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DCPC Board Approves New CCOP RFA Following Addition Of Public Health, Education Components

A concept for the recompetition of NCI's Community Clinical Oncology Program has been approved by NCI's Div. of Cancer Prevention & Control Board of Scientific Counselors. The concept, which would require control research efforts by

(Continued to page 2)

In Brief

Last Two NCAB Choices Named; Hellman Heads ASCO, Sartorelli Named President Of AACR

LAST TWO appointments to the National Cancer Advisory Board will go to Irene Pollin, Univ. of Maryland sociologist, and Louis Sullivan, president of Morehouse School of Medicine in Atlanta. President Reagan had not officially announced the appointments by press time this week, but **The Cancer Letter** learned that they had been informed they will fill the last two vacant seats on the Board. Pollin is a counselor in the Maryland crisis intervention program. She is the wife of Abe Pollin, owner of the Washington Bullets basketball team and Washington Capitols basketball team. Sullivan, an MD, is a hematologist and has been serving on the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control. . . . Other new NCAB members previously announced are Nancy Brinker, John Durant, Bernard Fisher and Phillip Frost. . . . **NEW OFFICERS** elected at last week's meetings of the American Society of Clinical Oncology and American Assn. for Cancer Research: Samuel Hellman, president of ASCO, the first radiotherapist to head that organization; B.J. Kennedy, president elect; Stephen Schimpff, reelected secretary-treasurer; and Robert C. Young and Bernard Fisher, new members of the board of directors. For AACR, Alan Sartorelli is the new president; Enrico Mihich is the vice president and president elect; and Robert Handschumacher was reelected secretary-treasurer. New members of the board are Margaret Kripke, Brigid Leventhal, Larry Loeb and Harold Moses. . . . **JOHN LASZLO**, professor of medicine at Duke Univ., will join the staff of the American Cancer Society June 1 as vice president for research. He will replace Stefano Vivona, who will become vice president for research systems and analysis. . . . **ROBERT HADSELL**, chief of the Reports & Inquiries Branch of NCI's Office of Cancer Communications, will leave next month to become director of public affairs at Fox Chase Cancer Center.

CCOP Cancer Control May Include Primary Or Secondary Prevention

(Continued from page 1)
all CCOP awardees, was rejected by the board at its May 8 meeting, but was approved the next day following the addition of modifications to the concept the night before. Only one member, Jerome DeCosse, opposed the modified concept, with two members, Kenneth Warner and Mary Claire King, abstaining. The board had voted six to five (with three abstentions) on Thursday to defer action on the concept until its next meeting in September due to concerns about the control component of the awards.

Following the vote, however, Jerome Yates advised the board that the action could create a hiatus in the program and jeopardize the continued funding of existing CCOPs in the period before new awards could be made. Yates heads DCPC's Centers & Community Oncology Program.

The original CCOP awards were scheduled to expire in 1986, but were extended for another year in order to allow completion of a comprehensive evaluation of the program. Last May, the National Cancer Advisory Board approved the extension of the current CCOP awards, but cautioned that it would be unwilling to okay another administrative extension of the program (**The Cancer Letter,** May 17, 1985).

The DCPC board's approval of the concept will allow NCI staff to remain with its planned schedule for recompetition of the award with no break in funding. The staff will take the concept to the NCAB next week. NCI plans to issue the new RFA in mid-July, with applications due in October, reviews scheduled for January and awards to be made in June, 1987.

Major concerns of the DCPC board centered around the requirement for cancer control activities by CCOP applicants. The RFA will require participating CCOP physicians to enter patients onto both treatment and cancer control research protocols approved by NCI through one or more NCI funded research bases (cooperative groups or cancer centers) or public health departments having cancer control expertise. According to the concept statement, cancer control research will include primary prevention, secondary prevention, patient management, rehabilitation and continuing care.

"Although secondary prevention through the early detection of cancer in high risk populations will be easier to accomplish in most of the existing multi-institutional clinical trial groups, primary prevention studies (chemoprevention and dietary studies) in high risk populations should receive increasing attention with the growth of this cancer control effort," it advises. "Because of the need for health education and social science expertise for prevention interventions, the research base will be expected to identify appropriate professionals to assure there is quality control of these interventions in the CCOPs."

The inclusion of public health departments and the requirement for health education and social science input were added based on recommendations by board member Lewis Kuller.

