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Funding NCI Bypass Budget The "Very Least" Congress Could Do, Congressman Durbin Says

Richard Durbin, Democratic congressman from Springfield, IL, has joined the growing number of members of Congress who placed themselves on record as unequivocal supporters of NCI's bypass budget. "The very least that Congress can do is fund NCI at the level recommend-

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In Brief

Lasagna Committee Report Finalized; Robinson Replaces Schmidt On MSK Boards

LASAGNA COMMITTEE--or the National Committee to Review Current Procedures for the Approval of New Drugs for Cancer & AIDS--has completed its report from more than a year of hearings. The report has been submitted to Armand Hammer, chairman of the President's Cancer Panel, and will be made public when Hammer submits it to President Bush, probably in a few weeks. . . . **JAMES ROBINSON,** chairman and CEO of American Express, has replaced **Benno Schmidt** as chairman of the Boards of Overseers and Managers of Memorial Sloan-Kettering Cancer Center. Schmidt is a long time member of the Boards, chairman since 1982. He will continue as chairman of the Institutional Policy Committee. . . . **LA JOLLA** Cancer Research Foundation has established a new endowed chair in molecular biology, named in honor of La Jolla resident and businessman William Drell. The creation of the chair will allow recruitment of a world-class scientist to lead the foundation's cancer gene research program, President and Scientific Director Erkki Ruoslahti said. . . . **GISELE SAROSY**, assistant professor at St. Louis Univ. School of Medicine, has accepted the position of chief of NCI's International Cancer Research Databank Branch. She is a senior investigator in the Investigational Drug Branch. . . . **HELMUTH GOEPFERT**, member of the M.D. Anderson Cancer Center faculty since 1974, has been named to the M.G. and Lillie A. Johnson Chair for Cancer Treatment and Research. . . . **RIA HAWKS,** research nurse clinician in pediatric hematology/oncology in Presbyterian Hospital's Center for Women and Children, is the winner of the 1990 Oncology Nursing Award given by Columbia Univ. Comprehensive Cancer Center. . . . **NCI BEGAN** its first Summer Science Enrichment Program July 1-Aug. 10 at Hood College in Frederick, MD. About 100 young persons are participating in the program, which is designed to reach children of poor and underserved populations and convince them to consider science careers. They come from throughout the country, including two each from Hawaii and Alaska. Claudia Baquet heads the program.

Congressman Durbin Joins Those Advocating NCI Bypass Budget

(Continued from page 1)

ed in its bypass budget," Durbin said at the recent annual meeting of the Assn. of American Cancer Institutes. "No less. And not for one year here and one year there. NCI has provided a five year blueprint. It should be consistently supported for all five years and beyond."

Durbin is a member of the House Appropriations Committee, which makes his support of the bypass budget even more important. He is also a member of the Budget Committee, which sets overall spending limits for Congress. In that capacity, he was instrumental in adding $750 million to the NIH budget above the Administration's request for the 1991 fiscal year.

Unlike his fellow Illinois congressman, John Porter, who earlier this year committed himself to the bypass budget (**The Cancer Letter**, Jan. 19), Durbin is not a member of Chairman William Natcher's Labor-HHS-Education Subcommittee, which writes the NIH appropriations bill. Durbin's subcommittees are agriculture and transportation. But his influence in the House is growing (he led the successful fight for a permanent ban on airline smoking), he serves as majority whip at large, and is cochairman of the Congressional Task Force on Smoking and Health.

Noting that the federal government had "declared war on cancer" 20 years ago with the National Cancer Act of 1971, Durbin said there is "one absolute maxim of war: victory does not come cheap. The one half to one trillion dollar price tag of World War 11 was a significant amount; but it was not significant relative to the loss of freedom and peace that was at stake had we not waged the war and won.

"Similarly, the war on cancer is costly. But is it too costly, too much, relative to the 500,000 lives lost each year? I hardly think so. In fact, relative to the destruction and harm inflicted on us by cancer, I think Congress and the Administration are trying to win this war with the barest minimum of necessary resources. And it won't work. It is the equivalent of equipping an army to fight with muskets and cannonballs. It's time for Congress to change course and give NCI the equivalent of cancer fighting B-2 bombers."

