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NCAB Ponders Patient Accrual Problems; Members Irate Over System That Discourages Participation

"Maybe we should tear down the whole goddamned thing and restructure it the way it should be done." That was National Cancer Advisory Board Chairman David Korn's comment after listening to a discussion of patient accrual problems encountered in clinical trials. He was referring to the clinical trials apparatus supported by NCI, primarily the cooperative groups, which was the focus of the presentation

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In Brief

ACS To Support $2 Billion NCI Budget; NCAB Backs Minority Enhancement Core Supplements

NCI'S BYPASS budget request for $2 billion in the 1989 fiscal year, which starts next Oct. 1, will be supported by the American Cancer Society at the upcoming congressional appropriations hearings. That would be more than $500 million more than NCI is getting this year ($1.469 billion). The Administration's budget request, which was scheduled to go to Congress late this week, will ask about $1.530 billion. . . . **NATIONAL CANCER** Advisory Board unanimously supported the decision by the Div. of Cancer Prevention & Control Board of Scientific Counselors to establish a minority enhancement awards program through supplements to cancer center core grants. The DCPC Board had recommended that up to $1 million a year be set aside for the five year awards, nearly three times the amount requested in the staff proposal (**The Cancer Letter**, Jan. 22). The NCAB went along. Barbara Bynum, director of the Div. of Extramural Activities which is collaborating with DCPC on the program, and Joseph Cullen, deputy director of DCPC, agreed that more money might be made available in subsequent years for additional awards. . . . **NCI HAS ASKED** NIH to turn over responsibility for the Cancer Nursing Service at the Clinical Center to NCI. NIH is still having difficulty recruiting nurses to meet the needs of clinical cancer research. "It doesn't make sense to have control of all the resources except the nurses," Director Vincent DeVita said. "I don't know if it would work any better under our control, but we'll never know if we don't try." NCI is not able to use all the beds allocated to it at the Clinical Center because of the nurse shortage. . . . **THE NEW** "Journal of the National Cancer Institute" will make its debut with the March 2 issue, delayed from mid-January because of start up problems.

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NCI Implementing Plan To Step Up Patient Accrual; Reibursement An Issue

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being made to the Board, but his ire was really aimed at a medical care system in which physicians are reluctant to "lose" their patients to clinical trials for economic and other reasons.

"Two and a half years ago, we did consider trashing the whole thing," Robert Wittes, director of the Div. of Cancer Treatment's Cancer Therapy Evaluation Program, said in answer to Korn. He was referring to the cooperative groups, not the medical care system. "But there's a lot of things being done by the groups that we're proud of. If we do trash it, the problem is how to preserve those things."

DCT Director Bruce Chabner and Wittes presented an outline of accrual problems and described their recently implemented plan to deal with them. This is the plan that has evolved in nearly three years of discussions between NCI staff, cooperative group chairmen and other representatives of NCI supported clinical trials. The plan was presented more or less in its final form at the meeting last summer of NCI and clinical trials representatives (**The Cancer Letter**, Aug. 21).

"The problem is that it is taking twice as long to complete many trials as had been projected at their start," Chabner said. Slow patient accrual is the primary cause of that problem, and accrual enhancement is the main goal of the new steps being taken.

Part of the new program involves designation of certain trials as high priority, with approval by the cooperative groups and DCT's Board of Scientific Counselors. Various incentives will be made available to encourage participation. Physicians at centers and in communities will be permitted to affiliate with groups involved in the high priority trials even if they are not ordinarily part of the group system.

Wittes said that an effort will be made to encourage participation by HMOs and for profit health care providers.

In addition to the cooperative group system, CTEP will take a more active role as a trials coordinator and will continue to organize specialisted trials of new approaches that are early in their development, as was done with the first LAK-IL-2 extramural studies.

