THE CANCER LETTER

Vol. 17 No. 4
Jan. 25, 1991

Price $205 Per Year US, Canada
$230 Per Year Elsewhere

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

Cancer Society, Centers Explore Collaboration On Public Issues, Education, Information Activities

The American Cancer Society has begun to seek ways to improve and strengthen its ties with the nation's cancer centers in order to provide better services to cancer patients and their communities and to avoid costly duplication of efforts. A joint meeting last week between ACS and

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In Brief

White House Appoints Six To NCAB; Calabrisi To Succeed Korn As Chairman; 2 Spaces Vacant

WHITE HOUSE last week appointed new members of the National Cancer Advisory Board to replace the six whose terms expired early last year. The new members are, **Frederick Becker,** vice president for research at M.D. Anderson Cancer Center; **Paul Calabrisi,** professor and chairman of the Dept. of Medicine at Brown Univ.; **Kenneth Chan,** director of the pharmacoanalytic laboratory at Univ. of Southern California; **Marlene Malek,** of the Vincent Lombardi Cancer Research Center at Georgtown Univ. and a registered nurse; **Kenneth Olden,** director of the Howard Univ. Cancer Center; and **Syndey Salmon,** director of the Arizona Comprehensive Cancer Center. Calabrisi was appointed chairman of the board, replacing **David Korn.** There still are two vacancies left on the board, created by the resignations more than two years ago of Lou Gerstner and Louis Sullivan. . . . **AMERICAN SOCIETY** of Clinical Oncology has hired a new director of government relations, **Stacey Beckhardt,** who will staff ASCO's Washington office and serve as a key player for the association in national, regional, and state policy affecting oncologic research and medical practice. Beckhardt has worked extensively on research policy issues and most recently was government liaison for the Consortium of Social Science Associations. She replaces Ellen Shillinglaw. For more information about ASCO's government relations activities, contact Beckhardt at 750 17th St. NW, Suite 1100, Washington, D.C. 20006, phone 202/778-2396. . . . **FRANK MEYSKENS,** director of the Univ. of California (Irvine) Clinical Cancer Center, has been named to the 1991 Scientific Advisory Board of the International Council for Coordinating Cancer Research. . . . **INVESTIGATIONAL NEW** drug application has been filed for taxotere, a synthetic form of taxol made by Rhone-Poulenc Rorer. . . . **ABSTRACT DEADLINE** is Feb. 15 for the International Conference on Long Term Antihormonal Therapy for Breast Cancer, June 30-July 2, Lake Buena Vista, FL. Contact 800/735-8450 or 215/735-8450.

Cancer Society, Centers Seek Ways To Work Together, Avoid Duplication

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representatives of the Assn. of Community Cancer Centers and the Assn. for American Cancer Institutes was a recognition of the fact that, in difficult economic times, "the luxury of everyone doing it by themselves in parallel to everyone else is probably not the best way," said Raymond Lenhard, Johns Hopkins Hospital and vice chairman of the ACS professional education committee.

First of a Two-Part Series

Closer ties to cancer centers and their professional organizations might improve efforts to influence public issues and enhance public and professional education, ACS executives and cancer center directors agreed. Centers don't always use ACS volunteers as well as they could, and ACS offers programs and services for cancer patients that some centers are not taking advantage of, the meeting participants said.

Even on the subject of fundraising, which often puts centers and ACS in direct competition, participants said joint activities could prove more lucrative than competing fund drives. At the very least, participants said, centers and ACS units could coordinate their activities so that similar events do not coincide.

'Real Opportunity' To Influence Politics

Perhaps the most important area in which ACS-centers linkages could have impact is public policy.

"We are on the threshold of real opportunity to impact the political situations regarding cancer at the federal, state, and local levels," said Alan Davis, ACS vice president for public affairs.

Davis, in his remarks to the ACS and centers representatives, laid the foundation for closer ties on public issues.

One immediate result of his speech was a proposal by Lee Mortenson, executive director of the ACCC, for ACS to work with ACCC on uniform state legislation for insurance reimbursement of off label drugs, an issue that ACCC has concentrated on in the last year or so. Mortenson invited Davis to meet with the ACCC board of directors directly after the ACS-centers meeting, held in Houston last week.

Most of those attending the meeting had worked with each other and exhanged memberships on each other's committees for many years, Davis said.

