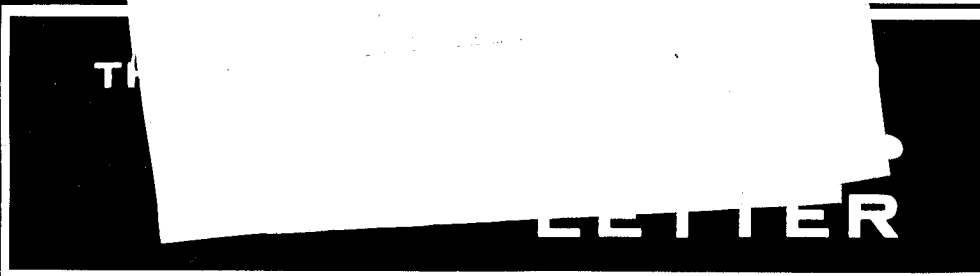


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House Appropriations For NCI Identical (So Far) To White House Request; Slight Increase For NIH

The House Appropriations Committee did not add a dollar to the President's 1989 fiscal year budget request for NCI, but it did leave the door open for some increases later when cancer control, training and, possibly, construction funds are added to the appropriations bill. Money for those programs was not included in the measure reported out last week by
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In Brief

Wittes DCT Acting Deputy Director; Spallone Leaves For Fox Chase; Ronald Evens Heads AUR

ROBERT WITTES will be acting deputy director of the Div. of Cancer Treatment, with the departure of Gregory Curt. DCT Director Bruce Chabner announced Wittes' additional duties, commenting, "as if he doesn't have enough to do" (as director of the Cancer Therapy Evaluation Program and also editor in chief of "Journal of NCI"). . . . ROBERT SPALLONE, chief of NCI's Extramural Financial Data Branch, has been appointed administrator of basic science and laboratory operations at Fox Chase Cancer Center. He will start at that position July 5. Spallone has been at NCI 19 years, with the government 25 years. . . . NORTHERN CALIFORNIA Cancer Center is seeking applications for the position of executive officer for cancer control programs. The executive officer will participate in development of programs in cancer detection, prevention and education and will be responsible for day to day management of them. Applications will be accepted until July 30 and should be sent to Leila Colmen, NCCC, PO Box 2030, Belmont, CA 94002. . . . RONALD EVENS, chairman of radiology at Washington Univ. School of Medicine, has been elected president of the Assn. of University Radiologists. William Thompson, chairman of radiology at Univ. of Minnesota Hospital & Clinic, is the president elect. Joseph Sackett, chairman of radiology at Univ. of Wisconsin (Madison), was elected secretary treasurer. . . . LUTHER BRADY, chairman of radiation oncology and nuclear medicine at Hahnemann Univ., has received an honorary doctor of fine arts degree from Colgate Univ. in recognition of his patronage of the arts. . . . KENNETH HOGSTROM, chairman of radiation physics at Univ. of Texas M.D. Anderson Cancer Center, has received the Becton-Dickinson Career Achievement Award from the Assn. for the Advancement of Medical Instrumentation.

NCI Reorganization:

—DEC Epidemiology

Stays In Place,

DCPC To Build

Its Own

—No Decision Yet

On Centers, Other

DCPC Programs

—CIS Moved To OCC,

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House, President Agree On Budget; No Control, Training, Construction \$\$

(Continued from page 1)

the committee, since biomedical research authorization legislation, including renewal of the National Cancer Act, has not yet been acted upon by Congress. That legislation specifically authorizes cancer control, training and construction; other elements of NIH are authorized under the general provisions of the Public Health Service Act.

The total NIH appropriation in the House bill is \$6.863 billion, including \$587.6 million for AIDS. The amount for AIDS is the same as the President's request, \$119.8 million more than the current, 1988, fiscal year.

The non-AIDS House figure for NIH, \$6.275 billion, is \$60.4 million more than the President requested. The combined total for NIH AIDS and non-AIDS activities in the House bill is \$510.2 million above the comparable appropriation for 1988. Those do not include \$320.7 million for the yet to be reauthorized programs.

The House figure in the committee bill for NCI is \$1,489,897,000, identical to the White House request. The White House had also requested \$71.3 million for cancer control and \$32.4 million for training (National Research Service Awards). Those would bring NCI's total to \$1.593.6 billion.

