THE CANCER LETTER

Vol. 12 No. 1

Jan. 3, 1986

Subscription $150 year North America
$175 year elsewhere

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

OMB PROPOSAL WOULD SLASH NIH BUDGET $500 MILLION, NCI'S REDUCTION COULD BE AS MUCH AS $125 MILLION

Cuts that would drastically alter NCI and NIH programs and operations are being considered by the White House Office of Management & Budget as part of the Administration's effort to meet the deficit reduction targets mandated by the Gramm-Rudman-Hollings balanced budget act. The proposed overall reduction for NIH in the

(Continued to page 2)

In Brief

GIFTS TO NCI TOTALED $332,226 IN FISCAL 1986; POSITION FREEZE SAID TO HURT DCE LABS

NCI RECEIVED $332,226 in gifts during the 1985 fiscal year and spent most of it on the fellowship program which provides summer training for about 40 students. Because of the OMB limit on positions, the program would have died without the gift fund. The fund also is used for entertainment of foreign visitors and for occasional equipment purchases.... **POSITION FREEZE** has adversely affected some laboratories in the Div. of Cancer Etiology, DCE Board of Scientific Counselors Chairman Barry Pierce told the National Cancer Advisory Board. "There is a great imbalance on the support staff. The problem has to be minimized," Pierce said....

OTIS BOWEN has been confirmed by the Senate as secretary of the Dept. of Health & Human Services. The vote was 93-2, with Sens. Jeff Bingaman (D.-N.M.) and Jesse Helms (R.-N.C.) against. Bowen, 67, is professor of family medicine at Indiana Univ. School of Medicine and a former governor of that state.... **JOHN HORTON** has resigned as head of oncology at Albany Medical College, but will remain as professor of medicine and will continue his clinical and editorial work..... **GENERAL MOTORS** Cancer Research Foundation has named seven new members to its 1986 awards assembly. They are Leroy Hood, California Institute of Technology; Kenneth Bagshawe, Univ. of London; David Phillips, Oxford Univ.; Renato Baserga, Temple Univ. School of Medicine; Harold zur Hausen, director of the German Cancer Center in Heidelberg; John Cairns, Harvard School of Public Health; and Michael Bishop, Univ. of California.... **TWO FIRMS**, Triton Biosciences Inc., a Shell Oil subsidiary, and Cetus Corp. have formed a general partnership to manufacture and market a genetically engineered version of human beta interferon. Trito has 51% ownership and control along with clinical development and regulatory responsibility, while Cetus is responsible for process development and production. Cetus retains ownership of relevant patents. Cetus stock, which soared to 29 5/8 on the publication of Steven Rosenberg's clinical trials using IL-2 supplied by the company, dropped to 23 1/4 at the start of this week.

CENTERS, GROUPS, INTRAMURAL STAFF WOULD BEAR BRUNT OF OMB NCI CUTS

(Continued from page 1)

current fiscal year range from $300-400 million as reported last week by the "Washington Post" to $500 million reported by sources to **The Cancer Letter.**

For NCI, that could mean a cut of as much as $125 million from its $1.258 billion budget this year. It would get worse for fiscal 1987, which starts next Oct. 1, according to sources. That budget, which President Reagan will send to Congress in late January or early February, could possibly drop NCI spending back to the $1 billion a year level.

Compounding the problem is that, thanks to the effective work of cancer program advocates and others in the scientific community, Congress has mandated that 6,100 competing grants be awarded by NIH this year. NCI's share of that number tentatively has been set at 931. Also, Congress has decreed that grants be funded as closely as possible to the peer review recommended levels. Those two factors thus work to prohibit NIH and NCI from slashing the RO1-PO1 grants pool to help meet the budget reductions.

That leaves cancer centers, cooperative groups, cancer control, contracts and intramural programs as the primary targets. Cuts of that magnitude would be devastating for all of them.

The reductions being considered by OMB must be approved by Congress under terms of Gramm-Rudman-Hollings before they can be implemented. But if Congress does not agree on them or alternative ways to meet the budget reduction goals, OMB, the Congressional Budget Office and the General Accounting Office will write the final plan.

