THE CANCER LETTER

Vol. 16 No. 20
May 18, 1990

Price $195 Per Year US, Canada.
$220 Per Year Elsewhere

P.O. Box 15189 Washington, D.C. 20003 Telephone 202-543-7665

NCI Bypass Budget For FY 1992 Requests $2.6 Billion; Support Grows In Congress

The 1992 NCI Bypass Budget was unveiled this week, offering the first look at what the institute and National Cancer Advisory Board consider the optimal amount that can be wisely spent on the National Cancer Program. The 1992 fiscal year Bypass Budget requests $2.6 billion,

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In Brief

Fred Rapp To Retire, Set Sail For Europe; Armand Hammer To Celebrate 92nd Birthday

FRED RAPP, associate dean for academic affairs, research and graduate studies, and chairman of the microbiology and immunology department at Pennsylvania State Univ., will retire on June 30, after 21 years at the university. Rapp's research was instrumental in supporting the theory that some human cancers may be caused by viruses. He and his wife, Pam, plan to sell their home in Hershey, PA, and set sail on their 42-foot sailboat, the Simplex. They are making plans to sail to Europe and back in 1992 by the same route used by Columbus 500 years earlier. . . . **ARMAND HAMMER,** chairman of the President's Cancer Panel, will celebrate his 92nd birthday on May 21. . . . **AMERICAN ROENTGEN** Ray Society honored three of its members at its annual meeting this week. Ted Leigh, now retired from Emory Univ. School of Medicine; Elliott Lasser, professor of radiology at Univ. of California (San Diego), and John Dennis, dean of the Univ. of Maryland Medical School, received Gold Medal Awards. . . . **JULES HALLUM** has been named director of the Office of Scientific Integrity within the NIH director's office. Hallum is a professor and chairman of the department of microbiology and immunology at the Oregon Health Sciences Univ. . . . **FREE SCREENING** of the breast and cervix for women below the poverty level has been proposed in a bill introduced by Rep. Henry Waxman (D-CA). Women with higher incomes would pay on a sliding scale. The bill would provide $50 million in FY 1991 to states to provide breast examination, mammography and pap smears. States would be required to match $1 for each $3 in federal funds. Senate companion legislation has been introduced by Sens. Nancy Kassebaum (R-KN) and Barbara Mikulski (D-MD). Marilyn Quayle appeared at a hearing on the bill recently to speak about the importance of breast and cervical cancer screening. . . . **CORRECTION:** Mayo Comprehensive Cancer Center, the host of the annual meeting of the Assn. of American Cancer Institutes next month, is located in Rochester, MN, not NY, as stated in the May 4 issue of **The Cancer Letter.**

NCI Bypass Budget For FY 1992 Asks $2.6 Million; Support Grows

(Continued from page 1)

nearly $1 billion more than the White House is asking for NCI in FY 1991. NCI will send the Bypass Budget to the President in September.

Other agencies call their initial funding requests their "professional needs" budgets. Those requests never legally are seen outside the chain of command up to the White House, except when and if they are requested by congressional appropriations committee members at budget hearings. They are sometimes leaked, but the bureaucrat caught doing that is in deep trouble.

NCI, on the other hand, is required by the National Cancer Act to develop its professional needs budget with the advice of the National Cancer Advisory Board, which considers it in open session. That budget is sent directly to the President; although the NIH director and HHS secretary may comment on it, they cannot change it. Hence the term, "bypass."

The Bypass Budget itself has been bypassed, almost every year since it was created in 1971. HHS officials did not try to change it; they simply ignored it and ordered NCI to develop another budget, based on a much smaller figure allocated by the department. That is the budget which is then incorporated into the President's formal budget submissions to Congress.

The gap between the Bypass Budget and the final budget which comes out of Congress has been growing, leading some to contend that the process is useless. But Director Samuel Broder, the American Cancer Society, and the various professional organizations have remained firm in support of the concept. They argue that the Bypass Budget is a statement to the President, Congress and the country of what resources are needed to make the best and maximum effort in cancer research and control.

Although this effort has seemed to fall on deaf ears for more than a decade, there may be a glimmer of hope that this time, the Bypass Budget message may be getting through. Consider:

* Members of both House and Senate Appropriations Committees, Democrats and Republicans, including the chairman of the Senate Labor-HHS-Education Appropriations Subcommittee, have expressed support for the Bypass Budget. Other influential members have also supported it, and the Budget Committees have added substantial sums for NIH with NCI one of the major beneficiaries.