Cancer program advocates might be disappointed that the House Appropriations Committee did not add money to the Administration's request. That request represented an increase of \$122 million, or more than eight percent, over the current budget. Although it was the first time in many years, probably all the way back to Richard Nixon, that a President had budgeted an increase of that size for the cancer program, more than \$35 million of the additional money was for AIDS research.

The Senate Appropriations Committee has not yet marked up its HHS-Labor-Education appropriations bill. The Senate usually is somewhat more generous with NIH than the House and probably will come in with another \$50-100 million for NCI. An increase of at least that size is needed to avoid some dislocations and difficult choices.

Although research project grants (ROIs and POIs) would get an 11.6 percent increase under the President's budget, that would still require reductions of 13 percent in competing grants and at least seven percent (the House

committee report said 10 percent) in noncompeting grants, from the peer review recommended levels.

The committee report lamented that reduction, but no extra money was provided to do something about it. Here's what the report said on the subject (on NIH grants):

"The committee continues to give the highest priority to the support of investigator initiated research projects. The bill includes approximately \$4.145 billion for these projects which is an increase of more than 10 percent over the amount of funds expected to be available for this purpose in 1988. The amount in the bill will allow NIH to fund the largest total number of research grants in its history.

"In contrast to previous years, the committee has not directed that a specific number of new projects be funded in 1989. Because of changes in the average size of projects and the length of time a project is funded, the committee believes that the number of projects is no longer an accurate measure of the volume of research being supported being supported. The FY 1989 recommendation is based on the concept of dollar levels as the most useful measure of the amount of research being funded in one year versus another.

"The committee has taken this approach partially in response to its concern about the increasing level of downward negotiation of grants which has taken place over the last several years. The 1989 budget request assumes downward negotiation of 13 percent of new research project grants and 10 percent for noncompeting projects. The committee does not consider this acceptable and encourages the director, in consultation with the institutes, to review spending plans to see if this problem can be addressed in 1989 while still maintaining the total number of projects above the 1988 level.

"Beyond expressing its concern about funding for investigator initiated research grants and policies on downward negotiations, the committee has attempted to minimize its directions to the institutes regarding the specific allocations related to diseases or research mechanisms. It is the committee's view that these decisions are best made by the scientists and the science managers at NIH based on the quality of the opportunities as they present themselves during the year."

The House once again withheld money for construction. Last year it called on NIH to conduct a review of the nation's biomedical

research construction needs. The review was carried out, and details of its report were made available, although the report has not yet been sent to Congress. The White House is holding it up, because of concerns about the amount of money recommended by the group which did the review: \$3 billion over seven years (*The Cancer Letter*, March 4).

The reauthorization bill drawn up by Sen. Edward Kennedy included the recommendations made by the review committee. No reauthorization bill has been written in the House. The Appropriations Committee was not overly impressed by the NIH review:

"As in fiscal year 1988, the bill does not include any funds for extramural facilities construction grants. While there is a continuing need to maintain, repair and expand facilities used in federally financed biomedical research, the extent of this need and its severity in contrast to other needs in health research is not well understood. In addition, no policy exists which defines the appropriate division of responsibility for financing this construction among the federal government, state and local governments and the private sector. Also of concern is the question of the role of indirect cost payments as a basis for fulfilling any federal role. These issues are currently being debated in the context of legislation reauthorizing certain activities of NIH. Pending final action on this legislation, the committee has not recommended funding for construction in 1989.

"The committee believes, however, that this issue will need to be addressed in the future whether or not a new facility construction authority becomes law during the 100th Congress. Last year Congress asked NIH to convene a meeting of experts which could make recommendations to Congress on the facilities question. That meeting was held in February, 1988. While no formal report has been submitted, the committee is concerned that this meeting was made up principally of officers of academic health centers or organizations representing these centers. The committee does not believe that this group, which was dominated by the interests of potential recipients of federal construction funds, can be expected to give unbiased advice to Congress on issues such as the relative need for construction dollars or the division of responsibility for financing construction. In this regard, the committee asks the Secretary (of HHS) to submit a separate report to the committee expressing

his views on this important question. This report, along with the report from the February meeting, should be submitted by Feb. 1, 1989."

NCI Director Vincent DeVita recently told the Div. of Cancer Treatment Board of Scientific Counselors that "construction funding is our biggest problem." Without construction money, "we can't even maintain Frederick."

