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Cancer Advocates Ask House For Bypass Budget; NCCR's Day Calls For $380 Mil. Minimum Increase

The National Coalition for Cancer Research and the American Cancer Society asked Congress to appropriate the bypass budget request of $3.2 billion for NCI.

However, the NCCR position included a fall-back position: a request for a $380 million increase over the Institute's current budget. Testifying before the Labor, HHS and Education Subcommittee of the House Appro-

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In Brief

Shalala Meets HIV-Infected Children; Einstein's Kornblith Moves To PCI; Yang Leaves Centers

HHS SECRETARY DONNA SHALALA met with HIV-infected children and their siblings last week on Capitol Hill. Shalala toured an exhibit of artworks in the Russell Senate Office Building by the children, who are undergoing treatment by NCI's Pediatric Branch. . . . PAUL KORNBLITH, brain tumor expert and chairman of neurological surgery at Albert Einstein College of Medicine, has joined the Pittsburgh Cancer Institute. At PCI, Kornblith is co-director of neuro-oncology and professor of neurological surgery at Pittsburgh Medical Center. Kornblith developed a system to study individual patient responses to chemotherapy using the patient's own brain tumor cells. His tissue culture test was adopted by NCI to screen potentially therapeutic cancer drugs. . . . SUE YANG, special assistant to NCI's **Brian Kimes**, director of the Centers, Training & Resources Program, Div. of Cancer Biology, Diagnosis & Centers, will transfer to the Div. of Cancer Treatment, Developmental Therapeutics Program, later this month. Yang, a molecular virologist who for the past several years has worked with the Cancer Centers Branch particularly on revision of guidelines for review of Cancer Center Support Grants, will return to her work on anti-AIDS drug development. . . . JACK GOLDBERG, Cooper Hospital-Univ. Medical Center, has been appointed American Cancer Society Professor of Clinical Oncology. Only 20 physicians hold these professorships, which provide three-year grants to further cancer research and education. . . . CANDLELIGHTERS Childhood Cancer Foundation has received a $60,000 grant from the A.K. Watson Foundation to produce "Educating a Child with Cancer," a program to help parents and teachers of children with cancer. . . . CORRECTION: American Cancer Society funds $89 million in grants, not $8 million as reported in the Feb. 19 issue of **The Cancer Letter**. Also, ACS study sections cost $30,000 per meeting to operate. . . . 'IN BRIEF' continues to page 8.

Capitol Notes

Societies Testify For Increase In NCI FY94 Budget Before Natcher

(Continued from page 1)

priations Committee, both NCCR and ACS said the Institute's budget should contain no "earmarks" giving priority to some cancers over others.

"We recommend your favorable consideration of the bypass budget," said Robert Day, president of NCCR. "Short of this level, we recommend the minimal funding request of $380 million."

The NCI bypass budget received an endorsement last week when the House Energy and Commerce Committee passed the NIH reauthorization legislation containing a provision for funding the Institute at the bypass level.

The provision, the first of its kind in nearly a decade, was introduced by Rep. Michael Bilirakis (R-FL), passed unanimously by the Subcommittee on Health and the Environment and, as part of the NIH reauthorization package (H.R. 4), cleared the committee. The reauthorization bill, though separate from the appropriation measure, could galvanize supporters of bypass level funding for NCI, several observers said.

"We are very pleased that the House Health and the Environment Committee adopted an amendment which authorizes NCI at $3.2 billion," Day, president of the Fred Hutchinson Cancer Center, said at the appropriations hearing. "Recognition of this research needs budget by the Congress is an important step in revitalizing cancer research and supporting cancer research as a national priority."

Last year, both ACS and NCCR asked for an increase of $170 million over the NCI's 1992 budget. (**The Cancer Letter**, May 8, 1992).

THE CANCER LETTER

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Opposition to "earmarks," reflected in NCCR and ACS testimony before Appropriations, has become the verbal shorthand used by the opponents of the National Breast Cancer Coalition, a patient activist group that last year got Congress to increase funding for breast cancer, thereby causing a reallocation of NCI resources as well as triggering an institutional struggle between NCI and the Dept. of Defense, that was given the bulk of the new breast cancer funds.