* The "peace dividend," although spoken for many times over by competing interests, will at least give those sympathetic members of Congress a fighting chance to divert significant sums to biomedical research.

The figures shown in the table on page 3 for the major NCI funding mechanisms compare the 1992 bypass budget to the President's request for 1991. The 1991 budget is still under development; the congressional appropriations committees have yet to mark up their bills.

Given the sentiment in Congress, as expressed in the committee hearings, the Budget Committee decisions, and by individual members on other occasions, it seems likely that NCI will receive somewhat more than requested by the White House. A few believe that the increase will be substantial, although not close to the 1991 Bypass Budget of $2.41 billion. The percentage of increases shown in the table, therefore, are subject to change.

The table includes NCI's AIDS dollars, which in the Bypass Budget is $217.7 billion. The President requested $160.8 billion for FY 1991, and the operating budget for the current, 1990 fiscal year is $150.3 million.

Totals for cancer research and control in the 1992 Bypass Budget is nearly $2.4 billion, compared with $1.5 billion in the President's request for 1991 and $1.48 billion in 1990.

When the Bypass Budget goes to the White House, it will include detailed breakdowns of proposed spending by programs, broad research areas, and funding mechanisms, along with narrative justifying and explaining all those efforts. The draft which was submitted to and adopted by the NCAB this week included only a sketchy explanation of how the additional money would be allocated:

Research Project Grants

These include RO1s, PO1s, OIGs, and all other

THE CANCER LETTER

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ISSN 096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter and AIDS Update.

National Cancer Institute (dollars in thousands)

Includes AIDS	1991 President's Budget	1992 By-Pass Budget	1991/1992 Amount	1991/1992 Percent
Research Project Grants	$780,686	$1,135,904	$355,218	45.5%
Cancer Centers	103,004	162,619	59,615	57.9
Other:				
Research Career Program	8,323	13,000	4,677	56.2
Cancer Education Program	2,942	7,560	4,618	157.0
Clinical Cooperative Groups	59,747	98,802	39,055	65.4
Other grants	11,618	30,929	19,311	166.2
Subtotal Grants	966,320	1,448,814	482,494	49.9
National Research Service Awards	35,793	53,409	17,616	49.2
R&D Contracts	200,552	323,156	122,604	61.1
Intramural Research	333,219	414,328	81,109	24.3
Research Mgt. & Support	81,237	111,219	29,982	36.9
Cancer Prev. & Control	75,459	182,274	106,815	141.6
Construction	1,479	78,800	77,321	
Total	1,694,059	2,612,000	917,941	54.2%

investigator initiated grants.

--Fund 50 percent of approved competing grants; approximately 1,500 awards.

--Restore 1991 proposed reductions for both competing and noncompeting awards. Competing grants will be "downward negotiated" (the current euphemism for "cut") by 20 percent from recommended levels; noncompeting, four percent.

Cancer Centers

Expand outreach and information dissemination initiatives.

--Fund approximately 62 centers, including new centers for minority initiatives (56 centers are presently funded).

--Restore 1991 reductions.

--Fund proposed grants at full level.

Clinical Groups

--Support high priority clinical trials and increase patient accrual by approximately 25,000 patients.

Training

--Support 1,750 trainees, an increase of nearly 350.

--Increase stipends for both pre and postdoctoral trainees.

--Expand initiatives for pain research training.

Instrumentation

--$10 million for small instrumentation needs of extramural community.

Cancer Prevention and Control

--Expansion of over $106 million; including chemoprevention, nutrition, CCOPs, underserved, and public health initiatives.

Construction

--Two year obligating authority, with $50 million for extramural grants.

Rehabilitation

--Initiate organ sparing and surgical reconstruction activities.

--Initiatives in behavioral and psychological aspects of cancer.

Proton Beam Therapy

--Includes $25 million for a proton beam unit.

Surveillance Activity

--Expansion of SEER program to include greater minority, rural, and underserved populations.

Cancer Vaccine

--A $30 million initiative proposed.

Minority/Rural/Underserved Populations

--Expand demonstration projects.

--Increase funding for minority specific initiatives such as Minority Investigator Supplements and Historically Black Colleges.

AIDS

--A $56 million expansion including an RFA for pathogenesis and clinical trials related to lymphomas and AIDS.

Information Dissemination and Education

--Cancer Information Service expansion to cover greater part of the country.

Nutrition and Diet

--Incorporates a program expansion of approximately $25 million.

Smoking, Tobacco, and Cancer

--Expand activities related to both ASSIST and COMMIT programs.

