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NCI Official Says Public Health Issue As Important As Data In Mammography

Consensus is building within and outside of NCI to keep the current national guidelines on mammography screening for women under age 50, though recent data from Canadian and Swedish studies do not show benefit for that age group, sources have told **The Cancer Letter** this week. Institute officials are said to be fearful of the public health

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In Brief

Extramural Affairs Director Diggs To Leave NIH; Bonadonna, Fisher Share Bristol-Myers Award

JOHN DIGGS, NIH deputy director for extramural affairs since 1990, is leaving NIH to take the post of vice president for biomedical research at the Assn. of American Medical Colleges. Diggs has been at NIH for 19 years. . . . **BRISTOL-MYERS SQUIBB** Award for Distinguished Achievement in Cancer Research will be presented to **Gianni Bonadonna**, Istituto Nazionale Tumori, Milan, and **Bernard Fisher**, Univ. of Pittsburgh. The annual award will be presented April 22 in New York City. . . . **PRESIDENT CLINTON** is expected to release his FY94 budget request on April 5. House Appropriations Committee has scheduled hearings on the NCI budget April 21. . . . **USC/NORRIS** Comprehensive Cancer Center will name a laboratory in its new tower after **Brian Henderson**, center director for 10 years who is leaving to become president of the Salk Institute. . . . **ISAIAH (JOSH) FIDLER**, M.D. Anderson Cancer Center, has received the Raymond Bourgine Award for Achievements in Cancer Research. The award was presented to Fidler by the mayor of Paris, who also honored Fidler with the Gold Medal of Paris. The Bourgine award is named for the late French journalist and politician who died of prostate cancer. . . . **MEETING** of the President's Cancer Panel Special Commission on Breast Cancer will be held April 29, Lowes Hotel, New York City, from 8:30 a.m.-5 p.m. Topics are research on possible environmental causes of breast cancer and delivery of breast cancer care and role of the payer. . . . **GEORGE BUCHANAN,** Univ. of Texas Southwestern Medical Center, has been named the first holder of the Children's Cancer Fund Distinguished Chair in Pediatric Oncology and Hematology. The Children's Cancer Fund of Dallas established the chair with $500,000 in gifts. . . . **POSSIBLE CANDIDATE** for NIH director is rumored to be **Gilbert Omenn,** dean of the School of Public Health, Univ. of Washington. Omenn, a Democrat, served in the White House Office of Science & Technology under President Jimmy Carter. . . . **'IN BRIEF'** continues to page 8.

Consensus To Keep Guidelines On Mammography Is Building

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implications--i.e., a reduction in mammography use overall--if the agency were to appear to back down from its recommendation for mammography screening beginning at age 40.

Adding to the pressure to keep the status quo is the stance of the American Cancer Society, which reaffirmed its support of the guidelines agreed to by the two organizations in the 1980s. ACS and NCI held workshops in February to review the data.

"We have evaluated the data from the studies and the workshops, and we feel there is no need to change," Gerald Murphy, ACS chief medical officer, said to **The Cancer Letter** last week.

The NCI/ACS guidelines call for mammography screening beginning at age 40 and continuing for one- to two-year intervals until age 50, when mammography should be performed annually.

A panel of experts commissioned by NCI to review data from eight randomized controlled trials said the trials show that mammography screening of women under age 50 does not significantly reduce breast cancer mortality in the first seven years after the test. There is an "uncertain" marginal reduction in mortality after 10 to 12 years, the experts said.

The report of the five-member panel was presented by Suzanne Fletcher of the American College of Physicians and editor of the "Annals of Internal Medicine" at a meeting of the President's Cancer Panel Special Commission on Breast Cancer last month held in Atlanta.

The "Fletcher report," as it is now called, was not intended to make recommendations for breast cancer screening, and did not make any.

NCI staff and outside experts will soon present a report to NCI's Executive Committee, which will make the final decision for the Institute. The Executive Committee is comprised of the director, deputy director, five division directors and the chief administrative officer.