Other concerns raised by the board included the availability of cancer control protocols, and the short time period applicants will have to devise control strategies.

Yates stressed, however, that NCI will judge applicants largely on their potential to conduct control activities. "The only people we're concerned about are those who don't want to do cancer control," he said, assuring the board "We're not going to have unrealistic expectations" of applicants.

Discussing the new RFA at the American Society of Clinical Oncology meeting last week, DCPC's Program Director for CCOPs Robert Frelick explained that NCI is interested in the potential of both research bases and investigators to do cancer control research. "It's the potential--the interest and adequate population," he said. "We're going to require all applicants to indicate interest and ability to do cancer control research." NCI has not yet decided where review of the control portion of the applications will take place. The institute could establish a separate review committee, he indicated.

Frelick added that "the surest way of trying to ensure continuity in this program is to show it can also do cancer control research." While funding has remained at $9 million, the number of awards will drop to 50 as compared to 62 in the first round. About 200 applications are expected.

Another new aspect of the RFA will be the assignment of credits for each study on the basis of the complexity of the intervention, data management requirements and followup. NCI proposes to standardize the credits CCOPs receive for patient accrual. Currently some

CCOPs are getting more credit for work in one research base than another. NCI is considering the use of a credit system in which CCOP credit per patient enrollment in simple treatment trials would receive less than one credit, usual trial would receive one credit and complicated curative trials would generate more than one credit. Cancer control studies would also be credited on their basis of complexity.

CCOPs would be required to accrue 50 credits per year in treatment protocols. The number of required credits for cancer control protocols would be phased in, with 20 credits required in the first year, 30 in the second, and 50 in the third year of the award. Cancer centers would also be required to have 50 credits per year for treatment protocols. "We are very well aware that only a few will be able to meet these requirements," Frelick said. "We may find a new way [for cancer centers] to develop relationships with communities."

In addition to expressing concern about limited availability of control protocols, board members suggested that the RFA should contain more examples of control activities to be carried out by CCOPs. The draft RFA listed examples of potential research projects in pain management, tumor markers, premalignant lesions, and cancer management in selected populations.

NCI staff had not wanted to provide detailed examples of activities that were considered for inclusion in the RFA out of concern that board members interested in applying for the award would have an unfair advantage in their own applications by the advance look. Following the vote to defer action, however, a list of examples was presented to the board. CCOPs will not be expected to be involved in large normal population studies.

According to the proposed examples of cancer control research, "the implications of the proposed studies for both the research bases and the CCOPs should be presented." The paper advises that "review of the cancer control aspects of these applications will be very difficult unless some yardstick for judging participation potential for the CCOPs and scientific feasibility allows some comparative judgments among the applicant pool. Having both the CCOPs and the research base address one or two model studies for the purpose of the application and also providing other studies that they select may offer the opportunity to assess the probable ability of future performance necessary for allocating the funding. Both types of applicants should address their ability to access the population necessary, the organizations or professionals required to carry out the protocol and the time necessary to reach a conclusion to the study. Costs in excess of those generally associated with the more routine protocol studies should be considered."

Examples of possible projects are:

* Evaluation of tolerance to chemotherapy by special populations such as elderly cancer patients and differences in ethnic and racial groups. "Differences in hereditary and metabolic factors, disease risks, and comorbid conditions may influence the response and survival benefit of chemotherapy. Companion studies to existing protocols are needed to determine the metabolism and toxicity of chemotherapeutic agents in different subgroups.

* Tumor markers. "New markers that have passed basic science development need to be tested in diagnostic trials in order to ascertain their sensitivity, specificity and clinical utility. Markers could be evaluated for use in following established cancer patients and possibly for early detection."

* Continuing care and rehabilitation in order to develop strategies for optimal outcome. Research protocols could be designed for specific tumor sites or problems. For example, protocols could consider exercise regimens for the postoperative patient, maxillofacial prosthesis usage or self help activities employed by patients to adjust to changes in body image; or long term effects on employment or role functioning. These studies could be accomplished in part by adding continuing care and rehabilitation protocols to existing treatment protocols or as companion studies, which would reduce the costs associated with such endeavors."

* Pain management. "Research studies that evaluate the efficacy of pain management interventions are needed. Examples follow: studies to evaluate the various approaches to improving the knowledge and utilization of state of the art pain management by community based health care practitioners; comparisons of the relative merits of short- and long term acting narcotic preparations or other new agents; or research to determine the best new use of new technological approaches to drug delivery, such as devices to provide continuous subcutaneous administration."