NBCC did not testify at the hearing last week.

"Budget constraints and special earmarks led to cuts in several important programs last year," said Reginald Ho, president of the American Cancer Society at the Appropriations hearing.

"If this trend in funding holds, future progress in short- and long-term payoffs would be halted.

"[ACS] has supported increased funding for breast, prostate and other reproductive system cancers as a high priority over the years. However, we have long held the belief that any new or targeted effort in site-specific research should be supported by new funds, not at the expense of existing programs," said Ho, professor of medicine at the Univ. of Hawaii.

Testifying for NCCR, Day agreed that new mandates should be accompanied by new funds:

"Last year, NCI was requested to increase its efforts in breast cancer, a critically important research priority, and one that we strongly support.

"However, new funds were not provided to meet the recommendations of the Congress. As a result, important research programs in other women's health programs, prevention and smoking cessation programs will be reduced in fiscal 1993 to accommodate this directive."

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Along with the funding of NCI's bypass budget, ACS requested the appropriation of $2.5 billion for the Centers for Disease Control.

This would include:

▶$200 million for the Breast and Cervical Cancer Grants program, which directs grants to states to establish breast and cervical cancer screening, referral and educational programs to serve the disadvantaged women.

Last year, Congress appropriated $73 million for the program, enough to provide funding to about 18 states. Core-capacity grants have been awarded to another 18 states.

▶$30 million for implementation of the 1992 Cancer Registries Amendment Act, which establishes a program of grants to states to set up or expand

incidence based tumor registries as well as study elevated breast cancer rates in the northeastern and mid-Atlantic regions of the US.

Last year, Congress authorized HHS to use $30 million over the next four years to set up the program, but no money was appropriated.

▶$25 million for the Office of Smoking and Health.

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The $380 million increase recommended by NCCR includes an additional $60 million for prevention and control; $155 million for basic research; $56 million for clinical research; $37 million for cancer centers; $5 million for rehabilitation nd survivorship; $33 million for construction and $34 million for research training and education (**The Cancer Letter**, Feb. 26).

Testifying before the Appropriations subcommittee, **American Society of Clinical Oncology**, a member of NCCR, called for a balanced approach to the cancer program.

"Maintaining a vigorous clinical research program demands that we take a balanced approach to distributing research funds," said Martin Abeloff, ASCO's past president and director of the Johns Hopkins Oncology Center.

According to ASCO's figures, funding for NCI's cooperative groups decreased by 3.3 percent in 1993, core support for cancer centers decreased by 2.5 percent and CCOP funding was cut by 2.3 percent. Specialized Centers of Research Excellence was the only clinical research program to receive an increase in funding. That increase was 23.7 percent.

"While we are pleased that new funds have been infused into SPORES, we are concerned that future appropriations be provided to maintain the viability of this important program," Abeloff said. "Without new monies to support these efforts, we will continue to see a drain on the funding available for the traditional clinical research mechanisms that have served us so well."

The American Assn. for Cancer Research, an NCCR member, said investment in biomedical research should be a major component of the Clinton Administration's plan to reduce health care costs.

"We believe that continued progress in the War on Cancer can have a significant impact on reducing overall health care costs," said Anna Barker, president and CEO of International BioClinical Inc. of Portland, OR.

Speaking for the **Assn. of American Cancer Institutes**, also an NCCR member, Joseph Simone said the centers are cost-effective in using government funds.

"Most cancer centers receive some funding from NIH, but this averages only about 20 percent of their budget, with 80 percent coming from other sources," said Simone, AACI president and physician-in-chief at Memorial Sloan-Kettering Cancer Center.

"The government can use this money very wisely to implement an overall strategic plan for the war on cancer while leaving to the cancer centers the specific details of its application in the particular geographic, scholastic and community environment," Simone said.

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Sen. Bill Bradley (D-NJ) and Rep. Mike Andrews (D-TX) last week introduced a bill that would bring the federal tax on a pack of cigarettes to $1.

