THE CANCER LETTER

Vol. 12 No. 19
May 9, 1986

Subscription $150 year North America
$175 year elsewhere

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New CCOP RFA To Encourage Cancer Control Research; Larger But Fewer Awards Are Likely

The new Community Clinical Oncology Program request for applications will encourage the CCOPs and their research bases to include cancer control research in their programs, along with their clinical trials efforts. NCI staff members

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In Brief

Lou Carrese, NCI Associate Director, Dies; Myers, Ransahoff Head Two New Organ Systems Groups

LOUIS M. CARRESE, 60, associate director for program planning and analysis at NCI since 1962, died of cancer May 2. Carrese made large contributions to planning for the systematic organization of NCI's Drug Development Program, and began planning in the 1960s for what ultimately became the Virus Cancer Program, out of which came recombinant DNA technology, oncogene research, and discovery of the AIDS virus. . . . **TWO NEW** organ systems groups authorized by the National Cancer Advisory Board are being established. James Karr, director of the Organ Systems Coordinating Center at Roswell Park Memorial Institute, announced the appointments of Eugene Myers, chief of the Dept. of Otolaryngology at the Univ. of Pittsburgh School of Medicine, as chairman of the Upper Aerodigestive System Working Group; and Joseph Ransahoff, director and chairman of the Dept. of Neurosurgery at New York Univ. Medical Center, as chairman of the Central Nervous System Working Group. Scientific administrators are Clement Ip for the UAS group and Harold Asch for the CNS group. Meetings this month will identify candidates for membership. . . . **MEDICAL RESEARCH** Investment Fund, new mutual fund formed to invest in U.S. and foreign health care and medical research firms, has two prominent oncologists as directors and four others on its advisory board. They are Earl Balis, head of the Laboratory of Cell Metabolism at Memorial Sloan-Kettering Cancer Center, president and director; and Roger Herdman, assistant director of the U.S. Office of Technology Assessment and former vice president of MSKCC, director. Advisors include Edward Boyse, who holds the William Snell chair in cell surface immunogenetics at MSKCC; Irwin Krakoff, chief of medical services at M.D. Anderson Hospital; John Laughlin, chairman of MSKCC's Dept. of Medical Physics; Charles Rubin, professor of molecular pharmacology, Albert Einstein College of Medicine.

CCOP Budget Held At $9 Million, Probably Cutting Total Awards To 50

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have been saying as much for weeks, but they made it official last week at a meeting of CCOP representatives and a subcommittee of the Div. of Cancer Prevention & Control Board of Scientific Counselors.

Recompetition of the CCOPs will include the same requirements as the first round, when 62 awards were made, for patient accrual into therapeutic protocols. Opening the door for cancer control research in the new round will necessarily mean that those CCOPs which are funded for cancer control as well as treatment protocols will have to get more money. NCI Director Vincent DeVita, hard pressed by the Gramm-Rudman cuts and other demands on the budget, has determined that the total CCOP budget cannot exceed its present level, about $9 million.

The inevitable result: the total number of CCOPs funded will drop, probably to around 50. Competition will be intense.

Nearly all of the present 60 CCOPs (one dropped out voluntarily, one was cut because of poor performance) have indicated they will join in the recompetition. Some of those are on probation, with one or two probably not in any condition to compete. However, there are a significant number of potential applicants who did not receive funding the last time. Some of those are considered by NCI staff to be very strong, with good chances of finishing well up in the review.

A cautionary note about the cancer control elements to be included: they must involve cancer control **research**. Proposals for outreach, education, rehabilitation, data management--any of the elements supported by NCI in the past under the cancer control umbrella will not be funded unless they involve research and can be demonstrated as good science.

Some examples cited by Robert Frelick, DCPC program director for CCOPs, include markers; dosage modification guidelines for various subsets of patients, particulary for age; the optimal way to follow patients; elements involved in early detection and early diagnosis. "The Div. of Cancer Biology & Diagnosis does basic research in markers, but getting the results of that research into clinical practice is something else," Frelick said. "New markers are coming along, and if they're good, we need to get them into use."

On early detection and diagnosis, Frelick noted that clinical oncologists do frequently interact with high risk groups, relationships that might be exploitable in cancer control protocols. Pain control is another prospect for cancer control research, since it is a factor which interests all clinical oncologists.

"We have to be careful that we don't get into a lot of mushy stuff," Frelick said.

