THE CANCER LETTER

Vol. 11 No. 28
July 12, 1985

Subscription $150 year North America
$175 year elsewhere

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

NCAB APPROVES YEAR 2000 REPORT; IMPLEMENTATION DEPENDS ON ADEQUATE FUNDING STARTING WITH FY 1986

The issue of whether NCI will receive the resources it needs to put together the drive to reduce cancer mortality 50 per cent by the Year 2000 will be thrashed out in Congress in the next few months, starting this week with the mark up of the House HHS appropriations bill (See In Brief, below). To have a realistic chance of meeting the

(Continued to page 2)

In Brief

GRANTS COMPROMISE STILL IN DOUBT AS NATCHER, CONTE HOLD OUT FOR 6,500; HOUSE MARKS UP BILL

BARRY SAKULSKY, St. Vincent Hospital (Los Angeles) surgeon and former chairman of the American College of Surgeons Approvals Commission, died recently of brain cancer. He was 50.... **CAROLYNE DAVIS** reportedly is planning to leave her job as administrator of the Health Care Financing Administration this fall for an academic appointment. A leading prospect to succeed her is Sheila Burke, health policy aide to Sen. Robert Dole.... **CONFEREES** on the 1985 fiscal year supplemental appropriations bill still are hung up over water project differences. Congress returned from its week long recess Monday, but no further progress had been made at press time. The Senate version of the bill contained the compromise crafted by Lowell Weicker, chairman of the Health Appropriations Subcommittee, to fund 6,000 competing NIH grants in both FY 1985 and 1986; the House bill did not. Chairman William Natcher and ranking Republican Silvio Conte of the House Health Appropriations Subcommittee are in agreement on holding out for the full 6,500 grants which the regular 1985 appropriations bill supported and for directing the Administration to drop its controversial forward funding scheme. Natcher's subcommittee was scheduled to meet in closed session this week to mark up the FY 1986 appropriations bill.... **JEROME DECOSSE** has resigned as chairman of the department of surgery and chief of the gastroenterology service at Memorial Sloan-Kettering. Physician in Chief Samuel Hellman named Willet Whitmore as acting chairman of surgery and John Daly as acting chief of the gastroenterology service. DeCosse will remain as professor of surgery at Cornell Univ. and attending surgeon at Memorial Hospital.... **HHS DISTINGUISHED** Service Awards were presented by Secretary Margaret Heckler to nine NIH staff members, two of them from NCI—Paul Van Nevel, director of the Office of Cancer Communications, and Stephen Katz, chief of the Dermatology Branch in the Div. of Cancer Biology & Diagnosis.... **LUTHER BRADY**, chairman of radiation oncology and nuclear medicine at Hahnemann Univ., received the 1985 Albert Soiland Memorial Award in Los Angeles last month.

PB-8507-018309

NCI WILL NEED $2 BILLION A YEAR BY 1990 TO REACH YEAR 2000 GOALS

(Continued from page 1)
goal, NCI will need a healthy increase in FY 1986 over the current year spending, and regular increases through 1990, when the budget will have to be around $2 billion.

Meanwhile, the National Cancer Advisory Board has approved a report drafted by NCI staff based on recommendations of four committees formed under the chairmanship of Lester Breslow, deputy director for cancer control research at UCLA Jonsson Comprehensive Cancer Center. The Board's approval was conditioned on incorporating into the final draft of the report recommendations received from a variety of individuals who were asked to comment on the original draft.

The report and comments were presented to the NCAB's Committee on Cancer Control for the Year 2000 by Edward Sondik, chief of the Operations Research Branch in the Div. of Cancer Prevention & Control. Excerpts from the report follow:

With this report NCI is establishing a set of quantified objectives to be used in charting a course to meet the following goal: a 50 per cent reduction in the projected cancer mortality rate by the Year 2000. This cancer control goal and associated objectives are predicated on full, aggressive application of existing knowledge about cancer prevention, screening and detection, and treatment and on the application of the gains in treatment that can reasonably be expected to occur during the next 15 years. The cancer control objectives are specified by quantitative indicators, or measures of cancer control: for prevention, for screening and detection, and for treatment. In turn, these indicators relate to potential incidence and mortality changes from the present to the Year 2000. The use of such indicators can help identify the relationship between resources applied to cancer control and the eventual gains in incidence and mortality. Thus, the objectives give direction to the allocation of resources in the National Cancer Program. In addition, these objectives, with adjustments to reflect specific regional cancer rates and cancer control problems, may also guide the development of and serve as objectives for regional cancer control efforts.