"Over the years we have had our differences--turf differences mostly--in 'outreach,' prevention, and public education activities; volunteer recruitment; fundraising; and public relations. These are understandable differences. These are mostly ironed out now," Davis said. Centers and ACS share leaders, providing a "healthy overlap in governance, policy development, and program activities."

Yet, while most ACS divisions (which represent states or large metropolitan areas) are involved with cancer centers on cancer matters, Davis said, very few are involved in public policy or public issues.

"The issue centers have been most concerned with has been money--appropriations, cost of research, cost of care. We all work on those, in Congress, frequently together," Davis said. "During the past few years we have been sending the same dollar figure message about the appropriations needs of NCI to Congress with little or no coordination. Serendipity. But you can't count on the Tooth Fairy every year. New issues--mammography screening, tobacco issues, animals in research, and even noncancer issues like tax exempt charitable deductions and third class nonprofit mailing rates--have increased the importance of working together.

"I think we could do better before the Congress if we have closer coordination--that means information exchange. It would help, for example, if we communicated our policy/position messages more directly and more frequently to center groups--APCI, ACCC, ASCO, AACR, Coalition for Cancer Research--and got the same from them."

Centers should understand ACS policy and the thinking behind particular positions, and ACS should learn the same about the policies of centers. ACS representatives should be invited to attend public issues meetings of these organizations, and ACS could do the same "to communicate policy moves and advocacy strategy to the centers, locally, and to centers organizations."

THE CANCER LETTER

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Subscription rate $205 per year North America, $230 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter and AIDS Update.

"After all, we really are working for the same objectives--the conquest of cancer--and if we are serious about that, in collaborative efforts we will concentrate on that as our end point, and not become encumbered with procedures, structures, and trappings along the way."

Official ties, such as committee appointments, are not necessary, Davis said. "While the society has traditionally acted independently of formal linkage with coalitions or associations, we have consistently acted in coordination and collaboration with organizaitons and institutions when we are working toward the same goals."

ACS is organized and staffed for legislative activity at its national and division levels, and in some cases, in its unit, or local, levels around the country, Davis said.

National policy matters are recommented to the ACS National Board of Directors by the Public Issues Committee. The ACS National Public Affairs Office in Washington does the advocacy work.

Each of the 57 divisions of ACS work in the same way, Davis said. The extent of public issues activity varies from one division to another, but ACS recently raised the importance of public issues by making the activity a "division charter standard," or a standard by which division effectiveness and performance are measured.

"Effective networks of volunteers prepared to respond to calls for personal contact with state officials and members of Congress are in place and functional in most divisions. They are being organized and trained in the remaining divisions," Davis said.

The National Public Affairs Office provides divisions guidance and orientation in their states' political process and is a clearinghouse for interpretation of national policies as they pertain to individual divisions. The office also has a clearinghouse on the socioeconomically disadvantaged. The office's government relations section is the ACS lobbying element, which tracks legislation, walks the halls of Congress and acts to advance cancer control issues, Davis said.

"The opportunities and advantages of increasing the cooperative efforts of center organizations and the ACS in Washington are exciting and we will actively pursue this," Davis said. He invited any center to contact his office to be placed on its mailing list for newsletters, status reports, and other materials that are provided to ACS volunteer leaders (202/546-4011).

However, Davis said that "greater opportunities" exist at the state level, "where the impact of legislation and regulation on hospitals and cancer centers is increasing as the cost of health care increases and the debate surrounding health care insurance for all Americans intensifies.

"I am sure there exist many situations where a division's public issues network could be encouraged to work in matters of mutual concern. Centers have their legislative or public policy offices. A vital first step will be for the voluteer and staff people responsible for these activities to get together and review each other's public policy priorities, decision making process, and resources. Thoughtful people will then decide in which areas they have common objectives and can work together to achieve these objectives in their state capitols."

"ACS and centers will not always see eye to eye on every issue. They may even have opposing views on some. Where these things occur, there should be a gentlemen's agreement that those issues are off the table, and unless some indication of possible accommodation becomes evident, centers and ACS go their separate ways on those matters.

"The important thing is that there are many issues important to centers and to ACS on which we do agree, and with which collective, cooperative effort will be advanced more effectively and more rapidly."