International Activities

--Expand short and long term training of scientists for Eastern European organizations.

--Expand electronic information demonstration projects with European, African, Caribbean, and Latin American nations.

Broder's comments in presenting the Bypass Budget to the NCAB Committee on Planning & Budget:

"The clinical cooperative groups, with their ancillary programs, CCOPs and CGOPs, are an extremely important component of the National Cancer Program. They have had to endure flat budgets, too, and $99 million is not a luxury budget for the groups. We will rely on the cooperative groups more and more. They can do prevention studies, and we are discussing with them the possibility of doing certain trials, such as tamoxifen in prevention of breast cancer among high risk women."

Div. of Cancer Treatment Director Bruce Chabner added, "The groups are a tremendous resource to do prevention trials. They can identify high risk persons, and patients at high risk for second primaries."

Broder: "The research project grant line has gone up the most of any mechanism. RPG is the dominant mechanism, by design. It is the dominant thing we want to support. It is not an accident. We have always said that and will continue to say it."

In response to a question on the status of a proposal to impose a cap on cancer center core grants, Broder said, after a long pause, "That is under discussion. I am considering adding that to the list of things an NCI director should never do (argue with the President, discuss indirect costs). I wax and wane on that. I am concerned that a cap would send the wrong message on peer review and excellence of centers. I'm uncomfortable with an arbitrary cap. At least I am today."

NCAB Chairman David Korn questioned the bypass earmark for a proton beam facility. "A number of people I know in the radiation oncology field say that proton beam facility cost (as estimated in a presentation by Herman Suit previously to the NCAB) is not worth it. They do not support it as their highest priority."

Broder: "The position is that if we had a budget of $2.6 billion we would consider a proton center as worthy of competing against other priorities. It could help a small core of patients, maybe 3,000, who could benefit from proton beam therapy and for whom there is no other reasonable alternative. There currently are two proton beam facilities, at Loma Linda Univ. funded by the Dept. of Energy and at Massachusetts General. If members of the radiation therapy community stand and say they don't want to do this, we could withdraw it."

Korn also questioned the earmark for cancer vaccine research.

"There are multiple facets to this," Broder said. "We already have a melanoma vaccine in a clinical trial."

He mentioned other possibilities which could come from basic research. Div. of Cancer Etiology Director Richard Adamson added the ras oncogene inserted in mice has stimulated antitumor activity.

Other possibilities exist for HPV and hepatitis C as possibilities for the traditional vaccines. NCI will hold a workshop on cancer vaccines in October.

"Worldwide, we have had the most success with the hepatitis B vaccine," which prevents liver cancer, Broder said.

Finally:

"If we were to get this Bypass Budget, we would give serious consideration--extremely serious consideration--to funding the DIET FIT trial," Broder said, referring to the study twice rejected by NCI because of the cost. It would have tested the hypothesis that reduction of dietary fat reduces the incidence of breast and colon cancer.

Here is how NCI plans to spend the $160.8 million it would receive in the President's 1991 budget, and the $217 it would get for AIDS in the 1992 Bypass Budget (first figure is for 1991):

Research project grants, $16.2 million, $24.8 million; cancer centers, $3.6 million, $3.8 million; clinical cooperative groups, none in 1991, $3 million in the bypass; R&D contracts, $62.7 million, $84.9 million; intramural research, $74 million, $94.4 million; research management and support, $4.2 million, $4.5 million; construction, none in 1991, $1.8 million in the bypass.

At Least One Mammography Unit In Every State Is Accredited

Nearly 1,200 mammography facilities that operate 1,466 mammography machines in the U.S. have been accredited by the American College of Radiology since the fall of 1987 in a program aimed at enhancing the quality of mammography imaging.

The ACR Mammography Accreditation Program was started two and a half years ago to provide radiologists with peer review and evaluation of their facility's equipment, staff qualifications and quality control.

A total of 2,436 facilities applied for accreditation for 2,947 machines as of May 1, according to Marie Zinninger, director of practice accreditation for ACR.

"Sometime next month we will hit 3,000 units that have applied. That's not bad for a voluntary program," she said.

The ACR program has accredited at least one mammography facility in every state, as well as three units in Puerto Rico.

Applications have been received from facilities in every major zip code area in the U.S., and a facility in Saudi Arabia, Zinninger said. Many are still in the accreditation process, including the Saudi facility.

Michigan is the state with the most accredited facilities, thanks to a strict state law that requires every mammography unit operating in the state to be accredited by the ACR program. There are a total of 400 units in the state. So far, 350 have been accredited.

