.C. 20006, phone 202-833-9680.

Advances in Hematology & Oncology—Oct. 8-11, New York. Contact Registrar, American College of Physicians, 4200 Pine St., Philadelphia 19104.

Oncology Economics '84—Oct. 9-13, Broadmoor Hotel, Colorado Springs. Assn. of Community Cancer Centers mid year meeting. Contact ACCC, 11600 Nebel St., Rockville, Md. 20852, phone 301-984-1242.

Oncology Update--Oct. 10-11, Bunts Auditorium, Cleveland Clinic Foundation. Contact Cleveland Clinic Education Foundation, Rm 3T01, 9500 Euclid Ave., Cleveland 44106.

Thyroid/Iodine 131 Assessment Committee--Oct. 10-11, NIH Bldg 31 Rm 2, 2-5 p.m. Oct. 10, 9 a.m.-adjournment Oct. 11, all open.

Advances in Care of the Head and Neck Tumor Patient—Oct. 11, Roswell Park continuing education in oncology. Contact Gayle Bersani, Education Office, RPMI, 666 Elm St., Buffalo 14263, phone 716-845-2339.

Challenge of 1984: Practical Approaches to Quality Care—Oct. 12-14, Waterville Valley, N.H. Contact Linda O'Connor, Baystate Medical Center, 759 Chestnut St., Springfield, Mass. 01199, phone 413-787-3368.

New Perspectives in Pediatrict Hematology-Oncology--Oct. 12-14, Chicago. Contact Univ. of Illinois, Conferences & Institutes, 912 S. Wood St., 2 North, Chicago 60612.

New Directions in Cancer Therapy--Oct. 13, Pittsfield, Mass. Contact Janet Rommel, American Cancer Society, 46 Summer St., Pittsfield 01201.

Div. of Cancer Treatment Board of Scientific Counselors—Oct. 15-16, NIH Bldg 31 Rm 10, open Oct. 15 8:30 a.m.-4:45 p.m., Oct. 16 8:30 a.m.-adjournment.

Human Hybridomas & Synthetic Peptides: Horizons in Clinical Medicine--Oct. 15-17, Kauai, Hawaii. Contact Dr. Daniel Watanabe, phone 800-231-6388 or 713-785-0532.

New Solutions to Old Problems in Surgical Pathology—Oct. 15-17, Bethesda, Md. Contact FAES, NIH, Bldg 10 Rm B1L101, Bethesda 20205.

Human Papillomaviruses & Squamous Carcinoma--Oct. 15-17, Chicago. Contact Barbara Trejo, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago 60612.

Div. of Cancer Etiology Board of Scientific Counselors—Oct. 18-19, NIH Bldg 31 Rm 6, 9 a.m. both days, open.

Eighth Annual Cancer Symposium and Fourth Annual Cancer Symposium for Nurses—Oct. 18-20, Sheraton Harbor Island Hotel, San Diego. Sponsored by Scripps Memorial Hospital. Contact Nomi Feldman, Conference Coordinator, 3770 Tansy, San Diego 92121, phone 619-453-6222.

Pediatrict Hematology-Oncology Examination—Oct. 19, Chapel Hill, N.C. Contact American Board of Pediatrics, 111 Silver Cedar Court, Chapel Hill 27514, phone 919-929-0461.

Forum for Death Education & Counseling—Oct. 20-23, Chicago. Contact Vickie O'Sullivan, Continuing Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago 60612, phone 312-942-7095.

Symposium on Cancer Chemosensitivity Assay—Oct. 21-25, Hyatt Regency Hotel, Long Beach, Calif. Contact Mrs. Mickles, 213-498-1000 Ext. 3600.

Workshop on the Use of Rodent Tumors in Experimental Cancer Therapy—Oct. 21-24, Stanford. Contact Dr. R.F. Kallman, Dept. of Radiology, Stanford Univ. Medical School, Stanford, Calif. 94305.