Davis ended by pointing out that ACS has the grassroots structure of volunteers in place. "We are organized for public education, public information, fundraising and direct service activities in every state, every metropolitan area, every county in the United States, Puerto Rico, Guam and the Trust Territories.... We are there, we are organized, we are sensitive, and we are capable, and we are anxious to do anything in our ability to help the cause against cancer."

Next Week, Part 2: ACS, centers discuss current relationships and ways to better coordinate education and information efforts. Also an update on two ACS programs, the Cancer Response Service and "Look Good...Feel Better."

Panel Says NIH Must Devise Means For Early Release Of Trials Results

NIH must develop a mechanism to rapidly disseminate critical information from clinical trials to physicians before the results are published in a peer review journal--but the task will require a careful balance of what one NIH official said are "competing, legitimate interests" of researchers, public health officials, practicing physicians, the medical press and the public.

That was the verdict of a panel of 25 medical researchers, NIH officials, journal editors and

journalists who met last week to discuss "Clinical Trials Results: Exploring the Dissemination Process."

The panel was convened in response to rising dissatisfaction in many circles with the way federal health agencies disperse information from clinical trials that could affect physician practice and save lives.

William Raub, acting director of NIH, said what the panel was concerned with were only "selected clinical trials"--those sponsored by NIH and deemed by that agency to have provided information of urgent importance to physician practice.

Reinventing The Wheel

The panel discussed six clinical trials sponsored by various NIH institutes for which clinically useful results were disseminated early--including one involving cancer. In each case the institute involved publicized a different amount of information by a different method at a different point in the research and review process.

What emerged from the accounts of the dissemination process was a picture of investigators beset with fears of spreading premature, inaccurate, or unclear information, and fears that such dissemnation would jeopardize the publication of the study; while the medical and patient communities responded that the information, regardless of its final form, was "too little, too late."

"NIH can't let every institute reinvent the wheel every time it has a problem," said Victor Cohn, medical journalist for the "Washington Post." "It has to have some kind of central advisory mechanism, very possibly with public participation and practicing physician participation."

In oncology, the sheer prevalence of some forms of cancer has intensified the debate about the merits and risks of such a release. The panel considered the case of the early release of data on clinical trials of adjuvant chemotherapy in node negative breast cancer.

In May 1988, NCI released a clinical alert containing data from three trials: two that tested the efficacy of chemotherapy in improving the disease free survival of node negative breast cancer patients; and one that tested the efficacy of tamoxifen, an anti-estrogen, in estrogen receptor positive, node negative breast cancer patients in extending survival.

At the time, the standard therapy for node negative breast cancer patients was surgery and radiation; but NCI said in the alert that "a sizable rate of treatment failure" had led the institute to sponsor the systemic therapy trials.

The clinical alert stated that "although the median follow-up is only 3 to 4 years, adjuvant systemic therapy has resulted in statistically significant improvement in disease free survival in all three studies." It went on to say that "adjuvant hormonal or cytotoxic chemotherapy can have a meaningful impact on the natural history of node negative breast cancer."

When the alert was released, the research articles on these studies were either in preparation or were undergoing peer review by the "New England Journal of Medicine."

Vincent DeVita, physician in chief of Memorial Sloan-Kettering Cancer Center and former NCI director, explained the urgency of the release in terms of a "window of opportunity"; that is, the amount of time that a public health agency could wait to disseminate information without missing a majority of the patients who had entered the system since the information became available.

The "size" of this window, DeVita said, is "roughly six weeks with the breast cancer study...during which some large fraction of patients will pass through and the therapy may or may not be usable in that population."

DeVita said if the investigators had waited until the studies had been published in NEJM several months later, "50,000 women would have passed through that window of opportunity" and would not have had the possible benefit of the new treatment.

But, Michael Friedman, director of NCI's Cancer Therapy Evaluation Program, said many physicians felt the results of the three studies were not compelling enough to warrant a change in therapy or a clinical alert, especially because of the relatively short follow-up time. Physicians also criticized the amount of information given and the way it was distributed.

Friedman cited one letter of the many sent by physicians to NCI in which the physician said he was "outraged not only by the manner in which the information was distributed, but also by the unethical and unprofessional manner of the whole enterprise."

The institute later asked approximately 11,300 physicians who had received the alert for their assessment of it. Of the 5,465 respondents, 60 percent thought the clinical alert had enough information to make a clinical decision; but "a substantial minority," 40 percent, did not, Friedman said. One-third of the respondents thought the information should not have been released before its publication in a peer-reviewed journal, he said.