Feasibility of achieving the goal and objectives

The current knowledge base about cancer and the existing network of cancer control resources are the basis for an aggressive effort to be launched now to control cancer. Since its inception, the National Cancer Program has emphasized research to elucidate the causes of cancer, research on treatment to improve the prognosis for cancer patients, and cancer control research which includes cancer prevention trials, smoking prevention and cessation, demonstration, education, and other programs to prevent, detect, diagnose, and treat cancer and to rehabilitate and counsel cancer patients. Major gains have been made during the past decade in understanding cancer etiology, in developing diagnostic techniques, and in developing more effective treatment. Furthermore, the cancer control research base is now in place to improve, evaluate, and accelerate these cancer control activities. With the recent establishment of NCI's Div. of Cancer Prevention & Control, activities to develop the means to transfer the results of reseach to practice and prevention have been given new emphasis. In addition, there has been considerable progress in building a network of resources (such as cancer centers and the Community Clinical Oncology Program) that are involved in, or have the potential to contribute to, the nation's cancer control effort.

Summary of Year 2000 objectives

Prevention objectives for smoking:

*By 2000, the prevalence of adults who smoke will decrease from 33.8 per cent in 1983 to 15 per cent or less.

*By 2000, the prevalence of youth who are smokers at age 20 will decrease from 36 per cent in 1983 to less than 15 per cent.

Prevention objectives for diet:

*By 2000, the per capita consumption of dietary fat will decrease from 160 grams per day to 100 grams.

*By 2000, the per capita consumption of dietary fiber in whole grains, fruits and vegetables will increase to 30 grams per day.

*By 2000, the prevalence of obesity will decrease from 20 per cent of all persons to five per cent.

Objectives for occupational exposure to carcinogens:

Specific objectives for the Year 2000 related to occupational exposure were not defined during this effort. Rather, a set of objectives for the year 1990 were outlined in concert with the Dept. of Health & Human Services prevention objectives ("Public Health Reports," 1983).

*By 1990, all firms with more than 500 employees should have a plan of hazard control for those processes, equipment, and installations associated with established or suspected carcinogens.

*By 1990, at least 25 per cent of workers should be able, prior to employment, to state the nature of their occupational health and safety risks and the potential consequences; they should be informed of changes in these risks while employed (in 1979, an estimated five per cent of workers were fully informed).

*By 1990, the majority of workers should be routinely informed of lifestyle behaviors and health factors that interact with factors in the work environment to increase risks for occupationally induced cancers.

*By 1990, at least 70 per cent of primary health care providers should routinely elicit occupational health exposures as part of patient history, and should know how to interpret the information for patients in an understandable manner.

Year 2000 screening objectives:

*By 2000, the proportion of women aged 40 to 70 who receive an annual breast examination and mammography will increase from 45 per cent for examination alone and 15 per cent for mammography to 80 per cent.

*By 2000, the proportion of women aged 20 to 39 who receive a cervical Pap smear every three years will increase from 79 per cent to 95 per cent, and of women aged 40 to 70 from 57 per cent to 85 per cent.

Year 2000 treatment objectives:

The treatment objectives for the Year 2000 are expressed as increases in five year survival rates based on application of current state of the art technology and treatment for each cancer site.

Major gains in the control of cancer, that is, in the reduction of cancer incidence and mortality, are possible with today's knowledge. This section... highlights major facts and concepts about the major risk factors for cancer, the potential of cancer screening to reduce mortality, the gains in treatment that are now reflected in increased survival, and patterns of cancer occurrence that reinforce the evidence that cancer mortality can be significantly reduced.