"We are committed to reviewing the guidelines on mammography. That does not mean we are committed to changing the guidelines," NCI Deputy Director Daniel Ihde said to **The Cancer Letter.**

'Must Weigh Public Health' Issues

At the meeting in Atlanta, Ihde described the NCI process for making a screening recommendation: "Once complete and accurate data about a screening method for a particular cancer has been assembled, a variety of experts on screening, both within and outside NCI, evaluate all available evidence. They decide whether this evidence warrants a recommendation or a revision of screening guidelines. This report is sent to the NCI Executive Committee, the senior management body of the Institute, which considers this expert opinion, as well as other factors, in determining the Institute's official guidelines.

"I must stress again that NCI must weigh the scientific information within a broad public health context in formulating and recommending guidelines," Ihde said.

"For example, we know that breast cancer incidence increases with age, making early detection in older women very important," he continued. "Yet there is little scientific evidence from controlled clinical trials that screening yields a reduction in cancer-specific mortality in women over age 70, primarily because this age group has infrequently been included in these studies. So other factors become paramount in developing a screening recommendation for this age group....

"We must be deliberate and pay careful attention to all scientific information as well as to the widespread and even profound public health repercussions of guidelines."

Ihde reiterated to **The Cancer Letter:** "We would consider not just the results of randomized trials alone, but also the public health implications. We are committed to seeing that women are informed about the facts in support of the guidelines."

For example, Ihde said, the Fletcher report "showed there is really strong evidence now of the ability of mammography to reduce mortality in women over the age of 50. In the trials of women under age 50, there was a suggestion that if you followed them for a longer time, say 10 years or more, there may be a reduction in mortality. We would be interested in

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following women for a longer time."

"There are four comments that keep coming back" to raise questions about the data, ACS's Murphy said. "First, it was a mistake to exclude nonrandomized trials such as the BCDDP, which clearly shows benefit for the 40-49 group. Second, following people in meta-analysis for seven years is not long enough, we need 10 years or more. Third, there is a failure to recognize the tremendous improvement that has occurred over the past decade in mammography quality. Fourth, mixing other studies, with different times of followup, confuses the issue."

The International Union Against Cancer (UICC) will hold a meeting in Geneva, Switzerland, in September to review the data. "Perhaps that will be another opportunity for discussions about what needs to be done," Murphy said. "It is a real question whether any study can be designed that can be carried out in a short amount of time that can answer any of these questions."

Fletcher Report Summary

Members of the Fletcher committee were William Black, Dartmouth-Hitchcock Medical Center; Russell Harris, Univ. of North Carolina School of Medicine; Barbara Rimer, Duke Comprehensive Cancer Center; and Sam Shapiro, Johns Hopkins School of Hygiene and Public Health.

Following is the Fletcher report's summary:

Breast cancer screening in women ages 40 to 49:

The most important question addressed during the workshop is the effectiveness of screening women ages 40 to 49 years. For this age group, it is clear that n the first 5 to 7 years there is no reduction in mortality from breast cancer that can be attributed to screening. There is an uncertain, and, if present, marginal reduction in mortality at about 10 to 12 years. Only one study provides information on long-term effects beyond 12 years, and more information is needed.

More research results should be available relatively soon. Continued analysis from the combined Swedish experience is needed. The control groups of women in several of these studies are now being screened, which may limit the conclusions that can be drawn about long term effectiveness. The degree to which reclassification of outcomes took place when individual trials were combined needs to be clarified.

Continued followup of the Canadian trial should also help determine whether and to what degree long term effects from breast cancer screening occur among women ages 40-49. It is worrisome that more patients in the screening group had advanced tumors, and this fact may be responsible for the results reported to date. Detailed review of the randomization procedures at each center would be helpful to determine with as much certainty as possible whether any breach in protocol occurred. The technical quality of mammography early in this trial is of concern, but it is not clear to what extent mammography and clinical breast examination in the Canadian trial was at least as good as that of mammography in the Swedish trial.