Next in order of the top ten states with the most accredited units are California, New York, Pennsylvania, Florida, Ohio, Maryland, Virginia, Texas and New Jersey.

"We want to see a better distribution (of accredited facilities) in large cities. We're also concerned about rural areas, making sure there is at least a mobile van that can get out to women," Zinninger said.

ACR hopes that as more facilities receive accreditation through the voluntary program, there will be peer pressure and perhaps some legislative pressure on all facilities to become accredited.

Some facilities have begun to use accreditation as a marketing tool, which seems to impel other facilities to apply as well.

For example, Zinninger said, there were only two mammography facilities accredited in Philadelphia last year until a newspaper article drew attention to the two accredited programs and to quality control in mammography.

"Immediately our phones started to ring with other facilities in the city calling to receive the application package," Zinninger said.

After an article on mammography recently in the "Long Island Newsday" that mentioned the program and published the ACR phone number, the college received 1,600 calls from women about where to find an accredited facility.

"Women haven't been aware that quality control is an issue in mammography," Zinninger said. "If women are aware, we believe they will seek out accredited facilities."

Inability to meet the ACR standards has driven at least one facility out of business, Zinninger said. The owner decided to close the facility after looking through the program's requirements. Even so, the program is designed to be educational, not punitive, Zinninger said.

ACR sends a list of accredited facilities to every state chapter of the American Cancer Society once a month. Callers to ACS seeking information about mammography are referred to accredited facilities in their states.

ACR estimates that there are about 6,000 mammographic facilities in the U.S. Currently, only half of the states have licensing laws for radiologists.

Seven bills have been introduced in Congress that would require Medicare reimbursement for mammography screening, which may serve to increase the number of mammography facilities in the country. Reimbursement was included in the catastrophic health insurance act that was passed last year, but did not survive when the act was repealed.

About 29 states have passed legislation on mammography reimbursement, and 15 have legislation pending.

Blue Cross/Blue Shield is paying for mammography screening in some areas, including Kentucky and the District of Columbia, but the insurance carrier requires that the facility must be accredited by ACR, Zinninger said.

About 30 percent of the facilities fail to receive accreditation on the first try. One third of those fail because their unit's images do not meet the clinical image evaluation requirements. Another third fail because their phantom images do not meet the standards. The remaining third fail because their units either exceed the maximum acceptable dose level or do not meet standards in all three areas.

The failure rate in multi-specialty clinics is about 21 percent, while about 15 percent of hospitals and private offices fail the accreditation process.

The failure rate is lower--12 percent and 9 percent--among hospitals and private offices if their film processor is dedicated to mammography.

About 17.5 percent of mobile units fail to receive accreditation, but Zinninger said the number of mobile units to apply has been much lower than the number of other facilities. "I don't know how valid that percentage is," she said.

Mobile mammography units are subject to the same accreditation standards. The program recommends that a test image of the phantom be made each time the mobile unit is moved.

There is an appeals process if facilities disagree with the reviewers, and facilities may reapply. Most facilities that fail do reapply after fixing the equipment, buying new equipment or otherwise remedying the problem, Zinninger said.

The cost of accreditation is $550 for the first unit and $450 for each additional unit. The facility also must buy a breast phantom, a device that simulates the fibers and masses found in the breast, for testing the equipment. Those cost about $325.

ACR now has insurance for the program, which it did not have before. Until the program was able to get insurance, facilities were required to sign a statement holding ACR harmless in the case of any lawsuit involving an accredited facility. In some states, insurance carriers were opposed to facilities signing such statements. Now that the program does have insurance, it may be easier for some radiologists to participate, Zinninger said.

The accreditation process begins with a questionnaire requesting information about the facility's practice, personnel, equipment and follow up.

Each facility must be under the direction of a board certified radiologist, and radiologic technologists must have certification from the American Registry of Radiologic Technology or an equivalent state license. Both professionals should have special training in mammography.

Other questions cover the mammography unit itself, when it was installed, the type of film and processor used. The mammograms must be performed only on dedicated mammographic equipment or equipment adequately modified in the case of xerography, and have an adequate device for compression.

Information also is collected on the facility's quality control program. The radiologic physicist should calibrate the unit at installation and then at least once a year.

Other questions are: What follow up procedures are there? Is a history and a physical done on site? Is the woman told she should have a physical exam? Are risk factors identified? Is the patient instructed in breast self exam?

