THE CANCER LETTER

Vol. 15 No. 26
June 30, 1989

Price $185 Per Year North America
$200 Per Year Elsewhere

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

Centers Bitter Over NCI's Reaction To IOM Report, Core Grant Losses, Program Staff Cuts

The honeymoon between NCI Director Samuel Broder and the nation's cancer centers, if there ever was one, is over. Center directors and staff members attending the annual meeting of the Assn. of American Cancer Institutes last week in Puerto Rico left little doubt about that. The centers feel that NCI leadership, along with the National Cancer Advisory

(Continued to page 2)

In Brief

Salmon Heads AACI, Owens President Elect; AMA Adds PDQ To Its Electronic Network

SYDNEY SALMON, director of the Arizona Cancer Center, assumed presidency of the Assn. of American Cancer Institutes at its meeting last week in San Juan. **ALBERT OWENS**, director of the Johns Hopkins Cancer Center, was elected vice president and president elect. New board members are **Robert Capizzi**, director of the Cancer Center of Wake Forest Univ.; and **Richard Steckel**, director of the UCLA Jonsson Comprehensive Cancer Center. **Edwin Mirand**, Roswell Park Memorial Institute, continues as secretary treasurer. . . . **NEW MEMBERS** of the DCBD Board of Scientific Counselors are Howard Schachman of Univ. of California (Berkeley), Eugene Bauer of Stanford Univ., Judith Campbell of California Institute of Technology, Margaret Kripke of Univ. of Texas M.D. Anderson Cancer Center, and Carolyn Whitfield of Howard Univ. Outgoing members are Sandra White, George Bell and Stephen Baylin. . . . **FOUR MEMBERS** of the Div. of Cancer Treatment Board of Scientific Counselors have ended their four year terms. They are Lawrence Einhorn, Charles Putman, Geraldine Schechter, and Robert Schimke. . . . **RONALD GOLDFARB**, who has been director of experimental therapeutics at the Pittsburgh Cancer Institute, has been appointed associate director for basic research. . . . **AMERICAN MEDICAL** Assn. announced last week that its AMA/Net electronic medical information network for physicians has added PDQ to its service. Developed and maintained by NCI, PDQ is the world's largest cancer treatment data base. AMA/Net has 35,000 subscribers. . . . **ERNST WYNDER** has received yet another honor, this time the Public Health Service Award, the highest given by the U.S. Surgeon General. The award is in recognition of his efforts in disease prevention as they relate to smoking. Wynder is president of the American Health Foundation.

Centers Bitter Over NCI's Reaction To IOM Report, Core Grant Losses

(Continued from page 1)

Board, have ignored the most important recommendations in the recent Institute of Medicine report on the state of cancer centers and have attempted to undercut AACI efforts in Congress.

AACI members appeared to be unanimous in criticizing NCI handling of the centers program, with Peter Greenwald, director of the Div. of Cancer Prevention & Control, offering the only defense.

They were not impressed by Broder's response to the IOM recommendation that NCI should reprogram up to $6 million of 1989 fiscal year money into the centers core grant budget: "We will look at the money that may be available, and will try to spend it as best we can to meet the total needs of the institute. Keep in mind that the National Cancer Institute is an organic whole, a delicate ecological system" (**The Cancer Letter**, May 5).

Subsequently, centers representatives were even less impressed by the fact that little if any money was reprogrammed into the core grant budget. The result: Four existing core grants will be phased out this year.

The number would have been five except for a creative bit of juggling, in which six centers are being funded only for 10 or 11 months with FY 1989 money; the last months will be picked up from the 1990 budget.

Broder is not insensitive to the problem. He told the Division of Cancer Biology & Diagnosis Board of Scientific Counselors last week that the centers program has shown the least proportional growth of any NCI mechanism over the past eight years. "This is a significant concern," Broder said. "Each cancer center has the potential to be a major resource in its community."

Centers people agree with that, but they wonder what Broder intends to do about it. The IOM report also recommended that sufficient money be included in the core grant budget for 1990 to avoid further reduction in number of funded centers, and to fund them at least at 85 percent of recommended budgets. The centers would be more confident that Congress will add money to the appropriations bills now awaiting markup if there had not occurred what they perceive as a stab in the back on Capitol Hill.