Some cooperative groups already are doing cancer control research. Frelick cited as an example the Cancer & Leukemia Group B study being done under the direction of Jimmie Holland, head of the psychiatric service at Memorial Sloan-Kettering Cancer Center. That study involves long term followup of patients cured of Hodgkin's disease and leukemia, looking at long term toxicities and other factors.

Frelick believes that although increasing the size of CCOP awards to accomodate cancer control research could result in fewer awards now, it could help expand the program in the long run. "If we can demonstrate that we've got a better way of doing things (namely, cancer control research), I think it would help us to better compete for cancer control money."

Frelick emphasized that CCOPs and research bases, in their applications, do not have to come up with specific protocols for cancer control research, but "they must show their potential and their interest. They have to show their ability to do the studies they say they want to do."

Another new factor in this round of competition is that the research bases--cancer centers and clinical cooperative groups--will have to submit their own applications in order to be eligible for work with CCOPs. Only those approved in the review may be used as CCOP research bases. First requirement is that they be NCI funded organizations--groups or centers. Frelick said that while it might be possible for a recently disapproved or unfunded group or center to be approved as a CCOP research base under special circumstances, that probably will not be easily done.

Review will be by ad hoc committees as it was the last time, with the difference that the committees now will have to include persons capable of reviewing the research bases. The schedule calls for release of the RFA in mid-July, deadline for applications in October, review in January and awards in June, 1987.

FCRF Recompetition Involves History That Is Intriguing, Controversial

The massive recompetition of NCI's five contracts for the operation of the Frederick Cancer Research Facility, which will take a bite of about $45 million out of the institute's budget, involves a variety of possibilities which could add further to the intriguing and sometimes controversial history of the facility. Consider:

*A foreign company quite possibly could end up with all three of the contracts, the lion's share of the operation, which are open to any firm.

*A small business could end up with all five. Although that is an unlikely possibility, if it did happen, the successful company would not be able to repeat that feat five or seven years from now, when the new contracts expire, because it would not be a small business then (average annual gross for three preceding years not exceeding $7 million).

*A university could win all three of the contracts not set aside for small business. In the previous competition, universities competed only for the basic research contract, but there is no reason why they couldn't go for the big operations and support contract and the animal production job.

*Commercial firms winning the four nonresearch contracts will have their profits determined through the award fee system NCI established in 1972, when the first contract for the entire operation went to Litton Bionetics. The basic research portion of those first contracts with Litton was excluded from that cost plus award fee plan, because of the difficulty in determining just how to assess the value of the performance of scientists performing basic research. For the rest of the work, and for the four nonresearch contracts awarded five years ago, profits were paid from a pool set aside as the maximum amount available for profits for each contract. The actual payments were determined by NCI staff assessing the performance of each contractor every six months.

That system is not possible with a university, or any nonprofit or not for profit institution. If any of the nonresearch contracts lands with one of those types of organizations, it would result in the usual type of contract award.

Litton Bionetics, which has had the basic research contract for the last five years, was broken up and sold by its parent, Litton Industries, last year. A Netherlands firm, Organon Technica, purchased that portion of the company which held the Litton contract. The subsidiary's name now is Bionetics Research Inc., and it intends to compete for the research contract, and possibly for some of the others as well.

All of the incumbents, in fact, intend to try to retain their present contracts--Program Resources Inc. for the $35 million plus operations and support contract, Harland Sprague Dawley for the animal contract, Information Management Services for computer services and Data Management Services for the scientific library.

The latter two, with the small business set asides, still qualify for that part of the competition, since their gross revenue has not averaged over $7 million a year. If one of those, or any other small business, lands the operations and support and/or research contracts, their gross, of course, would put them over the $7 million, disqualifying them for the next round.

"Wouldn't that unfairly penalize a small business, for being successful?" **The Cancer Letter** asked a Small Business Administration representative.

"That's what this program is all about," he replied. "We helped them get their start. "If they succeed and get big, we've done our job, and they can go on from there."

During the 1940s and 50s, Ft. Detrick, located in Frederick, MD, about 25 miles northwest of Bethesda, was the center of the Army's biological warfare activities. President Richard Nixon decided in 1972 to end that work and was persuaded to turn the facilities, which included a number of laboratories and animal holding buildings, over to NCI. The National Cancer Advisory Board strongly urged NCI to include a basic research element in the operation, under the theory that some science would enhance the other work performed there.