One of the most serious threats to clinical trials is the "alarming increase in denial of claims" by insurance companies for reimbursement of non-FDA approved indications, Wittes said. That is in addition to refusal to reimburse for drugs that are still considered experimental. "All the signs I see are going in the wrong direction. We need to make a major issue of this."

"We need to put a positive feature on this," Board member John Durant said. "Health care is competitive. Surgeons and physicians who control patients see trials as a loss of control. We need to make incentives available to insurers. They are unable to match actuarial gains (from clinical trials) with the year to year costs."

Durant said that in discussions with Blue Cross/Blue Shield in Philadelphia, it became clear that "we need to give physicians an incentive to participate. We're worried about phase 2 trials."

"With phase 3, we can make a strong argument to insurers," Wittes said. "The problem is with phase 1 and 2."

"All other problems pale into insignificance compared to the economic and control issues," Durant said.

Board member Howard Temin suggested that what is needed is social science research, to find out "why people don't participate. We need to find this out on a scientific basis, not anecdotally."

"It would take five years to do that," Chabner responded. But Div. of Cancer Prevention & Control Director Peter Greenwald agreed that there is a need for "cancer treatment epidemiology" and said some studies along that line have been published.

"It's a sad commentary on American medicine that physicians do not participate in clinical trials because of the fear of losing control of patients," NCI Director Vincent DeVita said. "They're the first to complain that we are not doing enough."

"The main reason a physician does not put patients on trials is that he does not want to give his patients away," Board member Victor Braren said. "It's an issue of power."

"He would rather have them die," DeVita said.

"Unfortunately, that's true," Braren said.

William Longmire, member of the President's Cancer Panel, noted that "there is one large reservoir of patients" not being tapped to the extent possible, those at Veterans Administration hospitals. NCI did support a VA based cooperative group, but that was

canceled several years ago.

"They didn't stay with their protocols, and we couldn't talk to the VA about it," DeVita said.

"To look upon clinical trials as an entrepreneurial exercise needs to be corrected," Board member Bernard Fisher said. "A clinical trial is a mechanism, a flow cytometer. Any good clinical trial should be testing a hypothesis. If there is no hypothesis that can be tested, then it's merely a promisory note, and that can be a bad debt."

Fisher said that cost "is not the absolute factor that influences participation."

Chabner was critical of cancer centers (other than those devoted exclusively to basic research) which do not participate in clinical trials. "I can't see labeling any center as comprehensive if it is not willing to participate in clinical trials." He acknowledged that some centers "are doing some very good studies."

"Physicians do not want to lose patients (to clinical trials) because of economic factors," Board member Helene Brown said.

"That's not true," Braren said. "It happens with Medicade patients. The pbysician-patient relationship is complex."

That was when Korn made his comment about tearing everything down--a fiery statement from the dean of one of the nation's most prestigious medical schools (Stanford).

"On the record, and for the benefit of the scribes in the room, nothing we have said applies to the pediatric groups," DeVita said. "They are doing very well. Bernie's group (Fisher's National Surgical Adjuvant Breast & Bowel Project) is doing very well. It's all the rest that we're talking about."

Fisher noted that the American Society of Clinical Oncology "is taking this problem seriously for the first time." The American College of Surgeons is also planning a program on clinical trials, he added.

"We will keep the issue of clinical trials accrual on the table at NCAB meetings until you tell me you're tired of it," DeVita said.

"I'm concerned that most of this talk is aimed at people already in church," Durant said. "The real resource is in the hands of those who never darken the door of the church, people who couldn't care less about clinical trials."

"Time after time people come to me and say they want to come to church, but they don't want to work with the cooperative groups," DeVita said.

CCOP, Another 'Jewel,' Into Second Life Following Bitter Recompetition

At one time or another, and by various NCI executives, but mostly by Director Vincent DeVita, cancer centers, basic research, the SEER Program, epidemiology, Frederick Cancer Research Facility, Robert Gallo's lab, even the sometimes maligned cooperative groups (see above) and most likely many other elements of NCI have all been called "a jewel in our crown."