"A few of us went to Congress and tried to explain the Institute of Medicine's recommendations," Albert Owens, director of the Johns Hopkins Cancer Center and AACI president elect, said at the meeting in San Juan. "We were followed by some who cast doubt on those recommendations."

Owens and others said the dissenters told congressional staff members that the IOM committee which held hearings on the centers situation and which drafted the report was stacked in favor of centers. "It was seen as some as a plot to increase core grants." Owens pointed out that a majority of the IOM committee members were not affiliated with cancer centers.

Ross McIntyre, director of the Norris Cotton Cancer Center and outgoing AACI president, reviewed the situation in his address to the meeting.

"Cancer centers (with NCI core grants) peaked at 68 in 1979, and the support for cancer centers, as measured in constant dollars. . . peaked in 1978. Unless strong action is taken by Congress and NCI, we will drop from 59 centers which are currently funded to 49 by the end of 1990.

"Since 1982," McIntrye continued, "the share of the NCI budget devoted to cancer center core grants has declined from 8.0% to 6.8% in 1988 and it is expected to decline further to 6.2% if the President's 1990 budget is adopted. During this interval, research project awards (RO1s and PO1s) have increased approximately 15% overall.

"Measured in constant dollars, the budget for cancer centers has declined by 35% while the budget for research project grants has increased 15%. Thus, each dollar committed to the scientific infrastructure represented by cancer centers is now supporting more RO1 research than ever before. In fiscal year 1987, more than half of all NCI grant dollars awarded went to institutions with cancer

THE CANCER LETTER

Editor: Jerry D. Boyd

Associate Editors:
Patricia Williams, Kirsten Boyd Goldberg

P.O. Box 2370, Reston VA 22090
Telephone (703) 620-4646
ISSN 096-3917

Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter and AIDS update.

centers where this infrastructure exists.

"Several years ago the leadership of AACI, recognizing these trends, sought out members of Congress and called attention to what was happening. Each year, the report language from the appropriations subcommittees strongly supported the role of cancer centers in carrying out the mission of NCI. On repeated occasions, AACI called the attention of Congress to the impending crises predicated by a flat budget for the centers, by the cessation of funding for the construction program, and by a withering of opportunities for cancer research training.

"During this time, it was clear Congress was receiving mixed messages.

"While AACI was pointing out trends in funding for cancer centers, others were pointing out the need for maintaining the number of RO1 grants in the face of budgetary pressures.

"In order to receive advice on the state of the Cancer Centers Program, the committee report that accompanied the NIH appropriations bill for 1989 requested that NIH contract with the Institute of Medicine to undertake a study which would report on the program's funding and organizational needs."

McIntyre noted that the IOM committee agreed with "the fundamental premise on which cancer centers are founded," and summarized the recommendations: strengthening core grant support, averting a crisis this year by adding up to $6 million to the program, develop an "adequate budget" for 1990, and enhance centers representation "in the NCI planning and decision making processes."

McIntyre said that AACI "once again visited members of Congress and participated actively in the appropriations subcommittee hearings on the 1990 budget. It is with considerable regret that I must report to you that during this same period, the NCAB and NCI staff received the Institute of Medicine report and were not at all enthusiastic about its major conclusions. Some are said to have viewed the report as 'self serving' and it is reported also that those of us involved in the Cancer Centers Program regard the NCI budget for centers as an 'entitlement.' You in this room who direct cancer centers know that within the house of your own institution you are often regarded as a 'prophet without honor.' The tone of discussion of the recent NCAB meetings and remarks by NCI leadership now suggest that you are viewed by NCI as without honor, too. This is indeed a tragic situation."

Sydney Salmon, director of the Arizona Cancer Center and new AACI president, said the IOM report was "superb" but that the NCAB appeared to have "damned it with faint praise."

Greenwald disagreed, contending that the NCAB Centers Committee, chaired by John Durant, had "strongly endorsed it."