Smoking

About 30 per cent of all cancer deaths (over 130,000 deaths per year) are related to smoking. Progress has been made in reducing the percentage of adult smokers. In 1965, 52 per cent of men were smokers; in 1983, the figure was 34.8 per cent. In 1965, 34.2 per cent of women were smokers; in 1983, the figure was 29.5 per cent, which represents a decrease, but not as great a decrease as for men. Those figures present both a promise—that declines are possible--and a challenge--to reinforce and accelerate the decline into a consistent, aggressive trend in smoking reduction and to stem the increase in smoking among our nation's youth.

Dietary components

In an extensive review of cancer causes, Doll and Peto (1982) estimated that 35 per cent of cancer deaths may be attributable to dietary components, with the possible range of effect being 10 to 70 per cent. A midrange estimate of 35 per cent would mean that about 150,000 lives could be saved annually with dietary changes. Because the research to test the effectiveness of dietary interventions to reduce cancer incidence and mortality for particular cancer sites is under way, these estimates cannot be considered definitive, yet even the most conservative estimate represents a potentially significant impact on cancer mortality. Meanwhile, a consensus is growing that certain changes in diet are prudent and may be important to reducing cancer incidence. A committee of the National Research Council has recommended a prudent change in the typical American diet which may lower the risk of cancer, specifically that the consumption of both saturated and unsaturated fats be reduced to 30 per cent of total calories and that fruits, vegetables and whole grain cereal products be eaten daily. NCI concurs and recommends a diet low in fat and high in fiber rich foods. In addition, a recent NIH consensus conference on cholesterol and heart disease noted that a diet low in fat is important for reducing heart disease. Therefore, reducing fat consumption simultaneously lowers the risk of cancer and heart disease.

Screening

Statistics indicate that, for most cancers, early detection affords a much greater chance of patient survival than detection and treatment at later stages of the disease. In particular, cancer mortality for breast and cervical cancer can be greatly reduced through aggressive screening. The research to date on screening for colorectal cancer is not yet considered definitive by NCI although many, including the American Cancer Society, recommend such screening. The screening objectives posed in this report relate to screening techniques for which there is scientific consensus of proven effectiveness—those for breast and cervical cancer.

Breast cancer accounts for about 18 per cent of all cancer deaths among women, and recent data show that the age adjusted incidence and mortality from breast cancer in women has not changed during the past decade. Yet the clinical evidence from a long term clinical study of over 60,000 women enrolled in the Health Insurance Plan of New York shows that breast cancer mortality is reduced 30 per cent in women over age 50 who are screened for breast cancer by mammography and physical examinatioin. Breast cancer screening is effective, but the lack of mortality reduction indicates that screening is not taking place at the rates necessary to reduce mortality.

Cervical cancer screening has long been known to be effective. Use of the Pap smear can reduce the risk of mortality from invasive cervical cancer by as much as 75 per cent according to recent figures. This figure, coupled with current screening figures, yields the estimate that use of the Pap smear for screening could reduce mortality from cervical cancer in the U.S. by at least 25 per cent. Surveys show that, at most, 80 per cent of women age 20 to 39 and 57 per cent of women age 40 to 70 (for whom the risk of cervical cancer is greatest) follow recommended guidelines on screening for cervical cancer.

Treatment

The most recent figures from NCI's SEER Program indicate that the likelihood of surviving cancer for at least five years from the point of detection, compared with the survival of the general population, are now over 49 per cent for cases diagnosed in 1976 through 1981 compared to 48 per cent for cases diagnosed in 1973-75 and an estimated 38 per cent for cases diagnosed in 1960-63. These figures do not account for the increased incidence of lung cancer, which if removed from the most recent figure means that the chances of surviving cancer (other than lung cancer) for more than five years--which for most cancer sites indicates a cured cancer, is 56 per cent. The figures show a steady gain in survival and for some cancers the gains have been dramatic. In 1960 only 40 per cent of patients survived Hodgkin's disease for more than five years;

the latest SEER figures show the rate to be 74 per cent, an increase attributable to the use of radiation and chemotherapy in treatment. Similarly, the use of cisplatinum in testicular cancer has increased survival from 76 per cent in 1973-75 to 87 per cent among patients diagnosed between 1977 and 1981. For many sites, the increase in survival is small, but recent and current application of continued clinical research on treatment has the potential to drive the survival figures higher. For patients to have the best chance of surviving cancer, they must receive timely and appropriate treatment, that is, state of the art treatment.