* Research on interventions to change physicians practice patterns. "Tumor registries and other data sources in hospitals such as discharge abstracts, and ACOS audits represent an underutilized resource for documenting patterns of care. Studies can be designed using such data bases to assess the state of cancer patient management and test a variety of interventions to change physician practice patterns where indicated. Examples include direct feedback at tumor conferences, disease specific educational programs, and hospital regulatory changes. Effectiveness would be evaluated by examining changes in cancer patient management over time.

* Premalignant lesions. Interventions to ascertain whether progression of precancerous lesions to invasive cancer can be reversed through intervention can include chemopreventive agents, dietary changes, behavioral modification, or other techniques designed to stop progression. Studies should focus on lesions likely to progress and interventions can be directed to patients with previous cancer such as head and neck, persons with dysplastic nevi, women with

atypical hyperplastic lesions of the breast, patients with pre-leukemia, or with other precancerous conditions.

* Early detection in high risk individuals. Diagnostic modalities that can be used for early detection include physical examination, flow cytometry, mammography and endoscopy. Studies are needed to evaluate the efficacy and cost effectiveness of early detection in individuals at high risk for cancer. Interventions could be targeted for specific groups such as industrial workers, minority groups, or for specific cancers such as lung, bladder or prostate.

* Screening for colon cancer. Because existing methods for detecting occult blood are relatively non-specific, studies are needed to evaluate other methods for detecting occult blood and the cost effectiveness of screening in high and low risk groups. Other tests for early detection need to be developed and evaluated.

* Evaluation of interventions for prevention and early detection. There has been virtually no structured evaluation of the effectiveness of cancer control activities conducted by local community groups, including the ACS, local health departments and hospitals and cancer centers. A CCOP working with a regional group or cancer center could conduct research on the particular methods and interventions used and their effectiveness in achieving the stated objectives. The ultimate outcome would be the development of models (or interventions) for more effective cancer control activities at the local level.

* Smoking prevention. Community physicians and nurses may wish to cooperate with school health educators to institute and/or evaluate ongoing programs for school pupils especially for those in the first eight grades. Programs should be designed to reduce future smoking incidence, possibly as compared to a similar population without the program. It might be desirable to study the relative value of programs focused on smoking prevention as compared to general health programs on decision making. The institution of a method to evaluate results, such as an effect on parental or sibling smoking, might be the major contribution of the CCOP in addition to underscoring the credibility of the health educator and the curriculum content.

Results of the CCOP evaluation and other concepts approved by the board will be reported in next week's Cancer Letter.

NCI's CCOP concept statement follows:

NCI expects to fund 50 CCOPs and 10 research bases, with an approximate annual budget per award of $9 million in FY 1987, $9.54 million in FY 1988, and $10.112 million in FY 1989. To be made in the form of cooperative agreements, the awards will be made for a three year period.

The Community Clinical Oncology Program is designed to utilize as a national resource the highly trained oncologic specialists who have entered community practice in the last 20 years. Combining the expertise of community physicians with treatment and other cancer control research offers opportunity for transfer of newest findings into community practice.

The currently funded CCOP: 1) provides support for expanding clinical research effort in the community setting; 2) stimulates quality care in the community through participation in protocol studies; and 3) fosters growth and development of a scientifically viable community cancer network able to work closely with NCI supported cooperative groups and university cancer centers. The second initiative will also support CCOPs as a focus for cancer control research in the community.

Because more than 80 percent of cancer patients are treated in the community, CCOP is designed to bring the benefits of clinical research to cancer patients in their own communities. Through CCOP participation, physicians have access to the latest anti-cancer agents and protocol information regarding treatment, followup and overall cancer patient management. Although many cancer patients will not be eligible for protocol research, the knowledge gained from protocol participation should be transferred to the treatment of patients not on protocols.

The initial CCOP RFA primarily provided support for physicians to enter patients on treatment research protocols. Although cancer control activities were encouraged, they were not supported. Current evaluation results show that the program has been successful in accruing patients to clinical research protocols, with 4,772 patients entered on study in the second year of the program. The use of research protocols and the number of participating physicians and hospitals has increased since the program began.

The cancer control research will include such areas as cancer prevention, early detection, risk assessment and patient management. Examples of potential research projects include pain management; tumor markers; premalignant lesions; cancer in selected populations; hospital based smoking programs; and primary prevention trials.