The NCAB committee's statement on the IOM report said that the Durant committee "considers (the IOM report) to be a constructive but incomplete document. . . (It) highlights important problems in the infrastructure of biomedical science in the United States. The Cancer Centers Program. . . is the core of a much larger apple of cancer research. Financial solutions to the problems. . . must be considered comprehensively as an investment in the future productivity of our economy and the health of our people. We urge that the solution come, not from reordering priorities in biomedical science funding, but in achieving a higher national priority for all of biomedical science. This means that the strength of the Cancer Centers Program is inseparably linked to the vitality of the biomedical research that it sustains and that the Cancer Centers Program can benefit from increased financial support only if that support is not obtained by subtraction from existing funding mechanisms for cancer research and training."

AACI's response is that other programs benefitted from subtraction from the centers program over the last seven years.

Greenwald agreed that the IOM report was "superb." He said NCI agreed that core support should be strengthened, but added that the budget process "lies in the hands of others," an obvious reference to NIH, HHS and the Office of Management & Budget.

On the short term funding issue of 1989 and 1990, Greenwald noted that there had been "a clustering" of competing applications at the payline (176 priority score), which left four centers with existing core grants unfunded.

[NIH procedure does not provide for publicly revealing the failure of grantees in competing for renewals. **The Cancer Letter** has learned that the four centers which did not succeed in getting their core grants renewed are Roswell Park Memorial Institute, Ohio State Univ. Comprehensive Cancer Center, the Markey Cancer Center in Lexington, KY, and the Northern California Cancer Center].

While the scores of the four ranged up to the high 200s, NCI executives said that had

the money been available, they probably would have been funded. NCI has not felt obligated to follow the priority score paylines established for ROIs and POIs in funding center core grants.

Greenwald said that Broder accepted the IOM recommendation to strengthen planning for the centers program and has established a staff committee chaired by NCI Deputy Director Maryann Roper. Other members are Judith Whalen, planning officer in the Office of Program Operations & Planning; Greenwald; Werner Kirsten, director of the Frederick Cancer Research Facility; Michael Grever, Div. of Cancer Treatment deputy director; David Longfellow, chief of the Chemical & Physical Carcinogenesis Branch in the Div. of Cancer Etiology; Faye Austin, chief of the Cancer Immunology Branch in the Div. of Cancer Biology & Diagnosis; Bill Wells, supervisory grants management specialist in the Grants Administration Branch; and Margaret Holmes, program director in the Cancer Centers Branch. Donald Fox, acting director of the Centers & Community Oncology Program, and Lucius Sinks, chief of the Cancer Centers Branch, will provide technical support.

Six centers representatives have been appointed to meet with Broder and the NCI committee: Owens, Alan Sartorelli of Yale, Shirley Lansky of Illinois Cancer Council, William Sharp of MIT, John Ultmann of the Univ. of Chicago, and Welter Eckhart of Salk Institute.

The IOM committee looked at the organizational structure of the Cancer Centers Program and recommended only that it be strengthened. AACI's position has been that it should be removed from DCPC and lodged in a new division along with facilities (construction) and training.

Before former Director Vincent DeVita left last year, he had all but decided to move the program into his office, feeling that a new division was not a practical answer.

Greenwald noted at the AACI meeting that the NCAB Centers Committee had recommended a new division. "There has been no decision on this," Greenwald said. "Dr. Broder says that he wants to hear from you."

Greenwald again passed the buck, somewhat, to higher levels. "A decision on establishing a new division is not entirely in NCI's hands," he said.

Also, Greenwald added, a new division would place further strains on NCI's crucial FTE problem (ceiling on number of employees). That is a matter of debate among NCI staff members, however. Centers, facilities and training would take their allotted slots with them into a new division. Some contend that at most two or three additional slots would be required.

Greenwald is still trying to recruit someone to head the Centers & Community Oncology Program, vacant since Robert Young left for Fox Chase last year. Fox, who is chief of the Research Facilities Branch, has been acting director since then.

That is not Greenwald's only recruiting problem. He also needs a deputy director, and an associate director for the Prevention Research Program. He is down to one program director in the Centers Program, and this week is losing the last person left in the Research Facilities Branch other than Fox and a secretary, with the retirement of Douglas Dolan.