The prospect of surviving cancer is not the same for all Americans, however. Estimates of survival by race show that for all cancer sites but one (ovary), blacks have a lower chance of surviving five years than whites--38 per cent vs. 50 per cent. Preliminary analyses of the role of socioeconomic status in these figures show that much of the differences can be explained by socioeconomic status, that is, that on the whole both black and white Americans with low incomes have a poorer prognosis from cancer than those whose income is above the median level. A challenge for the health care community is to develop systems that enable professionals to practice at state of the art technology levels, and that enable patients to have access to state of the art treatment and screening.

Another explanation for poor prognosis is one's general state of health. It is clear that, in general, low income persons have a poorer health status and a shorter life expectancy than affluent persons and that, therefore, efforts to reduce cancer morbidity must address general health status as well as specific cancer related issues.

(Some religious groups, especially Mormons and Seventh Day Adventists who abstain from tobacco and alcohol and practice various dietary restraints) have cancer death rates far below that of the general population. . . U.S. ethnic minorities have a unique and, in many cases, a poorer cancer experience than U.S. whites. The exceptions to this are certain segments of the U.S. Asian population who experience better overall cancer and certain site specific survival than whites. . . .

Addressing the cancer needs of minorities is critical to the achievement of the goal of 50 per cent reduction in mortality by the Year 2000. . . (It) requires aggressive and long term catch up efforts.

Strength of the cancer control network

The above and related data are evidence that a lower cancer mortality is possible. Moreover, the essential organizational and personnel capabilities for a wide variety of cancer interventions are in place. A network of cancer research centers has been developed, although not all areas of the country are served equally by such centers. Programs are being developed and evaluated to increase the pace of clinical research and to bring the benefits of clinical research to communities (CCOP, for example). Physician Data Query (PDQ), an information system for physicians on cancer treatment, has been introduced and is available to the clinician through the National Library of Medicine or through commercial information systems. The capability to monitor progress in cancer control has been increased through the expansion of the SEER Program, which tracks cancer incidence and mortality in 12 per cent of the U.S. population. The Cancer Information System maintains a nationwide toll free telephone network for immediate access to answers to cancer related questions from cancer patients, their families, the general public and health professionals. These resources form a network to speed the results of cancer research to cancer control application, and to track their impact.

Though the knowledge and resources are available, they are not yet being fully applied. Statistics indicate that full, aggressive application of knowledge resources could result in a 50 per cent reduction of cancer mortality by the Year 2000. This report identifies those aspects of cancer control for which a fuller application and impact can be realized, and presents objectives to direct and measure progress toward a full application. The purpose is to precipitate the individual and coordinated actions necessary to decrease cancer mortality during the next 15 years.

The impact

Analyses of the data show the potential contributions to the reduction of cancer mortality that are possible by achieving the prevention, screening and treatment objectives. . . Two parameters figure significantly into the analysis. The first is the reduction in smoking, since smoking is responsible for 30 per cent of all cancer mortality, and since the impact of a change in smoking prevalence would be observed within a 10 year period. The second parameter is the degree to which continuing advances in cancer treatment will improve the prospects of surviving cancer. . . Under an aggressive smoking reduction program and under an increase in cancer treatment survival of 1.5 per cent each year over the previous year, the age adjusted cancer mortality rate can be reduced by 50 per cent from current projections for the Year 2000.

Principles for formulating the objectives

NCI adopted several principles in formulating the objectives. First, it was felt that a single overall goal was necessary to serve as a unified target for cancer control--a goal that would be the direct result of gains that could be achieved in prevention, screening and treatment. This goal is to reduce the Year 2000 cancer mortality rate by 50 per cent of current projections. These current projections account for the increases in cancer incidence primarily in the smoking related cancers--particularly lung cancer--observed over the last 30 years. Even if all smoking were to cease today, lung cancer rates would rise as those who did smoke grow older. However, the impact of smoking cessation is dramatic and can lower the risk by at least half within 10 years after cessation.