The research is peer reviewed by the nongovernment, FCRF Advisory Committee. When space at the NIH campus became a problem, several NCI labs were moved to Frederick. NCI also closed out the labs it was operating under contracts with commercial firms in the Washington area and relocated some of them at FCRF. Production of some viruses, anticancer drugs and biological agents has also been carried on there.

CTEP Clinical Trials Proposals Reshaped By Discussion; BSC Next

Anyone with an interest in cancer clinical trials has to be intensely interested in the proposals put forth by NCI on how to address problems facing its clinical trials programs (**The Cancer Letter**, April 11, 18, 25, May 2). Several of the interested participants had an opportunity to comment, and those comments have helped reshape the proposals drawn up by the Div. of Cancer Treatment Cancer Therapy Evaluation Program staff.

At the heart of CTEP's proposals is what the staff feels is probably the most important need--a system to establish national priorities in determining which trials should be undertaken. CTEP's suggestion: a strategy committee which would meet regularly, assess the opportunities and needs, and assign priorities to them. Cooperative groups would initiate protocols within the framework of those priorities.

"The problem is how do we set up a priority system that really does prioritize, without ending up being wimpy?" CTEP Director Robert Wittes asked. He noted that selection of strategy committee members would be an issue.

Sydney Salmon suggested that CTEP should make the selections from among the members of the Div. of Cancer Treatment Board of Scientific Counselors, the cooperative groups, and clinical cancer centers, among others. It should be a standing, chartered committee, with some members appointed for long terms, others rotating off on shorter terms.

"You're already doing this to some extent," Lawrence Einhorn commented, referring to selection committees of the groups which meet once a year on each disease.

"What should be the nature of the committee's actions, advisory or mandatory?" Wittes asked.

"We don't want legislation, or a mandate," Einhorn answered. "We do want advice."

Salmon observed that the NIH consensus conferences "sometimes come out with recommendations that are not mandatory. They set up the conference, provide information and then see what happens."

"I think we all agree that it shouldn't have the force of legislation," Wittes said. "But that leaves the question, how does one deal with a suggested list?" He answered the question by saying that the basis should be "a flexible relationship." Advice could be overridden by issues such as quality assurance, individual and group loyalties, long term followup, administrative complexities within institutions, and disruptive competition. "We need advice on how to set up a system that has this built in, which can be used when we need it," Wittes said.

Comments on various other issues:

Todd Wasserman--"Some duplication for end points is good; if it's just imitation, that's bad. A successful trial may not mean successful therapy. Rapid accrual is important but that doesn't necessarily mean you will get rapid end point analysis."

Marvin Zelen--**"There is a surprising amount of unanimity here that we have to eliminate the 'free agent' concept, but I'm concerned about long term followup.** A variety of funding models are being used now. Each group should have flexibility in which model it would use. It is important that disease committee chairmen of the groups meet regularly. CTEP should take whatever steps are necessary to encourage intergroup communication. We need to avoid the problem of, 'I thought of it, you do it.' When that happens, it won't get done."

Rodger Winn--"In the past, community oncologists have been second class citizens (when they participate in clinical trials). Now, with the Community Clinical Oncology Program and the Cooperative Group Outreach Program, their participation is equal to that of university based investigators. The recent consolidation of cooperative groups has caused concern, that it is a step backward. I urge NCI to find ways so funding is not capricious and inconsistent. I hope we do not see a diversion of CCOP and CGOP funds. We should protect the integrity of community participation."

B.J. Kennedy--"The national groups evolved because of the advent of medical oncology, so they are seen as a medical oncology movement. But they do now include all modalities. The work of cooperative groups, being peer reviewed and with separate grants, is seen as science. If the system is changed so that payment is just by patient accrual, groups would lose that extremely sensitive position. I highly encourage you to keep institutional, peer reviewed grants."

Brigid Leventhal--(In discussing mechanics of reimbursement to investigators through the proposed systems involving payment directly to physicians for patient accrual, and investigators working for more than one

group) "How do you reimburse when a group gets together and decides not to do a study?" Through the group's core grant, she was advised. "The point is, we have to be careful, that we're not just passing out pain pills. We must make sure that what we're doing is good science, with good planning."

Wittes--(On indirect costs involved in the proposed subcontracts between groups and investigators)"You would not be bound by federal rules on negotiating indirect costs with each institution."

Leventhal--"My institution (Hopkins) won't accept lower indirect cost payments from other sources because the government would use that in its negotiations."