George Lundberg, editor of the "Journal of the American Medical Association," said the alert was premature. "I was confused by it, opposed to it. I think it was confusing and I don't think it was definitive."

If the outcome of a consensus panel meeting six months ago is any indication, Lundberg said, "there is

still a lot of confusion about what the appropriate treatment is. The only thing I can see that [the clinical alert] might have accomplished is it created a nice discussion about these problems [with early release]."

Circumventing The Traditional System

Arnold Relman, the recently retired editor-in-chief of the "New England Journal of Medicine," voiced strong support for the process of publishing medical research articles in peer review journals; he also discussed situations in which this process could be circumvented.

"The peer review system, with public release of information only at the time of publication of the manuscript, is the best way of communicating the results of new science for most studies," he said. "I believe that it serves everybody's interests best. It allows for quality control...avoids mistakes, errors in the data....and it prevents the dissemination of premature and unwarranted conclusions."

Lundberg said in his presentation to the panel that for his journal the average time from receipt of the manuscript to its publication was 174 days.

But Relman said that even with this delay, "most of the time, no harm is done because the information is not of urgent concern to the public health."

He agreed that "occasionally there is a rush, and we need a no less reliable system for [rapid] peer review and dissemination of information. We have to be particularly careful because the stakes are higher."

Questions from many panel members centered around what form the clinical trial data could take when released in an expedited manner without breaking two time-honored policies that medical journals follow when considering a manuscript for publication.

The first policy, called the Ingelfinger rule after Relman's predecessor at NEJM, bars manuscripts from consideration for publication if they have been published or are about to be published anywhere else in their entirety or in significant part.

On the other hand, the embargo is the policy that "once the manuscript we have received is under peer review...the information [must] not be released to the public, except for presentation at scientific meetings until the article appears in print in the journal," Lundberg said.

Both editors stressed that the presentation of the material at scientific meetings was still allowed under these policies.

And, Relman said, "we will set aside the Ingelfinger rule and the embargo when we and the authors and the sponsoring government agency agree that [the material] is of urgent importance."

In the trials discussed by the panel, the institutes usually expedited dissemination by producing a clinical alert or some similar synopsis of the findings that was sent electronically or by mail to practicing physicians.

But several speakers said that doctors who received clinical alerts often complained that the abbreviated information on the trial did not give them enough data to make decisions about patient care. Panel members repeatedly asked how investigators could provide physicians with the kind of detailed information found in a journal manuscript without, again, violating journal policy.

Relman pointed out that if an NIH institute wanted to release the information in some kind of manuscript form it had two choices.

"Our position is, if you want the manuscript that will appear in the journal you can have it when it's available, maybe as much as eight weeks before publication, maybe as little as three," he said. "When the final manuscript is ready you can have it as long as you credit it to us. Before that, it's not available because were still working on it."

He said the institute could issue its own version of the manuscript as an NIH advisory or summary but could not "say that that is what's coming out in the NEJM." Subsequent publication in "NEJM" would not be compromised, he said, if the journal had agreed to early release.

Michael Bracken, a professor of epidemiology at Yale University School of Medicine, noted that journals that accepted this "other manuscript" policy should make that clear because it is "a real source of confusion" for investigators.

Relman did emphasize that the "other manuscript" concept applied only to "those few situations where there is general agreement between the author, NIH as sponsor and between editors that this needs to get out right away. Clearly we couldn't have that for every article that people send us."

Relman and Richard Simon, chief of NCI's Biometrics Research Branch, both noted that the substance of a clinical alert, a secondary manuscript, or any other type of NIH advisory to physicians had to be considered as well.

"When advance advisories are released the emphasis ought to be on the data and what the range of reasonable interpretations are rather than saying this is the answer, this is the one right way to treat your patients," said Relman.

"At least for cancer clinical trials the decision to terminate a clinical trial by a monitoring committee does not lead in a simple way to recommendations for exactly who should or should not receive a therapy,"

said Simon. "Part of it is cost, part of it is side effects of treatment, part of it is heterogeneity of patients, part of it is various types of endpoints. I think lots of thought has to be given to this when you issue an alert."

Who Performs Peer Review?

Several panel members reiterated their support for the peer review process, saying that some sort of review is essential before any data should be released.