At the risk of making the crown top heavy, add another jewel--the Community Clinical Oncology Program, now well into the first year of its second life and going strong.

For the record, CCOP was entirely DeVita's idea, dreamed up to meet two pressing needs--to get positive results of clinical trials into community practice as quickly as possible, and to stimulate patient accrual to clinical trials.

DeVita had been convinced by CCOP predecessors--the Community Oncology Program, the Community Hospital Oncology Program and the Cooperative Group Outreach Program--that community physicians and hospitals could hold their own in clinical trials. He took a lot of flack when he could fund only 17 CHOPs out of 25-30 which had been approved with reasonably good scores in that 1980 competition. His response then was: "Those are only three year, demonstration programs. Let's put together something that is permanent, on a larger scale."

His plan then was to support about 200 CCOPs around the country. At first, DeVita was out in front by himself; the cooperative groups, cancer centers, and many of his own staff had serious doubts about the program, and some opposed it vociferously.

Even the community oncologists who had the most to gain from the program were cool, early on. But when DeVita invited them to join with group and center representatives to draw up guidelines, the community physicians became ardent supporters of the program. The late Edward Moorhead chaired the Assn. of Community Cancer Centers committee which worked on the guidelines and helped sell it to the groups and centers.

The cooperative groups now consider CCOP an absolutely vital part of NCI supported clinical trials. CCOP accounts for as many as half of all patients enrolled in group protocols.

Sixty two awards were made in CCOP 1. Two

dropped out voluntarily, and three others were dropped by NCI, primarily for failure to meet accrual goals.

Hopes that the program could be expanded when it was recompeted last year dwindled because of budget limits. Only a modest increase in the total funding was available, and with the addition of cancer control requirements in the new awards, most of the budget requests were larger. The result: 52 awards in CCOP 2.

Three ad hoc committees reviewed 133 applications in CCOP 2. That review produced extreme bitterness among many of those who did not receive scores in the funding range and among the cooperative groups which were their research bases. Some of those unfunded had been among the best CCOP producers; their principal investigators and cooperative group allies were dumbfounded by the priority scores.

"There was no logic, no reason for it," one group chairman told **The Cancer Letter**. "Some of those were my best CCOPs. They more than met their accrual goals; the quality of their data was as good as any we get. I just don't understand it."

One chairman had his own theory: the memberships of the three review committees had been arranged so that no committee included anyone affiliated with a cooperative group whose CCOP was reviewed by that committee. While that removed the prospect that a reviewer could unfairly upgrade his own group's CCOP, it did leave open the possibility that a reviewer--knowing the budget limits--could unfairly downgrade a potential competitor for the limited number of awards.

While some of the better CCOP producers were unfunded because of poorer scores, one was outright disapproved by the committee. That removed the possibility that NCI could fund it as an exception, which in fact was done in the case of eight of the 52 awards. The disapproved CCOP appealed to the National Cancer Advisory Board which could have overturned the disapproval but did not, probably because it would have been futile to do so. The Board can't change a review committee's decision, but can only call for a rereview. The mechanics of how that could be done, with an ad hoc committee and other factors involved, did not seem clear.

The disapproved CCOP has appealed to NIH, with a decision still pending.

The disapproval really hurt. "If we could get that changed, they could keep going even without NCI money," the group chairman said. "They could still go to the community and ask for support as an NCI approved CCOP."

That is exactly what most of the approved but unfunded CCOPs have done, one way or another. Some are continuing with their own institutional support, help from the community and wherever they can get it. Others are preparing to join the Cooperative Group Outreach Program, which is supported through the Div. of Cancer Treatment (CCOP is a Div. of Cancer Prevention & Control Program, as was CGOP until it was moved to DCT two years ago). CGOP doesn't give the community hospital as much money as CCOP and it involves more control by the cooperative group, but it has been successful nevertheless.

