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HAMMER SAYS "EXCITING TIMES" SHOULD CONVINCE PRESIDENT TO INCREASE BUDGET, OK ACT RENEWAL

Armand Hammer, after hearing once again details on some remarkable progress in cancer research, repeated his vow to take the case to President Reagan for increased cancer funding and for renewal of the National Cancer Act. "These are exciting times in cancer research but they also are anxious times," Hammer said Monday at meeting of the President's Cancer Panel, which he chairs, at Johns

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In Brief

LONGMIRE REAPPOINTED TO PANEL; NEW ORGAN SYSTEM GROUP FOR BRAIN-CNS TUMORS ASKED

WILLIAM LONGMIRE, distinguished physician at Los Angeles Veterans Administration Hospital and retired head of surgery at UCLA, has been reappointed by President Reagan to a second three year term on the President's Cancer Panel. Panel Chairman Armand Hammer announced the appointment this week at the meeting in Baltimore.... **PARTICIPANTS** in last week's meeting on brain tumors agreed on recommending to NCI that a new working group on malignancies of the brain and central nervous system be established within the Organ Systems Program. The recommendation will go to the Div. of Cancer Prevention & Control's Board of Scientific Counselors at the Board's meeting in May. It will be the first new organ site to be added to the program since the National Pancreatic Cancer Project was established 10 years ago under the old Organ Site Program.... **GERALD MURPHY,** director of the Organ Systems Coordinating Center, has appointed with NCI's concurrence the six members of the OSCC Advisory Board. The Board will meet annually to evaluate the OSCC and the progress reported by chairmen of the programs and to make recommendations for termination of ongoing programs or implementation of new ones. This Board members are James Cox, Medical College of Wisconsin; Walter Lawrence, Medical College of Virginia; Peter Magee, Fels Research Institute; Bradford Patterson, Dana-Farber Cancer Institute; William Shingleton, Duke Comprehensive Cancer Center; and Willet Whitmore, Memorial Sloan-Kettering Cancer Center.... **"DON'T RESTRICT** your planning on the basis of the present budget," NCI Director Vincent DeVita told center executives at their recent meeting with NCI staff. He was referring to the cuts in the core grants budget which has forced NCI to hold the second cycle of renewals to increases of 5 per cent over current levels. NCI hopes to find enough money to fund them at least at 85 per cent of recommended budgets. NCI would need a little more than $3 million to fund them all at 95 per cent of recommended levels, the amounts received by those in the first cycle.

HAMMER SAYS HE'LL ARGUE FOR BUDGET INCREASE, RENEWAL OF CANCER ACT

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Hopkins Univ. The plan by the White House Office of Management & Budget to "forward fund" enough NIH grants with 1985 fiscal year money to hold the number of competing grants to 5,000 has been determined by the General Accounting Office to be unlawful, Hammer noted. Congress had intended for 6,500 competing grants to be funded and appropriated sufficient money to do that.

"An equally disturbing problem," Hammer continued, "is reauthorization of the National Cancer Act." If the special authorities the Act gave the NCI director are taken away, it would have a serious, negative impact on cancer research, he said. He commended the American Cancer Society and the new National Coalition for Cancer Research, as well as other organizations and individual scientists for the efforts they have made in exerting pressures on the Administration and Congress. "The National Coalition can be especially helpful, as well as individual scientists," Hammer said. "New discoveries are coming from every side. They are astounding."

Hammer said he is hopeful "we can persuade President Reagan that there should be no cuts in the cancer budget. If anything, the budget should be increased."

Citing the evidence of progress presented by Hopkins and Univ. of Maryland investigators at the meeting Monday; the work of Steven Rosenberg at NCI in treating cancer patients with interleukin-2; Roland Mertelsmann clinical studies with IL-2 at Memorial Sloan-Kettering; UCLA's recent decision to undertake IL-2 clinical studies; and a comment by MSK's Lloyd Old that there have been "more advances in cancer immunology in the last few months than in the last 25 years," Hammer said this "astonishing progress. . . will be brought to the attention of the President. I think then that Mr. (David) Stockman (OMB director) should be directed to give his attention to other fields and stay away from cancer research."