CCOPs are experienced in the rigorous application of protocol studies, and provide access to national research studies to patients in their own communities. The program means enhanced research opportunities and patient resources to NCI. The concept statement cites many advantages to involving community physicians in other areas of cancer control research. Examples include: 1) CCOPs often draw from geographic areas that include cross sections of the population, providing mixes of patients not always available in university settings; 2) multi-institutional clinical trials, which have been demonstrated to be essential for testing new treatment regimens, can be extended to include other areas of cancer control; 3) some of the CCOPs are affiliated with large clinics or HMOs that provide the opportunity for studies in screening and early detection; 4) CCOP investigators who treat cancer patients have access to family members who may be at high risk of developing cancer and thus be candidates for prevention and detection studies. Many of the CCOPs and research bases have successful cancer control activities in place which, with appropriate evaluation, could evolve into research studies; 5) the CCOPs, with the resource of community patients, form a national network for the potential expansion of cancer control studies that require large numbers of patients; for example, chemoprevention studies in high risk patients, and other studies that may not be possible in individual clinics or groups of hospitals.

Participating CCOP physicians will be required to enter patients onto NCI approved research protocols (both treatment and cancer control) through one or more NCI funded research bases (cooperative groups or cancer centers) or public health departments having cancer control expertise.

The research bases will be responsible for protocol development and data analysis and are expected to form a collaborative relationship with the CCOP investigators. Both CCOP and research applicants will be expected to have demonstrated ability to participate in NCI approved clinical trials and in other cancer control studies. The CCOP can affiliate with one or more research base for treatment, other cancer control research, or a combination of both. Multiple awards will be made.

The CCOP may be a clinic, a group of physicians, a hospital, a HMO, or a consortium of physicians and/or hospitals and/or HMOs that agree to work together with

a principal investigator. The CCOP investigators and research bases must have adequate facilities and a demonstrated potential to conduct clinical research and an interest in participating in cancer control research.

Cancer control research will include primary prevention, secondary prevention, patient management, rehabilitation and continuing care. Although secondary prevention through the early detection of cancer in high risk populations will be easier to accomplish in most of the existing multi-institutional clinical trial groups, primary prevention studies (chemoprevention and dietary studies) in high risk populations should receive increasing attention with the growth of this cancer control effort. Because of the need for health education and social science expertise for prevention interventions, the research base will be expected to identify appropriate professionals to assure there is quality control of these interventions in the CCOPs.

Consideration will be given to geographic distribution and inclusion of investigators and patients in underserved areas in an effort to expand clinical trials to minority populations. The primary teaching hospital of a medical school will not be eligible to apply. University, military and Veterans Administration hospitals may participate as a non-dominant member of a consortium led by a community institution. University hospitals participating as Div. of Cancer Treatment funded Cooperative Group members will not be eligible. Unfunded, non-university group members will be eligible.

Each CCOP must have access to a sufficient number of cancer patients to satisfy the requirements for accrual; data management support and patient followup capability; access to a tumor registry; patient resources for cancer control research; assurances for quality control of data; multidisciplinary input from committed professionals, including oncology nurses and social workers; institutional support services; and existing cancer control activities.

Responses Made To Bailar's Charge That "We Are Losing War On Cancer"

National Cancer Program participants have been busy this week defending themselves and the program against charges that Americans are losing the war on cancer and that NCI's goal of halving cancer mortality by the year 2000 is "unrealistic."

An article published in the May 8 issue of the "New England Journal of Medicine" maintains that "we are losing the war against cancer, notwithstanding progress against several uncommon forms of the disease, improvements in palliation, and extension of the productive years of life." Entitled "Progress Against Cancer?" the article was authored by John Bailar and Elaine Smith of Harvard School of Public Health and the Univ. of Iowa Medical Center.

Bailar and Smith analyze the overall progress against cancer during the years 1950 to 1982. The authors contend that the change in age adjusted mortality rates associated with all cancers combined in the total population is the "best single measure of progress against cancer." Between 1960 and 1982, crude mortality rates have increased by 25 percent (from 151 to 188.8 per 100,000), and age adjusted mortality rates have increased by 8.7 percent (from 170.2 to 185 per 100,000). From 1973 to 1981 the crude incidence rate for all neoplasms combined rose by 13 percent, and the age adjusted incidence rate rose by 8.3 percent.