DeVita is especially concerned that the move to authorize extramural construction support by NIH will result in providing funds for the separate NCI construction authorization, which was written into the National Cancer Act of 1971 and included in every renewal of it. The Kennedy bill, and the NIH facilities review committee's recommendation, would continue NCI's separate authorization. However, some in the NIH and HHS hierarchy want all construction money to be in the same pot, with cancer centers and labs, and NCI intramural facilities as well, competing with the rest of the biomedical research community and the rest of NIH for support.

"That could mean that, even if we only wanted to move a lab wall three feet, we would have to stand in line with the other institutes," DeVita said. "That would be like General Motors getting control of Ford's budget."

DeVita has two "biggest problems," the other being what government people call "FTEs", or full time equivalents. In regular English, that means positions, slots, people.

DeVita pointed out that since 1984, NCI's budget has increased 48 percent while FTEs have decreased 20 percent. "I'm opposed to FTE ceilings," he said. "It should be a management decision, whether to spend our budget on more people or on something else. CTEP (Cancer Therapy Evaluation Program, which manages most of NCI's extramural clinical research efforts) needs more staff. We can't talk out of both sides of our mouths, demanding that the cooperative groups do more with CTEP not being able to do its part."

The House committee had something to say about that issue:

"During the last several years, staffing levels at NIH have gone through rapid expansions and contractions which have not matched changes in the level of activity at the institutes. During the early 1980s the number of positions increased rapidly reaching a high level of 13,661 FTEs in 1984. In 1985 and 1986, however, staffing levels were reduced drastically, declining by more than 1,100 FTEs

over two years. This took place during a period when the number of research projects and the budget for NIH as a whole increased by more than 20 percent.

"While there has been some restoration of staff during fiscal years 1987 and 1988, staffing increases have been allocated for the most part to increasing personnel needs related to AIDS. Recent testimony of the NIH AIDS coordinator has provided compelling evidence of the need for additional staff in this area. It is the committee's view that increased staff resources are essential in FY 1989 if NIH programs, both AIDS and non-AIDS, are to be managed efficiently and effectively.

"The committee has therefore added \$9 million to the budget of the office of the director to allow an additional 300 positions for NIH.

"It is the committee's intention that these positions be allocated equally between AIDS and non-AIDS programs. The committee expects to monitor closely the allocation of these resources. Beginning on Oct. 1, 1988, the committee will expect to receive bimonthly reports on staffing levels at NIH."

Cancer centers, apart from their construction needs, will be in very tight circumstances in FY 1989 unless the Senate adds more money to NCI's budget. For years, the centers have had to put up with reductions in their core grants from recommended levels. This year, new and competing renewal core grants are being paid 91 percent of the recommended levels; noncompeting core grants are getting only 85 percent.

If the House/President's budget prevails, and if NCI can't reprogram money from other areas into core grants, centers may look back on this year as the good old days. To maintain the same number of grants, NCI would have to slash their funding 31 percent under recommended, or five centers would be dropped.

To complicate matters further, 16 existing centers are at risk, that is, they are up for renewal with their core grants. Also, six new centers have submitted or are preparing to submit applications. Some look very strong and probably will do well in the review.

Every new one that is funded could mean an existing center knocked out. Not a prospect that bodes well for the Year 2000 goals, with the hope of doubling the number of centers during the 1990s.

The House committee expressed interest in two programs of primary interest to NCI but with application to other institutes and other

agencies within HHS, diagnostic imaging and the national bone marrow registry. NCI's Radiation Research Program, in the Div. of Cancer Treatment, presently has the entire NIH grants portfolio and prime responsibility for diagnostic imaging research.

"The committee is aware that promising new imaging technologies are helping scientists and physicians better understand the causes of cancer, heart disease, Alzheimers disease, and many other diseases and disorders. The contributions in this field cut across most of the NIH institutes. In recognition of the importance of this field, the committee urges NIH to consider the merits of creating a Diagnostic Radiology Coordinating Committee which would be responsible for coordinating ongoing research, as well as to develop an NIH wide long range research plan for diagnostic radiology. The director should be prepared to discuss this matter with the committee when he appears to present his fiscal year 1990 budget.