Albert Owens, director of the Johns Hopkins Oncology Center, said the center had been established because of stimulation of the National Cancer Act. Owens said major problems the center faces include training of physician scientists, initial support for young faculty members, initial support for novel research, application of research results to practice, and the potential impact of the prospective payment (DRG) system.

"We would like for you to carry the message back that we absolutely support renewal of the National Cancer Act," Owens told the Panel. "Not to renew would be a most retrogressive and regretful step."

Owens said he was "most distressed" by the multiple year funding plan of OMB. The Hopkins center would lose 14 grants if that plan is carried out. "We need generous and stable funding for biomedical research. The NCI bypass budget is reasonable and soundly based. I understand the argument about reducing the national deficit, but the argument for increased support for biomedical research is not entirely self serving. The Constitution gives Congress the power to 'provide for the common defense and general welfare.' We want to be sure that 'general welfare' gets proper attention."

NCI Director Vincent DeVita asked Owens if he could predict a time would come when cancer center core grants are no longer necessary. He also asked what role construction grants played in developing the center.

The core grant, Owens answered, is becoming a progressively smaller part of the center's budget, down from one third at the start to about 12 per cent now. However, "if we lost the core grant, we would lose something vital. It funds young investigators, and provides the operational capability for shared resources, an increasingly important element in pooling our resources. Also, it provides 10-15 per cent of the salaries for the major program leaders working in the center."

As for construction grants, "the need for matching funds proved a very effective way to open conversations with a number of people. Having that grant approved started the process rolling."

NCI Deputy Director Jane Henney, referring to the problem cited by Owens of training physician investigators, referred to "oversaturation of physicians, even in oncology subspecialties."

"There may be a surfeit of physicians in general, but I don't think we've been overwhelmed by numbers in oncology," Owens said. "We need more of those individuals. It's not just a matter of supporting them in training. They're concerned about what institutions and programs will be there for them when they complete training. They need to see the challenge."

Panel member William Longmire commented that although there may be an oversupply of surgeons, "not enough of them are interested in cancer research."

Stephen Baylin, associate professor of oncology at Hopkins, said "it is inconceivable that we're talking about whether the National Cancer Act would be renewed. It is indispensable. The Cancer Program is the best money the federal government spends."

Bert Vogelstein, associate professor of oncology,

said "Most of the exciting discoveries in cancer research are in the United States, the bulk of them supported by NCI. That should be a great source of pride for us all. We need first a place to do research and second, the support to do it... There must be much greater stability in that support."

Stanley Order, professor of oncology, described his studies in using radiolabeled antibodies in the treatment of hepatomas. The process apparently has cured some patients in the most advanced stages. One "with the largest tumor I have ever seen," Order said, weighing 7,200 grams, has had the tumor shrink to 1,700 grams. Others have had unresectable tumors reduced to resectable size. No toxicity has been observed from the treatment.

Order mentioned his major concern about cancer funding. "Each of us in the medical profession has certain commitments. One I have stuck with is radiolabeled antibodies. The other is in training young scientists." He referred to the late Rachel Carson's book "Silent Spring" which warned about potential effects of environmental poisoning. "We face in oncology research another silent spring, which would be the result of cutting off support for research training."

George Santos, professor of oncology at Hopkins and a leader in development of bone marrow transplants in the treatment of some cancers and aplastic anemia, described current results. With matched donors, "we should be able to get 70 per cent survival" in aplastic anemia.

With allogeneic bone marrow transplant for acute lymphocytic leukemia given during first or second remission, 50 per cent long term survival is being achieved. In chronic myelogenous leukemia, use of cyclosporine to combat graft vs. host disease resulting from bone marrow transplant has improved the prospect for long term survival.

In acute nonlymphocytic leukemia, patients under age 20 have 65 per cent disease free survival after BMT. For those over 20, 30 per cent disease free survival is being seen "but that should move up to 50 per cent."

"Without the National Cancer Act, this would not be happening," Santos said. "Ninety per cent of my research is funded by NCI." He agreed with Order on training of new investigators. "We need people to take our place."

Richard Ross, dean of the Johns Hopkins Medical School, said that at first "the idea of taking pieces out of departments" in starting the oncology center did not meet with "universal enthusiasm. Now, 10 years later, there is no question of its success. It was a wise decision."