After calling on Congress to "at the very least" give NCI the bypass budget, Durbin continued, "The bypass budget is a realistic and comprehensive assessment of the needs of NCI for the cancer program. For Congress and the Administration to turn their backs on the bypass budget would be to break the pledge made in 1971 when war was declared on cancer. We must remind ourselves continuously that victory doesn't come cheap or easy."

Durbin offered a few tips to cancer center personnel at the meeting on how to get their message across to their senators and representatives.

"Make no mistake. You are the key to additional funds. I can assure you that my colleagues in Congress will respond positively to helping NCI if they know the facts. You have to inform them."

Letter writing can be helpful, and campaign contributions, although not necessary, "don't hurt," but personal contact with the member of Congress when he or she is in the home district can have far more results, Durbin said.

"Find out when your congressman [or senator] is going to be in your area. We all go back to our districts regularly, and we set aside time to talk with our constituents. Make an appointment, come in, and tell us about your center's needs, and the cancer program's needs. Invite us to visit your center, and show us how important your research and clinical work is to our constituents. You'll be surprised at how well we listen."

[Ed. note: Absent from Durbin's advice was a recommendation to visit your congressman in Washington. Demands on their time when Congress is in session are incredible, and most visiting constituents end up giving their messages to staff members. While that can be a worthwhile activity, it is not reaching the members themselves].

"Come see us when we're home," Durbin repeated. "Get to know us. Ask if there is anything you can do to help, stuffing envelopes, things like that."

Durbin said that when the budget resolution was being marked up, "as I was struggling to obtain the highest figure possible for NIH, I was surprised and pleased by the level of support expressed by my

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colleagues. We have to tap that goodwill more frequently."

After referring to progress in cancer research and treatment over the last two decades, Durbin asked, "So where is the problem?" He then mentioned a few:

"Cancers of the liver due to viral infection, preventable through immunization, should not be tolerated. Yet we lose thousands of lives a year by not aggressively attacking these preventable cancers. The 43,000 plus annual deaths from breast cancer are a national disgrace. A government that can afford $700 toilet seats for army bases can afford $50 mammograms for the poor.

"And, of course, there is lung cancer. Our national policies regarding tobacco are nothing if not downright demeaning. We subsidize a product that kills more Americans in two years than all the Americans combined who have died in battle from the Revolutionary War to the Vietnam war. I can assure you that members of Congress are actively seeking an end to the tobacco holocaust. Interestingly enough, tobacco advocates are moving away from arguing that smoking is not dangerous. The overwhelming preponderance of medical evidence, that many of you helped to provide, is drowning out that tobacco industry argument. They are now reduced to framing the debate as a battle over 'smoker's rights' and as an economic one. Tobacco bashing, they claim, will cost jobs. Let me tell you, I'll gladly trade a few jobs for 390,000 lives, any day of the year."

Durbin said he was aware that AACI members had made a strong case to Congress "about the low level of funding for the cancer centers program." Lack of significant increases in the centers budget for the last few years "concerns me deeply. . . These paltry increases will not allow the advances and progress in the cancer center program that Congress and the public envision."

Durbin concluded:

"In the past decade, we have learned more about the cancer cell than in all the decades before, and the process is accelerating. We should not jeopardize the real and valuable success of our fight against cancer by trying to fund the research, prevention, and treatment of cancer on the cheap. The price of the bypass budget is high, but the cost of our present indifference is even higher."

AACI presented Durbin with its "AACI Leadership Award" in recognition of his efforts in banning smoking from domestic airline flights and for increased cancer research funding. "These activities exemplify the best kind of public service in the U.S. Congress," AACI President Sydney Salmon said.

AACI members also approved a resolution directed to members of Congress, calling for a 1991 NCI appropriation at the bypass budget level. The resolution states:

"The National Cancer Program is in serious trouble because of insufficient funding, as clearly pointed out in the 1989 Institute of Medicine report on cancer centers.

"Therefore, we seek your support of the bypass budget of the National Cancer Institute as an urgent national priority. The $2.4 billion requested for FY 1991 is needed to regain some of the momentum which has been lost as a result of chronic underfunding of cancer research, and to realize the many promising scientific opportunities which are at hand.

"Currently over three quarters of peer approved NCI research grants go unfunded, and those which are supported are funding at 20 percent less than peer recommended levels.