The questionnaire asks what the mammography report includes and what mechanisms are in place for following up with the physician. ACR recommends at least a phone conversation with the physician and a written follow up report. The facility also should make sure that self-referred patients have a primary care physician.

The accreditation program also asks whether the facilities are keeping track of patients after their mammograms, and the result of biopsies. The goal is to accumulate some outcome data in order to create a national database, Zinninger said.

Once the facility completes the questionnaire, ACR sends a dosimeter and information on purchasing a breast phantom. The facility must image the phantom and expose the dosimeter. The films are sent to ACR and reviewed independently by three radiologic physicists for image quality, dose and half value layer.

The facility also must submit clinical films of a dense breast, usually from a woman under age 50, and a fatty breast, from a woman over age 50. Those images are also reviewed.

The accreditation program set standards for the number of fibers, specks and masses that must be visualized on the phantom image, and determined the parameters that are scored on the clinical images. The parameters are positioning, compression, exposure level, resolution, contrast, noise, exam identification and artifacts. The average glandular dose as determined by the dosimeter may not exceed 0.4 rads per view.

If the equipment receives passing scores on the phantom image, the clinical films and the dose parameter, as well as the overall information on the questionnaire, ACR grants accreditation for three years for each unit that passed.

In November, the first facilities to receive accreditation three years ago will come up for reaccreditation. An ACR committee met this week to finalize the reaccreditation procedures, which will be very similar to the original accreditation program, Zinninger said, except that the reaccreditation will ask for a month's data on processor quality control.

ACR is also working on a quality control manual, which is now in its final draft and should be available this summer.

In addition, a home study course funded by ACS will be available this summer. The course provides 40 hours of CME credit for radiologists who may not have had mammography training. Radiologists may contact ACR for information and applications for the course.

The accreditation program is directed by the ACR Committee on Practice Accreditation of the

Commission of Radiologic Practice. The ACR Task Force on Breast Cancer and the Physics Subcommittee assisted in developing the program. ACS provided seed money for the pilot project that preceded the accreditation program.

Mammographic facilities interested in applying for accreditation may contact the American College of Radiology, 1891 Preston White Dr., Reston, VA 22091, or phone 1-800-ACR-LINE.

For information on accredited facilities, contact a state division of the American Cancer Society, or NCI's 1-800-4-CANCER information line.

ACS Unveils 'Global Plan' For Combating Tobacco Marketing

The American Cancer Society this week unveiled what it called a global plan to lobby against worldwide cigarette marketing by tobacco companies and to influence U.S. trade policies that permit such marketing.

"Trade for Life: A Global Plan to Resist Aggression by the Transnational Tobacco Companies" was developed earlier this year at an ACS-sponsored summit of tobacco control leaders from around the world. The plan sets forth some broad objectives for countering tobacco marketing. The society said it hopes that anti-smoking organizations around the world will participate in the plan's program of action to stop "death from tobacco--the 20th Century's brown plague."

The plan was released May 17 after a hearing on the world health implications of international tobacco trade, held by the House Subcommittee on Health & the Environment, which is chaired by Rep. Henry Waxman (D-CA).

By the year 2000, 12 million people worldwide will die each year of tobacco-related diseases, or five times the current rate, unless the current trends are slowed, according to "Trade for Life." The majority of the deaths will occur in Asia, Latin America, Africa and Eastern Europe.

"As we now know too well, tobacco use is highly addictive and deeply rooted in the history and cultures of many countries," the plan said. "The chronic inertia of governmental authorities in failing to adopt appropriate public health measures to combat the promotion and use of tobacco products has been reinforced by the tobacco and allied industries' relentless defense of their right to promote this deadly product. With economic and political force, the transnational tobacco companies have conducted a highly organized, international campaign of marketing aggression and resistance to policy reforms."

In the face of such resources, tobacco control advocates say they are concerned about making progress against tobacco use, especially in lesser developed countries. The advocates developed "Trade for Life" in the realization that "urgent action was needed to stave off the threatened epidemic," the plan said.

Following is a summary of the recommendations of the plan:

Objective 1: Take action in exporting countries to reduce world trade in tobacco products and curb the marketing aggression of transnational tobacco companies through a "Trade for Life" campaign.

▸Secure the passage of legislation to end the U.S. government's support for the attempts by U.S. cigarette exporters to gain access to overseas markets.

▸Persuade the U.S. government to drop the General Agreement on Tariffs and Trade case, seek no further action against Thailand and to accept no future tobacco cases.