Congress has usually been protective of the NIH budget to forestall major cuts proposed by previous Administrations, none of which were as serious as the reductions being considered now.

Those proposed reductions were leaked by OMB to the "Washington Post" no doubt as a trial baloon, to test the reaction of Congress and NIH constituents. OMB means business, however, and apparently set out deliberately to take on a congressional favorite to drive home the point that deficit reduction means that some treasured domestic programs are going to be hurt in a major way. **The Cancer Letter** has learned that NIH executives have been told to come up with plans for implementing a 10 per cent cut in the budget this year and another 10 per cent next for FY 1987. NIH appropriations for 1986 totals about $5.5 billion; the "Post" said that the initial NIH request to OMB for 1987 was about $5.9 billion. NCI's bypass budget request for each year was about $1.45 billion.

OMB also has proposed that some of the reduction be achieved by slashing indirect costs of grants from 26 to 20 per cent.

The "Post" reported that in a separate proposal, OMB is recommending that total spending on AIDS for FY 1987 be held to $213 million, about $30 million less than Congress has appropriated for 1986. OMB also may ask that AIDS funds go directly to the HHS assistant secretary for health, who would distribute it to the various agencies involved. Congress is not likely to go along with that one.

Another OMB proposal takes dead aim at the size of the NIH establishment. After whittling away in recent years on the number of positions authorized for NIH, cuts which have had serious impacts on patient care at the Clinical Center and on management of intramural and extramural research, OMB intends to ask for further reductions in positions. That almost certainly will stir up opposition in Congress. The Senate, in its version of the 1986 appropriations bill, included language ordering the Administration to restore the NIH cuts in full time equivalent (FTE) positions. That language did not survive the conference with the House, but the House probably would go along with resisting further cuts.

Under OMB's proposals, the RO1-PO1 payline probably would remain at about the same level projected under the $1.258 billion budget this yearl NCI is to receive $1.258 billion in fiscal—about 160. That would still leave a lot of good research unfunded.

Last year's budgetary fiasco which was caused by OMB's ill fated effort to "forward fund" a number of NIH grants and thus cut the number awarded from about 6,500 to 5,000, resulted in disparate paylines because of the different budget projections available in the fall cycle and those in the remaining two cycles. Last year, grants and centers reviewed in the first funding cycle were funded at lower priority scores than those that were reviewed in the latter two cycles.

The fate of OMB's NIH budget reduction proposals for 1986 may be known by the end of the month or in early February. They would take effect March 1.

NCI currently is providing only two or three months funding to grants that have to be paid, such as those with November start dates.

Under the balanced budget legislation, across the board budget cuts of $11.7 billion are expected for fiscal 1986 in order to achieve the targeted deficit level of $171.9 billion for the current fiscal year.

The legislation sets a deficit target of $144 billion in fiscal 1987; $108 billion in 1989; $72 billion in 1990; and $36 billion in 1990. The law is intended to achieve a balanced budget by 1991.

President Reagan signed the measure into law the day after its passage by Congress in mid December, but the final word on where the $11.7 billion in cuts will be made in fiscal 1986 isn't expected until late this month, or when the President's order imposing the cuts is issued Feb. 1. The cuts would go into effect March 1.

The initial calculation of program by program spending reductions mandated by the bill will be carried out by OMB the Congressional Budget Office. The report basically constitutes a draft order for the President's signature. If the OMB and CBO disagree, they are supposed to work out a compromise "so as to report a single consistent set of findings, along with each director's own finding" to the General Accounting Office, the law directs.

The GAO has the final review of the cuts. It will review, make any necessary changes and submit the report to the White House later this month. The GAO is scheduled to receive the draft report on Wednesday, Jan. 15, and must submit it to the White House on Monday, Jan. 20. President Reagan is obligated to implement cuts set out in the GAO report.