The measure, called the Tobacco Health Tax Act, could deter smoking and generate $12.1 billion in tax revenue. The proceeds, estimated at $54 billion by the bill's sponsors, would be allocated to Medicaid expansion, general health prevention and advertising that would counter tobacco ad campaigns.

Portions of the revenues would be used to offset state and local losses caused by increases in federal tobacco tax and to encourage farmers to cultivate crops other than tobacco.

"The best way to reduce smoking related cancers is first, for people to quit smoking and second, to prevent the initiation of smoking among children," said Joseph Bailes, chairman of ASCO's ad hoc committee on smoking.

Cancer Leadership Council Releases Statement On Health Care Reform

Seven organizations representing cancer patient advocacy groups nationwide have developed a health care reform statement that has been sent to First Lady Hillary Clinton, chairman of the President's Task Force on National Health Care Reform.

The groups last year formed a Cancer Leadership Council to write the statement to ensure that health reformers are made aware of the needs of persons with cancer (**The Cancer Letter**, Feb. 5).

The statement spells out "the minimum basic requirements which all reform measures should meet, including access to basic health care for all Americans," Ellen Stovall, executive director of the National Coalition for Cancer Survivorship, wrote in a letter to other cancer organizations which the Council hopes will endorse the proposal.

"We believe that our insights are unique, since our members have experienced both the best and worst aspects of the current U.S. system as they battle

cancer," Stovall wrote.

The Cancer Leadership Council is comprised of seven organizations: The National Coalition for Cancer Survivorship, Cancer Care Inc., Candlelighters Childhood Cancer Foundation, The Susan G. Komen Foundation, National Alliance of Breast Cancer Organizations, US TOO, and Y-ME.

Following is the statement:

Cancer Leadership Council's Statement On Health Care Reform

There is an urgent need for major health care reform to improve the accessibility and affordability of health insurance and health care for all Americans. American cancer patients have had access to some of the most advanced medical technology available in the world. At the same time, we have been exposed to some of the greatest failings of the current U.S. system. Cancer now strikes one in three Americans and kills one in four. Based on our first-hand experience with the current system of care, we propose a series of recommendations as essential components of a health care reform package.

These recommendations are not intended as a comprehensive statement of all necessary reform measures; however, they do represent consensus on those issues for which our experience offers a unique perspective.

In addition to these recommendations, proposals for national health care reform must (at a minimum) contain costs by seeking to enhance administrative efficiency, reduce unnecessary or ineffective care, and encourage personal responsibility for good health. However, while cost containment measures are an inevitable component of health care reform, measures that will eliminate or jeopardize access to essential services for all Americans are insupportable. Cost-containment measures that fail to acknowledge the necessity for comprehensive, high quality cancer services, as well as their long-term cost-effectiveness, would contradict the overall objectives of health care reform.

Eligibility

Discrimination Based on Health Status: Health insurance should be available to all persons at a reasonable price regardless of their health status or medical history, occupation, or other risk factors. The use of experience rating to establish premiums should be forbidden.

Coverage and Benefits

Pre-Existing Conditions: The use of pre-existing condition clauses should be declared an unfair insurance practice as it relates to those persons who are already covered by insurance and who need to change plans, or at least regulated to assure that they are not used to deprive consumers of fair insurance coverage.

Catastrophic Expenses: All health care reform measures should ensure that individuals and families are protected from devastating out-of-pocket medical expenses arising from catastrophic illnesses.

Adequate Coverage for Anti-Cancer Drugs: Reimbursement for therapies, including associated hospital and physician costs, should be available for any FDA-approved anti-cancer drug for any medically appropriate indication (as reflected in standard medical compendia or peer-reviewed literature).

Coverage of Investigational Treatment: Reimbursement for new therapies still under investigation should be available when the following circumstances are present:

a) Treatment is being provided pursuant to a clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an Investigational New Drug (IND) exemption; the Department of Veteran Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants; and,

b) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB); and,

c) The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training; and,

d) The patients receiving the investigational treatment meet all protocol requirements; and,

e) There is no clearly superior, noninvestigational alternative to the protocol treatment; and,

f) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the alternative.