Mark Nesbit--(On Wittes' gloomy assumption that NCI and DCT will not be getting significant increases in appropriations in the foreseeable future)"I'm disappointed that we all accepted that. It is inappropriate. There should be attempts, by you and by all of us, to get more money. CTEP should try to get more money from NCI. It bothers me, that the same amount we spend on clinical trials is spent by the government in one week in the Mediterranean or Central America."

Wittes--"I tried to speak with Caspar Weinberger about getting troops out of Central America, but he wouldn't return my call." More seriously, "We have decided it is not fruitful for us to go that route. We prefer to discuss improving the system. NCI has other priorities. There is a big commitment to fund basic research in a major way. Drug development has already been cut drastically. You can give us 50 lashes for not doing a better job of advocacy (in competing for funds within NCI), but after we lick our wounds, we would be back telling you we don't have any more money."

Carl Kardinal--"Community programs represent 40% of patient accrual. If the cooperative groups are restructured to only two or three major groups, communities may be playing less and less of a role."

Wittes--"I can't see any system that will narrow down the number of groups that drastically. . . It seems to me that community physicians fit in the way everyone else does. The major role of community physicians is putting patients into clinical trials. They are critical to accrual. Groups have to have their participation. Physicians in communities are on group committees, involved in group decisions, on the same basis as everyone else."

Salmon--"In the core grants to groups, can there be some developmental funds included? Is it possible to negotiate that?'

Wittes--"It is probably not possible at noncompeting times. If we did that, we would have to renegotiate it away from someone else. More likely, that can be done at competition time."

Summarizing what he felt was the consensus of the discussion, Wittes said:

1. On per case reimbursement, it should not replace institutional grants but may be acceptable if superimposed on a grant based system. Groups should have flexibility in deciding how the per case system should work for them. Some institutions might be supported by grants and others by subcontracts with groups.

2. On strategy committees (establishing national priorities), this is acceptable in principle but they can't be used to dictate science. Selection of members is an issue that needs to be worked out. They would include broad representation of clinical trials groups. They would be advisory to CTEP as well as to the groups. CTEP has to do a better job of communicating information. They would not deal with phase 1 or phase 2 studies.

Although a majority of participants in the meeting (not counting NCI staff) favored retaining the present system with only some "fine tuning," they were willing to consider some major changes.

During the next few months, NCI staff will be working at persuading ayone who will listen to go along with at least some of their proposals.

The various issues and proposals will be presented to the DCT Board of Scientific Counselors at its May 29-30 meeting, with two hours set aside on the agenda for that discussion. It will be brought up again at a meeting of cooperative group chairmen, tentatively set for June 30. There may be other meetings before the fall meeting of the DCT Board.

At that time, Wittes and DCT Director Bruce Chabner would like to get an up or down decision from the Board on any changes or modifications still surviving. If Board members, or a consensus of cooperative group members, feel they need more time, NCI would let it go over into next year. But NCI executives believe that changes, if any, should be implemented no later than fall of 1987.

AIDS Drug Discovery Groups RFA Draws 20 Applications From 70 Labs

NCI has received 20 applications in response to an RFA issued in December for national cooperative drug discovery groups for the treatment of acquired immune deficiency syndrome. The applications involve more than 70 laboratory programs, John Venditti, chief of the Drug Evaluation Branch in the Div. of Cancer Treatment's Experimental Therapeutics Program, told **The Cancer Letter.**

NCI has set aside $3 million for first year funding of the groups. The institute expects to make four or five awards for the drug discovery groups, which will be patterned after DCT's successful National Cooperative Drug Discovery Groups for cancer therapeutic agents.

Review of the applications will not be completed until June, after the spring meeting of the National Cancer Advisory Board. In order to fund the groups by Sept. 30, NCI will send results of the review to NCAB members by mail.

The five year awards will be made in the form of cooperative agreements, to be jointly funded by NCI and the National Institute of Allergy & Infectious Diseases. The groups will be directed toward the preclinical discovery of effective and curative treatment of AIDS. Scientific approaches may range from interference with infecting virus replication or function to the maintenance or restoration of immune responses.

The RFA is one of several related to AIDS drug development issued by NCI and NIAID.

The two institutes have received 24 applications for basic studies on the development and assessment of retroviral vaccines. Of the 24 applications reviewed, 19 have been approved. Seven of the applications have been assigned to NIAID, and 12 to NCI. These grants will be administered by the Div. of Cancer Etiology.