Reviewers will first determine what percentage of cuts are necessary to reduce spending by $11.7 billion in fiscal 1986, then decide what appropriations accounts the percentage should be applied against.

The bill lists programs that are exempted from the legislation, such as Social Security, Medicaid, Aid to Families With Dependent Children, and food stamps.

Some health programs such as Medicare, Veterans Health, Community and Migrant Worker Health and Indian Health programs will receive special protection from the cuts. These programs can be cut only 1% in FY 1986, and only 2% after that year.

Half of the mandatory cuts imposed in any year must come from the defense budget and the remaining half from domestic programs.

Each August, beginning this year, OMB and the CBO will submit estimates of the likely budget deficit for the fiscal year that begins Oct. 1. If the budget deficit exceeds the mandatory target by more than $10 billion, GAO will draft a plan for across the board budget cuts necessary to meet the target. The Presidential order imposing the cuts will be issued Sept. 1, but not become effective until Oct. 15, so that Congess can use the six week period to reach the target by enacting budget cuts or raising taxes, or both.

Court actions are being threatened over the law, with at least one suit challenging the constitutionality of the measure already filed.

COSTS OF ROSENBERG'S LAK AND IL-2 THERAPY MAY HINDER GROUP TRIALS

The high cost of treating patients with Steven Rosenberg's LAK (lymphokine activated killer) cell and recombinant interleukin-2 therapy was one of the main concerns of participants at a recent meeting between NCI staff members and representatives of cooperative groups.

A number of investigators interested in the technique pioneered by the institute's Surgery Branch chief met with Rosenberg and other DCT staff in December. The meeting was held to discuss the feasibility of and to develop plans for expanding the trials around the country.

Although participants seemed to agree that there are adequate clinical and technical skills to perform the treatment outside NIH, the costs of the therapy could prove to be one of the biggest obstacles in expanding research efforts.

So far, treatment costs run about $100,000 per patient treated with LAK cells and IL-2. Each cycle of the treatment costs between $30,000 and $50,000, and most patients require at least two cycles of therapy. That does not include the cost of IL-2, which has been provided free by Cetus Corp.

DCT has been having a number of meetings to discuss the logistics of bringing the adoptive immunotherapy to outside investigators and centers. Funding such trials is the main issue.

Following a presentation by Rosenberg on animal and clinical studies with the therapy, participants at the meeting had an opportunity to ask questions about the treatment that has received extensive media attention in recent weeks.

Rosenberg emphasized the need for persons interested in employing the technique at their institutions to visit NIH and see how the treatment and patients are managed at NCI. He also emphasized the toxicity associated with the therapy, such as weight gain due to fluid retention.

Cooperative groups interested in participating in studies with the regimen are in the process of submitting concepts to NCI's Div. of Cancer Treatment.

The two studies currently underway at NIH's Clinical Center and at the Frederick Cancer Research Facility with the therapy already had long waiting lists even before the therapy received front page headlines across the nation early last month.

So far, one institution has announced that it will begin clinical trials with the Rosenberg regimen. The Univ. of Wisconsin plans to start trials with the regimen in January.

NCAB HEARS CANCER IS A DISAPPEARING DISEASE, AND OTHER CONTROVERSIES

"Cancer is a disappearing disease."

John Cairns, professor of cancer biology at Harvard Medical School, using the historical analogy of tuberculosis to cancer, made that comment to the National Cancer Advisory Board last month in a discussion on cancer statistics. Pointing to the fact that cancer rates are starting down, he said that in "both morbidity and incidence, that is akin to the drop in tuberculosis" which was seen in the 100 years from 1860 to 1960. "That was not treatment, it was prevention and avoidance. When the environment gets better, you see a drop, particularly in the young."

The NCAB session was a seminar on cancer statistics, featuring Cairns; Emil Frei, director of the Dana-Farber Cancer Institute; James Holland, chairman of neoplastic diseases at Mt. Sinai School of Medicine; and Philip Cole, director of epidemiology at the Univ. of Alabama Comprehesive Cancer Center.