Preventive and Early Detection Services: Adequate reimbursement should be available for effective primary preventive measures (such as childhood immunizations) and early detection health measures (such as mammography for breast cancer and PSA testing for prostate cancer).

Adequate Coverage of Mental Health & Rehabilitation Services & Therapies: Reimbursement routinely should extend to mental health and

rehabilitative services rendered by health care professionals as part of a comprehensive treatment plan addressing both the physical and mental consequences of cancer.

Hospice, Home Health and Related Services: Any basic package of benefits should be at least as comprehensive as those currently provided under Medicare, including coverage for such services as home health or hospice care.

Self-Insured Employer Plans: Health care reform measures must apply to all individuals, including those covered through self-insured plans.

Choice of Providers: The continued ability of individuals to choose among qualified providers and a range of specialists must be reflected in any health care reform proposal. If a network of providers is restricted, then provision must be made for care outside of the network.

Individual Responsibility for Good Health

Promotion of Good Health: Any health reform measure should include educational programs designed to promote healthy lifestyle choices and significantly increased excise taxes on tobacco and other products known to cause cancer so as to deter their use.

Copies of the Cancer Leadership Council's Statement on Health Care Reform are available from the National Coalition for Cancer Survivorship, 1010 Wayne Ave. N.W., Fifth Floor, Silver Spring, MD 20910, phone 301/650-9127.

General Says HHS Funding Shift Leaves Army In 'Untenable Position'

The Clinton Administration's plan for shifting the $210 million breast cancer research funds from the Dept. of Defense to NIH next year could leave the Army in an "untenable position" of managing a penniless research program, the Army general responsible for the program said last week.

"If there were a transfer in September, I will still be left with the responsibility of orchestrating and providing oversight to the research," Maj. Gen. Richard Travis, commander of the U.S. Army Medical Research & Development Command, said to **The Cancer Letter.**

"That leaves me as a manager in an untenable position," Travis said. "It's a very curious twist of events."

The twist came when HHS Secretary Donna Shalala announced that President Bill Clinton's economic plan includes a "technical adjustment" to shift the DOD funding to NIH for FY94.

Congress last year provided the Army a two-year appropriation of $210 million for breast cancer research as a way to increase spending on the disease while bypassing spending caps on the domestic budget.

The money came to the USAMRDC, which contracted with the Institute of Medicine for advice on spending the money. The IOM committee, which has met twice, is considering the mix of grants or contracts, the specific subject areas, and the method of peer review.

"I have been given no instructions to change course," Travis said to **The Cancer Letter.** "We are leaning forward in the foxhole to carry out this program."

However, Travis said, "I support the President. If there is going to be a change, we will salute the flag and get on with it."

The Army expects to obligate the funds between October 1993 and February 1994, for four to five year grants, Travis told **The Cancer Letter.**

"There would probably have to be a negotiation," Travis said. "We either stay in the program and stay responsible for it, or we just pass it to HHS and they maintain the program."

HHS View

Shalala's announcement also took NIH and NCI officials by surprise.

"We're having the same problem you are, figuring out where did this come from and what does it mean," an NCI staff member said to **The Cancer Letter.** "If the intent is to get money into the agency that does biomedical research, we would agree with it."

In addition, it is not definite whether the funds will remain in the Clinton budget, since Congress and the Administration are working this week on proposals to cut domestic spending. The President has said his budget will be finalized by the first week in April.

An HHS staff member explained to **The Cancer Letter** that under the Shalala announcement, the Army's funded research projects would not transfer to NIH. Only the budget authority associated with the FY93 appropriation to the DOD would shift agencies. Thus, there is no net increase in funding for breast cancer research, only a change in the organization in which the FY94 funds would be appropriated.

Here's how it would work:

▶ The DOD $210 million program remains on the books as an FY93 program.