Second, the framework for developing objectives was the reduction of cancer mortality rates, age adjusted to a base year of 1980 (age adjustment to a base year weights sex specific and age specific rates according to the population distribution by

age and sex of the base year, thereby adjusting for the effects of age or sex changes in the population). Mortality rates are a better yardstick of progress than the total number of deaths because the population is growing and aging, which will likely mean more actual deaths and would mask the progress achieved in the reduction of the cancer death rate.

Third, the objectives were based on the data and trends at hand. For example, the impact of changes in cigarette smoking must necessarily extrapolate from the base of existing data to estimate the potential future effect.

Fourth, a continued, gradual advance in treatment is anticipated, and a concomitant application of these advances is the basis for the objectives. While major breakthroughs and therefore major advances in treatment are possible, such breakthroughs were not factored into the assessment of trends.

Fifth, the objectives reflect solely the impact that actions would have on cancer mortality rates. Other benefits would very likely accrue, such as a reduction in heart disease from reduced cigarette smoking. The analysis does not address the economic benefits or cost of achieving these objectives because the cost of cancer control interventions will vary in response to a variety of forces in the health care system. For example, the cost of mammography varies widely, from as little as $25 per exam to over $200. It is clear that economic market forces, health care organization, and changes in technology could considerably change the cost of implementing mammography. The intent was to emphasize the potential benefits (in terms of reduced mortality) of meeting the objectives. Issues of identifying the least costly ways to meet these objectives will be addressed as part of the NCI Cancer Control Research Program and through the efforts of other organizations.

The inch thick report continued with detailed descriptions of various efforts which will have to be made to implement the program. A key sentence on prevention through smoking cessation:

"Because of the lag time required for reduction in risk after cessation, intensive cessation efforts must be made soon to bring about a major change in lung cancer mortality by the Year 2000."

Actually, intensive efforts must be made soon in all areas, as NCI pointed out in the 1986 bypass budget. The expansion in clinical trials, increasing number of cancer centers, expanding CCOP, and stepping up public awareness and education programs, all must be more or less in place and going full blast by 1990 if the impact on mortality is to be seen in 2000. The upcoming fiscal year, 1986, which starts next Oct. 1, is crucial. If Congress does not significantly increase NCI's budget over 1985, everything will be shoved back a year. You can stop talking about the Year 2000; make it 2001.

Sondik told the NCAB committee that comments on the draft report included whether enough is known about diet to know if changes would have an impact; that the section on treatment was not as positive as it could have been, particularly on results of chemotherapy; that surveillance should be more organized and expanded to include other registries than those in the SEER Program.

Board member Helene Brown said that the report consists primarily of objectives. "I wish we had a document we could take to Congress and say, 'Here's what we can do if we have the money, and here is how many lives that will be lost if we don't.'"

"I question how well documented it is that reduction in fat will reduce cancer mortality," Board member Richard Bloch said.

"There is a large body of data that suggests that," DCPC Director Peter Greenwald said.

"Is it as strong as saccharin was a few years ago?" Bloch asked.

"It is far better," Greenwald answered. "There are a lot of sources. With saccharin, there were just a few animal studies. The dietary fat (related to human cancer) is based on many epidemiology studies."

"I had a number of problems with the report," NCAB Chairman David Korn said. "I don't want us to get caught up in a situation where if it is not working out as well as projected, we caught caught up in trying to do more and more to reach the particular azimuth as we get closer to the Year 2000. I don't want us to get caught up in a financial crunch, where massive population studies consume more and more of the budget. I'm convinced that if we all ate less fat and more fiber, and if we got rid of the damn cigarettes, we'd all be better off, whether or not it impacts on cancer. But I don't want us to wind up chasing our tails, chasing elusive goals. Much of the effort will be out of our hands."

Greenwald acknowledged, "We need some research on the diffusion and adoption of new technology as it becomes proven. For instance, the benefit of mammography is well documented now, but is still not being used."

"I worry about people saying NCI is spending all this money and the incidence is still going up, mortality is still going up," Bloch said. "Kellog is on TV, telling the public about fat. It comes across that cutting fat is more important than cutting cigarettes."