The center represents "separation without isolation. . . It is not isolated from the main stream of educational effort. That's where the young people are." Ross said he was pleased by Hammer's reference to Steven Rosenberg, a Hopkins alumnus. "We're very proud of him. He's had a magnificent career in surgery and research."

Ross continued, "If the whole institution operated as well as the oncology center, we would be a better place. The research is first class." He noted that two thirds of the center's budget comes from the peer review system, with 49 of 61 faculty members having RO1 or other primary support through an independent review mechanism. "I'm especially delighted to see an emphasis on basic research and clinical research working together. Nowhere is the link between basic research and patient research stronger than in the oncology center." However, "that is a threatened activity because of patient costs and reimbursement policies."

Robert Heyssel, president of Johns Hopkins Hospital, told the Panel, "We need your help and some assurances that we won't fall back." Referring to inconsistencies and unfair reimbursement posed by the prospective payment system, Heyssel mentioned the DRG for anemia. "There is iron deficiency anemia and aplastic anemia."

Stephen Schimpff, director of the Univ. of Maryland Cancer Center in Baltimore, described the development of the center from 1981, when NCI's Baltimore Cancer Research Program was ended and the center was established, to the present. The staff in 1981 had had no prior extramural grant experience and the center had no money in peer reviewed grants. Today the center has $1.3 million in grants.

Schmimpff said the two centers in Baltimore are "complementary" in cytogenetics and AIDS research; they "overlap with breadth" in leukemia research; and "overlap with depth" in pharmacology.

Thomas Kelly, professor of molecular biology & genetics at the Univ. of Maryland Cancer Center, said, "This really is a very exciting time in basic cancer research and basic science in general. That is not an accident. It is the result of support from the federal government. Recent reductions and those contemplated will take a toll. It is essential to provide adequate support for new investigators, not only to train them, but it is essential that we provide support for their projects after training. Our fellows and faculty have a great deal of anxiety about the stability of support."

Julius Pericola, president of Bristol Laboratories, described his company's involvement in cancer research and development of anticancer drugs. At the time Bristol-Myers made the decision for a major effort in cancer, the conventional wisdom in the pharmaceutical industry was that the market potential was not enough to justify research and development costs, Pericola said. "We believed to the contrary, and that proved to be sound judgment.

Bristol-Myers is now the country's leading maker and marketer of anticancer drugs."

Bristol-Myers' program of making unrestricted grants to selected institutions (now totaling 17) was started at Owens' instigation, Pericola said. The clincher in Owens' argument was his statement that "Bristol-Myers support will provide a window on the unexpected," according to Pericola.

"We hoped that other companies would follow suit, and some have," Pericola said. "We are proud of our program. We believe in it, and we intend to stick to it. But it has a limit. I still feel (as he said he had when Owens made the suggestion) that it is a drop in the bucket. If NCI's basic research budget is substantially reduced, will private enterprise pick up the difference? In my opinion, the answer is no. Bristol-Myers couldn't add enough. Our role is narrowly defined. Our major commitment has to be to applied research, which depends on basic research. To assume that private enterprise can make up for substantial cuts in basic research is unrealistic."

Comments from members of the audience included:

Jerome Cardin, representing an organization called the Basic Cancer Research Foundation—"We believe basic research is our best hope, and the Johns Hopkins Oncology Center is one of the best. Government should provide increased support for basic research. (Recent actions by the government) have sent a confusing message. On one hand, the Administration is encouraging private support; on the other hand, it is withdrawing funds already appropriated by Congress. I hope you can convince the President that he can't encourage private support by withdrawing federal commitments."

David Ettinger, on the DRG issue—"Clinical cancer research equates with the best cancer treatment. It is sometimes costly. (HHS Secretary) Margaret Heckler's statement that DRGs will have no impact on clinical research has no basis in fact."

Linda Arenth, director of nursing at Hopkins—"We are concerned about prospective payment. Variations in cancer treatment are not fully reflected in DRG rates. They must recognize severity of illness and variations in treatment."

Norman Rockwell, private citizen—"I'm overwhelmed by the progress which appears to have been made in the last 35 years. But from the point of view of the dying patient, it is too little, too late." He described the facility at Hopkins for dying patients and family members. "The only intelligent course for this country is to carry out research with all possible resources."