ELM's CCOP Batting Average Continues High With 17 Of 19 Applicants Under Payline

ELM Services Inc., the Rockville, MD firm that, among other ventures, has compiled an enviable batting average as advisor to CCOP applicants, came through again in CCOP 2. In CCOP 1, 14 of 17 organizations which had retained ELM to help prepare their applications were funded. This time, 17 of 19 ELM assisted applicants were funded, including all of ELM's incumbents.

The question remains: Why was the review so badly botched, at least in some cases?

"It was a mess," commented one NCI staff member. "Most of those people we had to bring in for that review were from communities. We had to have them, given the nature of the program. But few of them had had any experience reviewing NIH grants, and we didn't have much time to work with them. We did have some from the review of CCOP 1, but that was five years ago and they hadn't done anything like this since. No one had. This is a diverse program, involving institutions of all sizes and people with different expertise, and a lot of applications."

That staff member agreed with Robert Frelick, who had been CCOP program director before returning last year to his home in Delaware to help run the state Dept. of Health's chronic disease program.

Frelick said he did not believe that any applicants had been downgraded deliberately by potential competitors on the review committees. Place the blame for the unfair

reviews on the failure of NCI program staff to adequately brief the reviewers on the nature of the program and on what constituted a good CCOP.

"I understand the reason for separating program staff from review staff," Frelick said. "But I think they have gone too far in that direction. They did give us a little time to talk to the committee members, but it wasn't nearly enough."

"That's why we have the system where we can make funding exceptions, to correct injustices and to support work we think is important," the NCI staff member said. "I hope we were able to fix it this time with that flexibility."

At least one CCOP PI, funded the first time but given an unfundable score the second, did not think the review was unfair.

"We got just what we deserved," he said. "We didn't put enough patients on protocols. In fact, we're fed up with the whole thing. The (cooperative group) didn't give us any protocols that were worth a damn. Our physicians wouldn't put their patients on those lousy protocols, and they didn't like the heavy handed way the chairmen told them they had to or else."

That attitude was unusual. **The Cancer Letter** talked with most of the unfunded incumbent CCOPs; most of them indicated they would continue participating in clinical trials and would try to keep their organizations together.

CCOP 2's requirement for cancer control research so far has produced 92 concepts which have been or are still being reviewed by the DCPC Cancer Control Review Committee.

Approval by the committee is required before the CCOPs and their research bases may proceed with those projects. Among the concepts presented to date are:

--Smoking cessation, directed to self help education interventions using physicians' offices.

--Breast screening of women with first degree relatatives who have had breast cancer, involving a collaboration with several research bases.

--Several chemoprevention studies, including one with persons at risk for head and neck cancer who would receive 13 cis retinoic acid.

--Analgesic studies alternating delivery systems for pain control.

--Screening for GU cancer.

--Several quality of life studies.

Carrie Hunter, acting CCOP coordinator, said that the cancer control element of the program "is going a little slower than we would like, but that is to be expected. I feel there are good studies being proposed. We are very positive about the cancer control portion of CCOP."

Leslie Ford is acting chief of the Community Oncology & Rehabilitation Branch, which includes CCOP.

Following is the complete list of funded CCOPs, including their participating hospitals, clinics and other institutions, and the principal investigators. The first named institution is usually the headquarters of the CCOP. They are listed by states; the order does not relate to priority scores or any other ranking.

Greater Phoenix CCOP, David King--Good Samaritan Medical Center, John C. Lincoln Hospital & Health Center, Maricopa Medical Center, Maryvale Samaritan Hospital, St. Joseph's Hospital & Medical Center, Phoenix Children's Hospital, Thunderbird Samaritan Hospital of Glendale.

San Joaquin Valley CCOP, Phyllis Mowry--Fresno Community Hospital & Medical Center, VA Hospital, Valley Medical Center, Saint Agnes Hospital, Greater Bakersfield Memorial Hospital, Kern Medical Center, Mercy Hospital, San Joaquin Community Hospital, Regional Cancer & Blood Disease Center of Kern.