Fox revealed that efforts are being made to recruit internally, from the ranks of the Public Health Service Commissioned Corps. "The response has been limited."

Sinks observed that "it is a remarkable fact that most" of the major NIH programs and institutes "are headed by people who have spent their entire careers in the government. There is a saying that war is too important to be left to the generals. I think biomedical research may be too important to be left to government career people." He suggested that some method should be developed to permit senior scientists from academia to work for a few years at NIH without being penalized by their institutions in seniority and pension rights.

It was pointed out that Sen. Edward Kennedy (D-MA) is considering legislation which would provide for portability of accrued of federal pension rights in those situations.

Ray Morrison, who retired recently as a program director in the Cancer Centers Branch after 13 years with NCI, had been invited by AACI to attend the meeting and accept accolades due him for his work with centers. He was unable to attend but sent a letter which, in the opinion many AACI members, succinctly and accurately described the situation in the program. Sinks read the letter at the meeting.

"I worked for the NCI centers program for 13 years," Morrison wrote. "For a couple of years before that I was an executive secretary involved with the peer review of program projects and core grants. So I may have been

the NCI staff person with the longest term perspective on the centers program. I was somewhat disappointed when I retired that the leadership of the institute for the division did not recognize that long term service by asking me for any thoughts or suggestions at the time I left. That's OK, because in recent years I came to consider myself to be working for you at the centers rather than for NCI.

"The NCI centers program has been a great success. . . Obviously, that success has been primarily because of the efforts at the centers and the commitment of the parent institutions; but I believe a major contribution has been made by the core grants. . . The core grant program of NCI is now recognized to be of high quality and is used as a model by other institutes of NIH for new center programs. . . I believe that several senior officials of NCI do not fully appreciate this success. At least they have not provided the support such success deserves nor do they appear to be making plans to take appropriate advantage of the centers as resources. . . You all know the budget problems with four centers losing core grants this year and more than that slated to go down next year. . . NCI decided it could not rebudget funds from other programs to alleviate the situation. The excuse seemed to be that other NCI programs also are critically important, that they are part of the 'apple' of funding for centers and to increase the core funding would take a 'bite out of the apple.'

"That's a very neat argument but it doesn't wash. The logic of not rebudgeting is that there is no program which has a lower priority; if there were then the lower priority one could be reduced in order save the core grant of a center or two. Bites are being taken from the core for cancer control and other programs. . . at least $2 million a year of core grant funds are now being used for cancer control activities which are either inappropriate to the mechanism or were to be funded from the cancer control line item. . .

"Additional evidence of the lack of support . . . is the woeful state of the staffing of the Centers Branch. With my departure the staff is down to a branch chief, one program director and one supporting staff. That is simply ridiculous for this very large and important program. . . In the early 80s the branch was staffed with six program director professionals and three secretaries. . . I believe there is a danger that NCI will modify core grant guidelines to pursue some currently popular goal and damage the integrity of the core grant."

Cancer Prevention Grants Awarded To 5 States And District Of Columbia

NCI has awarded grants to health departments in five states and the District of Columbia to plan and implement programs to reduce cancer mortality.

The grants will total $960,000 in the first year and are being awarded as cooperative agreements. The grants are to health agencies in the District, Georgia, Maryland, North Dakota, Vermont and Washington. Two more states, Pennsylvania and Louisiana, are expected to receive similar grants soon.

The eight cooperative agreements are an expansion of NCI's 1987 Data Based Intervention for Cancer Control project, which has grants with six state health departments--Illinois, Nebraska, New York, North Carolina, Texas and Wisconsin. The Div. of Cancer Prevention & Control administers the project.

"We estimate that cancer mortality could be cut in half using what we already know about cancer prevention and treatment," said NCI Director Samuel Broder in announcing the grants. "These cooperative agreements will allow existing cancer data in each of the eight regions to be utilized more fully, creating new cancer control programs in tune with the needs of each population."

HHS Secretary Louis Sullivan said the agreements are "an integral step toward achieving our national goal of reducing cancer mortality by 50 percent by the year 2000."