"Over the past 10 years, the number of peer approved cancer center support grants that could be funded has declined from 64 to 57, and five of these 57 are currently receiving phase out funding.

"The 52 centers receiving three to five year cancer center support grants have had funding reduced by 15 percent. If funding were given at peer recommended levels, only 46 centers could be supported.

"At our cancer centers, we are faced with increasingly serious dilemmas which have profound negative implications for our country's health, as well as the strength and productivity of its multi billion dollar per year biomedical enterprise.

"Sustained funding at the level of the bypass budget is needed if we are to meet these challenges in FY 1991:

* A total of $1 billion is required to fund 50 percent of approved research grants.

* A total of $144 million is needed to restore funds to the cancer center support grants sufficient to enable peer approved support to 50-55 cancer centers.

* A total of $66.5 million is required if half of the much needed qualified scientists and physicians are to receive training in cancer research and open new fields in cancer treatment and prevention.

* A total of $156 million is required in order to exploit the scientific opportunities for advances in cancer prevention and control which will reduce our national burden of cancer morbidity and mortality.

* A total of $60 million is required in the construction program to replace aged facilities and modernize others.

"If the objectives of the National Cancer Act are to be realized, the annual funding provided to the National Cancer Institute will have to support all elements of the National Cancer Program as envisioned in the bypass budget. There is a high degree of interdependency amongst the program elements. Our 'chain' cannot tolerate any 'weak links.'

"We are most grateful for your past support. We are encouraged by the recent positive actions of many members of Congress in regard to cancer research funding. We seek your further strong support of our request so that we can address our national responsibilities effectively."

ASCO Meeting Explores Differences In White, Minority Cancer Problems

The extent of the differences in cancer incidence, mortality, and survival in white Americans and blacks, hispanics, and native Americans, and a variety of proposals on what to do about it, were the subject of a day long conference sponsored by the American Society of Clinical Oncology and its new Committee on Cancer Prevention and Control.

The conference was held prior to the society's annual meeting in Washington DC. Frank Meyskens, chairman of the committee, and John Simmons were cochairmen of the conference.

Claudia Baquet, associate director for the Cancer Control Science Program in NCI's Div. of Cancer Prevention & Control, described the epidemiology of cancer in blacks, hispanics, and native Americans.

Incidence rates for all sites together are higher for black males, lower for black females, and higher for most but not all of six selected cancers. Mortality follows the same general pattern, except that it is higher for black females than white females. Five year relative survival is superior for whites in almost all categories except multiple myeloma, and is 51.8 percent vs. 38.7 percent for all sites and both sexes, white vs. black, respectively. That latter difference, which has widened in recent years, is the impetus for the increased concern of the black community, and NCI.

Incidence rates for hispanics vs. anglos in New Mexico show a different story. Incidence for all sites and for all most individual sites is significantly less for hispanics, the major exception being cervix uteri and gallbladder. Mortality shows the same pattern. But in five year relative survival, which reflects the effect of treatment, hispanics did less well overall and in most individual sites than non-hispanic whites.

In comparing American Indians with anglos in New Mexico and Arizona, the pattern was similar to that of the hispanics: lower incidence for the minority group, lower mortality, substantially worse five year survival.

Comparing native Hawaiians with the white population in Hawaii, the incidence is lower overall, although higher for cervix uteri, multiple myeloma, lung cancer (both sexes), and breast cancer. Significantly higher rates in colon/rectum cancer (46.7 vs. 31.7 per 100,000) and prostate cancer (81.0 vs. 56.1) was the major difference in elevating white over Hawaiian incidence. However, overall mortality was greater for Hawaiians, and five year survival was worse.

Comparing Japanese to white Americans in San Francisco-Oakland and Hawaii, incidence was less overall and in all six selected sites--significantly less except in colon/rectum. Mortality followed the same pattern, but survival overall was virtually the same, although showing up a shade better at each individual tumor site. The same general pattern held true for Chinese and Filipinos in San Francisco-Oakland and Hawaii.

Baquet listed as probable contributing factors to the differences:

--Variations in risk factors, including tobacco, tobacco and alcohol, diet/nutritional status, and occupation.

--Knowledge, attitude, practices.

--Stage at diagnosis and treatment.