Bart Fisher, chairman of the Aplastic Anemia Foundation Advisory Commission—"Fifty one billion dollars appropriated for defense has not been obligated." He recommended a freeze on the defense budget which he contended would not cut actual defense spending due to the unobligated funds left over from prior years. Failing that, "the medical community will have to lobby our fellow citizens for more taxes to pay for biomedical research."

GEOGRAPHY REMAINS AN ISSUE FOR CANCER CENTERS; NCI "HOLY WATER" OR MONEY?

Since the early days following enactment of the National Cancer Act of 1971, NCI has had to contend with pressures from a variety of sources, not the least of which is Congress, to make available to all regions of the country the best and latest in the diagnosis and treatment of cancer. That was strongly implied in the section of the Act which authorizes NCI support for "new centers for basic and clinical research into, training in, and demonstration of, advanced diagnostic, prevention and treatment methods for cancer."

The goal in those days was to encourage development of either comprehensive cancer centers or clinical centers with advanced capabilities so geographically distributed that no patient would have to drive more than half a day to reach one. That goal evolved into the various community programs initiated and supported by NCI, including regional cooperative groups, the Cooperative Group Outreach Program and Community Clinical Oncology Program.

The issue of geographic distribution of NCI supported cancer centers remains alive, however, and the pressures are still there.

Jerome Yates, who heads the Centers & Community Oncology Program in the Div. of Cancer Prevention & Control, presented a discussion paper on the issue at the recent meeting of cancer center executives at NCI:

"NCI cancer centers are often portrayed as organizations where excellence in the diagnosis and management of cancer as well as concentrated cancer training and research occurs. Research, patient care and training are present to a varying extent in all of the NCI cancer centers. Basic science research is coordinated in some centers without clinical components and some clinical research is conducted in locations without laboratory research or onsite training activities. The NCI centers program has developed and maintained excellence through the peer review system.

"NCI has not stipulated that every center have programs in training, basic research, clinical research, cancer control research, or outreach activities. Indeed, NCI formally recognizes and funds flourishing laboratory and cancer control centers without clinical care components. These specialized centers and consortial centers are foci

of research without direct cancer patient management responsibilities. They are largely located in environments providing a critical mass of research expertise--most often at universities or in free standing institutes.

"One major intent of the National Cancer Act of 1971 was to provide patients with access to optimal patient care through replication of NCI centers in the U.S. Multiple models for geographic distribution have been developed over the past 15 years. All have addressed patient access to centers. However, the lack of clinical research capability and laboratory and training programs persists in some areas of the country, and this is unlikely to change. The shifting of oncologists trained in clinical research from large urban centers to moderately sized cities without medical schools has gradually increased the level of interest and ability of medium sized communities to participate in clinical research. Successful NCI community clinical research programs such as the Cooperative Group Outreach Program and the Community Clinical Oncology Program demonstrate new abilities of community clinical investigators. They also serve as regional leaders for consultation in diagnosis and management of cancer in a selection of geographic areas presently devoid of cancer centers.

"We are considering an in depth analysis of the community clinical trials efforts as data become available from our community program evaluation. The relationship of these community clinical research efforts to their research bases (clinical trials groups and cancer centers) and the regional networks formed by some, for example, the Northern California Oncology Group, North Central Cancer Treatment Group, Piedmont Oncology Group, and the Illinois Cancer Council represent different models which have been able to extend their interests beyond treatment research to regional cancer control research.

"The cancer center consortial concept was developed to encourage this type of interaction, but most community physicians involved in clinical research will still interact primarily with the national clinical trials groups."

The paper offered these questions to consider:

1. What are the advantages and disadvantages for designating community cancer centers without readily accessible NCI (prototype) cancer centers in their regions?

2. What are the appropriate criteria for their designation, their location, and their research participation?

3. What should the relationship of the community cancer centers be with other regional cancer interests, clinical trials groups, and the formally designated NCI cancer centers in regions where this may occur?

4. Should cancer control activities be a requirement to the primary activity of such a center? If so, to what extent should financial and organizational stability be assured? Is such assurance realistic in our present environment?

5. Centers serving concentrated minority populations provide benefits for their communities by increasing awareness and facilitating access to state of the art care for cancer—might an NCI designation foster improved patient management?