Central Los Angeles CCOP, Cary Presant--Los Angeles Oncologic Institute, St. Vincent's Medical Center.

Sacramento CCOP, Vincent Caggiano--Sutter Community Hospitals, Sutter Cancer Center, Mercy Hospital of Sacramento.

Medical Center of Delaware CCOP, Irving Berkowitz--Wilmington Hospital, Christiana Hospital (Newark).

Florida Pediatric CCOP, James Talbert--Florida Assn. of Pediatric Tumor Programs, All Children's Hospital (St. Petersburg), Jacksonville Wolfson Children's Hospital, Orlando Regional Medical Center, Sacred Heart Children's Hospital (Pensacola), Pediatric Univ. Hospital (San Juan, PR), Auxilio Mutuo Hospital (Hato Rey, PR).

Mt. Sinai CCOP, Mark Wallack--Mt. Sinai Medical Center (Miami).

Atlanta Regional CCOP, Colleen Austin--St. Joseph's Hospital.

University Hospital CCOP, Stephen Shlaer--University Hospital (Augusta), Medical College of Georgia.

Kellog Cancer Center CCOP, J.D. Khandekar --Evanston (IL) Hospital.

Illinois Oncology Research Assn. CCOP, Stephen Cullinan--Methodist Medical Center of Illinois (Peoria), St. Francis Medical Center, Oncology-Hematology Associates of Illinois, Midwest Radiation Therapy Consultants Ltd.

Central Illinois CCOP, Gale Katterhagen--Voluntary Hospitals of America-IL, Memorial Medical Center, Decatur Memorial Hospital.

Carle Cancer Center CCOP, Alan Hatfield--Carle Clinic Assn., Carle Foundation Hospital.

Iowa Oncology Research Assn. CCOP, Roscoe Morton--Iowa Methodist Medical Center, Iowa Lutheran Hospital, Mercy Hospital Medical Center, Des Moines General Hospital, Charter Community Hospital.

Wichita CCOP, Henry Hynes--St. Frances Regional Medical Center, St. Joseph Medical Center, Wesley Medical Center.

Ochsner CCOP, Carl Kardinal--Ochsner Clinic, Ochsner Foundation Hospital (New Orleans), Children's Hospital, Forrest General Hospital and Methodist Hospital (both of Hattiesburg, MS), Medical Center of Baton Rouge, Radiation Oncology Center, Baton Rouge General, Mary Bird Perkins Radiation Center, Hattiesburg Clinic, Intercommunity Cancer Center and Ochsner Clinic (Baton Rouge).

Eastern Maine Medical Center CCOP, Alan Boone--Eastern Maine Medical Center Cancer Control Program, Bangor.

Southern Maine CCOP, Ronald Carroll--Oncology Hematology Associates, Maine Medical Center, Mercy Hospital, Southern Maine Medical Center (Biddeford), St. Mary's Hospital (Lewiston), Central Maine Medical Center, (Lewiston).

Grand Rapids CCOP, James Borst--Butterworth Hospital, Blodgett Memorial Medical Center, Ferguson Hospital, Saint Mary's Hospital, Metropolitan Hospital, Holland Community Hospital.

Kalamazoo CCOP, Phillip Stott--Borgess Medical Center, Bronson Methodist Hospital.

Duluth CCOP, James Krook--Duluth Clinic Ltd., St. Mary's Medical Center, Miller-Dwan Radiation Therapy Dept.

Metropolitan Minneapolis CCOP, Patrick Flynn--Park-Nicollet Medical Foundation (St. Louis Park), Methodist Hospital, Abbott-Northwestern Hospital (Minneapolis), Metropolitan Medical Center (Minneapolis), North memorial Medical Center (Robbinsdale), Fairview-Southdale Hospital (Edina), Mercy Medical Center (Coon Rapids), Unity Medical Center (Fridley).