"Everyone eats," DCPC Deputy Director Joseph Cullen said. "Only 5.5 million smoke. In the long run, diet affects more people." Cullen, who heads the HHS Task Force on Smoking, emphasized he was not putting down the importance of that problem.

Sondik said that "it looks like, very soon, the lung cancer rate will peak and start declining,

although not in females. But the male age adjusted rate is most encouraging."

Answering Board member Louise Strong's question on what the purpose of the report was supposed to be, Brown said, "Someone has to set objectives, say this is the goal... The Pap smear was developed in 1938. No one wanted to tell the public. No one did until 1955 when the American Cancer Society did. Someone in NCI has evidence, acceptable to this committee, which makes it possible to say to the public and to Congress, this is our goal, this is what can be done."

Korn said, "We need a statement, that continued support of basic research is still the No. 1 priority. We don't know enough yet. We do know enough to try to reduce mortality through a variety of means."

Summarizing other comments by Board members:

*It is important to make this information useful to the lay public. Perhaps this could be done in the recommendations of the report. This information might also include tradeoffs between and among different canser risks, e.g. the relative importance between smoking and reduction of fat in the diet.

*Uses for the report would be multiple depending on the institution, organization and agency that would use the document localizing its implementation.

*General consensus was that the report should be completed and disseminated as quickly as possible.

*The report indicates actions outside the traditional NCI scope. Should NCI engineer all these changes? Can NCI deliver on all the "promises" implicit and explicit in the report?

*In response to these concerns, it was suggested that by developing a flexible planning system with good monitoring of what is going on, the pressure for resource decision making and tradeoffs will be minimized. It was further pointed out that in the scheme of things resources for cancer control have been far from optimal. The need for cancer control research (which does not pay for services) is evident in order to determine how best to use what is known from basic research. There is a need for strong interface between basic research and cancer control research.

*Numerical projections of mortality changes for each year between 1985 and 2000 should be included in the report in order to provide a sense of more immediate change taking place.

*It was generally agreed that the report needed a preamble to explain some of the points and concerns discussed above. Also, information should be developed to address how the document can be used at the local levels by government and nongovernment institutions, organizations and agencies.

The report was approved unanimously.

HERBERMAN LEAVING NCI TO HEAD NEW PITTSBURGH CANCER INSTITUTE

Ronald Herberman, chief of the Biological Therapeutics Branch in NCI's Biological Response Modifiers Program, will leave NCI in September to become director of the new Pittsburgh Cancer Institute.

Herberman, who was acting director of BRMP for about a year after the program's first director, Robert Oldham, left, has been with NCI for 19 years. Dan Longo was recently named BRMP director by Div. of Cancer Treatment Director Bruce Chabner.

The Pittsburgh Cancer Institute, headquartered at the Univ. of Pittsburgh, is a consortium of two universities, including Carnegie Mellon, and six hospitals. Thomas Detre, Univ. of Pittsburgh vice president for health sciences, told **The Cancer Letter** that the new center has a strong financial base guaranteeing support of about $6 million a year. Contributing that support are the participating institutions, the state of Pennsylvania and the Richard King Mellon Foundation. The grant from the foundation is guaranteed for three years, with a fourth and fifth year available depending on the center's performance.

"Other contributions have been promised once the center is functioning," Detre said. "We have a strong hard money base." In addition to cash, each of the institutions is providing one additional staff member to the center.

Although there never has been an organized cancer center in Pittsburgh, faculty of the two universities are engaging in cancer research and have cancer related grants totaling about $6 million a year.

Detre said that "we're not in a hurry to apply for a planning grant," but that the center would seek such a grant from NCI once it is organized, "in another half year or so." Plans definitely call for seeking a regular NCI cancer center core grant.

The center will focus on cancer treatment and clinical research, Detre said.

Herberman said that he is trying to recruit people for the center, "from Frederick (BRMP headquarters) and elsewhere." The center will need 20-30 investigators, including a senior medical oncologist, a senior preclinical scientist and a biological geneticist, with a core group of investigators in experimental therapeutics.

Herberman plans to continue his own research in addition to his role as center director, and he hopes to take with him one or two individuals who have worked closely with him.