Cairns commented that trends seen in incidence studies in smaller countries, such as Norway and Scotland with populations, environment and lifestyles less varied than in the U.S., trends in incidence and mortality can be seen more quickly. The drop in Hodgkin's disease mortality in Scotland in the 1960s was apparent sooner than it was in the U.S. He noted that he rates for colorectal cancer "are drifting down, and the death rate from cancer in women age 30 to 40 is coming down a bit. And there has been a sharp drop in cervical cancer deaths since 1950, due to the Pap smear."

He insisted that the declines in incidence and mortality parallel those of tuberculosis since 1860 and that, like TB, "cancer is a disappearing disease."

However, he further insisted, "we need continued support for basic research." More money for NCI would "surely be at the expense of the rest of NIH. . . If basic research is to be plundered to support more (cancer) clinical trials, that would be a mistake."

(Ed. note: Cairns' premise, that increased funding for NCI would have to be at the expense of other institutes, is not based on historical fact. Overall since NCI's budget increased dramatically following adoption of the National Cancer Act of 1971, NIH's budget has gone up at least as much, percentage-wise. In fact, funding for the rest of NIH has increased at a somewhat higher rate than has NCI's in recent years. Cairns further ignores the fact that at least half of NCI's extramural budget supports basic research, and a substantial portion of the intramural activities involves basic research).

NCAB Chairman David Korn said that "the Board agrees on the need to support basic research. There is no division of opinion on that." But he did not agree that basic research has suffered because of NCI's support of clinical trials.

Cairns deplored the fact that, despite the knowledge since the 1960s that "cigarette smoking has been established as the major cause of lung cancer, few nations have made much of an effort to contain the further expansion of the tobacco industry. Unfortunately, there are huge financial incentives for nations to sit back and do nothing. The cigarette is a readily taxable commodity. In the U.S. it provides the federal and state governments with about $6 billion a year. More important (at least for the British government and perhaps also in the eyes of the U.S. government), smoking cuts down the bill for old age benefits because it reduces life span. At the price of a slight increase in costs for health care the current smokers in the U.S. will on the average each have saved the U.S. government about $35,000 in Social Security payments simply because they will on the average die sooner than nonsmokers. Most of the deaths occur after retirement and are not from cancer but from cardiovascular disease and chronic lung disease, the incidence of which is also raised by smoking. The loss of life span represents a total saving of some $10 billion a year over the next half century or so."

Cairns' presentation included material from his article in the November issue of "Scientific American." In that, he noted that "the conquest of the commonest of all lethal cancers (lung cancer) depends on the will power of governments and not on the skill of physicians or the ingenuity of scientists. Fortunately, the affluent and better educated are now smoking less than they used to. Because they tend to set the pace, the trend may eventually spread to the populatioin as a whole.

"For the other major cancers the issues are less clear cut. In order of descending numerical importance these are cancer of the large intestine, breast, prostate and pancreas. . . Within the U.S. it is possible to find certain groups of people for whom the death rate from cancer is only about half the average national rate. Surely this proves that most forms of cancer are preventable. . . Cancers of the cervix and liver are usually due to a viral infection, and each should be preventable by immunization. This could save 14,000 lives per year in the U.S. and perhaps as many as 500,000 in the world as a whole. The causes of most of the other important cancers are not yet known well enough for anyone to predict how or when they will be

prevented. But eventually they will be, because they do have causes that await discovery. . .

"No one knows what new forms of chemotherapy may be invented, or when they will be invented. While such discoveries are awaited, more effort should be directed to certain proven forms of screening and much more effort to prevention. It seems bad cost accounting for the federal government to subsidize chemotherapy of the common cancers of adults and not to subsidize screening of women for breast cancer. Worse, it surely is an act of folly to pour hundreds of millions of dollars every year into giving a growing number of patients chemotherapy while doing virtually nothing to protect the population from cigarettes."

Frei, who helped pioneer cancer chemotherapy at NCI in the 1950s and 1960s, had a more positive view of the impact of chemotherapy.