6. What is the role of all types of cancer centers in the NCI goals for decreased mortality and morbidity for the Year 2000?

Yates offered these options to consider:

1. Geographic distribution of centers should be allowed to develop spontaneously within the existing center and consortial guidelines (the draft of guidelines for the new consortial cancer center grant were discussed by the center executives who suggested some changes and will be presented to the DCPC Board of Scientific Counselors in May—**The Cancer Letter,** April 19).

2. Free standing clinical cancer centers with peer reviewed approved participation in clinical research should be considered.

3. Only community cancer centers with clinical research links to existing cancer centers in or close to their regions should be considered.

4. Require 2 or 3 above but also demonstrate that multidisciplinary cancer management planning is the norm.

5. Need for different types of centers to provide access to patients from underserved areas (minority or geographic) to state of the art screening, prevention, diagnosis and treatment.

Yates opened the discussion with the question, "Where should we go in supporting community centers where no prospect exists for basic research?" He said he plans to bring together persons representing community centers, cooperative groups, traditional cancer centers, DCPC and the Div. of Cancer Treatment to discuss the issue. However, "The bottom line is where will the money come from? We've invested a fair amount of money in community programs. We ought to use information coming out of them in logical planning to determine if we should issue new RFAs for CCOP or its successor."

"Are you about to get into an accreditation process?" asked John Durant, Fox Chase Cancer Center. "Is it a matter of money, or is it holy water, holy water being accreditation? Why do you have to tie money to holy water?"

"You could say that the core grant acts as an

accreditation system," Yates replied. He added that criticism from Congress has included charges that rural physicians who participate in clinical research sometimes "feel they are being treated as second class citizens."

"What business are we in?" asked Ross McIntyre, Norris Cotton Cancer Center. "Is it coping with the most difficult biological problem man has ever addressed? Or are we in the business of satisfying political expediency?"

The resounding answer, from Yates and others in the room, was "Both!"

Franco Muggia, New York Univ., asked if "there is any thought of tieing in community activities with the consortium centers?"

"That's a good point," Yates answered. "Maybe through that sort of thing (other mechanisms to improve geographic distribution) will not be necessary."

BIOLOGICAL MODIFIERS JOURNAL SAYS IT WILL OK RELEASE OF CLINICAL DATA

At least one professional journal in the cancer research field objects to the policy of the "New England Journal of Medicine" relating to release of information prior to publication.

In an editorial in the "Journal of Biological Response Modifiers," Editor Robert Oldham called NEJ's policy "indefensible" when clinical studies are involved and set forth his journal's policy of making available to inquiry immediately data from any study accepted for publication.

Oldham's editorial acknowledged that scientists have proprietary rights to the products of their studies which they may consider "as their personal intellectual property." However, "while such feelings are natural and probably occur in all of us, it is important to examine the effect of such feelings and their resulting actions on others. For research activities in the laboratory, where the results do not have immediate clinical application, the question of timing and privacy are probably not of major importance. . .

"Clinical research activities should be viewed differently. As is illustrated by the recent controversy surrounding the publication of research results from the National Surgical Adjuvant Breast Program, it is clear that this issue has major implications for patients. In the press analysis of this controversy, it was reported that Dr. Bernard Fisher (NSABP chairman) was unwilling to share the results of a clinical study involving the use of radical vs. less radical surgery in patients with breast cancer. This study was to be published in the "New England Journal of Medicine." Their policy of not releasing information prior to publication was the basis for Dr. Fisher's unwillingness to share these data in advance of publication. Such a practice has been defended by the Journal's editor, Dr. Arnold Relman, on the grounds that his journal publishes rapidly and contains 'newsworthy' scientific articles.

"As the editor of this journal and as a clinician scientist, this position seems indefensible. Timeliness and newsworthiness may mean one thing to a journal editor or to a clinical investigator, but it has quite another meaning to the patient. For the patient, timeliness is today and newsworthiness relates to facts which might be important to the treatment of the disease. It can be easily envisioned that several hundred to several thousand women may have been affected in this controversy. The study. . .addressed an important issue for each woman developing breast cancer. . .Over the span of a few weeks, hundreds of patients across the United States and around the world will have to make the decision to have or not have a more or less radical surgical excision of their breast cancers. This personal decision must be made on a 'real time' basis and if data have already accrued which might influence this decision, it should be available to those patients immediately.