"The ideal guideline is that a manuscript is submitted and at least accepted by a journal before a clinical alert is released," said Friedman. "But this rule can be circumvented."

"We feel it's imperative that peers outside the study group review the methodology and findings and review here means the manuscript submitted for publication," said Bracken.

He added that if investigators planned a press conference in addition to some kind of clinical alert, "it's essential that publication not only be planned, but guaranteed by a journal's acceptance of the manuscript [when] the press conference is held."

Relman noted that NEJM could usually review an expedited paper in one to three weeks.

One member of the audience asked the panel if it would be possible for NIH to have its own peer review board to expedite the review of urgent clinical trials "independent of the journals."

Michael Walker, director of the Div. of Stroke and Trauma of the National Institute of Neurological Disorders and Stroke, said that this "certainly is a consideration. Exactly how to implement that will depend on what the finding is on any future trial."

But if such a review board decided to release data early, Relman said, journal editors wouldn't waive the Ingelfinger rule and embargo unless they also agreed that the information was urgent enough to warrant expedited dissemination.

Panel members said this would create a recurring argument over whether a journal editor was more qualified than an agency or NIH advisory body to decide whether data was sufficiently urgent.

Physicians First

After questions of what and when to disseminate are answered, the panelists said, questions remain about who should receive the information.

Despite legitimate press needs, said Friedman, he shared many physicians' feeling that "there's nothing more confusing or troubling to a patient than bringing information to a physician, asking for guidance [and] care...when the physician hasn't had the opportunity to at least assimilate a synopsis of the information."

DeVita said that physicians "have the right to get some kind of information in advance of a press release. It's important to credibility that physicians at least have something that they can deal with in reference to a question from a patient."

But the Post's Victor Cohn argued that in emergency situations, "if you try to notify physicians a few days ahead of the media, somebody in the media is going to find out about it and print it or broadcast it anyway, in a less rigid way than if he or she had the full information. So the full information has to go out to the physician and the media simultaneously."

Anthony Fauci, director of the National Institute of Allergy & Infectious Diseases, said the idea that information could get to the general medical community without the lay press getting wind of it was "unrealistic."

Reaching the Right Physicians

Within the complexities of the expedited dissemination process another issue arises: that of getting the information to as many of the right physicians as possible.

"If an NIH study is ended prematurely because of decisive results that are important to the health of patients, it seems to me that NIH has a responsibility to send out a 'Dear Doctor' to every practicing physician," said Relman. "Most physicians do not read any journal regularly. So I think if we want to get to all doctors right away, that is NIH's responsibility."

Donald Lindberg, director of the National Library of Medicine, said that the library can help disseminate information in several ways: significant results can be presented in a headline form to Medline users; Medline can run the text of any press release; the press release could be faxed to major medical libraries; and once the manuscript is available, it can be electronically disseminated in Medline before it is published, if the publication agrees.

Some Guidelines

Several of the panel members presented the guidelines they had used when deciding to release the results of clinical trials early. Friedman said his team's considerations before issuing a clinical alert included:

- How relevant or appropriate is the clinical research protocol?
- How valid are the data? Are the data carefully monitored, and to what extent are quality control measures employed?
- What data are so important they deserve the extra attention provided by a clinical update or clinical alert?
- How will the information actually be disseminated?

In addition, Bracken said it was important that the the study was peer reviewed and accepted for publication; and that the a public health agency had requested release in the public interest.

"While one would not want to censor investigators from releasing information without the encouragement of some public body," said Bracken, "investigators themselves would be wise to not go public unless some outside public authority has deemed the work of sufficient public importance to do so."

NCI Advisory Group, Other Cancer Meetings For Feb., March, Future

Midwinter Radiological Conference--Feb. 1-3, Los Angeles, CA. Contact Los Angeles Radiological Society-MWRC, PO Box 91215, Los Angeles, CA 90009-1215, phone 213/827-9078.

Major Advances In Oncology: Update on Hematopoietic Growth Factors--Feb. 2, Cleveland, OH. Contact Education Coordinator, Ireland Cancer Center, Univ. Hospitals of Cleveland/Case Western Reserve Univ., 2074 Abington Rd., Cleveland, OH 44106, phone 216/844-7858.

Chemical Modifiers of Cancer Treatment--Feb. 2-5, Florida. Contact American College of Radiology, 1101, Market St., 14th Floor, Philadelphia, PA 19107.