The applications will go before the NCAB in May, Padman Sarma, program director for RNA virus I studies, told **The Cancer Letter.** While NCI has set aside $1.25 million and NIAID $750,000 for first year funding of the project, Sarma said that the institutes still could have some money left over, depending on what payline is established. Priority scores for the applications range from 127 to 385.

DCT's Board of Scientific Counselors last fall approved AIDS concepts totaling $13 million (**The Cancer Letter** Oct. 11). Another project approved is a $3 million per year project for the preparation of investigational dosage forms for AIDS treatment. The agents will be chosen by a joint NCI/NIAID Drug Selection Committee. The two institutes will also provide funds of approximately $1.5 million per year for three year projects for preclinical toxicology and pharmacology of drugs developed for AIDS and related illnesses.

Fox Chase, US Healthcare Conduct Joint Cancer Screening Program

A joint screening program by Fox Chase Cancer Center and the health maintenance organization US Healthcare will provide free screening for breast and colorectal cancer to 120,000 age eligible members of the HMO in Pennsylvania and New Jersey. Women who are 40 and over will be eligible for breast cancer screening with mammography and men and women 50 and over will be eligible for colorectal screening.

Through its sponsorship of the US HEALTHCHECK screening program, US Healthcare becomes "the first major health care plan to pay for screening mammograms on a periodic basis," the company said. Fox Chase medical and cancer control staff have developed guidelines and standards, educational materials and data collection and tracking systems for the project.

Under the program, eligible members of the HMO are entitled to receive mammograms and Hemawipe at home colorectal cancer screening kits at no cost. Members will receive news of the screening program via special mailers containing information on mammography. breast self examination and colorectal cancer testing. In order to participate, members return an assessment form.

To date, the HMO has committed nearly $1.5 million to the project. The firm says the program represents an "unprecedented cooperative effort between a cancer center and an HMO to detect two major cancers, breast and colorectal, in their earliest most curable stages."

The project also combines important services with a major research study, it said. "This study provides an opportunity to learn whether applying these methods to a large, defined population will result in significantly lower cancer mortality, and can be a cost effective way of detecting cancer."

US HEALTHCHECK will standardize the delivery of mammography by requiring all mammography vendors to meet quality standards for equipment and staff, and the consistency of their system for interpreting mammography results. Primary physicians in the HMO will receive specially designed handbooks on breast and colorectal cancer screening and on the medical followup of any person with positive findings. MDs may also attend workshops and seminars at Fox Chase in order to sharpen their cancer screening and detection skills.

In addition to the potential for reducing cancer death rates from the two cancers, the program has the potential to lower area health care costs for certain procedures such as mammography and colonoscopy by capitating payments to vendors or MDs while increasing system wide volume.

Mobile mammography screening, another joint project, will tie in with the program and begin shortly. The van, which is jointly owned by US Healthcare and Fox Chase, will be used in addition to area radiologists. The van will be used in employee sites and areas in which there are no convenient, approved radiology offices. Primary physicians who want to offer the service to their patients will be served as well. Women who are not members of the HMO will be eligible to use the van either by paying a fee or by having their employers pay for mammogram screening for all eligible women in their companies. In addition to state of the art equipment, the van features videotapes and educational materials on mammography and breast self examination.

US Healthcare and Fox Chase Cancer Center began their first joint program a year ago with the start of the Cancer Consultative Service (CCS). Under CCS, primary physicians from the HMO can recommend that any of their diagnosed HMO cancer patients come before a multidisciplinary panel of cancer specialists. The patient and family then meet with the panel for a full review of the case and discussion of treatment recommendations. The panels consist of three or more experts, usually members of the Fox Chase medical staff, with special knowledge of the patient's specific cancer type. In more than 40% of the cases seen by the panel, patients leave with changes in their treatment, reflecting up to the minute knowledge and treatment, the company said. There is no cost for the service to the patient or physician.

National Center For Nursing Research Moves Into Offices On NIH Campus

The new National Center for Nursing Research moved into offices on the NIH campus in Bethesda this week. The move involved the Div. of Nursing of the Health Resources & Services Administration, in accordance with the Health Research Extension Act of 1985 that created the new center. The House report for the bill stated that "the committee intends that the nursing research activities conducted by the Div. of Nursing in [HRSA] be transferred to NIH."