"It is indefensible to withhold such data from patients who are making this decision because of journal policy, newsworthiness, privacy of data or any of these kinds of issues. In particular, this study, being supported by public funds (government grants) is at risk for criticism when the information from it is not freely available at any point in time during the conduct of the study. Statisticians have many arguments as to when data must be analyzed, and there has been much written on the dangers of a preliminary analysis of an ongoing trial. However, once the data have been analyzed and submitted for publication, the timing of statistical analysis, the acceptance of the article and the timing of the publication become moot issues. The data have been analyzed and the study, for the purpose of that publication, is complete. Information from such studies should be freely available to patients when these studies might immediately influence patient decisions and clinical care. While no system exists for the rapid or instantaneous dissemination of such clinical information to patients or to their physicians and while it is unclear that the initiation of such a system of rapid communication (in preference to standard publication of medical journals) would be useful or cost effective, it is clear that data which are available and accepted for publication should not be restricted when investigators are specifically asked questions on results of their studies.

"It is our policy to make available to any inquiry clinical data from any study accepted for

publication in the 'Journal of Biological Response Modifiers.' The time frame from acceptance to publication may be only one to two months or may be as long as three or four months. In either case, it would be unreasonable to withhold data from clinical studies which might be relevant to 'real time' decision making by patients and their physician. I would urge other editors of medical journals to take a similar stance on this issue."

NCAB COMMITTEE STILL DEBATING ISSUE, HOW TO ENCOURAGE SURGICAL ONCOLOGY

The National Cancer Advisory Board's Committee on Innovations in Surgical Oncology continues to debate the seemingly never ending issue of how surgical oncology can be encouraged and developed. The committee, chaired by Ed Calhoon, is scheduled to meet again during the May session of the NCAB.

"We have made a giant step forward in competing for young surgeons through NCI's surgical oncology training programs," committee member Robert Hickey said at the last meeting.

"One of the paramount functions of this committee might be to talk with our colleagues, persons interested in surgical oncology, and ask them their views of NCI programs," committee member Victor Braren commented. "I still think NCI has a tolerant view of surgical oncology. NCI would like to have more surgeons involved in the Cancer Program but doesn't know how to get them. There are too many study sections with no surgeons, with no one looking at grants from a surgeon's viewpoint."

Iris Schneider, NCI director of staff operations, objected to the word "tolerant" and suggested instead, "puzzlement," which Braren agreed was appropriate.

"Surgeons do not think NCI is interested in surgeons," Braren continued. "There needs to be a basic change in approach by NCI." eeds to be a

"We have to change the entire atmosphere," committee member Geza Jako said. "Since this committee was formed, Dr. (Bruce) Chabner (director of the Div. of Cancer Treatment) and the NCI atmosphere have changed."

"I know surgeons," said Calhoon, one himself. "There are five in my family. At AMA, they're difficult to deal with. Who gets the press? Surgeons. They'll have to be spoon fed on grantsmanship. That is something NCI will have to do."

"Jonathan Rhoads (first chairman of the NCAB) was a practicing surgeon," NCI assistant director Elliot Stonehill said. "There has always been more than tolerance for surgeons on the NCAB. The lack of interest has been on the part of surgeons, not NCI. We have to stimulate them to develop good research ideas. It is not an issue of tolerance. The issue is lack of raw material."

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR MAY, JUNE, FUTURE

Society of Head and Neck Surgeons Fifth Annual Joint Meeting—May 5-8, Cerromar Beach, Puerto Rico. Contact Dr. James Helsper, SHNS Secretary, 635 E. Union St., Pasadena, Calif. 91101.

Clinical Cytopathology for Pathologists--May 6-17, Johns Hopkins. Contact John Frost, M.D., 604 Pathology Bldg, Johns Hopkins Hospital, Baltimore 21205.

Biometry & Epidemiology Contract Review Committee--May 6-7, NIH Bldg 31 Rm 8, open May 6 8:30-9 a.m.