Treatment of acute lymphocytic leukemia involved three elements, all of which were needed to lift the cure rate from zero to 50 per cent in the 1960s—first, obtaining complete responses in a majority of patients; developing prophylactic therapy for the CNS sanctuary; and treatment during remission, Frei pointed out.

"In 1950, we expected 2,000 deaths a year from ALL," Frei said. "By 1980, there was a 50 per cent decline in the number of deaths. We had seen a 50 per cent cure rate in clinical trials in 1965, but did not see that nationally until 1980. In 1978 or 1979, we had in clinical trials disease free survival rates of 75-80%. The 50% decline is an underexpression of what is happening in centers.

"In Hodgkin's disease, with drug combinations such as MOPP, we went from 10% complete responses in 1970 to 70%. In testicular cancer, we went from 10% cure in 1970 to more than 80%. That's as close to a home run as you can get," Frei continued.

"With adjuvant chemotherapy, we have the example of the Gastrointestinal Tumor Study Group in its clinical trial of radiotherapy and chemotherapy now getting 70% cures, a significant difference... Now we are seeing neoadjuvant chemotherapy, with new strategies using chemotherapy initially on solid tumors. One objective is to stage reduce, to permit curative surgery or radiotherapy, and to get micrometastases earlier. One well kept secret is that head and neck tumors are responsive to chemotherapy. We are seeing 80-90% complete responses, and 85% of complete responders survive five years. With no response, the best five year survival, in the general experience, is 10-20%. All progress in chemotherapy is heralded by complete responses, and I think that's what is happening with head and neck cancer.

"With bladder cancer," Frei continued, there was no significant response from chemotherapy 10 years ago. Now, some combinations are getting partial responses of 60% and complete responses of 20-40%."

Frei offered "some selected conclusions: That curative chemotherapy exists; that disease free survival plateaus are being seen from five to 20 years; that chemotherapy is effective inversely related to age; that quality of life for cured cancer patients generally is good, and they do very well considering problems faced by patients with cardiovascular and other diseases; that the quality of life made possible by radiotherapy is a mega-advance; and that the marginal patient benefits from clinical trials even short of cure."

Holland, mentioning Cairns' emphasis on prevention, said, "it takes a long time to effect social changes. Two hundred ten years after Potts' finding (that chimney sweeps got scrotal cancer from exposure to soot), we're still fighting the effects of combustion, which is the cause of our most lethal cancer."

After referring to a clinical trial in which Cancer & Leukemia Group B compared CMFVP to CMF for adjuvant therapy of breast cancer, in which the five drug regimen has produced five year survival of 60% compared to 50% for CMF, Holland deplored the findings of a yet to be published survey in which 51% of physicians responding said they still are using CMF. "Fifty per cent of our doctors are a generation behind," Holland said.

Holland said the "third generation" CALGB study comparing CMFVP to CMFVP plus the combination of vincristine, adriamycin, thiotepa and halotestin (VATH) (**The Cancer Letter**, June 7, 1985) continues to show that the two combinations are significantly more effective.

"Clinical trials are not a futile undertaking," Holland said. Noting that mortality from cancer for those under age 30 has dropped significantly, that it is decreasing for those under 45 and has plateaued for those under 60, all due to improvements undertaken through 1975, "If you bring that up to 1985, I believe you would see major differences."

Taking issue with Cairns, Holland said, "I object to the contention that we are plundering basic research. We are bringing the fruits of their work to the benefit of cancer patients."

Board member Rose Kushner commented that at the consensus conference on adjuvant therapy of breast cancer last September, "all patients and physicians were encouraged to participate in clinical trials. Surely, you are not advocating that all patients use CMFVP."

"I believe whole heartedly in clinical trials," Holland said. "But we should not solidify through

women's magazines that tamoxifen is the end all in breast cancer treatment."

"I second that," Board member Gale Katterhagen said. "It is a misconception for physicians and women to believe that tamoxifen is the drug of choice." The consensus conference had recommended that tamoxifen be considered for postmenopausal, ER positive patients with positive nodes.