"The committee is aware of legislation approved by the House which would authorize the Secretary of HHS to assume responsibility for oversight of the National Bone Marrow Donor Registry. The registry is currently funded through the Navy. The committee has discussed the registry with the Secretary and the director of NIH during the hearings and notes the interest expressed by NIH in assuming responsibility for this program. The committee would expect that, should the pending legislation to transfer authority of the registry be enacted, the Dept. of Health & Human Services and NIH would work closely with the Dept. of Defense to ensure a smooth transition of the program and transfer of funds between departments if such a transfer of funds would be beneficial to the long term goals and objectives of the program."

The committee came up with another item that could cause all sorts of mischief for NCI.

"Several of the agencies and institutions funded in the bill support important research involving human nutrition. The committee wishes to renew its concern that the federal government speak with one voice when it issues dietary information and nutrition guidance to the public. To the end of ensuring that the American public has the latest information concerning dietary trends and human nutrition, the committee has designated the Dept. of Agriculture, through the Human Nutrition Information Service, as the lead

agency for issuing federal nutritional guidelines to the public.

"To maintain the scientific integrity and objectivity of data provided by the federal government, USDA has been directed to maintain appropriate oversight and coordination of all dietary and nutritional studies, reports, analyses, and guidelines undertaken by any department or agency of the federal government. This includes work carried out by any private or quasigovernmental groups receiving federal funds. The committee expects NIH to cooperate fully with this directive."

Apart from the issue of whether an Appropriations Committee can, without any legislative authority, "designate" USDA as the lead agency for nutrition information, this is one of the least worthy ideas the committee has promulgated in years.

The Dept. of Agriculture by its nature has a vast number of very close ties to the food industry. To turn over control of nutrition information as it relates to health matters would be like hiring a fox to guard the chickens.

There are enough delays and impediments as it is in getting health information out to the public. Running it through another level of bureaucracy, one with which NIH has not the slightest influence and one with possibly a vested interest in delaying or sidetracking it, does not make sense.

An effort should be made to keep this idea out of the Senate committee report. If it shows up in both reports, NIH and NCI would have a difficult time ignoring it, although since it is not in the bill itself, it does not have the force of law.

The committee refused once again to go along with the Administration's request that all AIDS money be consolidated in the office of the assistant secretary for health.

"The committee has approved the full amount requested for AIDS in the President's FY 1989 budget as well as his proposed allocations of these funds among institutes and among research mechanisms. The committee has not, however, approved the President's request that these funds be appropriated in a consolidated account under the assistant secretary for health. While the committee is sensitive to the need for coordination of AIDS research with other activities of the department, it has concluded after careful study that research funds are most effectively utilized if provided directly to the institutes."

Among the items in the section of the report dealing specifically with NCI, the committee zeroed in on:

--Basic research. Noting that NCI has heavily invested in basic research, the report says that "many of today's breakthroughs came from the support provided to the cancer virology program and the discovery of the enzyme known as reverse transcriptase." Significance of the study of oncogenes, progress in studies of metastasis, and virus studies are mentioned.

"Work on the lymphoma virus is particularly notable in that it resulted in the discovery and isolation of the AIDS virus. This advancement has produced further benefits in the form of diagnostic tests for AIDS, the development of anti-AIDS drugs, and the increasing potential for a vaccine. The committee encourages the institute to continue its support of basic research programs, specifically in the areas of molecular genetics, cancer immunology, mechanisms metastasis and viral research and its role in the development of tumors."

--Treatment. "As the results of basic research have been brought into the clinic, cancer treatment has become more effective for certain cancers. In the past year, new treatments have been developed for two of the most resistant cancers, bladder cancer and colon cancer. With the addition of these two new therapies, a treatment program that reduces mortality within the study population is available for every common cancer, with the exception of pancreatic and liver cancer. Treatments today are also more tolerable and much less morbid, thus enhancing the quality of life. The committee applauds the process and is hopeful that cancer survival rates can be further improved as a result of these new treatment strategies.

"The development of biologics has revolutionized the scope of cancer treatment. Since 1979, when the Biological Response Modifiers Program was established, over 35 biologics have been identified with potential for cancer treatment. Interferon has been found to be effective for treatment of hairy cell leukemia and chronic myelocytic leukemia. Interleukin-2 has emerged as a treatment of choice for metastatic melanoma and metastatic kidney cancer, previously two of the most resistant cancers. In the past year, significant progress has been made in reducing the life threatening side effects of chemotherapy with the introduction of colony stimulating factors. . . The committee encourages NCI to continue clinical

research opportunities in the area of biologics and evaluation of their potential use in the management of cancer.