As HHS staff explained, under multi-year funding authority, the DOD grant funds will go into a Treasury account, and a grantee draws down funds

over the life of the project, say four years. Thus, approximately $50 million flows out of the Treasury each year for four years. This is different from the usual NIH practice. NIH, which does not have multi-year funding authority, generally obligates grant funds year-by-year.

▶ Starting with FY94, NIH gets a completely new $216 million program ($6 million added for inflation) for breast cancer research. NIH would have multi-year funding capability for the money.

No Affect On IOM Deliberations

Members of the IOM committee advising the DOD on the FY93 breast cancer program said the HHS announcement will not affect its recommendations on how to spend the $210 million.

The committee, which is working at a fast pace, met last week in California to draft its recommendations. The committee's next meeting will be to review the draft, which will then be submitted to peer reviewers. The committee's report is expected to be released at the end of April.

Committee members are under instructions not to discuss the recommendations, but one member described the process as involving "a lot of compromise."

NCI News Roundup

Cancer Center Directors Support Idea For Treatment Referral Center Growth

NCI's Treatment Referral Center, established in 1991 to make taxol more available to women with refractory ovarian cancer, should be expanded for the study of other drugs and cancers, a cancer center director said last week.

Through the TRC, 43 NCI-supported cancer centers put 2,000 women into a compassionate use protocol of taxol for ovarian cancer. Patient costs were borne mainly by the hospitals.

Paul Bunn, director of the Univ. of Colorado Cancer Center, said the TRC trial was "an amazing accomplishment." His remarks were made at an NCI workshop for cancer center directors last week.

"TRC is a great mechanism, but it needs to be refined," Bunn said in a question-and-answer session following a presentation by Div. of Cancer Treatment Director Bruce Chabner. The TRC taxol protocol still leaves questions about the dose, duration and scheduling of the drug unanswered, Bunn said.

NCI established the TRC when it became apparent that taxol had activity against ovarian cancer and that the supply of the drug would be limited. The objective of the TRC was to handle the huge volume of phone calls from patients and their doctors eager to receive the drug. The Institute was concerned about not creating any appearance that taxol would be available only to those with "connections."

The TRC referred patients to the cancer center nearest them conducting clinical trials for ovarian cancer using taxol or other drugs, and developed the compassionate use protocol for patients not eligible for other taxol trials.

Data collected on the TRC protocol were presented before the FDA's Oncologic Drugs Advisory Committee as part of the approval process for taxol. In fact, an FDA reviewer praised the TRC protocol for "a remarkable job" on collecting data (**The Cancer Letter**, Nov. 20, 1992). Bunn is a member of ODAC.

The TRC protocol "could have done a little better" on the amount or quality of data collected, Chabner said. "Our objective was to get this drug out to you as fast as possible."

When the TRC was set up, Chabner said, "the idea of collecting meaningful data was not the major consideration. We didn't have the personnel and the money to pay for data collection to the extent we thought was needed."

"We could have answered every question I've ever heard posed about taxol" with some modification of the TRC protocol, said Robert Young, director of Fox Chase Cancer Center.

The TRC model could be used, Young said, to design trials and recruit the experts to run them, "instead of trying to fit trials into existing mechanisms."

NCI has attempted in recent years to find ways to support more clinical trials, and has tried to encourage clinical investigators to tap the only NIH money source that always increases, the research project grant pool that funds R01 and P01 grants.

"Maybe we need another ad hoc mechanism for putting trials together," Chabner said. "Particularly if there's no price tag [for NCI]."

"We have more active [investigational] drugs than we've ever had before," Bunn said. "There are six drugs just for lung cancer. Call us in and we'll set up TRCs for them."

Martin Abeloff, director of the Johns Hopkins Oncology Center, said the Institute should place a higher priority on the scientific questions about new drugs rather than "mass distribution." He urged more communication between DCT and cancer centers on future TRC projects.

Michael Friedman, director of NCI's Cancer Therapy

Evaluation Program, which is in charge of the TRC, said center directors were involved in establishing the TRC.

"There was enormous skepticism" when the center was established, he said. "You did have input. CTEP didn't do this all by itself."