North Mississippi CCOP, Julian Hill--North Mississippi Medical Center (Tupelo).

Columbia CCOP, Ronald Vincent--Ellis Fischel State Cancer Center, Columbia, MO.

Kansas City CCOP, Robert Belt--Baptist Memorial Hospital, Kansas City, MO; Menorah Medical Center, Research Medical Center, St. Mary's Hospital, Trinity Lutheran Hospital, Shawnee Mission Medical Center.

Ozark Regional CCOP, John Goodwin--St. John's Regional Health Center, Springfield, MO; Lester E. Cox Medical Centers.

St. Louis CCOP, Patrick Henry--St. John's Mercy Medical Center, Christian Hospital NE/NW, Missouri Baptist Hospital, St. Joseph's Hospital (Kirkwood), DePaul Health Center (Bridgeton).

Southern Nevada Cancer Research Foundation CCOP, John Ellerton--Univ. Medical Center of Southern Nevada (Las Vegas), Valley Hospital Medical Center.

Bergen-Passaic CCOP, Richard Rosenbluth--Hackensack Medical Center, Holy Name Hospital (Teaneck).

Twin Tiers CCOP, Bruce Boselli--Our Lady of Lourdes Hospital, Binghamton, NY; Robert Packer Hospital, Sayre, PA.

North Shore Univ. Hospital CCOP, Vincent Vinciguerra--North Shore Univ. Hospital Div. of Oncology, Manhasset, NY; North Shore Univ. Hospital Pediatrics, New York Hospital (NYC), Univ. of Connecticut Health Center (Farmington);, State Univ. Hospital (Brooklyn), Brookdate Hospital Medical Center (Brooklyn), Montefiore Medical Center (Bronx).

St. Vincent's CCOP of New York, Mary Kemeny--St. Vincent's Hospital & Medical Center.

Iroquois CCOP, Kishan Pandya--St. Mary's Hospital Medical Oncology, Rochester, NY; Mary Imogene Bassett Hospital (Cooperstown).

Central New York CCOP, Santo DeFino--Hematology-Oncology Associates of Central New York (Syracuse), St. Joseph's Hospital Health Center, Crouse Irving Memorial Hospital, Community General Hospital.

Southeast Cancer Control Consortium CCOP, Charles Spurr, Winston-Salem, NC--(North Carolina), Forsyth Memorial Hospital, Medical Park Hospital, Memorial Mission Hospital (Asheville), St. Joseph's Hospital (Asheville), VA Medical Center (Asheville), Presbyterian Hospital (Charlotte), Moses H. Cone Memorial Hospital (Greensboro); Brodkin, Slatkoff & Hopkins (Winston-Salem), Asheville

Hematology & Oncology Associates, Wilmington Health Associates, Dept. of Radiation Therapy-New Hanover Memiral Hospital (Wilmington).

South Carolina--Richland Memorial Hospital (Columbia), Baptist Medical Center (Columbia), W.J.B./Dorn VA Hospital (Columbia), Self Memorial Hospital (Greenwood), McLeod Regional Medical Center (Florence), Carolina Health Care-Companion HMO (Florence), Piedmont Internal Medicine (Greenwood).

Tennessee--Holston Valley Hospital & Medical Center (Kingsport).

Virginia--Memorial Hospital (Danville), memorial Hospital of Martinsville & Henry County.

St. Luke's Hospitals CCOP, Greg McCormack. St. Luke's Hospitals, Fargo, ND, Fargo Clinic Ltd., MeritCare.

Columbus (Ohio) CCOP, Jerry Guy--Grant Medical Center, Mt. Carmel Health, St. Anthony Medical Center, Doctors Hospital (North and West), Community Hospital (Springfield and Clark County), Mercy Medical Center (Springfield).

Dayton CCOP, James Ungerleider--Kettering Medical Center, Kettering, OH; Good Samaritan Hospital, Grandview Hospital, Miami Valley Hospital, St. Elizabeth Medical Center, 'VA Medical Center.