--Application. The report mentions the "national network of application programs" including centers, the Community Clinical Oncology Program, cooperative groups, Cooperative Group Outreach Program, SEER, PDQ and the Cancer Information Service.

"Despite the comprehensiveness of this network, the transmission and translation of advances in cancer research continues to present a difficult and perplexing challenge. It is reflected in NCI's Year 2000 goal--to reduce the cancer mortality rate by 50 percent. This goal, established in 1984, was based on knowledge and practices already available that could be applied. Part of the current difficulty is that many state of the art treatments are not being utilized or received. For instance, it is known that if every woman over age 50 had an annual mammogram, mortality from breast cancer could be reduced by 30 percent, thereby saving 15,000 lives. Similarly, it is estimated that widespread use of the PDQ system alone could reduce cancer mortality in this country by 10 percent per year by effectively applying known treatments."

--Cancer progress. "Recent data on cancer morbidity, mortality and survival rates are contradictory. On the one hand cancer survival rates for certain cancers, particularly childhood disorders, have improved dramatically. On the other hand, the total number of cancer deaths continues to rise and has reached approximately 500,000 deaths annually. While a portion of this increase in cancer deaths is the result of the aging of our population, this increase also reflects lack of progress against certain common and lethal cancers as well as continued problems in getting research findings into actual use by practitioners.

"The committee is fully supportive of its investment in cancer research but is impatient that more progress has not yet been made."

--Melanoma and skin cancers. "The committee is pleased to learn of the active role of the National Cancer Institute in convening a meeting of interested organizations to discuss the creation of a national program to combat melanoma and other skin cancers. The committee strongly urges that the recommendations for research and public and professional education which arose from that meeting be given a high priority for action by NCI."

--Minority emphasis. "Because of special problems of cancer incidence, treatment and mortality, considerable expansion of the institute's activities directed toward minority populations has taken place. Nearly 20 minority specific initiatives have been put in place throughout the institute with the aim of reducing the incidence and mortality of cancer in these populations.

--Diagnostic imaging. The committee is aware that a physician's choice of the most effective therapeutic approach is dependent on the information received from the diagnostic evaluation of the patient. Research to improve detection and diagnosis is, therefore, critical. New diagnostic imaging techniques are improving the ability to detect small lesions and to provide better staging information. In fact, several major new diagnostic imaging modalities that demonstrate superior potential in cancer detection, e.g., x-ray computed tomography, magnetic resonance imaging, positron emission tomography, have emerged in the past five years.

"Thus, in recognition of the importance of this field, the committee urges NCI to utilize a portion of the increased funding to expand its support of research in the field of diagnostic radiology."

The House bill includes a total of \$1.235 billion for all HHS AIDS activities, including the \$587.6 million for NIH. With AIDS funds for the Food & Drug Administration which are included in another bill, the total for AIDS is \$1.3 billion. The Health Resources & Services Administration, Centers for Disease Control, and Alcohol, Drug Abuse & Mental Health Administration share in that budget.

Pittsburgh Cancer Institute Lands NCI Core Grant; Herberman Director

Pittsburgh, the home of Bernie Fisher, Norman Wolmark and the NSABP; the home of the Oncology Nursing Society, the Pirates, the Steelers and Iron City beer, is now the home of an NCI supported cancer center.

From the start it has made, it appears that the new Pittsburgh Cancer Institute has or soon will join those named above as among the most outstanding in their field (disregarding recent Pirate and Steeler seasons).

Pittsburgh is the only new cancer center to be funded by NCI in the current fiscal year. It achieved that goal after only two and a half years of existence, a remarkably short time in

a highly competitive field. How that was done might serve as a blueprint for others.

Ronald Herberman, former NCI scientist who served for a time as acting director of the Biological Response Modifiers Program, is director of the Pittsburgh Cancer Institute. His formula for putting together a program which cleared peer review with a very good priority score was simple: Get solid financial backing, round up some strong collaborating institutions; and recruit some good people.

The financial support came in the form of a commitment from the Richard King Mellon Foundation for \$1 million a year for six years. Not a bad start.