Univ. of Pittsburgh is the headquarters for the National Surgical Adjuvant Breast & Bowel Project, whose chairman, Bernard Fisher, is professor of surgery there.

PB-8507-018311

TACOMA TESTS FIND BURTON SERA HAS HEPATITIS, AIDS CONTAMINATION

Not only are cancer patients who go to the Bahamas to receive something called "immunoaugmentive therapy" spending a lot of money for an unproven treatment; not only is the material given them sometimes contaminated with bacteria and hepatitis B virus (**The Cancer Letter**, June 8, 1984); but now it appears that some of them, at least, are being exposed to HTLV-3, the AIDS virus.

That prospect became known when the bottles of sera two patients from the Tacoma, Wash., area received from the Bahamas clinic operated by Laurence Burton were tested by S.J. Insalaco, director of the Pierce County Blood Bank, and Gale Katterhagen, director of oncology for Multicare Medical Center of Tacoma.

Each patient submitted nine bottles of sera produced at Burton's clinic in Freeport. All 18 bottles tested positive for hepatitis B. Nine of the 18 bottles—five from one patient, four from the other—tested positive for HBsAg, the antibody to HBLV-3 virus, the etiological agent for acquired immune deficiency syndrome.

"When we saw that," Katterhagen told **The Cancer Letter** this week, "we called the patients back in and tested them for the AIDS antibody." Both were positive, meaning they had been exposed to HTLV-3 and possibly are infected.

Insalaco sent samples of the sera to the Centers for Disease Control in Atlanta for testing. CDC confirmed the Tacoma findings.

"We think it is extremely important that physicians who know of patients who have received the treatment from Burton should contact them and advise them to come in for tests," Katterhagen said. "They should also ask for the sera the patients have brought home to be brought in for testing." Katterhagen is a member of the National Cancer Advisory Board and former president of the Assn. of Community Cancer Centers. He is also principal investigator for the Community Clinical Oncology Program in Tacoma.

The process Burton claims to have developed involves removing blood from patients, fractionating plasma proteins by centrifugation and organic solvent extraction, which he says replaces deficient proteins. In the process, the blood of a number of patients is pooled, thus opening the way for transmission of the hepatitis and AIDS viruses.

Insalaco and Katterhagen quickly wrote up their findings and submitted them as a letter to the editor of the "New England Journal." Incredibly, the Journal declined to publish it with the excuse that "we receive too many letters to publish all of them." The fact that NEJ did not recognize the importance and urgency of the information should not be surprising, considering that it also sat on the important results of the NSABP breast cancer study for more than a year before publishing it.

Bruce Chabner, director of the Div. of Cancer Treatment, and his deputy, Gregory Curt, last year reported on their attempts to get Burton to submit samples of his sera for testing and to agree to a protocol in which NCI would test his material in the clinic. Burton refused to communicate with NCI directly, but NCI did obtain a number of unopened vials of sera Burton had given patients to be administered to them at home. NCI analyzed the material, and all vials were contaminated with bacteria. Chabner said then that NCI was concerned about the prospect of AIDS contamination in the Burton sera.

PB-8507-018312

LITTON SELLS CLINICAL LABS, PLANS TO BE IN FCRF CONTRACT RECOMPETITION

Litton Industries has completed the sale of one of its subsidiaries, the regional clinical laboratories it has operated in Virginia, Maryland and West Virginia, and is negotiating the sale of its toxicology testing laboratories. The latter involves about 150 employees, the clinical labs somewhat fewer.

"We've been divesting ourselves of a lot of operations over the last two years, such as the publishing group, typewriter manufacturing, and so on, which do not fit into our long range plans," a Litton spokesman told **The Cancer Letter.**

The clinical labs were sold to MetPath, a subsidiary of Corning Glass. MetPath operates clinical labs nationwide and is the largest in the country.

Litton's Medical Research & Products Group, headed by James Nance, still includes Litton Bionetics, Litton Institute of Applied Biotechnology, DataMedix, and Helige. Litton Bionetics and the Institute are headquartered in Rockville, Md. DataMedix is in Sharon, Montana, and Helige in West Germany.