Followup of the Edinburgh trial should be useful as well, although to date the number of breast cancer deaths in women younger than 50 is small. If the large study on breast cancer screening in women ages 40-41, now in the planning stages in the United Kingdom, takes place, it may provide the most definitive evidence about the effectiveness of breast cancer screening in women younger than 50 years. It is unlikely that large randomized clinical trials on this question will be mounted elsewhere in the Western world.

A second meta-analysis of the data from all available trials of screening in women ages 40-49 may be useful, especially when longer followup is available and when the effect of reclassification is clarified in the combined Swedish studies. Such a meta-analysis should use the raw data from each of the trials.

Breast cancer screening in women ages 50 to 69:

For women ages 50 to 69, the evidence presented at the workshop strengthens the scientific observation that screening leads to reduced breast cancer mortality. Every study presented found a protective effect for women in this age group. The combined analyses of the four Swedish trials provide increased precision of the estimated mortality reduction seen in the individual trials. That analysis and the meta-analysis by Elwood raise our confidence that screening women ages 50-69 reduces mortality approximately 30 to 35 percent. The results of the Canadian study of screening women ages 50 to 59 years do not contradict the Swedish studies because the study addressed a different question, the incremental effect of mammography over a careful physical examination.

Three important questions relating to screening women ages 50 to 69 remain unanswered. First, what is the optimal interval for mammography? The Swedish studies suggest that a screening mammogram as infrequent as every 33 months reduces breast cancer mortality, at least in a population with a high compliance rate and in a setting with high quality mammography.

Estimates of lead time in this age group range from 21 months in the HIP study to 42 months in the two-

county study. These data raise the possibility that a screening interval of every 12 months may not be necessary in this population. Further studies to determine the optimal screening interval would be useful, as is planned in the United Kingdom.

The second question is, What is the most effective screening modality? Previous studies have demonstrated that mammography and physical examination detect breast cancer in a complementary manner. Initial results from the Canadian study suggest that a careful clinical breast examination may be as effective as mammography, although more followup is needed. Research should be undertaken to determine which components of the clinical breast examination correlate with early cancer detection and how to acquire these skills.

The third question in regard to screening in this age group is, Is a single view mammogram as effective as a two view mammogram? Trials varied in the number of views they used. Further research should be carried out to determine the degree to which adding the craniocaudal projection to the to the mediolateral oblique projection changes intermediate measures such as sensitivity and specificity.

Because scientific studies provide clear evidence of a difference in the effectiveness of breast cancer screening between younger and older women, further studies to determine the mechanism of this difference should assume high priority. Possible biologic reasons, such as menopause, should be studied.

Breast cancer screening in women age 70 and older:

Women in their 70s are a high risk group for breast cancer. The currently available clinical trial data for these women are inadequate to judge the effectiveness of screening because the numbers of women wee small, the compliance was poor, and the screening episodes were too few. Because of the prevalence of screening in North America, it is probably not feasible to conduct a trial in which the control group is not screened. It may be possible to study the effectiveness of different screening intervals of mammography using a randomized controlled trial. Furthermore, clinical breast examination may be particularly effective in older women and trials should evaluate this possibility.

Other issues:

To date, breast cancer screening has been evaluated in a number of specific age groups, usually by 10-year intervals. These groupings are arbitrary and without biologic justification and are probably due to relatively small numbers in individual trials. If data from all trials could be combined, it might be possible to examine the effectiveness of breast cancer screening in age groupings as small as one year. If so, beginning screening at a less arbitrary age than the beginning of the fifth or sixth decade might be beneficial.

Discussions during the workshop dealt with the vexing problem of age at diagnosis versus age at entry in all the trials and one analysis was proposed. Methodologic research should be undertaken to resolve this issue. The new trial in the United Kingdom plans to include only women ages 40-41 years at entry so that during the course of the study (seven years) no woman will be diagnosed with breast cancer after age 50.