In the first phase of the project, the state health agencies will review cancer data in their state and identify groups at greatest risk. Second, the agencies will form a coalition of organizations that will use the data to create new cancer control plans. Third, the groups will conduct cancer control intervention projects and improve access to cancer diagnostic techniques. In the final phase, the groups will evaluate the effectiveness of the prevention and control efforts.

All of the cooperative agreements are for seven years. The average estimated cost over the seven year period is $765,000. A third series of agreements are to be awarded in 1990 to another group of state health agencies.

Reviewers Found For Chronobiology Grants; 'Time Of Day Can't Be Ignored'

Enough scientists knowledgeable in chronobiology have been found to enable NCI to form a review committee for an RFA in chronobiology.

The Div. of Cancer Treatment issued the RFA last October, but most of the few investigators in the country knowlegable about chronobiology submitted applications in response to the RFA, leaving few available to do the review (**The Cancer Letter,** April 28).

The review of the applications should be completed soon. DCT had originally intended to fund the grants from fiscal 1989 money, but the funds were committed to other projects. The grants will go to the National Cancer Advisory Board at its fall meeting, and they will be funded out of the fiscal 1990 budget.

The initial problem of finding scientists for the review committee underscores a major concern of those in the field. Despite evidence, turned up mainly by William Hrushesky, that it does make a difference what time of day or night cancer patients receive chemotherapy, the field gets little attention.

"Some people question whether chronobiology is really a science," said Sandor Szabo, associate professor of pathology at Harvard Medical School. He spoke at a meeting on Clinical Applications of Chronobiology earlier this month, jointly sponsored by NIH and the International Society for Chronobiology.

Szabo told the following joke to make his point.

Q: Is Communism a science? A: No, because if it were, it would have been tested in animals first.

"So, chronobiology is a science because it has been tested in animals," Szabo said.

At the meeting, 13 chronobiologists discussed aspects of their work in a variety of areas, including asthma, immune disorders, cardiovascular disease, hypertension, coronary disease, diabetes, psychiatry, sleep disorders, and gastrointestinal problems.

Hrushesky discussed his work since 1979 at the Univ. of Minnesota, and now the Albany Medical College of Union Univ. in New York.

"The time of day of anticancer drug administration can no longer be ignored," he said.

A paper just published in the "Journal of the National Cancer Institute" describes Hrushesky's study of 60 patients with advanced ovarian cancer who were put on a two arm study. One group was given morning treatments of cisplatin, and one group got evening treatments with the same dosage. Patients on the evening schedule did better in tolerating toxicity, had increases in plasma protein binding and decreases in nephrotoxicity compared to the morning cycle.

In animal studies using cisplatin and doxorubicin, Hrushesky found that the nephrotoxicity was "very, very different," depending on the time the drugs were delivered. The best time was in the very early morning, just before usual wakening. Rats on that regimen had a two and a half fold increase in cure rate over others.

In another study of patients with kidney cancer, Hrushesky found he could double the dose of FUDR for patients using a variable rate infusion pump. Patients using a constant rate pump could not tolerate the higher dosage. Hrushesky reported six complete responses, eight partial responses and four minor responses.

Hrushesky now is studying tumor necrosis factor. His hypothesis is that the therapeutic index of TNF is circadian stage dependent. In trials he has found that the worst time to adminsiter TNF is in the early morning, when it is more lethal. He noted that is the time when most phase 1 studies are conducted.

"If the circadian timing of TNF is ignored, results will be highly variable and not reproducable, and it will be lethal," he said.

DCBD To Fund Diagnostic Clinical Trials By Cooperative Groups, CCOPs

A new NCI wide committee is planning to provide supplements to cooperative groups and the Community Clinical Oncology Program for diagnostic clinical trials.

The new committee, formed in the Div. of Cancer Biology & Diagnosis but with representatives from each NCI division, will work to move diagnostic research more rapidly into clinical trials.

The Diagnostic Decision & Implementation Committee will decide whether a diagnostic test is ready for large scale clinical testing and will provide funding supplements to help move the research along. Supplements will go through the Div. of Cancer Treatment to the cooperative groups and the Div. of Cancer Prevention & Control to CCOPs.