Collaborators are the Univ. of Pittsburgh, Carnegie Mellon Univ., Presbyterian Univ., Montefiore Hospital, Magee Women's Hospital, Western Psychiatric Institute & Clinic, Children's Hospital, Folk Clinic, and Eye & Ear Hospital. All are affiliated with the Medical & Health Care Div. of the Univ. of Pittsburgh, and together have committed \$750,000 a year for five years.

The top staff persons are Wolmark, associate director for surgical oncology; John Kirkwood, associate director for medical oncology; William Bloomer, associate director for radiotherapy; Joyce Yasko, associate director for nursing and patient care service; Seymour Grufferman, associate director for epidemiology and preventive oncology; and Jules Heisler, associate director for administration.

Fisher, professor of surgery at the Univ. of Pittsburgh and chairman of the National Surgical Adjuvant Breast & Bowel Project, is a member of the center.

A total of 57,000 square feet has been dedicated to the center, under the control of Herberman. The space includes 24,000 sq. ft. for basic research; a 14,000 sq. ft. outpatient facility; 7,000 sq. ft. for administration; a 10,000 sq. ft. blood bank building; 30 medical oncology beds at Presbyterian; 20 for surgical oncology at Montefiore and 11 more for a bone marrow transplant unit there; 50 beds for gynecologic oncology at Magee; and 18 for head and neck cancer at Eye & Ear.

Epidemiology Program Stays Put; NCI Decides DCPC Will Start Its Own

NCI staff members participating in the institute's semiannual retreat this month took up the various reorganization proposals which have been floating around for much of the

past year. The result: the most significant and/or controversial of the suggested changes will not be implemented at this time, but changes will be made eventually.

The proposal which caused the most furor was to move the Epidemiology & Biostatistics Program from the Div. of Cancer Etiology to the Div. of Cancer Prevention and Control (The Cancer Letter, June 17). This was resolved through a compromise:

--The program will remain where it is, in DCE. It has recently been relocated, to the new Executive Plaza Building, where DCPC offices soon will be moved. NCI executives hope that proximity of epidemiologists and DCPC's prevention experts will lead to more collaborative efforts. However, DCPC will build its own epidemiology program, as positions become available. That means that the DCE epidemiologists will not be required to undertake application oriented projects which may not suit their capabilities or interests; on the other hand, DCPC will get any new slots which might become available for epidemiology, and probably will pick up some from DCE through attrition.

The highly prized collaboration between DCE epidemiologists and the basic scientists thus will not be disturbed, and DCPC will be allowed to bring in epidemiologists more inclined to application of prevention programs.

The other major reorganization proposal involved moving cancer centers and other resource programs now located in DCPC either into NCI Director Vincent DeVita's office or to a new division to be created for them. This would have included, in addition to the Cancer Centers Branch, the Community Clinical Oncology Program, Research Facilities (construction) Branch, Organ Systems Program, and Cancer Training Branch.

"We decided to wait on that until the (National Cancer Advisory Board's) review of the centers program has been completed," DeVita said. An exception may be organ systems, because "that is going so smoothly." He was referring to the phase out of the external Organ Systems Coordinating Center, distribution of organ systems grant portfolio to the program divisions, and what appears to be genuine enthusiasm among NCI staff and Organ Systems Working Groups about the new program.

The NCAB Centers Committee is conducting a meeting July 21-22 to further discuss requirements/characteristics of comprehensive cancer centers. "When that has been

completed, I think everything else will fall into place," DeVita said. The committee meeting is not scheduled, at this time, to go into the organizational arrangements of the centers program.

One change which will not be made is the move of the Cancer Therapy Evaluation Program from the Div. of Cancer Treatment to DeVita's office. That proposal was discussed very little publicly, probably because few took it seriously. The advantages were unclear, and it would have removed the clinical cooperative groups and much of the rest of NCI extramural treatment programs from DCT. If the centers and CCOPs were moved into the director's office, having CTEP there also would bring those collaborating programs into a position for closer coordination.

The disruptions and potential damage to DCT made a CTEP not seem worthwhile, so it was dropped.

Other moves considered but dropped involved the Diagnostic Branch of the Div. of Cancer Biology & Diagnosis to DCT, which already has the imaging elements of diagnosis, in the Radiation Research Program; and the Grants Administration and Research Contracts branches, from the office of the director to the Div. of Extramural Activities. No advantages were seen in any of those moves, except possibly what might accrue from bringing together all elements of diagnosis into DCT.