Discussing problems in interpreting recent incidence and survival data, the authors also question whether incidence rates or case survival rates can be used as reliable indicators of change in the overall progress against cancer. "Mortality data do, in contrast, measure biologic behavior rather directly," which is the primary reason the authors believe age adjusted mortality data are the best single measure of overall progress.

The authors specifically "disagree with the decision of [NCI] to emphasize survival (and the short range goal of a five year overall relative survival rate of 50 percent), because it is subject to substantial bias from changing standards of diagnosis and reporting."

The article also contends that "it is clear that [NCI's year 2000 goal] will not be attained unless the present upward trend is reversed very soon and there is a precipitous and unprecedented decline. We do not believe that hopes for such a change are realistic."

While acknowledging that "a full analysis of current program plans and directions would require substantial expertise, time, and support," the paper states that "On the basis of past medical experience with infectious and other nonmalignant diseases, however, we suspect that the most promising areas are in cancer prevention rather than treatment."

For example, "opinions that attempts to prevent smoking have been discouraging are wrong," it says. "In scarcely 20 years of half hearted effort, this country has reversed historic trends in smoking and altered its casual tolerance of smokers."

"Research opportunities in other areas of cancer prevention may well merit sharp increases in support, even if this requires that current treatment related research must be sharply curtailed."

While NCI officials agree that more support is needed for prevention research and programs, they argue that more support is

also needed for treatment and screening research and programs, as well as for basic research. "These are complementary, not competitive," Peter Greenwald, director of the Div. of Cancer Prevention & Control, told a meeting of the division's Board of Scientific Counselors the day following the publication of the article.

NCI's main spokesperson to respond to the article's charges, Greenwald had been on 15 broadcast interviews concerning the article by the afternoon of May 9.

Greenwald noted that each year more than 900,000 people in the U.S. are diagnosed as having cancer, only a portion of which are preventable. "The strong emphasis on treatment as well as screening and prevention must continue," he said, adding, "I think screening needs a strong push."

Noting that NCI has been increasing its emphasis on prevention, Greenwald pointed out that two NCI divisions have etiology and prevention as their major mandate. "We would be delighted to hear from Dr. Bailar or anyone else about the specifics of what further prevention research they think we should be doing," he said. "We really would like to know, and might even want to invite him sometime to discuss that."

NCI "certainly agrees with Dr. Bailar's point about the need for a broader societal effort against smoking." In both his presentation to the board and interviews with the media, Greenwald emphasized that the NEJM analysis of treatment deals with the fairly distant past. "Their analysis looks at mortality rates through 1982 -- three to four years ago," he said. "Mortality rates have the disadvantage of being slow to reflect progress." For example, 18% of breast cancer deaths in 1982 were diagnosed before 1972, some 13 to 14 years ago, with a substantial number of 1982 breast cancer deaths diagnosed six or more years before 1982. Greenwald cited mortality reductions in stage 2 breast cancer patients who receive adjuvant therapy, and the downturn in lung cancer mortality in white men that followed the decline in smoking that occurred 30 years before in 1953. "Thus, research advances of the 1980's -- those already benefitting the public -- would not yet be reflected in Bailar and Smith's statistics."

"Whenever we have had improvements in survival rates in clinical trials, these have been followed by changes in mortality rates," he said. Examples of declining mortality rates include childhood cancers, lymphomas, small cell lung cancer, testicular cancer, premenopausal breast cancer and rectal cancer. Five year survival is the earlier indicator, with survival rate changes being predictive of mortality rate changes, he said. "We need all measures: incidence, survival, and mortality."

While recognizing that NCI's year 2000 goals are ambitious, Greenwald stressed that the goals "also are achievable, if the country is willing to make the effort."

Board member Johanna Dwyer agreed with Greenwald that "I don't think the way to further prevention measures is to bash treatment measures."

Board member Lewis Kuller, however, spoke in support of the Bailar article. "I support what Bailar's saying and I think he's right," he said. "Mortality rates mean a lot. I think Bailar's making a very good point that this committee needs to look at." He also suggested that "it's time the people here say prevention is not getting its due at the National Cancer Institute. The real issue is prevention application, which is key to reducing mortality and it's not getting its due at NCI."

Kuller added that "smoking should be the first priority of NCI and NIH. I think the money NIH spends on it is ridiculous considering the magnitude of the problem."