It is too early to tell how much money the committee will have available for the supplements, Sheila Taube, chief of the Cancer Diagnosis Branch told the DCBD Board of Scientific Counselors last week.

The committee will base its recommendations for supplements on information from diagnostic research which indicate that a

procedure is ready for clinical trials. Appropriate protocols will be developed, and the committee will review them. Once a protocol has been approved, a study population will be identified, from the cooperative groups or from CCOPs.

"We will work closely with the division involved to put into trial the particular diagnostic approach," Taube told the board.

The committee will not develop major new RFA programs soliciting grants from outside NCI, she said, but will consider clinical trials proposals from DCBD and other NCI divisions.

In addititon to providing supplements to the cooperative groups and CCOPs, the committee will contract with research laboratories to conduct any necessary tests.

The impetus for the diagnostic clinical trials effort came from former NCI Director Vincent DeVita, who said that promising diagnostic tests had to be moved more rapidly into clinical trials. He had suggested moving the Cancer Diagnosis Branch to another division, Taube said.

"We felt there had to be more interaction with clinical programs," Taube said. "DCT and DCPC have the groups, the statisticians, all of the structures, but they don't have support to do the biologic studies. Centers are saying they need to test flow cytometry in breast cancer, for example."

The committee held a workshop that brought academia and industry representatives together to discuss the need for resources for diagnostic testing.

Taube said the committee is evaluating those discussions and will issue some recommendations. One idea that came out of the workshop was to set up a clearinghouse that would provide information on various tests and their stage of development.

"We'd like to let industry know what we feel are important tests," Taube said.

Members of the committee are in addition to Taube, John Antoine, Michael Friedman and Richard Ungerleider, DCT; Leslie Ford and Charles Smart, DCPC; Toby Hecht, FCRF; Adele Leff, Grants Administration Branch; Robert Miller, Div. of Cancer Etiology; and Beverly Wyatt, Research Contracts Branch.

Taube said this represents the "core" committee, and representatives from industry or other areas would be invited to meetings as a specific expertise is needed.

The new committee is not to be confused with DCT's Diagnosis Decision Network Committee.

DCBD Board Approves Recompetition, Expansion Of Human Tissue Network

NCI's Div. of Cancer Biology & Diagnosis plans to expand a network that supplies investigators with human tumor tissue, adding one or two more institutions to the cooperative agreement that supports the network.

The division's Board of Scientific Couselors last week gave concept approval to the recompetition and expansion of the Cooperative Human Tissue Network, for a total annual $8 million over five years.

Three to five awards will be made, for a total annual amount of $1.5 million. The cooperative agreement mechanism is intended to support activities that stimulate research and which require substantial NCI staff participation.

Roger Aamodt, program director for pathology-cytology in the Cancer Diagnosis Branch, cited increasing demands for human tissue as the reason for expanding the network, which began in January 1987.

The network was shipping 80 tissues a month to investigators in its first month of existence. By last September, the network was shipping more than 600 tissues a month.

"There's no question the growth will continue," Aamodt told the board. "This has made possible a lot of research that wouldn't have been done otherwise."

Following is the text of the concept statement:

Cooperative human tissue network. This concept is to continue and expand the Cooperative Human Tissue Network, established in January 1987. The original concept for the CHTN called for the development of a cooperative network of tissue procurement laboratories to provide tumor and normal tissue to investigators in the major biomedical research centers throughout the U.S. The CHTN was established in response to the perception by the biomedical research community that lack of access to appropriate human tissues posed a major obstacle to cancer research, particularly molecular genetics. Since its creation, the CHTN has become a vital part of the resources used by the cancer research community. CHTN has experienced rapid growth and has provided thousands of specimens to hundreds of researchers.

In 1984, aware of the increasing demand for human tissue, the Cancer Diagnosis Branch of DCBD invited an ad hoc working group to evaluate the need. Its recommendations provided the basis for the development of the CHTN.