The TRC was a way for NCI to deal with the "crushing social, emotional and political problems" that taxol presented, Friedman said. "I understand the concerns about not letting that drive the scientific system. However, we--NCI and you as scientific leaders--are being accused [by patient advocates and Congress] of an arrogance. If we are to deal with that, we have to demonstrate sensitivity to patients."

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High priority areas for research in NCI's Div. of Cancer Treatment were outlined at last week's workshop of cancer center directors by DCT Director Bruce Chabner.

Chabner listed the following areas:

1. Disease specific research in breast, prostate, ovarian, and cervical cancer.

2. New therapies (translational research) including new drugs, biological agents, gene therapy and vaccines.

3. Cooperative group trials. Plans are to expand trials in early prostate cancer, expand combined modality trials in initial therapy of aerodigestive tumors, and integrate cooperative groups with basic research laboratories.

Following are some research questions he asked the center directors for help answering:

In prostate cancer, define the role of surgery and radiotherapy in early disease. Does "curative" therapy for early prostate cancer benefit elderly patients? If so, which subgroups of lesions does it pay to treat? Should PSAs be routinely obtained in elderly asymptomatic patients?

In combined modality trials: Is surgery necessary in esophageal cancer? Does neoadjuvant therapy prolong survival in gastric and head and neck cancer? Do intensified regimens with ABMT and ifosfamide prevent recurrence in soft tissue sarcomas? Is there a role for neoadjuvant therapy in recurrent bladder cancer?

He also discussed the NCI-Navy Medical Oncology Branch regimen for metastatic colon cancer, which has resulted in 20 partial responses (45%) and 4 complete responses (9%) in 44 patients, more than half with performance status of zero.

The regimen is: interferon-alpha 5 mil U/m^2 s.c. days 1-7, 5-fluorouracil 370 mg/m^2 days 2-6, i.v. bolus, and leucovorin 500 mg/m^2 days 2-6, i.v. bolus.

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Seven of the NCI-supported cancer centers have interim directors and are seeking permanent appointments, and three centers are expecting new directors soon.

Brian Kimes, director of the Centers, Training & Resources Program, told cancer center directors at an NCI workshop last week that centers have relatively high turnover rate in leadership.

He called it a "leadership crisis among center directors."

The search for new center directors often takes a long time; more recent new appointments have been promotions from within centers, Kimes said. For example, Martin Abeloff last year became director of the Johns Hopkins Oncology Center, and Azorides Morales was promoted to director of the Sylvester Comprehensive Cancer Center.

Finding a new director from within a center has advantages, since the candidate will understand the center's strengths and weaknesses, Kimes said.

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NCI submitted proposals for tuberculosis projects to NIH for funding through the emergency $9.2 million tap announced by NIH Director Bernadine Healy, but none of the NCI proposals will be funded, NCI Deputy Director Daniel Ihde said to the Div. of Cancer Treatment Board of Scientific Counselors at its meeting last month. NCI will contribute $1.9 million to the emergency fund.

Group Splits Over Dose Testing Of Chemicals For Carcinogenicity

A National Research Council committee has split over the continued use of tests in which animals are exposed to massive doses of a chemical in an attempt to determine if the chemical causes cancer.

The committee issued a report in which a majority recommended that such tests continue to be used as part of an overall strategy for testing possible carcinogens. However, reflecting disagreement in the scientific community, a third of the committee recommended that such testing be replaced with a new approach that attempts to understand the mechanisms by which more moderate doses of a chemical affect animal physiology and health.

"There are a lot of ideas out there for new approaches to carcinogenicity testing," said committee chairman Bernard Goldstein, director of the Environmental and Occupational Health Sciences Institute, Robert Wood Johnson Medical School, Univ.

of Medicine and Dentistry of New Jersey. "However, the majority of the committee decided that use of maximum tolerated dose testing should not be replaced with a dramatically new approach until there are more data to support such a change."

The council is the operating agency of the National Academy of Sciences, based in Washington. The study, "Issues in Risk Assessment," was sponsored by a consortium of federal agencies and private organizations.