National Cancer Advisory Board--Feb. 4-5, NIH Bldg. 31 Rm 10, open 8 a.m. both days.

Genomic Instability & Cancer--Feb. 4-10, Tamarron, CO. Contact UCLA Symposia, 2032 Armacost Ave., Los Angeles, CA 90025, phone 213/207-5042.

Mid-Pacific Radiological Conference--Feb. 5-9, Maui, HI. Contact MPRC, PO Box 91215, Los Angeles, CA 90009, phone 213/827-9078.

International Congress on Neoadjuvant Chemotherapy--Feb. 6-9, Paris, France. Contact Service d'Oncologie Medicale, Pitie-Salpetriere 47, Bd. de l'Hopital, 75651 Paris Cedex 13, France.

American Cancer Society/American College of Clinical Pharmacology National Conference on New Oncologic Agents--Feb. 6-8, 1991, Dallas, TX. Contact ACS, 1599 Clifton Rd. NE, Atlanta, GA 30329, 404/329-7606.

Testicular Cancer--Feb. 7-8, Knoxville, TN. Contact Education Coordinator, Thompson Cancer Survival Center, phone 615/541-1749.

Advances In Oncology--Feb. 7-9, Cancun, Mexico. Contact UCI Clinical Cancer Center, 714/634-5081.

Biotherapy of Cancer: Symposium for Clinicians & Nurses--Feb. 7-9, 1991, Newport Beach, CA. Marriott Resort Hotel. Contact Meeting Mangement, Biotherapy of Cancer, 5665 Oberlin Dr. #110, San Diego, CA 92121.

Developmental Genetics of Childhood Cancer--Feb. 8-11, San Diego, CA. Catamaran Resort Hotel. Contact American Assn. for Cancer Research, Public Ledger Bldg., Suite 816, 6th & Chestnut Sts., Philadelphia, PA 19106, phone 215/440-9300.

Southwest Oncology Nursing Symposium--Feb. 8-9, Phoenix, AZ. Contact Debbie Todd, Outreach Services, Good Samaritan Medical Center, 1111 E. McDowell Rd., T12A, Phoenix, AZ 85062, phone 602/239-3250.

Membrane Transport In Multidrug Resistance, Development & Disease--Feb. 10-14, Alberta, Canada. Contact American Assn. for Cancer Research, Public Ledger Bldg. Suite 816, Sixth & Chesnut Sts., Philadelphia, PA 19106, phone 215/440-9300.

NCI Div. of Cancer Biology, Diagnosis & Centers Board of Scientific Counselors--Feb. 11, NIH Bldg. 31 Rm 6, open 8:30-11:30 a.m.

International Conference on Cancer Prevention: Facts, Maybes & Rumors--Feb. 12-13, 1991, NIH Lister Hill Auditorium, Bethesda, MD. 8 a.m. both days. Contact Veronique Malet-Dupont, 212/319-6920.

Radiation Oncology--Feb. 13-16, Lake Buena Vista, FL. Contact Div. of Continuing Medical Education, Univ. of Miami School of Medicine, PO Box 016960 (D23-3), Miami, FL 33101, phone 305/547-6716.

St. Joseph's Cancer Institute Cancer Conference--Feb. 15-16, Tampa, FL. Contact St. Joseph's, 3001 W. Buffalo Ave., Tampa, FL 33677, phone 813/870-4991.

Cytokine Use In The 1990s--Feb. 15, San Diego, CA. Contact Meeting Management, 5665 Oberlin Dr. Suite 110, San Diego, CA 92121, phone 619/453-6222.

NCI Div. of Cancer Treatment Board of Scientific Counselors--Feb. 19-20, NIH Bldg. 31, sixth floor conference rm, open 8:30 a.m. on Feb. 19; open 12:30 p.m. on Feb. 20.

Cancer Prevention Convention--Feb. 21-23, Houston, TX. Contact Jeff Rasco, Conference Services, Box 131, M.D. Anderson Cancer Center, 1515 Holcombe Blvd., Houston, TX 77030, phone 713/792-2222.

Care of the Older Cancer Patient: Clinical & Quality of Life Issues--Feb. 23-24, Long Beach, CA. Contact St. Mary Medical Center, Cancer Care Center, 213/491-9997.