The majority of board members appeared to agree that NCI should pay particular attention to increasing its efforts in the area of smoking prevention and cessation.

"Smoking is not just an NCI problem, but NIH," board member Saxon Graham said. "We need to mount a campaign" similar to that mounted for syphilis in which centers throughout the country and all health departments played an active role, he suggested.

Board member Kenneth Warner suggested that NCI provide leadership in an effort to have a portion of the federal excise tax on cigarettes be used for prevention and research efforts. A one penny share of the federal excise tax on cigarettes would amount to $300 million per year, with five cents per pack totaling $1.5 billion, half a billion less than the estimated $2 billion spent annually by the tobacco industry for cigarette advertising, he said.

Members also discussed the need for

efforts to increase utilization of screening and early detection for cancer, such as mammography. "If we can link early detection to state of the art treatment, there is no doubt that mortality, particularly in breast and colon cancer, would decrease," Paul Engstrom said.

The article and the assumption by network broadcasters that Bailar's conclusions are correct outraged ASCO and AACR members attending their annual meeting in Los Angeles.

"Bailar's article says in effect we all are losing the war," said John Durant, outgoing ASCO president, at an AACR symposium on the cancer budget crisis. "Those are chilling words for the support of basic research. He says we should concentrate on prevention, presumably without knowing anything about cancer."

Bailar has not been the most popular figure in the field of cancer research since his criticism in the 1970s of the Breast Cancer Detection Demonstration Project, in which he charged that mammography might be causing more cancers than it finds. His article led to a sharp drop in the number of women asking for mammography, bringing on charges that many of those women were thus doomed unnecessarily to presenting with more advanced breast cancer. But it also stimulated more intense monitoring of BCDDP administered mammography and significant reduction in radiation doses.

James Holland, one of the pioneers in clinical cancer research and an outspoken defender of it, carried his rebuttal of Bailar to a national television audience and repeated it at a press conference.

"Bailar said one thing with which I certainly agree," Holland said. "That is, 'The sharp and continuing rise in deaths from lung cancer, nearly all from cigarette smoking, is now widely recognized as a medical, social, and political scandal.' It is a great problem because Congress does not have the will to impose a cigarette tax high enough to make it too expensive for young people to smoke."

Holland noted Bailar's observation that removing lung cancer mortality figures flattens out the cancer death rate per 100,000. "But when he does that, he says that you should also take out the rates for stomach and cervical cancer, which have been declining spontaneously, because those declines were not achieved as part of the 'war on cancer.' I say, if you do that, then you also have to take out all other cancers caused by cigarette smoking--esophagus, bladder, pharyngeal, oral.

"On breast cancer," Holland continued, "Bailar's mortality data goes up to 1982. The great part of the improvement in treating the common cancers, specifically breast cancer, was in the period of time not reflected in 1982 figures. He specifically said there has been no change in breast cancer mortality up to 1982. Bonadonna first reported his (adjuvant CMF) studies in 1976, and Fisher (the NSABP trials) at about the same time. You wouldn't expect to see any results by 1982 because of the lag in implementation at the community level."

That meant, Holland said, "that those who died by 1982 are listed as failures, while those who are still alive are not included in his graphs."

Holland said Bailar played down the significance of dramatic improvement in survival for many of the cancers afflicting those under age 30. "Those who are cured of cancer at earlier ages and are thus leading normal, productive lives are of much greater significance than those who are salvaged at age 75," Holland said. "That is not an inconsequential result."

Holland insisted that 25,000 cancer patients are being cured each year with chemotherapy alone, and that surgical and radiotherapy and combination modality treatments have continued to improve cure rates.

"The capacity to cure more is here. It has to do with implementing the best therapy in the community."

Agreeing with Bailar's point that an increasingly aged population will result in an increase in cancer incidence, Holland said the "striking reduction in cardiac deaths, and the overall diminishing in number of competitive causes of death, will result in more cancer deaths."

No one is against prevention, Holland said. "But the implication that the war on cancer is being lost is ridiculous. There are many cures already there. They just haven't come out of the computer yet. When that happens, Bailar will have another paper to write."

NCI Director Vincent DeVita, commenting at the AACR symposium, said that "it is because of guys like Bailar" that people say "'nothing works' against cancer. One half of all cancers are curable, and that's a fact."