Board member William Powers asked Holland if he knew the number of physicians qualified to administer CMFVP and if he was advocating it for patients with less than four positive nodes.

"I don't know," Holland answered. "I'm disappointed that a majority of oncologists are using CMF when we know from solid clinical trials that CMFVP is better."

"I'm even more surprised that although the benefit from full doses of chemotherapy has been demonstrated, 50 per cent of patients are not getting full doses," Powers said.

Powers was referring to comments by NCI Director Vincent DeVita in recent public statements. "I was referring to histiocytic lymphoma," DeVita said. "Fifty per cent are curable with full doses, but only half are getting full doses. I suspect that in breast cancer, it is even worse. The Cooper regimen (CMFVP) is not terribly toxic."

Cole discussed what he said was "the major statistic that will determine the cancer experience in the next 30 years"—the advancing age of the population.

The life expectancy for white males born in the U.S. in 1900 was 48; for those born in 1984, it is 72, Cole said. "But in 1900, one third died early, and the rest lived to age 70."

A more realistic way to look at life expectancy: For those born in 1900 who reached age 40, they could expect to live another 28 years. Those born in 1950 who reach age 40 can expect to live another 31 years. Those born in 1985 who reach 40 can expect to live another 35 years, Cole said.

The years 1950-1970 "were a public health disaster," Cole said. During that time, Americans added only two years to their life expectancy. The big advances in the first half of the century occurred because of improved childhood survival. Now, the trend is based on "not saving children but saving adults."

If cancer incidence remains as it is now, Cole said, "by the Year 2000, it is irrevocable that 40% of the population will get cancer, not 30% as it is now, and 25% of us will die of it, rather than 20% as now. If we are to make a meaningful change on the impact of cancer, small improvements in treatment won't do it. We have to change the incidence."

Cole called for more emphasis on etiology and screening, increased public education efforts on avoiding contact with carcinogenic substances, legislation improving regulation and taxation related to cancer prevention, and more attention to the psychosocial aspects of cancer.

"We don't need more consensus on what's going on in the cell. We need better low technology, the distribution of care. We need to get the message across, don't smoke. Basic science is fine, but ask yourselves, how much has it contributed so far in therapy and approaches to prevention?"

Cole said he realized that most of those present would disagree with him, and he was right.

"Our first priority is basic research and always has been," DeVita said. "But the National Cancer Act directed us to apply what we have learned."

"I've learned to live with the conception that basic research is the only real research," Cole said. "To some, epidemiology is like mirrors. Of course, I recognize the importance of basic research. It's the keystone of all we do.'

"I've spent my life in pathology," Korn said, "and lately, God help me, as a dean (of Stanford Medical School). I think there is good research in epidemiology, in clinical research, and in what we regard as basic research. There is also a lot of garbage."

"It would be a mistake to cut any of our basic research effort," Board member Enrico Mihich said, "especially now with the explosion in knowledge. However, the time has come to implement, transmit to the field, what we have learned. The problem is limited funds. We may be now at the beginning of an era when we could use more money."

Bruce Chabner, director of NCI's Div. of Cancer Treatment, said he was disappointed in the recent survival statistics reported by the Surveillance, Epidemiology & End Results (SEER) Program.

"Particularly in the diseases in which major progress has been made, that progress has not been reflected in survival," Chabner said. He attributed that, to a large extent, to failure by many physicians to use chemotherapy even when its value has been clearly demonstrated.

"SEER can give us some information on the type of treatment being given," Chabner said. "I was shocked by what I saw." The SEER data indicated that only 60% of stage 3 and 4 ovarian cancer patients are receiving chemotherapy. Others: stage 3 testicular cancer, 64%; small cell lung cancer, 58%; stage 2 breast cancer—patients under age 50, 32%; over 50, 16%; and those over 50 getting

hormonal therapy, 8%; stage 2-4 diffuse histiocytic lymphoma, 61%.