Arizona Cancer Center International Workshop on Chromosomes in Solid Tumors--Feb. 24-27, Tucson, AZ. Abstract deadline Nov. 30, 1990. Contact Nancy Rzewuski, Conference Coordinator, Arizona Cancer Center, Tucson, AZ 85724, phone 602/626-2276.

Electric & Magnetic Fields: An Issue for the 1990s--Feb. 25-26, Arlington, VA. Contact Barry LeCerf or Carolyn McNasby, 215/359-1249.

Palliative Care of the Cancer Patient--Feb. 28-March 1--La Jolla, CA. Contact Scripps Clinic, phone 619/554-9592.

Alabama Cancer Congress--Feb. 28-March 2, Birmingham, AL. Contact Alabama Cancer Congress, 800/292-4935 or 205/879-2242.

Monoclonal Antibody Immunoconjugates for Cancer--Feb. 28-March 2, 1991, San Diego, CA. San Diego Marriott Hotel & Marina. Sponsored by the new San Diego Regional Cancer Center. Contact Cass Jones, Professional Conference Management, 7916 Convoy Ct., San Diego, CA 92111, phone 619/565-9921.

Cancer Management Course--Feb. 28-March 2, Orlando, FL, Marriott Orlando World. Contact American College of Surgeons, Cancer Dept., Morton Wilhelm, 55 East Erie St., Chicago, IL 60611, phone 312/664-4050.

Transrectal Ultrasound Seminar--Feb. 28-March 2, Scottsdale, AZ. Contact DCMI, PO Box 2508, Ann Arbor, MI 48106, phone 313/665-2535 or 800/458-2535.

Stereotactic Treatment of Brain Tumors--Feb. 28-March 3, New York, NY. Contact Roberto Fuenmayor, CME Office, Memorial Sloan-Kettering Cancer Center, phone 212/639-6754.

Major Advances In Oncology: Update on Cancer of the Head & Neck--March 1-2, Cleveland, OH. Contact Education Coordinator, Ireland Cancer Center, Univ. Hospitals of Cleveland/Case Western Reserve Univ., 2074 Abington Rd., Cleveland, OH 44160, phone 216/844-7858.

Molecular Therapeutics: Cancer Therapy Into The 21st Century--March 3-6, Research Triangle Park, NC. Contact Dr. Brian Huber, Wellcome Research Laboratories, 3030 Cornwallis Rd, Research Triangle Park, NC 27709, phone 919/248-3779.

Assn. of Community Cancer Centers Annual

Meeting/Symposium on New Technology--March 6-9, Washington, Capital Hilton Hotel. Contact ACCC, 11600 Nebel St., Suite 201, Rockville, MD 20852, phone 301/984-9496.

Membrane Transport in Multidrug Resistance, Development & Disease--March 10-14, Banff Centre, Banff, Alberta, Canada. Contact American Assn. for Cancer Research, Public Ledger Bldg. Suite 816, Sixth & Chestnut Sts., Philadelphia, PA 19106, phone 215/440-9313.

European Society of Mastology 1st International Conference--March 12-14, Venice, Italy. Contact EUSOMA Secretariat, Via Venezian 1, 20133 Milan, Italy.

International Symposium on Angiogenesis--March 13-15, St. Gallen, Switzerland. Contact International Scientific Secretary, Research Dept., Haus 09, Kantonsspital, 9007 St. Gallen, Switzerland.

Differentiating Your Hospital's Cancer Program--March 13-15, San Antonio, TX. Contact Ron Guilden or Joanna Mitchell, CDP Services, 1050 Crown Pointe Parkway, Suite 210, Atlanta, GA 30338, phone 404/391-9872.

Advances In Cancer Treatment Research/Autologous Bone Marrow Transplantation Symposium--March 13-15, Bronx, NY. Contact Office of Continuing Medical Education, Montefiore Medical Center, 3301 Bainbridge Ave., Bronx, NY 10467, phone 212/920-6674.

Prostate Cancer--March 15, Knoxville, TN. Contact Education Coordinator, Thompson Cancer Survival Center, phone 615/541-1749.

Cancer Management Course--March 15-16, Youngstown, OH. Contact Dr. Richard Memo, American College of Surgeons, Cancer Dept., 55 East Erie St., Chicago, IL 60611, phone 312/664-4050.

American Cancer Society Conference on Colorectal Cancer--March 20-22, New Orleans, LA. Contact ACS, 1599 Clifton Rd. NE, Atlanta, GA 30329, phone 404/329-7606.