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-CP-EB-61040-21
Title: Operation and coordination of a nationwide multiple study, high volume death certificate acquisition and management system
Deadline: Approximtely July 10

The Epidemiology & Biostatistics Program of the Div. of Cancer Etiology is seeking a contractor to provide support to 25 or more studies requiring nationwide data gathering and death certificate acquisition activities which are simultaneously going on in the EBP at any point in time. An NCI project officer and multiple assistant project officers will monitor the work of this project, which is expected to last for five years.

The objective of this project is to acquire large numbers of death certificates, simultaneously, from vital statistics offices of multiple states using the contractor's own distinct death certificate acquisition and management system. An average of 12,000 death certificates per year will be requested from vital statistics offices throughout the U.S. It is anticipated that in providing support, the contractor will initiate work only when so directed by a task order.

Contracting Officer: Nancy Coleman
RCB Blair Bldg Rm 114
301-427-8888

Program Announcement

Title: Breast cancer in diethylstilbestrol treated mothers and in DES exposed offspring
Application receipt dates: Feb. 1, June 1, Oct. 1

The Div. of Cancer Prevention & Control of NCI, through the Organ Systems Program (Breast Cancer), seeks applications for studies on breast cancer in DES treated mothers and in DES exposed daughters. The objectives are to evaluate whether there is an increased incidence of breast cancer among women with prior exposure to DES, to characterize the types of breast cancer and of benign or premalignant breast lesions that develop in these women, and to compare women exposed to DES who develop breast cancer with women so exposed who do not, to explore possible interacting risk factors. It is anticipated that information on breast cancer associated with DES exposure should lead to a better understanding of breast cancer pathogenesis in relation to estrogens. It is also important to understand possible interaction of DES exposure with other, perhaps avoidable risk factors for breast cancer. The cohort of DES exposed individuals is large. For their possible benefit, it is important to assemble as much potentially useful information as possible.

The questions to be addressed are (1) is there an increased incidence of breast cancer in DES exposed individuals relative to appropriate comparison groups; (2) if so, can the increased incidence be clearly associated with DES exposure (as distinguished, for example, from association with difficulties in maintaining pregnancy that precipitated the use of DES); (3) in relation to breast cancer development, is DES exposure interactive with, or potentiated by, any other of the known risk factors for breast cancer, e.g., other exposure to exogenous estrogens, or family history of breast cancer; (4) what are the pathologic types, receptor status, and other characteristics of breast cancers developing in DES exposed persons; and (5) is there an increased incidence of benign or premalignant breast lesions in DES exposed individuals and what are the histopathologic and other characteristics of any such benign or premalignant lesions, especially in women who subsequently developed breast cancer.

It is important to explore in considerable detail the questions of DES and breast cancer, as the 1985 DES task force has recommended. Long term followup is also clearly of value. Aspects that have been identified as being of particular interest include:

A. Possible documentation of dosage, timing and duration of DES treatment, and any comparison of doses.

B. Reasons for DES treatment, and any information on hormonal characteristics of exposed and comparison women, and of DES exposed women who developed breast cancer compared with those who did not.

C. Any data on alternative hormone treatment or other hormone exposures.

D. Incidence of and information on breast cancers developing in DES treated mothers and DES exposed daughters: age of onset, pathologic type, receptor status, prior benign or premalignant breast lesions and details of such lesions, etc.

E. Similar information on benign breast lesions: incidence in DES treated mothers and DES exposed daughters, age of onset, histologic type, treatment, etc.

F. For breast cancer cases and comparison women, epidemiologic information on other risk factors related to breast cancer.

G. Information on other cancers developing in DES exposed mothers or offspring and time relationship of these to breast cancer and/or premalignant breast lesions.

Collaborative investigations should be feasible and are encouraged, to use comparable methodology, to increase sample sizes, and/or to achieve standardized pathology review. Observational followup studies on women known to have been exposed to DES have already been shown to be appropriate, feasible and fruitful. A case control study design might also be feasible, perhaps among women in the age group of daughters exposed in utero.

Applications should be submitted on PHS form 398, with the title of this program announcement typed on line 2 of the face page. They may be submitted to Grant Application Receipt Office, Div. of Research Grants, NIH, Westwood Bldg Rm 240, Bethesda MD 20892.

A brief letter of intent may be sent to, and further information obtained from, Dr. Elizabeth Anderson, Breast Cancer, Organ Systems Section, CCB, DCPC, NCI, Blair Bldg Rm 717, Bethesda MD 20892, phone 301-427-8818.

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