Eight applications that were submitted in response to the RFA were reviewed by an NCI ad hoc review group in September 1986 and three groups were selected. The CHTN consists of the Univ. of Alabama (Birmingham), the National Disease Research Interchange and Ohio State Univ. Pediatric tumor tissues are provided by the Children's Cancer Study Group under a subcontract to Ohio State.

The CHTN operates under the guidance of a coordinating committee consisting of the principal investigator and one additional representative from each of the participating institutions, a representative from the CCSG and a

representative from NCI. This group is responsible for establishing general operating policies. The network is organized into three divisions, each having primary responsibility for one geographic area of the U.S. Provision has been made for networking of requests for rare tissues and tissues that cannot be obtained rapidly so that investigators can be assured that they will be served in a timely fashion.

Access to the network is on a rotating basis with first priority going to peer reviewed funded investigators. New investigators and investigators developing new projects are given second priority and other investigators receive third priority. In addition, investigators who are requesting small amounts of tissue will receive priority over those who want large amounts. The network also has emphasized protection of researchers against biohazards, and has produced and distributed a comprehensive set of biosafety guidelines to assist in the establishment of good safety practices.

The success of the network is reflected in its tremendous growth during the two and one half years of funding by NCI, the continuation of that growth and the number and quality of the investigators who are regularly using the network. It is becoming clear that the continued success of the network will depend on maintaining and expanding access to tissues. This is already underway in each of the existing divisions of the network, but may also require one or two additional participating institutions.

The network is intended to support the cancer biology and diagnosis research communities and stimulate cancer research in areas such as molecular biology, immunology and genetics, areas which are primarily supported by DCBD. This concept has already been demonstrated to advance research by making tissues available to basic scientists who are otherwise unable to establish the clinical collaborations required to obtain tissues and to provide a simple way for other researchers to obtain tissue for limited projects.

Vittorio Defendi, a board member, said he was concerned that the network does not provide much information about the tissue, such as the patient's survival and other factors. Aamodt said some of that information is not released to protect patients, and that the network asks investigators to spell out the information they will need before they receive the tissue.

"It is a problem, as people want to do more follow up studies," DCBD Director Alan Rabson said. He asked Aamodt to determine how the network could provide more information to investigators.

The concept was approved unanimously.

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

N-Nitroso Compounds, Mycotoxins and Tobacco Smoke: Relevance to Human Cancer--July 2-7, Beijing, China. Contact IARC, 150 cours Albert Thomas, 69372 Lyon Cedex 08, France.

British Assn. of Surgical Oncology--July 6-7, Reading, Berks, UK. Contact BASO, Royal College of Surgeons, Lincoln's Inn Fields, London WC2A 3PN, UK.

Ninth Sapporo Cancer Seminar--July 6-8, Sapporo. Contact Atsuko Suehiro, Laboratory of Pathology, Cancer Institute, Hokkaido Univ. School of Medicine, Sapporo, Hokkaido 060, Japan.

Conservative Treatment of Breast Cancer--July 11-13, Venice. Contact Secretariat, Rm FA89, European School of Oncology, Via Venezian, 1, 20133 Milan, Italy.

Treating the Drug Resistant Cancer Patient--July 13-15, Disneyland Hotel, Anaheim. Fourth Annual UCI Cancer Conference. Contact Univ. of California (Irvine) Cancer Center, UCI Medical Center, 101 City Drive South, Bldg 44, Rt. 81, Orange, CA 92668, phone 714/634-5081.

Surgical Management of Advanced and Recurrent Malignancies--July 15, Ohio State Univ. Hospitals, Rhodes Hall Auditorium, Columbus. Contact OSU Center for Continuing Medical Education, PO Box 21697, Columbus, OH 43221, phone 614/292-4985.

National Conference on Breast Cancer--July 19-21, Chicago. American Cancer Society conference for health professionals. Contact ACS, 1599 Clifton Rd. NE, Atlanta, GA 30329.

National Committee to Review Current Procedures for Approval of New Drugs for Cancer and AIDS (Lasagna Committee)--July 20, NIH Bldg 1 Wilson Hall, 9 a.m.-4 p.m., open.