--Health and medical resources, including distribution of state of the art detection, diagnosis and treatment; access, availability, and utilization of health services; quality of medical care; and compliance.

--Other factors, including immune function, histologic differences, socioeconomic status, comorbidity, and treatment considerations.

Baquet suggested as possible strategies for cancer prevention: tobacco use cessation, reduction in alcohol consumption, dietary changes to reduce fat and increase fiber, expansion of screening efforts, improve treatment access and quality, and increased public and professional awareness.

ASCO President Robert Young listed as future goals for the society:

1. Increase physician orientation toward cancer prevention and early diagnosis.
2. Formal position papers on prevention.
3. Focus attention on unique cancer problems of minorities.
4. Support expanded research efforts to define obstacles to improve minority access and outcome.

5. Encourage expansion of cancer treatment research through minority CCOPs mechanism.

6. Encourage expanded cancer centers role in prevention and minority outcome research.

7. Focus on developing educational programs addressing cancer myths.

8. Develop further cancer prevention symposia.

9. Address national healthcare priorities to achieve proper cancer research support.

10. Join the national discussion on improving healthcare access and cost control.

NCI Director Samuel Broder, after citing research advances and declining mortality for some cancers, said that "again this year, NCI statistics show that minority groups, the poor, the underserved, and those over 65 have disproportionately high rates of cancer. The reasons are complex and relate in part to special problems in terms of access to state of the art prevention, early detection, and treatment.

"Speaking specifically to the disproportionately high cancer mortality rates in blacks, there are many factors to be considered. Among the known risk factors are tobacco, both cigarettes and smokeless forms of tobacco, alcohol, diets high in fat and low in fiber, employment in occupations with special risks, and patterns of care related to a failure of early detection, diagnosis, and less than state of the art treatment.

"Historically, our experience with public health in this country has shown us how many differentials in illness can historically be linked to sanitation, overcrowding, poverty, diet, water quality, adequate clothing, decent housing, and access to doctors. Our more recent public health efforts have added an awareness of risk factors such as smoking, alcohol use, and exercise to the more traditional list.

"We want the results of NCI's research to reach all Americans regardless of their race, age, income, social status, or place of residence. We cannot hold, even for a moment, the idea that cancer death rates must inevitably be worse for blacks or members of other minority groups than for whites."

Harold Freeman, president of the American Cancer Society, addressed the issue of poverty and its impact on cancer.

"A disproportionate number of people who develop cancer and die of the disease are among the socioeconomically disadvantaged of all races," Freeman said. "There are 34 million poor Americans. Two thirds of the poor are white, and nearly one third are black. A total of 37 million Americans have no health insurance.

"Combining the two overlapping segments of the population who are poor and uninsured, approximately 55 million Americans experience significant difficulties in gaining access to early diagnosis and treatment of cancer.

"Poor Americans regardless of race have a five year survival rate that is 10 to 15 percent lower, as well as a higher rate of cancer incidence, compared with other Americans. The recurrent cycle of poverty is a key component in the problem of cancer control.

"Racial disparities in cancer results are due primarily to differences in economic status. The relatively poor cancer results in black Americans are an indication of health consequences that befall a group that represents one third of the poor and one fourth of the unemployed, but only one tenth of the population.

"There is no known genetic basis for racial differences in cancer incidence and outcome. Race, on the other hand, is a significant proxy for culture, tradition, belief system, and lifestyle. Accordingly, race (culture) becomes a prism through which the effects of poverty are reflected.

"In 1983, the war against cancer took on a new approach when the National Cancer Institute set a goal to diminish the mortality from cancer by 50 percent by the year 2000. The achievement of such a goal requires, among other things, the dramatic narrowing or elimination of the gap in cancer survival between the socioeconomically disadvantaged and other Americans. To substantially reduce this disparity by the year 2000, energetic application of culturally targeted public education to the disadvantaged is needed, along with strong advocacy for legislative changes both locally and nationally so that all Americans will be provided with adequate information and appropriate access to cancer screening, diagnosis, and treatment.

"In the words of the great civil rights leader, the Rev. Martin Luther King Jr., 'Of all the forms of inequality, injustice in health is the most shocking and inhumane.'"

To that, Freeman added, "We allow poverty to be an offense that is punishable by death."