Katterhagen challenged those figures. "We're part of SEER (in Tacoma), and I know that the data extraction done with SEER is not capable of tracking patients after they leave the hospital. Most ovarian cancer chemotherapy is started after the patient leaves the hospital. Unless SEER is tracking what's happening in the medical oncologist's office, that (information) is irrelevant."

"I was told that it did track to the doctors' offices," Chabner said.

John Young, chief of the Demographic Analysis Section in the Div. of Cancer Prevention & Control, said that SEER only collects first course data. "Even in the first course, a weak spot is our ability to pick up data outside the hospital. That is attempted, but some SEERs are better than others."

"SEER data are inadequate to form conclusions on patterns of care," Katterhagen insisted.

"You're right," Chabner agreed, "but they do give us an indication that there is a lag. ASCO (American Society of Clinical Oncology) is concerned and has decided to undertake a patterns of care study."

Chabner, citing NCI's treatment research budget which he said has remained level at 28% of the total for the last five years, including funds for AIDS treatment research, said "there is no trend to plundering basic research. To the contrary, treatment research has stimulated basic research. Cancer treatment research has been applied to other diseases. If anything, basic researchers are beating down our doors to apply what they have learned."

"An issue here is that technology that can be exported to the boonies has to be relatively low technology," Cairns said. "Only a small percentage of patients can receive treatment in highly specialized cancer centers. I would have thought that you would be pleased to have a low technology agent like tamoxifen."

"Tamoxifen is a subspecies of chemotherapy," Holland answered. "I'm not convinced that tamoxifen patients are cured. You are a pessimist. Chemotherapy can be given effectively anywhere by physicians properly taught."

Holland added a plea "to the journalists in this room. You can do a public service. Patients need to be encouraged to demand effective treatment. You do not need a university to apply effective cancer therapy."

Kushner said that she feels there may be "over emphasis on cure and saving lives. We older women would be happy for control and prolongation of life. All this talk about cure raises expectations and leads to making people think we've failed. I was glad to see tamoxifen accepted as worthwhile. Perhaps adjuvant chemotherapy for breast cancer is not more widely used because it is so expensive, like screening with mammography. Why hasn't tamoxifen been approved for adjuvant therapy yet by FDA? Three months after the consensus conference?" She noted that insurors will not pay for tamoxifen until it has been approved by FDA for marketing. "Tamoxifen costs $1 a pill."

"You may stipulate that you don't want to discuss cure, but I don't think you can stipulate that to the general population," Holland said. "We have the obligation to find a cure. I have no doubt that in my lifetime we will have cures for some cancers. As for screening, the most effective is breast self examination, and it is free. We need education efforts there. Mammography is a technological dinosaur. It is too expensive."

Board member Helene Brown had observed in one of Cairns' slides that the incidence of tuberculosis had increased during World War 1 and 2. "That was because resources were siphoned off for uses other than science. We are facing limits now, placed by an Administration with priorities other than mine. The rise of lung cancer is a deliberate intervention by tobacco companies to sell a product that is addictive and causes disease."

As for mammography, Brown said "it is heartbreaking that it is so expensive. In Los Angeles, it costs from $150 to $200."

DeVita noted that in Utah, special efforts have succeeded in reducing the cost of mammography to $36 per examination.

"I recognize that mammography can identify smaller tumors," Holland said. "But I think it woiuld be well worthwhile for NCI to let a contract, to a group using subprofessional women to teach breast self examination. It would provide a much higher yield."

Board member Richard Bloch said that NCI "has the tools to overcome" lack of state of the art information getting out to physicians. He was referring to PDQ (Physician Data Query), the computerized data base on state of the art treatment information and on type and location of clinical research protocols, available to physicians through two commercial networks and the National Library of Medicine.

DeVita said that Bloch's point is "until PDQ is available to the public, it won't put pressure on doctors to use it. That's a controversy we have gone over before. Some day we may have to address it again." PDQ was Bloch's idea and he contributed much of the money for the building where it is housed. The NCAB voted to restrict PDQ's use, as much as possible, to physicians, over Bloch's objections.