Cancer Management Course--July 21-22, St. Louis. Contact Cancer Dept., American College of Surgeons, 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

Cancer Management Course--Aug. 25-26, Buffalo. Contact as above.

Gastrointestinal Cancer--Aug. 27-Sept. 1, Jerusalem. Second international conference. Contact GIA Secretariat, PO Box 50006, 61500 Tel Aviv, Israel.

XI Congreso Nacional de Cancerologia--Aug. 27-31, Lima. Contact President, Instituto Nacional de Enfermedades Neoplasticas, Av. Angamos Este 2520, Surquillo, Lima, Peru.

FUTURE MEETINGS

Advances in Drug Development and Delivery--Sept. 8-9, Lexington, Ky. Lucille Parker Markey Cancer Center Second Annual Cancer Symposium, with separate programs for physicians and nurses. Contact Karen Christian, Markey Cancer Center, 800 Rose St., Lexington, KY 40536, phone 606/257-4500.

Innovative Approaches in Cancer Therapy--Sept. 8-9, Pittsburgh. Fourth annual Mary A. Davis Memorial Symposium. Contact Kristine Krutules, Pittsburgh Cancer Institute, 200 Meyran Ave., Pittsburgh, PA 15213, phone 412/624-1023.

Transrectal Ultrasound in the Diagnosis and Management of Prostate Cancer--Sept. 14-16, Chicago. Fourth international symposium. Contact Diversified Conference Management, PO Box 2508, Ann Arbor, MI 48106, phone 313/665-2535.

Neoadjuvant Therapy and Upper Gastrointestinal Cancer--Sept. 20, Cleveland. Contact Ronald Bukowski MD, Cleveland Clinic Cancer Center, 9500 Euclid Ave (T33), Cleveland, OH 44195, phone 216/444-6825.

Cancer Biotherapy Achieving State of the Art--Oct. 11, Cleveland. Contact Ronald Bukowski MD as above.

Recent Progress in Nutrition and Cancer--Nov. 1-3, Nagoya, Japan. UICC workshop. Contact Dr. Curtis Mettlin, Chairman, UICC Nutrition and Cancer Program, Roswell Park Memorial Institute, Buffalo, NY 14263, phone 716/845-4406.

Immunobiology of Renal Cell Carcinoma--Nov. 6-7, Cleveland. First international symposium. Contact Ronald Bukowski MD, Cleveland Clinic Cancer Center, 9500 Euclid Ave. (T33), Cleveland, OH 44195, phone 216/444-6825.

New Approaches to Problems in Radiation Oncology: Applications of Molecular Biology--Nov. 12-15, Tucson. Deadline for poster session abstracts is Sept. 1; forms available from Arizona Cancer Center. Contact Mary Humphrey, Conference Coordinator, Arizona Cancer Center, Univ. of Arizona, Tucson, AZ 85724, phone 602/626-2276.

Cancer Communications--Jan. 10-12, 1990, Washington, DC. Sixth national conference. Contact Communications Conference, 1801 Rockville Pike, Suite 500, Rockville, MD 20852, phone 301/468-6338.

Diagnostic Cytopathology for Pathologists--Feb.-April, 1990, Home Study Course A; April 23-May 4, In Residence Course B, Baltimore. 31st annual postgraduate institute offered by Johns Hopkins Univ. School of Medicine. Applications due before January. Contact John Frost M.D. or Betty Ann Remley, 111 Pathology Bldg, Johns Hopkins Hospital, Baltimore, MD 21205, phone 301/955-8594.

Adjuvant Therapy of Cancer--March 7-10, 1990, Tucson. Sixth international conference. Deadline for abstracts (AACR/ASCO format) is Dec. 1. For abstract forms, copies of the preliminary program and further information, contact Mary Humphrey, Conference Coordinator, Arizona Cancer Center, Univ. of Arizona, Tucson 85724, phone 602/626-2276.

Head and Neck Cancer Rehabilitation--March 15-18, Dearborn, Michigan. Multidisciplinary international conference and workshop. Contact Wayne State Univ., School of Medicine, Dept. of Otolaryngology, 4201 St. Antoine, 5E-UHC, Detroit, MI 48201, phone 313/577-0804.