Leading Away From MTD Use

The committee minority said there already is sufficient evidence to warrant replacing the MTD method.

"The scientific data from hundreds of tests have come in and they are trying to lead us away from the use of the MTD," said Richard Reitz, a member of the committee minority and an associate scientist with Dow Chemical Co. "However, some [on the committee] are willing to be led there more rapidly than others."

A majority of the committee recommended that MTD testing continue to be used as an initial test of possible carcinogens. If animal tests using MTD do not produce cancers then, generally, no additional carcinogenicity tests are needed, they said. If the MTD results in cancer in test animals, additional studies should be performed to examine the chemical's physiological effects and how it is metabolized.

The minority recommended that MTD animal studies not be used as an initial test of a chemical's carcinogenicity. Instead, studies should be done first to determine a chemical's physiologic and metabolic mechanisms, including the mechanisms by which it causes toxicity in animals. Based on these studies, a panel of experts could then design high-dose animal tests that would yield results more relevant to humans than do MTD studies, they said.

An example of the problems created by the use of MTD is the case of saccharin, Reitz said. MTD bioassays find that saccharin has carcinogenic potential, but last year, Univ. of Nebraska scientists found that rats are more sensitive to saccharin as a carcinogen than humans. Saccharin causes bladder cancer in rats by reacting with urine proteins to form toxic crystals, the researchers said. Human levels of these proteins are 100 to 1,000 times less than in rats. The Nebraska scientists concluded that it is unlikely that saccharin would cause cancer in humans.

"Issues in Risk Assessment" is available from the National Academy Press, 2101 Constitution Ave. NW, Washington, D.C. 20418, phone 202/334-3313. Cost of the report is $37.50 plus $4 shipping for the first copy and $.50 for each additional copy.

In Brief

AACR Seeks Applicants For Award Honoring Wellcome's Gertrude Elion

(Continued from page 1)

. . . **AMERICAN ASSN.** for Cancer Research is seeking applicants for its first career development award, the new **Gertrude Elion** Cancer Research Award, presented annually to one untenured scientist at the level of assistant professor engaged in meritorious basic or clinical research in cancer causation, prevention, or treatment. The $30,000 award is supported by an educational grant from Wellcome Oncology in honor of Elion, now a scientist emeritus with the company, and a past president and honorary member of AACR. Elion's research at Burroughs Wellcome Co. earned her the Nobel Prize in 1988. Application deadline is April 9. For application information, contact Jenny-Anne Martz at AACR, Public Ledger Bldg., 620 Chestnut St. Suite 816, Philadelphia, PA 19106, phone 215/440-9300. . . . **FRED HUTCHINSON** Cancer Research Center was awarded a $3 million grant from NCI to investigate the relationship between breast cancer and two common by-products of electric power: extremely low frequency magnetic fields and light-at-night. **Scott Davis** is principal investigator of the four-year study, which is being conducted in collaboration with Battelle Pacific Northwest Laboratories. About 1,600 women in two counties in Washington will participate, half recently diagnosed with breast cancer and half without breast cancer. . . . **NATIONAL EYE INSTITUTE** and the Univ. of Texas Southwestern at Dallas are seeking people with AIDS who have cytomegalovirus retinitis for a study to determine the safety and effectiveness of the surgical implantation of a device that releases ganciclovir into the eye to control CMV infection. Contact Susan Mellow at NIH, 301/496-7254 or Linda Poellnitz in Dallas, 214/688-3838. . . **UNIV. OF ALABAMA** at Birmingham Comprehensive Cancer Center has recruited two specialists: **Barton Guthrie**, of George Washington Univ. Medical Center, joins UAB as an associate scientist with the neuro-oncology program. **Matthew Carabasi**, of Memorial Sloan-Kettering Cancer Center, will work with UAB's bone marrow transplant program as an associate scientist. . . . **AMERICAN NURSES ASSN.** met with **Hillary Clinton** and members of the President's Task Force on National Health Care Reform last week. The nurses called for a "restructured delivery system driven by patients' needs with universal access to a continuum of services and a priority on primary health care."