Toledo CCOP, Charles Cobau--Toledo Community Hospital Oncology Program, Toledo Hospital, Riverside Hospital, Flower Memorial Hospital (Sylvania), St. Charles Hospital (Oregon, OH), Fremont Memorial Hospital, Firelands Community Hospital (Sandusky), Emma L. Boxby Hospital (Adrian, MI), St. Joseph Mercy Hospital (Ann Arbor, MI), the Toledo Clinic.

Natalie Warren Bryant CCOP, Alan Keller--Saint Francis Hospital (Tulsa).

Columbia River CCOP, Gordon Doty--Providence Medical Center, Portland; Emmanuel Hospital, Good Samaritan Hospital and Medical Center, St. Vincent Hospital and Medical Center, Southwest Washington Hospitals, Vancouver.

Geisinger Clinic CCOP, Albert Bernath--Geisinger Clinic and Medical Center, Danville, PA.

Allegheny CCOP, Reginald Pugh--Allegheny General Hospital, Pittsburgh; Sewickley Valley Hospital, YHA Inc. Western Reserve Care System, Washington Hospital, Frick Community Health Center (Mt. Pleasant), Jameson Memorial Hospital (New Castle).

Mercy Hospital CCOP, William Heim--Mercy Hospital (Scranton), Hematology and Oncology Associates of Northeast PA.

Spartanburg CCOP, John McCulloch--Spartanburg (SC) Regional Medical Center, Mary Black Memorial Hospital, Doctor's Memorial Hospital.

Sioux Falls Community Cancer Consortium CCOP, Loren Tschetter--Central Plains Clinic Ltd., Sioux Falls, SD; McKennan Hospital, VA Hospital, Sioux Valley Hospital, Medical Oncology Associates, Medical Xray Center.

Green Mountain CCOP, James Wallace--Green Mountain Oncology Group, Rutland, VT; Rutland Regional Medical Center, Central Vermont Hospital (Barre), Fanny Allen Hospital (Winooski).

CCOP of Roanoke, Stephen Rosenoff--Roanoke, VA, Hospital Assn.; Roanoke Memorial Hospitals, Community Hospital of Roanoke Valley, Lewis-Gale Hospital (Salem), VA Medical Center (Salem), Bluefield Community Hospital (West Virginia), Oncology and Hematology Associates of Southwest VA.

Virginia Mason CCOP, Albert Einstein--Virginia Mason Medical Center (Seattle), Valley Medical Center (Renton), Evergreen Hospital Medical Center (Kirkland), Kadlec Medical Center (Richland), Valley Internal Medicine (Renton), Richland Clinic.

Northwest CCOP, Ronald Goldberg--Multicare Medical Center (Tacoma General), St. Joseph Hospital, Humana Hospital, Lakewood Hospital, St. Joseph Hospital (Aberdeen), Grays Harbor Community Hospital (Aberdeen), St. Peter Hospital (Olympia), Black Hills Community Hospital (Olympia), Good Samaritan Hospital (Puyallup), Kaiser Permanente (Portland).

West Virginia CCOP, Steven Jubelirer--Charleston Area Medical Center, Raleigh General Hospital (Beckley), St. Mary's Hospital (Huntington), Cabell Huntington Hospital, VA Medical Center (Huntington), St. Joseph's Hospital (Parkersburg), Wheeling Hospital.

Marshfield CCOP, Tarit Banerjee--Marshfield, WI, Medical Research Foundation, St. Joseph's Hospital, Marshfield Clinic.

Organizations which were approved as research bases for CCOPs were:

*Clinical trials groups--Eastern Cooperative Oncology Group, Paul Carbone, chairman; Southwest Oncology Group, Charles Coltman, chairman; North Central Cancer Treatment Group, Charles Moertel, chairman; Radiation

Therapy Oncology Group, James Cox, chairman; Cancer & Leukemia Group B, Bradford Patterson, chief of staff; National Surgical Adjuvant Project for Breast and Bowel Cancers, Bernard Fisher, chairman; Childrens Cancer Study Group, Denman Hammond, chairman; Pediatric Oncology Group, Jeffrey Krischer, statistical office.