James Hampton, Cancer Center of the Southwest, reported on cancer in American Indians and Alaska natives.

"The occurrence of cancer in the native American population of North America has been studied only sporadically. At the beginning of the 20th century a number of descriptive articles stated that American Indians 'never had cancer.' Carcinoma of the cervix in

American Indian women was observed at mid-century to be a major problem especially in the younger women and with a more lethal outcome.

"Southwestern tribes were studied by Sievers and later by Samet and clearly demonstrated to have a high incidence of biliary malignancies. The association of cholelithiasis and carcinoma of the gall bladder in American Indians and admixed Mexican and American Indians was observed by a number of different investigators whose reports span most of the North American continent. This constellation of obesity at an early adult age, adult onset diabetes mellitus, the formation of cholesterol stones and gall bladder cancer, especially in females, suggested a gene environment interaction, and Weiss designated it as the 'New World Syndrome.'

"Specific cancers such as hepatomas and nasopharyngeal cancers which occurred in Alaska natives were associated with specific viral infections, i.e. the hepatitis B virus and the Epstein-Barr virus. Carcinoma of the esophagus, initially a problem in Alaska natives, has appeared to be declining with the changing health patterns in the circumpolar peoples. Certain remote American Indian populations in Canada have had a high incidence of renal cell carcinoma. Carcinoma of the lung is much higher also in the Inuits who have increased their cigarette consumption.

"Welty described an increased age adjusted mortality due to lung cancer in tribes of the northern Great Plains. Areas served by the Indian Health Service from the period 1984-86 with the highest rate of discharges by principal diagnosis of malignant neoplasms were the Amerdeen area, the Alaska area, the Albuquerque area, the Billings area, the Navajo area, the Oklahoma area, and the Phoenix area. Age adjusted death rates for American Indians in the U.S. in 1981 showed that malignant neoplasms ranked second in the women and third in the men from Indian Health Service statistics.

"With the changing lifestyles of partially assimilated North American Indians, intervention to curtail the rise in cancer demands accurate research. The cultural heterogeneity of the over 250 American Indian nations who are surviving at the end of the 20th century must receive special attention. As more of this indigenous population survives beyond the age of 45 the dramatic increase in cancers similar to the larger population can be expected."

Edward Savage, King/Drew Medical Center, Los Angeles, discussed inner city cervical cancer screening.

"Since the advent of the Papanicolaou smear in the early 1940s, the mortality rate from cervical cancer has steadily declined. This decline has not been as dramatic in African-American and Latino populations and thus remains a major health problem.

"Differences in incidence and mortality rates are seen in every age group from 30 to 85. Cancer control projects beginning in Los Angeles in 1977 were designed to screen low income hard to reach women and continued through 1983 by the American Cancer Society with limited success. These projects were conducted outside the existing health care settings.

"In 1983, NCI funded a study called 'Compliance Behavior Among Women in the Abnormal Pap Smears.' This study was designed to provide personalized patient followup, slide tape program prior to initial smear, and transportation incentives. A preliminary analysis revealed that only 54 percent of patients adhered to all of the recommended protocols. The major reasons were financial and inadequate communication.

"It has been estimated that as many as 75 percent of unscreened low income women (at any given time) have received medical care within the previous five years. It would, therefore, appear that a large percentage of unscreened low income women could be reached within the existing health care settings.

"Another study done in Los Angeles indicated that only five of 19 hospitals had a protocol for cervical cancer screening. Of the sexually transmitted disease clinics it is estimated that only five percent of women had smears done, though pelvic exams were performed on all women.

"The current study, 'Reduction in Cervical Cancer,' was funded in 1987 by NCI with the goal of reducing mortality from cervical cancer within a defined population of south central Los Angeles. The objectives are:

1. To determine the knowledge, attitudes, and health care practices related to health and disease of a sample of women at clinical and community intervention sites.

2. To evaluate a cervical cancer screening program in attendees of four sexually transmitted disease clinics, inpatients of the Martin Luther King Jr. General Hospital, and members of selected churches.

3. To evaluate a personalized intensive followup protocol for women with abnormal Pap smears which addresses previously identified barriers to adherence."

Marilyn Frank-Stromborg, professor of oncology nursing at Northern Illinois Univ., discussed an educational approach to increasing involvement of nurses working with minorities.