Biomedical Computing: Beginnings and Prospects--Oct. 22-24, NIH Lister Hill Auditorium. Contact Div. of Computer Research & Technology, Information Office, NIH, Bldg 12A Rm 3027, Bethesda 20205, phone 301-496-6023.

In Vitro Toxicology—Oct. 23-24, Baltimore. Contact Office of Continuing Education, Johns Hopkins School of Hygiene & Public Health, Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-6046.

Symposium on Methodology and Quality Assurance in Cancer Clinical Trials--Oct. 24-26, Washingtom D.C. Sponsored by the Biometrics Research Branch of NCI's Cancer Therapy Evaluation Program. Contact Mark Brown, Social & Scientific Systems Inc., 7101 Wisconsin Ave. Suite 610, Bethesda 20814.

Viral Infections in Laboratory Rodents: Effects on Biomedical Research--Oct. 24-26, Bethesda, Md. Contact Dr. John Holman, Div. of Research Resources, NIH Bldg 31 Rm 5B59, Bethesda 20205, phone 301-496-5175.

AIDS: Immune Defects and Treatment—Oct. 24-26, New York. Contact Dr. M. Crieco, St. Luke's Roosevelt Hospital Center, 428 W. 59th St., New York 10019.

Biometry & Epidemiology Contract Review Committee—Oct. 25-26, NIH Bldg 31 Rm 4, Open Oct. 25 8:30-9 a.m.

American Society of Clinical Pathologists and College of American Pathologists--Oct. 27-Nov. 2, New Orleans. Joint meeting. Contact Patrick Raleigh, ASCP, 2100 W. Harrison St., Chicago 60612, or J.W. Lipe, CAP, 7400 N. Skokie Blvd., Skokie, Ill. 60077.

Cancer Clinical Investigation Review Committee--Oct. 29-30, NIH Bldg 31 Rm 6, open Oct. 29 8:30-9 a.m.

American Assn. for Cancer Education—Oct. 30-Nov. 2, New York Medical College, Valhalla, N.Y.

National Toxicology Program Board of Scientific Counselors—Oct. 30-Nov. 1, Research Triangle Park, N.C.

Leukemia Society Annual Symposium—Nov. 2, Alameda Plaza Hotel, Kansas City, Mo. Contact Jan Johnston, Univ. of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kan. 66103, phone 913-588-4480.

Advances in Hematology—Nov. 2, Boston. Second William B. Castle Symposium. Contact Dr. Andrew Schafer, Hematology Div., Brigham & Women's Hospital, 75 Francis St., Boston 02115, phone 617-732-5840.

Lung Cancer—Nov. 2-3, Cincinnati. Third Cincinnati Cancer Conference. Contact Thomas O'Connor, Medical Staff Education, Bethesda Hospitals, 619 Oak St.,

Cincinnati 45206.

Cancer Nursing '84—A Developmental Approach—Nov. 5-6, Turner Auditorium, Johns Hopkins Medical Institutions. Contact Program Coordinator, Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-6046.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--Nov. 7, NIH Bldg 31 Rm 6, 8:30 a.m., open.

Lung Cancer 1984—Nov. 7-9, Shamrock Hilton Hotel, Houston. Contact Office of Conference Services, Box 131, M.D. Anderson, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Chemotherapy Foundation Symposium IV: Innovative Cancer Chemotherapy—Nov. 7-9, Barbizon Plaza Hotel, New York. Phone 212-650-6772.

Workshop on Monoclonal Antibodies and Breast Cancer—Nov. 8-9, San Francisco. Contact Dr. Roberto Ceriani, Bruce Lyon Memorial Research Lab., Children's Hospital Medical Center, Grove & 52nd St., Oakland, Calif. 94609.

Leukemia Society Regional Medical Symposium—Nov. 8-10, Hyatt Regency Hotel, New Orleans. Contact Leukemia Society of American, 800 Second Ave., New York 10017.

High Technology Route to Virus Vaccines—Nov. 8-10, Houston. Contact Dr. Daniel Watanabe, phone 800-231-6388 or 713-785-0532.