"That program is going very well where it is, under Brian Kimes," DeVita said.

Two moves which apparently were without much if any controversy were approved: the Cancer Information Service, with its nationwide network of offices supplying phone and printed information to the public and professionals, will move from DCPC to the Office of Cancer Communications, which is DeVita's Office; and the International Cancer Information Center, which will be removed from the Office of International Affairs and will report directly to DeVita. OIA will remain in DeVita's office, but with greatly reduced scope of activities, primarily handling NCI's international agreements.

ICIC includes PDQ, International Cancer Research Data Bank, "Journal of NCI," and related information programs.

NCI Advisory Group, Other Cancer Meetings For July, August, Future

Biochemistry of Chemical Carcinogenesis (a Satellite Symposium of the 14th International Congress of Biochemistry)--July 6-9, Prague, Czechoslovakia. Contact Dr. J. Hradec, Dept. of Molecular Biology, Research Institute of Tuberculosis and Respiratory Diseases, Bulovka, 1807 Prague 8, Czechoslovakia.

Cancer Pain-2nd International Congress--July 14-17, Rye, NY. Contact Mary Callaway, Memorial Sloan-Kettering, 1275 York Ave., New York, NY 10021.

Third Annual Cancer Conference--July 14-16, Disneyland Hotel, Anaheim, CA. Sponsored by the Univ. of California (Irvine) Cancer Center. Theme of the conference will be "Health Care for Women." Contact Joanne Clayton, Communications Manager, UCI Cancer Center, 101 The City Dr., Orange, CA 92668, phone 714/937-7724.

Chemotherapy of Clinical and Experimental Cancer, Gordon Research Conference--July 18-22, Colby-Sawyer College, New London, NH. Contact Thomas Tritton, Dept. of Pharmacology, Univ. of Vermont Medical School, Burlington, VT 05405.

Fourth International Symposium on Selenium in Biology and Medicine--July 18-20, Univ. of Tubingen, West Germany. Contact Dr. A. Wendel, Physiologisch-Chemisches Institute der Universitat, Hoppe-Seyler-Strabe 4, D-7400 Tubingen, Germany, or Dr. O. Levander, USDA, Agricultural Research Service, Human Nutrition Research Center, Beltsville, MD 20705, phone 301/344-2504.

National Cancer Advisory Board Centers Committee--July 21-22, Washington DC Capitol Hilton Hotel, 8:30 a.m. Workshop on development of criteria for comprehensive cancer centers.

FUTURE MEETINGS

Advances In Chemotherapy of AIDS--Sept. 23, Univ. of Alabama (Birmingham). Organized by the Div. of Clinical Pharmacology. Contact CME Office, phone 205/934-2687 or 1-800/231-0507.

Challenges of Oncology Nursing--Sept. 28-30, Bunts Auditorium, Cleveland Clinic Foundation. Contact Dept. of Continuing Education (TT31), Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, OH 44195, phone 444-5695 (local); 800/762-8172 (Ohio); 800/762-8173 (elsewhere).

Fifth Biennial Conference of Indian Assn. of Cancer Chemotherapists--Feb. 17-19, 1989, Bombay. For information on registration and submission of abstracts, contact Dr. Nagraj G. Huligol, Div. of Radiation Oncology, Nanavati Hospital & Medical Research Centre, S.V. Road, Vile Parle, (W), Bombay-400 056, India.

Sixth NCI EORTC Symposium on New Drugs in Cancer Therapy--March 7-10, Free Univ., Amsterdam. Includes sessions on new drug design, new anticancer agents, interleukins and LAK cells, growth factors, interferons and monoclonal antibodies. Contact EORTC New Drug Development Office, Free Univ. Hospital, DeBoelelaan 1117, NL-1081 HV Amsterdam, The Netherlands.

American Radium Society--April 15-19, Stouffer Grand Beach Resort, St. Thomas, U.S. Virgin Islands. 71st annual meeting. Contact Suzanne Bohm, Administrative Director, American Radium Society, 1101 Market St., 14th Floor, Philadelphia, PA 19107, phone 215/574-3179.

The Cancer Letter _ Editor Jerry D. Boyd

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