"In the last 30 years, cancer incidence rates for

black Americans have increased 27 percent in contrast to an increase of 12 percent for white cancer rates. In answer to an obvious need for intervention to lower incidence and mortality, the Oncology Nursing Society offered five regional two day workshops that focused on the primary prevention of cancer in black Americans. The intent of the workshops was to increase the number of black nurses who are prepared to be actively involved in cancer prevention and early detection among blacks.

"For the five regional workshops, 744 black nurses from 40 states, Puerto Rico, and the Virgin Islands responded. In selecting participants, high priority was given to those nurses who documented past or present community involvement and whose letters of support indicated that they were perceived as leaders in the community. The rationale for this was based on research that clearly documents that change occurs in communities when it originates from within as opposed to when it is mandated from outside forces.

"To evaluate the success of the workshops, a cross sectional, repeated measures with matched assignment into the workshops and nonworkshop groups was used. Three study instruments were used to measure cognitive, behavioral, and attitude changes related to primary prevention of cancer. All instruments were administered prior and six months following the workshops. The tool measuring cognitive changes was also given immediately after the workshop.

"The workshop content focused on the epidemiology of the cancers that are most frequently found in blacks, cultural attitudes toward these cancers, techniques for early detection, and strategies for implementing primary prevention programs in the community. The results indicated that:

1. The workshops made a significant difference in knowledge about cancer prevention and early detection as measured by the cognitive instrument.

2. Involvement in cancer prevention/early detection activities increased to a greater extent and for more activities for the workshop participants than for non-workshop participants.

3. The workshops did not significantly change attitudes toward cancer.

"While not statistically significant, attitudes toward cancer in workshop participants were more positive following the workshop experience than the attitudes of nonworkshop participants. Most importantly, the workshop participants reported increased community activities in primary prevention of cancer in traditional and nontraditional settings. All the participants indicated that they routinely initiated discussions about primary prevention and early detection of cancer with black Americans since the course and these discussions took place in both their work and community settings.

"The success of the regional workshops was due to the active involvement of the participants in the learning process and serves as a model for training minority nurses for active, creative roles that can be instituted in the community to assist other health professionals in lowering the high cancer incidence or mortality rates found in black Americans."

Carrie Hunter, NCI Div. of Cancer Prevention & Control, presented a preliminary report on NCI's black/white study of breast cancer.

"In 1985, NCI implemented a population based prospective cohort study of possible social, behavioral, lifestyle, and biological factors, and treatment and health system factors which may contribute to the observed 12 percent difference in survival between black and white breast cancer patients. Data were collected from medical records, patient interviews, and a centralized pathology review of 650 black and 574 white breast cancer patients aged 20-79 diagnosed in 1985-86 in Atlanta, New Orleans, and San Francisco-Oakland.

"A significant difference in stage at diagnosis between blacks and whites was observed ($p < .0001$). Blacks had less in situ and stage 1 cancers than whites and more stage 3 and 4 cancers. Blacks had less education, lower total family incomes, and more aggressive tumors (i.e., less estrogen receptor positivity, and increased grade and nuclear atypia) than whites. At presentation of cancer, blacks were more symptomatic and had greater comorbidity.

"Significant differences were observed between blacks and whites in access to care. Forty five percent of black and 70 percent of white patients reported coverage by a private health insurance, and 29 percent of blacks and 6 percent of whites either had no insurance or received health care services through public assistance. Thirty five percent of whites and 25 percent of blacks had had a mammogram during the preceding six years.

"Stage at diagnosis was associated with income, delay, history of mammography, access to care, and the biological characteristics of the tumor. Further analyses of those factors that need to be considered in understanding the sources of differences between blacks and whites and stage at diagnosis are in progress."

Eliseo Perez-Stable, Univ. of California (San Francisco), discussed smoking cessation in hispanics.

"Although the overall prevalence of cigarette

smoking is lower for hispanics than for whites and blacks, there is a marked difference between men and women. The proportion of current smokers among hispanic men is similar or even greater that for white men, but a substantially lower proportion of hispanic women smoke compared to white women.