Practical Approaches to Oncology--Nov. 9, Holiday Inn, Fargo, N.D. Contact Medical Education, St. Luke's Hospital, 5th St. N. at Mills Ave., Fargo 58122, phone 701-280-5933.

President's Cancer Panel—Nov. 9, Cancer Center of Hawaii, Univ. of Hawaii at Manoa, Honolulu, 9 a.m.-4 p.m., open.

Safety Evaluation & Regulation of Chemicals--Nov. 13-16, Zurich. Contact F. Homburger M.D., Bio-Research Institute, 9 Commercial Ave., Cambridge, Mass. 02141, phone 617-864-8735.

1984 Urologic Tumor Symposium—Nov. 15-17, Memorial Sloan-Kettering Cancer Center, New York. Contact CME Conference Planning Office, C-180, MSKCC, 1275 York Ave., New York 10021, phone 212-794-6754.

Tumors of the Hand and Forearm—Nov. 15-17, New York. Contact American Society for Surgery of the Hand, 3025 S. Parker Rd., Suite 65, Aurora, Colo. 80014.

Lymphoproliferative Diseases: Pathogenesis, Diagnosis, and Therapy—Nov. 16-17, Louis B. Mayer Auditorium, Univ. of Southern California, Los Angeles. Contact Betty Redmon, Coordinator, phone 213-224-7123.

Radiological Society of North America—Nov. 25-30, Washington D.C. Contact A. Swenson, Executive Director, 1415 W. 22nd St., Suite 1150, Oak Brook, Ill. 60521.

National Cancer Advisory Board—Nov. 26-28, NIH Bldg 31 Rm 6. Open all three days for annual program review.

Clinical Cancer Program Project Review Committee—Nov. 29-30, Biscayne Bay Marriot Hotel, Miami. Open Nov. 29 8:30-10 a.m.

Myelosuppressive Effects of Antineoplastic Drugs—Nov. 29-30, Doral Beach Hotel, Miami Beach. International symposium preceding annual meeting of the American Society of Hematology. Contact Meniscus Health Care Communications, PO Box 30,000, Philadelphia 19103, phone 215-735-8450.

Biomolecular Events Underlying Cancer--Nov. 29, Roswell Park continuing education in oncology.

FUTURE MEETINGS

Second International Conference on the Modulation and Mediation of Cancer by Vitamins and Micronutrients—Feb. 10-13, 1985, Tucson. Contact Mary Humphrey, Conference Coordinator, Arizona Cancer Center, Tucson 85724, phone 602-626-6044.

19th Annual Clinical Symposium—Feb. 22-23, 1985, Memphis. Topic will be "Childhood Tumors: Multidisciplinary Approach to Sarcomas." No fees, but attendance will be limited to 200 physicians. Contact Dr. Joseph Simone, Director, St. Jude Children's Research Hospital, Box 318, Memphis 38101.

NCI CONTRACT AWARDS

TITLE: Studies of iatrogenic cancer and radiation dosimetry
CONTRACTOR: Univ. of Texas/M.D. Anderson Hospital, $547,085.

TITLE: Biomedical computing support services
CONTRACTOR: Information Management Services Inc., Rockville, Md., $1,715,065.

TITLE: Cancer Communications Network: NCI is negotiating with the following for continuations
CONTRACTORS: Dana Farber Cancer Institute, Institute for Cancer Research, Duke University, Illinois Cancer Council, Howard University, Mayo Foundation, Memorial Hospital (New York), Univ. of Miami, Michigan Cancer Foundation, New York State Dept. of Health, Penrose Hospital, Colorado Springs; Univ. of Southern California, M.D. Anderson Hospital, Univ. of Wisconsin, Yale Univ.

TITLE: Systems planning support services for the NCI National Cancer Plan, modification #21
CONTRACTOR: JRB Associates, $173,968.

TITLE: Biomedical computing support in cancer control and prevention
CONTRACTOR: Information Management Services, Inc., $2,788,432.

The Cancer Letter _Editor Jerry D. Boyd

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