▸Lobby GATT to recognize the unique unfitness of tobacco for normal trade considerations, to ensure that national governments retain the power to place restrictions on the import, distribution and marketing of cigarettes and other tobacco products in their countries.

▸Require transnational tobacco exporters to adhere to labeling requirements and advertising restrictions at least as stringent as those in force in their home country.

▸Place tobacco on the United Nations list of goods whose sale or distribution has been banned or severely restricted.

▸Persuade the UN to apply its consumer guidelines to tobacco and adopt a marketing code for tobacco companies.

▸Remove all export assistance to tobacco manufacturers and producers.

▸Undertake shareholder education campaigns and take measures to hold those with stakes in tobacco companies accountable for the activities of their companies.

Objective 2: Place tobacco control at the top of the agenda of international governmental and nongovernmental health and development organizations.

▸Organize a UN resolution and mobilize support from member nations on the need for countries to recognize the public health threat posed by tobacco and to implement effective anti-tobacco measures.

▸Raise the priority given to tobacco control by the World Health Organization.

Expedite routing by retaining

▸Persuade the United Nations Development Program to introduce a tobacco control program to fund research, dissemination and advocacy in target countries.

▸Persuade the United Nations Environmental Program to adopt a tobacco program to discourage tobacco cultivation in order to counter the environmental damage done by tobacco curing and pesticide use.

▸Persuade the Food and Agriculture Organization to adopt effective crop substitution programs.

▸Seek greater funds from the World Bank, the Regional Development Banks and from other donor agencies for tobacco control projects in developing countries.

Objective 3: Bolster national resistance to the transnational tobacco companies, particularly in newly targeted and potential target countries.

▸Secure the adoption of more stringent anti-tobacco measures by the industrialized countries.

▸Secure more stringent tobacco control policies in target countries.

▸Enhance the information flow worldwide on successful tobacco control strategies and provide an early warning system for new tobacco company and governmental actions.

▸Increase "indigenous" data available to tobacco control advocates in target countries.

▸Develop new educational materials both in target and exporting countries.

▸Develop and broaden the tobacco control coalition in target countries.

▸Provide training for national tobacco control leaders in target countries.

Electric Blanket Use Possible Risk Factor For Childhood Cancer

Using an electric blanket during pregnancy and childhood could slightly increase the risk of childhood cancer, such as leukemia and brain cancer, according to Univ. of North Carolina researchers.

In a case-control study, the researchers interviewed parents of 252 children diagnosed with cancer during 1976-83 and the parents of 222 healthy children. All participants were from Denver.

The researchers determined how often electric blankets, heating pads, portable heaters, hair dryers, television sets, heated waterbeds and bedside electric clocks were used.

Only electric blanket use appeared to be associated with cancer risk.

The mother's use of electric blankets increased the overall risk of childhood cancer 30 percent, with a stronger effect for brain cancer, the study found. The study was recently published in the "American Journal of Epidemiology."

Electric blankets are a source of prolonged magnetic and electric field exposure, and are associated with intimate contact with the person, the researchers said.

Thirty-one parents, or 12 percent, used electric blankets and only four percent of the children used them.

David Savitz, the lead author of the study, cautioned that a more thorough evaluation is needed to assess whether electric blankets constitute a health hazard.

In another study, Univ. of Washington researchers have reported that electric blanket use does not appear to be a risk factor for testicular cancer.

The study identified all 20-69 year old white males from 13 counties in western Washington who had been diagnosed with testicular cancer during 1981-84. Seventy-two percent agreed to be interviewed, as did a sample of healthy men.

About a third of the men had used electric blankets occasionally and about 14 percent had used them regularly for more than two years. The usage pattern was about the same for those with testicular cancer and those without.

NCI Contract Awards

Title: Procurement of transformed lymphocytes, lymphoblastoid lines, and DNA for genetic linkage studies
Contractor: American Type Culture Collection, Rockville, MD; $1,319,374.

Title: Tracing through credit bureaus to determine vital status and current addresses of patients treated in orthopedic hospitals
Contractor: Equifax Inc., Washington, D.C.; $14,875.

Title: Operation and maintenance of the DTP Biological Data Processing System
Contractor: Capital Technology Information Services Inc., Rockville, MD; $2,895,152.

Title: Biomedical computing: design and implementation
Contractor: Information Management Services Inc., Rockville, MD; $1,375,974.

Title: Biomedical computing: design and implementation
Contractor: Information Management Services Inc., Rockville, MD; $5,615,255.

Title: Booklet printing
Contractor: Art Litho Co., Baltimore, MD; $49,200.