First International Conference on Skin Melanoma—May 6-9, Venice. Contact Conference Secretariat, Istituto Nazionale Tumori, Via Venezian 1, 20133, Milan, Italy.

National Tumor Registrars Assn.--May 7-10, Hotel Queen Mary, Long Beach, Calif. 1985 annual meeting. Contact Cynthia Creech, Cancer Program Manager, Huntington Memorial Hospital, 100 Congress St., Pasadena, Calif. 91105, phone 818-440-5186.

Div. of Cancer Etiology Board of Scientific Counselors--May 9-10, NIH Bldg 31 Rm 10, open 1 p.m.-adjurnment May 9, 9 a.m.-adjournment May 10.

Div. of Cancer Prevention & Control Board of Scientific Counselors—May 9-10, NIH Bldg 1 Wilson Hall. Open May 9 8:30 a.m.-3 p.m., May 10 8:30 a.m.-adjournment.

DCPC Board of Scientific Counselors Prevention Committee--May 9, NIH Bldg 1 Wilson Hall, open 5-7 p.m., closed 7 p.m.-adournment.

Advances in Cancer Treatment—May 9, Roswell Park continuing education in oncology.

Cancer Chemotherapy Update: 1985--May 9-10, Allentown, Pa. Contact Richard Attilio, Allentown Hospital, 17th & Chew Sts., Allentown 18102.

Society for Clinical Trials Sixth Annual Meeting—May 12-15, New Orleans. Contact Dr. Curt Furberg, 600 Wyndhurst Ave., Baltimore 21210, phone 301-435-4200.

Challenge of Local Tumor Control and Its Impact on Survival—May 12-17, Rome. Third Rome International Symposium. Contact Associazione Italiana per la Promizione dello Studio delle Mallattie Oncologische, Via Ple di Marmo, 18, Rome, Italy.

National Cancer Advisory Board Committee on Organ Systems Programs—May 12, NIH Bldg 31 Rm 8, 7 p.m., open.

National Cancer Advisory Board--May 13-15, NIH Bldg 31 Rm 6, open May 13 & 15, 8:30 a.m.-adjournment, closed May 14.

NCAB Committee on Construction—May 13, 5 p.m., closed.

NCAB Committee on Year 2000 Goals—May 14, NIH Bldg 31 Rm 2, 5 p.m., open.

NCAB Committee on Information—May 14, NIH Bldg 31 Rm 6, 7:30 p.m., open.

NCAB Committee on Surgical Oncology—May 14, NIH Bldg 31 Rm 4, 8 p.m., open.

NIH Technology Assessment Meeting on Registries for Bone Marrow Transplantation--May 13-15, Masur Auditorium, NIH, Bethesda, Md. Contact Peter Murphy, Prospect Associates, Suite 401, 2115 E. Jefferson

St., Rockville, Md. 20852, phone 301-468-6555.

European Assn. for Cancer Research--May 13-15, Bratislava, Czechoslovakia. Eighth meeting. Contact Dr. Marta Grofova, Secretary General, 8th Meeting EACR, Cancer Research Institute, ul csl armady 21,812 32 Bratislava.

Oncology Nursing Society 10th Congress--May 15-18, Houston. Contact Nancy Berkowitz, ONS, 3111 Banksville Rd., Suite 200, Pittsburgh 15216, phone 412-344-3899.

International Meeting on Advances in Virology--May 15-18, Catania, Italy. Contact Angelo Castro M.D., Institute of Microbiology, Univ. of Catania, Via Androne, 81, 95124 Catania.

Cancer Research Manpower Review Committee--May 16-17, Bethesda Holiday Inn, open May 16 8:30-9 a.m.

National Assn. of Oncology Social Workers--May 16-18, Houston. Contact Office of Conference Services, Box 131, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030.

Worthless Cancer Treatments--May 17-19, Victoria, B.C. Contact Blue Mountain Oncology Program, PO Box 327, Walla Walla, Wash. 99362, phone 509-525-1290.

American Society of Clinical Oncology--May 19-22, Houston. 21st annual meeting. Contact ASCO Executive Director, 435 N. Michigan Ave., Suite 1717, Chicago 60611, phone 312-644-0828.

Society of Surgical Oncology--May 19-22, Houston. Annual meeting. Contact Charlene Terranova, SSO, 13 Elm St., Manchester, Mass. 01944.