Board member Victor Braren commented that MEDIS, one of the two commercial

vendors for PDQ, had recently placed ads in "JAMA" which did not mention PDQ.

Susan Hubbard, director of the International Cancer Information Center, said that MEDIS did not have a contractual obligation to advertise PDQ.

"I misunderstood. I thought they did," Braren said. "The point is, we are still not getting the word to the practicing doctors."

NEW PUBLICATIONS

"Disorders of Hemostasis and Thrombosis, Principles of Clinical Practice," by Rodger Bick, $49.95, Thieme-Stratton, 381 Park Avenue South, New York 10016.

"What It Is that I Have, Don't Want, Didn't Ask For, Can't Give Back, and How I Feel About It," a 20 page illustrated booklet for teenagers with leukemia, Hodgkin's disease and other forms of cancer. Free from the Leukemia Society of America, 733 Third Ave., New York 10017, phone 212-573-8484.

"Alternatives," by Rose Kushner. New paperback edition is an update of the 1982 edition of "Why Me?", $4.95 plus $1 postage, Warner Books, 666 Fifth Ave., New York 10103.

"Official Proceedings and Series 3 Videotapes" of the 1985 Convention of the American Institute of Ultrasound in Medicine and the Society of Diagnostic Medical Sonographers held in Dallas Oct. 8-11. The proceedings is available to members at $9 and to nonmembers for $17. To purchase or obtain brochure on videotapes, contact the Publications Dept., AIUM, 4405 East-West Highway, Suite 504, Bethesda, Md. 20814.

The following are available from the American Chemical Society, 1155 Sixteenth St., NW, Washington, D.C. 20036:

"Polycyclic Hydrocarbons and Carcinogenesis," edited by Ronald Harvey, $74.95.

"Formaldehyde: Analytical Chemistry and Toxicology," edited by Victor Turoski, $89.95.

The following are available from Springer-Verlag New York, 44 Hartz Way, Secaucus, N.J. 07094:

"TNM-Atlas Guide to the TNM/pTNM-Classification of Malignant Tumors," 2nd edition, edited by B. Spiessl, P. Hermanek, O. Scheibe and G. Wagner. A UICC publication, $14.50.

"Advances in Immunity and Cancer Therapy," edited by P.K. Ray, $42.

"Recent Results in Cancer Research: Perioperative Chemotherapy," edited by U. Metzger, F. Largiader, and H.-J. Senn, $39.50.

"Psychological Aspects of Early Breast Cancer," by Colette Ray and Michael Baum, $24.90.

"Recent Results in Cancer Research: Peptide Hormones in Lung Cancer," edited by K. Havemann, G. Sorenson and C. Gropp, $48.50.

"The Interferon System," edited by F. Dianzini and G.B. Rossi, $49.50. Colects papers presented at the International Ares-Serono Symposium on the Interferon System in Rome in May 1985, Raven Press, 1140 Avenue of the Americas, New York City, 10036.

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. 20892. 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 NCI-CM-67881-72
Title: Primary rodent production centers
Deadline: Approximately Feb. 3

NCI is seeking organizations with the capabilities and facilities for producing large numbers of inbred rodents which are genetically sound and free of pathogenic organisms. To be considered for award of a contract, respondents should meet the following criteria:

1. The principal investigator and other key personnel must have experience and expertise in the production of highest quality inbred rodents; 2. A facility must be available at the time of contract award, capable of producing highest quality rodents at task specified levels; 3. organizational experience in pertinent areas of quality inbred rodent production including pedigreeing procedures, isolator production, etc. at a scale commensurate with task performance must be available.

It is anticipated that one award will be made for this effort. This represents a recompetition of an existing effort currently being performed by Charles River Breeding Laboratories.

Contract Specialist: Jackqueline Ballard
RCB Blair Bldg Rm 224
301-427-8737

The Cancer Letter _Editor Jerry D. Boyd Associate Editor Patricia Williams
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.