Lineburger Comprehensive Cancer Center Annual Symposium: Molecular Basis of Cancer Therapeutics--March 21-22, Chapel Hill, NC. Contact Lineburger Comprehensive Cancer Center, Univ. of North Carolina, Campus Box 7295, Chapel Hill, NC 27599-7295, phone 919/966-3036.

International Congress on Biological Response Modifiers--March 22-24, Quebec City, Canada. Contact Dr. Michel Bergeron, Congress Coordinator, CH Universite Laval, 2705 boul. Laurier, Quebec City, Quebec, Canada GIV 4G2, phone 418/654-2705.

Future Meetings

Ultrasound & Prostate Cancer: New Directions 1991--April 11-13, Mobile, AL. Contact DCMI, PO Box 2508, Ann Arbor, MI 48106, phone 313/665-2535 or 800/458-2535.

Gynecologic Oncology Symposium--April 11-13, Baltimore, MD, Hyatt Regency Inner Harbor. Contact Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Bldg., 720 Rutland Ave., Baltimore, MD 21205, phone 301/955-2959.

Cancers of the Skin 4th World Congress--April 18-20, New York City. Contact Roberto Fuenmayor, CME Office, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York, NY 10021, phone 212/639-6754.

Gene Transplant Therapy--April 19, Memphis, TN. Contact Dr. James Hamner, Forum Director, Univ. of Tennessee, 847 Monroe, Suite 235, Memphis, TN 38163, phone 901/528-6354.

National Assn. of Oncology Social Workers Annual Conference--April 28-May 1, Monterey, CA. Contact Christina Blanchard, Div. of Medical Oncology A-52, Albany Medical College, Albany, NY 12208, phone 518/459-0703.

Early Detection of Prostate Cancer, Transrectal Ultrasound 1991--May 4, Boston, MA. Contact DCMI, PO Box 2508, Ann Arbor, MI 48106, phone 313/665-2535 or 800/458-2535.

Complications & Treatment of Children & Adolescents for Cancer--June 12-14, Buffalo, NY, Hyatt Regency Hotel. Contact Dr. Daniel Green, Dept. of Pediatrics, Roswell Park Cancer Institute, Elm & Carlton Sts., Buffalo, NY 14263, phone 716/845-2334.

Longterm Antihormonal Therapy for Breast Cancer--June 30-July 2, Lake Buena Vista, FL. Contact International Conference Headquarters, PO Box 30,000, Philadelphia, PA 19103, phone 800/735-8450 or 215/735-8450.

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-15617-13

Title: Cancer following long term exposure to radioactive thorotrast

Deadline: Jan. 27

NCI's Radiation Epidemiology Branch seeks firms capable of performing a study entitled "Cancer Following Long Term Exposure to Radioactive Thorotrast." The major objectives of this study include the determination of the risk of various malignancies in patients exposed to thorotrast and the characterization of the pattern of risk over time.

This contract shall include 1) identification of thorotrast exposed patients and, if available, comparable nonexposed patients, 2) collection of demographic and exposure variables, 3) ascertainment of vital status and cause of death, 4) identification of source of general mortality rates, and 5) submission of technical progress reports and edited data tape. Contractors will be responsible for obtaining all necessary permissions and clearances to conduct the study. All responsible and technically qualified sources are encouraged to submit an offer and will be considered. No collect calls accepted.

Contracting officer: Sharon Miller
RCB Executive Plaza South Rm 620
301/496-8611

RFP NCI-CP-15619-18

Title: Resource for procurement of human tissues from donors with an epidemiological profile

Deadline: Feb. 16

NCI's Div. of Cancer Etiology has a requirement for a resource for procurement of human tissues from donors with an epidemiological profile. This will include 1) performing pathological analysis (morphological, cytochemical, and immunocytochemical characteristics) of collected tissues from the fresh, unfrozen, normal, premalignant and malignant tissues to define conditions of the specimens at "time 0" of collection, 2) delivery of tissues to NIH within two hours of availability, 3) obtaining participation from smoking and nonsmoking male and female adults, 4) collecting viable specimens of blood components, 5) delivering donor questionnaires to NIH. All responsible sources are encouraged to submit an offer and will be considered. No collect calls accepted.

Contract specialist: Catherine Baker
RCB Executive Plaza South Rm 620
301/496-8611