Known risk factors for breast cancer are important but do not provide the basis for selective screening within age groups. New developments in molecular genetics and biomarkers may lead to much more powerful predictors of breast cancer risk. In the future, it may be possible to identify women who are at such low risk that they will not need to be screened.

An important aspect of breast cancer screening is communication with women regarding breast cancer risks by age and the benefits of breast cancer screening. Presently, perceptions of breast cancer risk are highest in women of lowest risk and lowest in women of highest risk by age group.

More effective ways of describing risks to women must be developed. Likewise, better communication techniques are needed when discussing screening abnormalities with women to avoid adverse psychological sequelae from false positive examinations.

Generic Drug Makers Setting Sights On Worldwide Market For Taxol

As Bristol-Myers Squibb proceeds with its marketing of taxol, competition is not far behind.

Last week, a maker of chemical and pharmaceutical grade taxol, NaPro BioTherapeutics Inc. of Boulder, CO, announced its deal with a subsidiary of F.H. Faulding & Co. of Australia to market its version of the drug in 10 Asia-Pacific countries.

Faulding has a worldwide presence, which includes a U.S. generic drug subsidiary, Purepac. The deal involves Faulding's injectable drug subsidiary, David Bull Laboratories of Australia.

Announcing the deal, Faulding and NaPro said their clinical trials of the drug in refractory breast and lung cancer patients will take about two years to complete.

Bristol has already filed for marketing approval in most countries, and it is likely to obtain approvals

before its competitors. However, observers said, by seeking approvals now, the competing firms are likely to solidify their grip on the market for taxol's generic equivalents.

"Because paclitaxel is not patented or patentable, we expected that the market would become competitive," Bernie Mogelever, a spokesman for Bristol-Myers Squibb said to **The Cancer Letter.** "Therefore the announcement is not a surprise.

"We expect that generic versions of the drug will become available shortly after the period of exclusivity ends. In the interim, we expect competition from the drug taxotere."

Taxotere, a taxol analogue developed under a Cooperative Research and Development Agreement between NCI and the French company Rhone-Poulenc Rorer, is expected on the market within two years.

Bristol's U.S. market exclusivity expires on Dec. 29, 1997. After that date, taxol will become fair game for generic manufacturers, including Faulding.

Outside the U.S., generic drug makers are free to proceed to market their versions of taxol as soon as they can obtain regulatory approvals.

NaPro is a privately held company founded in 1991. In the U.S., it has been advertising in chemical trade journals, offering its version of taxol for research use.

Tamoxifen Trial Accrues 6,000, NCI Makes Plans For Proscar Trial

The NCI-sponsored Breast Cancer Prevention Trial has accrued 6,000 women as of March 17, nearly 40 percent of the 16,000 women needed for the study of tamoxifen, an NCI official said.

NCI-funded Community Clinical Oncology Programs account for 30 percent of the accrual to the trial, a number that is "very gratifying," said Leslie Ford, chief of the Community Oncology & Rehabilitation Branch in the Div. of Cancer Prevention & Control. Before the trial began, NCI estimated that CCOPs would account for 20 percent of accrual.

Since the tamoxifen trial opened in June 1992, the National Surgical Adjuvant Breast & Bowel Project has processed risk assessments for 46,000 women, found 26,000 of those eligible for the study, and has randomized more than 6,000, Ford told a CCOP Special Interest Group session at the annual meeting of the Assn. of Community Cancer Centers, held last month in Washington.

Ford also gave an update on the CCOP program and discussed NCI's plans for a trial of the drug Proscar (finasteride) for prevention of prostate cancer.

Minority Recruitment A Problem

So far, NCI and NSABP are pleased with the accrual data for the tamoxifen trial, except for the low accrual of minority women.

"Clearly, there is a problem with minority recruitment," Ford said. However, she noted that "there are no previous trials to compare this with."

Approximately 97.6 percent of the women enrolled are white, 1.1 percent black, and 1.2 percent "other."