Litton Bionetics holds the contract with NCI for operation of the basic research program at Frederick Cancer Research Facility. The spokesman said the company intends to participate in recompetition of the contract and in fact may join the competition for the $30 million a year contract for operations and support, and possibly for the animal production contract, at Frederick. Litton Bionetics had the entire contract for the facility for the first 10 years of NCI's presence there. Program Resources Inc. won the operations and support contract when the overall contract was divided into five separate contracts in 1982. Harlan Sprague Dawley won the animal contract.

RFPs AVAILABLE

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

RFP NO1-CN-35011
Title: Support to the Smoking, Tobacco & Cancer Program
Deadline: Approximately Aug. 15

A sole source acquisition is being solicited. The specific project is the provision of support services for the Surgeon General's Advisory Committee on Health Effects of Smokeless Tobacco. STCP has utilized the same services under the support contract awarded to Prospect Associates Inc., Rockville, Md., for its own conferences, meetings and workshops.

This contract action is for the supplies or services for which the government intends to solicit and negotiate with only one source. Interested persons may identify their interest and capability to respond to the requirement or submit proposals. This notice of intent is not a request for competitive proposals. However, all proposals received within 45 days after the date of publication of this synopsis will be considered by the government. A determination by the government not to open the requirement to competition based upon responses to this notice is solely within the discretion of the government. Information received as a result of the notice of intent will normally be considered solely for the purpose of determining whether to conduct a competitive procurement.
Contract Specialist: Susan Hoffman
RCB Blair Bldg Rm 2A07
301-427-8745

RFP NCI-CP-61006-21
Title: Biomedical computing—design and implementation
Deadline: Approximately Sept. 5

The Radiation Epidemiology Branch of the Epidemiology & Biostatistics Program of NCI's Div. of Cancer Etiology is recompeting an ongoing project for research and development and data processing support which is currently being performed by Capital Systems Group Inc. The contractor will provide computer related research and services for the scientific activities of the Branch. This will involve:

1. Research and development in computer science to develop specialized software.
2. The use of existing software and systems for supporting Branch projects.
3. The development of custom programs and systems.

These services will be applied to data already collected as well as data in the process of being obtained from ongoing and planned intramural research projects for which computer support is not provided by other means.

Prospective offerors must have expertise in biomedical/statistical computing. The estimated initial level of effort will be 29 staff years over a four year period. All development and production processing will be done using the NIH Computer Center and the contractor will be expected to use this facility by remote access.

Frequent face to face discussions between the NCI project officer, the project director and other key personnel are required to monitor and review progress on project activities. The NCI facility is located in the Landow Bldg in Bethesda.

This acquisition will be a total small business set aside with a size standard of $12.5 million.

The concept from which this RFP was derived was approved by the DCE Board of Scientific Counselors at its winter meeting and reported in The Cancer Letter March 15, page 7.

Contract Specialist: Barbara Shadrick
RCB Blair Bldg Rm 114
301-427-8888

NCI CONTRACT AWARDS

TITLE: Cancer communications systems
CONTRACTORS: New York State Dept. of Health, $1,334,583; Michigan Cancer Foundation, $925,817; Memorial Hospital, New York, $1,649,785; Illinois Cancer Council, $1,072,840; Fred Hutchinson Cancer Center, $914,687; Univ. of Hawaii, $960,975; Yale Univ., $1,113,246; Univ. of Wisconsin, $1,538,334; M.D. Anderson Hospital, $1,969,965; Fox Chase Cancer Center, $1,584,842; Dana Farber Cancer Institute, $1,328,641; Penrose Hospital, $873,270; Univ. of Southern California, $2,641,473; Univ. of Miami, $1,368,405.

TITLE: Cancer in the opposite breast following radiotherapy for primary breast cancer
CONTRACTOR: Danish Cancer Registry, $279,012

TITLE: Radiation risk estimation in Israelis irradiated for childhood tinea capitis
CONTRACTOR: Chaim Sheba Medical Center, $72,160

TITLE: Marmoset colony for cancer research
CONTRACTOR: Oak Ridge Asssociated Universities, $824,956

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