"The 'Programa Latino Para Dejar de Fumar' was launched as a community wide smoking cessation intervention in the San Francisco Bay Area in November, 1987. Design and content of the smoking cessation intervention was developed after two years of basic research evaluating attitudinal, behavioral, and cultural differences between hispanic and white smokers. The importance of developing culturally appropriate interventions extensively pretested in the targeted community cannot be overemphasized. Although hispanics reported having less information on where to obtain information on cessation services, they also stated that they needed less help in quitting and felt more capable of quitting on their own. The most frequently cited method by hispanic smokers in helping them quit was 'voluntad propia,' or will power.

"These findings are consistent with the hypothesis that latinos are less dependent on nicotine and may be more likely to quite on their own with brief interventions or self help guides. Hispanics felt more certain that quitting smoking would produce improved family relationships and provide a better example for their children."

LaSalle Leffall, professor of surgery at Howard Univ. and former president of the American Cancer Society, closed the conference with an inspiring appeal to oncologists to assume leadership in prevention.

"Ernst Wynder [president of the American Health Foundation] has said, 'There are no gold stars in prevention. The goal of prevention is to die young as late in life as possible.'

"The oncologist's role is leadership. The oncologist must be a member of the team. Teamwork never goes out of style. The oncologist must believe in it, and be familiar with problems in the local area, to be able to apply the appropriate strategy in the community.

"All oncologists--medical, radiation, pediatric, surgical, gynecologic--must be concerned about prevention and control. They must work with nurses, and social workers.

"We must never forget that the object of our affection is the cancer patient. In my 42 years in medicine, I never had a patient say, 'I would rather be dead.' But I have had patients say, 'Dr., if I had to live like this, I would rather be dead.' Quality of life is important.

"Hope. There is always something you can do to help. Hope is the greatest of human joys. Let them know we care, that we will treat them with respect and dignity. By doing that, we maintain our dignity. . . . "You have a deep, personal sense of satisfaction when you know you did the right thing."

Leffall said he has seen patients "with stubborn insistence on hope when there is no reason to hope. People with faith, and strong moral fiber. I have seen demonstrations of courage that defy description. That let's me know that I have to do more, to care."

RFA Available

RFA CA-90-18

Title: DCBDC small research grants on animal models of solid tumors

Letter of Intent Receipt Date: Sept. 1

Application Receipt Date: October 10

The Cancer Immunology Branch of NCI's Div. of Cancer Biology, Diagnosis & Centers invites applications for small grants to develop and establish animal models of solid tumors of non-hemopoietic origin to improve the understanding of the complexities of the human immune response to these tumors. Models are sought which demonstrate similar biological characteristics to human cancer, and which could be used in future studies to analyze the immunobiology of host-tumor interactions.

The goal of this initiative is to provide funds for the development of new, or further characterization of existing, animal models of solid tumors of non-hematopoietic origin which are relevant to human cancer. The initiative is not limited to small laboratory animals; however, appropriate reagents, such as antibodies for cellular identification, must be available for the immunologic study of any animal model proposed.

The scope of this initiative may comprise the use of transgenic animals, mice with the severe combined immunodeficiency defect, spontaneously arising tumors, transplantable tumors from the site of origin to the same site within the recipient, or other tumor systems developed by the applicant. Tumors induced by chemicals, viruses or radiation will be considered if the tumor type exhibits characteristics analogous to a human tumor. Animal models which utilize congenitally athymic mice where human tumors are injected subcutaneously into these mice primarily for maintaining the tumor will be excluded from review, and those applications will be returned to the applicant.

The small grants mechanism provides research support specifically limited in time and amount for studies in categorical program areas. Small grants provide flexibility for initiating studies, which are generally for preliminary short term projects and are non-renewable.

Approximately $700,000 in total costs per year for three years will be committed to fund applications in response to this RFA. The total direct costs per application may not exceed $50,000 per year. Approximatley 10 awards will be made. This funding level is dependent on receipt of a sufficient number of applications of high scientific merit. The total project period should be at least one year and may not exceed two years. The earliest feasible start date for awards will be April 1, 1991.

Prospecive applicants are strongly encouraged to discuss their ideas with Dr. John Finerty, Program Director, Cancer Immunology Branch, NCI, Executive Plaza South Rm 634, 6120 Executive Blvd., Rockville, MD 20892, phone 301/496-7815.