While much of the policy matters of the new center remain in the air, the center does have an acting director, Doris Merritt, a special assistant to NIH Director James Wyngaarden. Research training and research resources officer in NIH's Office of Extramural Research & Training, Merritt was named acting director of the center last week. She was named project leader for the center's implementation in January (**The Cancer Letter,** Jan. 10).

According to the legislation establishing the center, its general purpose "is the conduct and support of, and dissemination of information respecting, basic and clinical nursing research, training and other programs in patient care research."

Specific authorities granted the director of the center allow the director to "provide research training and instruction and establish, in the center and other nonprofit institutions, research traineeships and fellowships in the study and investigation of the prevention of disease, health promotion, and the nursing care of individuals with and the families of individuals with acute and chronic illnesses." The director may also "provide individuals receiving such training and instruction or such traineeships or fellowships with such stipends and allowances ...as the director determines necessary."

The director may also "make grants to nonprofit institutions to provide such training and instruction and traineeships and fellowships."

The bill also calls for the establishment of an advisory council to consist of ex officio members and up to 18 members to be appointed by the HHS secretary. Two thirds of the members will be appointed from among leading representatives of the health and scientific disciplines including public health and the behavioral or social sciences.

At least seven "shall be professional nurses who are recognized experts in the area of clinical practice, education or research. One third of the members will be from the general public, to include leaders in the fields of public policy, law, health policy, economics and management."

Ex officio members will consist of the HHS secretary, NIH director, the center's director, the chief nursing officer of the Veterans' Administration, the assistant secretary of defense for health affairs, the director of the Div. of Nursing of HRSA, or the designees of such officers.

Clinical Nurse Scholar Applications Being Sought By Robert Wood Johnson

Applications for clinical nurse scholars are being sought by the Robert Wood Johnson Foundation. Conducted at three universities, the program consists of two-year fellowships that are full 24 month appointments.

The fellowships consist of concentrated experiences in patient care and clinical research and exposure to issues in hospital management. Programs will be individually tailored to help the scholars acquire advanced expertise in assessment and management of nursing care problems and the application of research methods appropriate to the identification of clinical nursing problems and the design and conduct of clinical studies. The scholars will also become involved in the management processes of their chosen training institution.

Grants will cover stipends equivalent to a scholar's current salary up to a maximum of $80,000 for the 24 month period, plus fringe benefits and a round trip travel and moving allowance, within a maximum of $1,000.

The program is conducted at the Univ. of California (San Francisco), the Univ. of Pennsylvania, and the Univ. of Rochester. Examples of potential areas of study in oncology at UCSF include studying the development and treatment of cancer across the life cycle. Clinical research is currently being conducted on the influence of age on treatment outcomes, disease response and psychosocial measures in patients receiving radiation therapy, and the psychophysiological impact of chemotherapy on the family unit.

At the Univ. of Rochester, scholars interested in oncology may become involved with research in areas such as the psychological and physiological responses to diagnosis and treatment.

Up to nine scholars will be selected annually. Scholars will be selected from registered nurse applicants who hold a bachelor's degree or higher in nursing, an earned doctorate degree (or expectation of receipt of the doctorate prior to the start of the fellowship), and a commitment to academic careers in nursing, combined with clinical practice and research in teaching hospital settings. Eligibility is limited to permanent residents of the U.S.

The deadline for submission of applications for the 1987-88 academic year is July 1. Inquiries and requests for applications should be addressed to Rheba de Tornyay, EdD, director, Robert Wood Johnson Clinical Nurse Scholars Program, School of Nursing, SM-24, Univ. of Washington, Seattle 98195, phone 206-543-6227.

Blochs To Sponsor "Fighting Cancer Rally" June 1 In Kansas City

Richard Bloch, the National Cancer Advisory Board member who was cured of lung cancer only after a horrifying experience of trying to find a physician who would administer curative therapy, is now devoting most of his time and much of his fortune to spreading the word that cancer is curable.

The latest effort by Bloch and his wife, Annette, is what they call "the first annual Fighting Cancer Rally." It will be a two hour rally, at Brney Allis Plaza, in Kansas City, June 1, starting at noon. Persons who have had cancer, their families and friends, and health care professionals are invited to participate.

"This will visually demonstrate to the entire community that life does go on after a diagnosis of cancer," the Blochs said in an announcement of the event, which is free. Music and refreshments are planned.

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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.