*NCI supported cancer centers--Dana-Farber Cancer Institute, Bradford Patterson; Memorial Sloan-Kettering Cancer Center, David Kelsen; Oncology Research Center of Bowman Gray School of Medicine, Robert Capizzi; Fox Chase Cancer Center, John Durant; Northern California Cancer Center, Theodore Phillips; Univ. of Rochester Cancer Center, John Bennett; Illinois Cancer Council, Nancy Cairns; M.D. Anderson Hospital & Tumor Institute, Rodger Winn.

*State health department--Minnesota Dept. of Health, Donald Bishop.

New Publications

"Current Advances in Cancer Research," a monthly current awareness service with listings of titles of cancer research papers published throughout the world classified into 17 main areas. Screened from more than 3,000 source journals. Volume 1 Number 1 was published last month. Pergamon Press, $43 year. Pergamon Orbit InfoLine Inc., 8000 Westpark Dr., McLean, VA 22102.

"GRATEFUL MED Version 3.0," a new and more powerful verson of the National library of Medicine's software for searching NLM databases. The new version makes it possible for health professionals, scientists and students to have personal access to the Library's 10 million computerized records from office and home microcomputers. This is a 70 percent increase over the number of records searchable through previous versions of GRATEFUL MED. Present users of GRATEFUL MED will automatically receive the updated software and documentation at no charge. New purchasers may order Verson 3.0 for $29.95 plus $3 shipping from National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161.

"Closing in on Cancer," a 40 page booklet providing a 6,000 year overview of medical and cancer history, illustrating the explosion of knowledge that has occurred in the last 15 years. The booklet includes the messages and illustrations of the self contained, walk through exhibit now touring the country's major science museums. Available free from NCI's Office of Cancer Communications, Bldg 31 Rm 10A30, NCI-NIH, Bethesda, MD 20892.

"Principles of Cancer Biotherapy," edited by Robert Oldham. The first major text on cancer treatment using biological substances and biological response modifiers. To be published by Raven Press (no price was given). Raven Press, 1185 Avenue of the Americas, New York 10036, phone 212/930-9500.

"Cellular Signalling," a new journal by Pergamon Press, scheduled for publication late this year. Manuscripts are solicited dealing with biochemistry, cell biology, molelcular biology, pharmacology, neurobiology, molecular endicrinology and molecular oncology. Miles Houslay, Univ. of Glasgow, is editor in chief. Contact Pergamon Press, Fairview Park, Elmsford, NY 10523.

"Exploring Meat and Health," a booklet published by the National Live Stock and Meat Board. It purports to show how moderate amounts of meat can fit into low fat diets. For instance, a three ounce cooked, trimmed portion of beef contains 78 calories of tat, contributing only four percent of a daily calorie intake of 2,000. Free from National Live Stock and Meat Board, 444 N. Michigan Ave., Chicago 60611.

"Medical Oncology and Tumor Pharmacotherapy," edited by James Holland, Georges Mathe and Peter Reizenstein. Four issues per year, $105. Pergamon Press, Fairview Park, Elmsford, NY 10523.

"Cambridge Monographs on Cancer Research," edited by Maurice Coombs, John Ashby and Herbert Baxter.

"Fight for Your Life: Survival Techniques for Those with Cancer," video featuring four long term survivors of cancer, including Richard Bloch, who has just completed a six year term on the National Cancer Advisory Board, and Morris Abram, prominent New York attorney who chaired a President's Committee on Medical Ethics a few years ago. Fight for Your Life Co., 63 Elm St., Camden, ME 04843, 1-800/225-5669, $65.

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

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