Effect of Tin on Malignant Cell Growth--May 19-22, Scranton, Pa. Second international symposium. Contact Dr. Larry Sherman, Chemistry Dept., Univ. of Scranton, Scranton 18510, phone 717-961-7705.

American Assn. for Cancer Research--May 22-25, Houston. 76th annual meeting. Contact AACR, Temple Univ. School of Medicine, West Blvd, Rm 301, Philadelphia 19140.

American Assn. for the Advancement of Science--May 26-31, Los Angeles. Contact AAAS Meetings Office, 1101 Vermont Ave. NW, Washington D.C. 20005.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--May 29, NIH Bldg 31 Rm 9, open 9-11 a.m.

Cancer Resources & Repositories Contract Review Committee--May 31, NIH Bldg 31 Rm 9, open 9-9:30 a.m.

President's Cancer Panel--June 3, Memorial Sloan-Kettering Cancer Center, New York, 9 a.m., open.

Div. of Cancer Treatment Board of Scientific Counselors--June 10-11, NIH Bldg 31 Rm 10.

Advances in Hematology--June 10-14, London. Contact Mrs. E. Barker, School Office, Royal Postgraduate Medical School, Du Cane Road, London W120HS, England.

Advances in the Care of the Child with Cancer--June 12-14, Hilton Hotel, Los Angeles. Contact American Cancer Society, 777 Third Ave., New Yoirk 10017, phone 212-371-2900.

Breast Preservation: Workshop on the Technique of Conservative Surgery and Radiotherapy for Early Breast Cancer--June 14-15, 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.

Assn. of American Cancer Institutes--June 16-18, Washington Hilton Hotel, Washington D.C.

Clinical Oncology and Cancer Nursing--June 16-20, Stockholm. Contact Mrs. Ira Thilen, Stockholm Convention Bureau, Jakobs Torg 3, S-111 52 Stockholm, Sweden.

Membranes in Tumor Growth--June 17-20, Catholic Univ., Rome. Contact Scientific Secretariat, Istituto Patologia Generale University' Cattolic, S. Cuore, Largo F. Vita, 1-00168, Roma, Italy.

Toxicology Update '85--June 17-19, Johns Hopkins School of Hygience & Public Health, Baltimore. Contact Program Coordinator, Toxicology Update '85, Turner Rm 22, 720 Rutland Ave., Baltimore 21205.

Critical Care and Medical Management of the Cancer Patient--June 20, Roswell Park continuing education in oncology.

Hereditary Gynecologic & Breast Cancer--June 23-25, Red Lion Inn, Omaha. Contact Hereditary Cancer Institute, Creighton Univ., Omaha, Neb. 68178.

Fourth International Conference on Environmental Mutagens--June 24-28, Stockholm. Satellite symposia are scheduled on genetic toxicology of the diet in Copenhagen June 19-22; risk assessment in relation to mutagens and carcinogens in Oslo June 20-22; and monitoring of occupational exposure to genotoxicants in Helsinki June 30-July 2. Contact Congress Office, ICEM-85, Stockholm Convention Bureau, Box 1617, S-11186, Stockholm.

FUTURE MEETINGS

XIIth International Symposium on Comparative Research on Leukemia and Related Diseases--July 7-12, Hamburg, Germany. Contact Dr. David Yohn, Secretary General, Suite 302, 410 W. 12th Ave., Columbus, Ohio 43210, phone 614-422-5602.

Topics in Gastroenterology & Liver Disease--Oct. 3-5, Turner Bldg, Johns Hopkins Medical Institutions, Baltimore. Contact Jeanne Ryan, Program Coordinator, Office of Continuing Education, Johns Hopkins Univ. School of Medicine, 720 Rutland Ave., Baltimore 21205.

Immunobiology of Cancer and Allied Immune Dysfunctions--Nov. 4-7, Copenhagen. Includes presentations on human cancer immunobiology, markers, exogenously induced immunodeficiencies, clinical management, AIDS, new approaches to immunomodulation, and immunobiology of metastases. Contact M. Rodler & Co., Freyung 6, Postfach 155, A-1014 Vienna, Austria.

The Cancer Letter _Editor Jerry D. Boyd

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