Ford pointed out that 270 centers are participating. "If each center enrolled five women of color, we would meet our goal."

Jazz singer Nancy Wilson recently taped a public service announcement urging black women to consider seeking a risk assessment. Ford said this may help generate some inquiries.

Cost to participants whose insurance does not cover preventive services is "not the main issue" in minority recruitment, Ford said. More relevant, she said, is "distrust of clinical trials" stemming from the infamous Tuskegee trial which continued to observe persons with syphilis up until 1973, long after a cure was found.

'What Are We Doing Wrong?'

"What are we doing wrong?" one CCOP administrator asked.

"I don't know that it is an issue of you doing anything wrong," Ford said. She noted that one reason the Minority-based CCOP program was started was the recognition that the catchment area of CCOPs is primarily white.

One CCOP administrator said that he and his staff have done many workshops in the black community, but "not a single minority has filled out a risk assessment."

"We're going to have to keep hammering at it," Ford said. "It's going to be a little bit here, a little bit there."

NSABP Chairman Bernard Fisher sends periodic letters to participating CCOPs noting whether the CCOP is on target with accrual and how many patients are needed to stay on track, Ford said.

ACCC president-elect Albert Einstein Jr. asked whether anyone was having success with minority enrollment. No one raised a hand.

Carl Kardinal, Ochsner CCOP in New Orleans, said he tried to recruit minorities among Ochsner employees or their families, without success.

"At a minimum, we should document the efforts we are making," in order to address potential criticism of the trial, Ford said.

A CCOP administrator asked Ford to consider more

NCI-sponsored public service announcements for the trial.

Ford complained about the "negative media" the trial received last fall as a result of Congressional inquiry into the informed consent (**The Cancer Letter,** Oct. 30, 1992).

Ford said she and Fisher "spent a lot of time" with television news shows to get their side of the story across, but their comments were cut. "You have no control and you don't come out good," against opponents of the trial, she said.

January A 'Slow Month'

One CCOP administrator asked why accrual overall has seemed to wane in the past few months.

"There has been somewhat of a decrease in the number of risk assessments," Ford said. "But there is still the pool of 26,000." She said January "was a slow month" for staff.

Ford provided the following accrual data:

The relative risk of those entering the study on average is double the minimum required risk, even in women over 60, Ford said.

About 61 percent have at least one first degree relative with breast cancer. Approximately 247 women have lobular carcinoma in situ. Seven percent have atypical hyperplasia. Over 50 percent have had at least one biopsy.

Age distribution of those randomized is:

--12 percent age 40-44
--25 percent age 45-49
--19 percent age 50-54
--12 percent age 55-59
--14 percent age 60-64
--10 percent age 65-69
--5 percent age 70-78

Proscar Trial Planned

"Chemoprevention is the wave of the future," Ford said. "That's the direction we want to go."

NCI recently sent the 51 CCOPs and 10 Minority-based CCOPs letters inviting them to submit breast cancer biomarker studies. Other chemoprevention trials that have opened include:

--13-cis-retinoic acid to prevent second head and neck tumors.

--13-cis-retinoic acid to prevent second primary non-small cell lung cancer.

--DFMO in patients with superficial bladder cancer.

--Alpha interferon in cervical dysplasia.

Trials that will soon open to accrual are:

--calcium carbonate to prevent recurrent adenomas and colorectal carcinomas.

--aspirin to prevent colonic polyps.

--finasteride (Proscar) to prevent prostate cancer. This trial will be called the Prostate Cancer Prevention Trial (PCPT).

The prostate trial will be coordinated by the Southwest Oncology Group and centers interested in participating will go through an application process similar to that used for the tamoxifen trial. Application packages will soon be mailed to cancer centers and CCOPs.

"I'm convinced [the application process] made a difference in improving accrual," Ford said. "It forced participants to think about how to accrue patients.

The prostate trial will require 18,000 men age 55 and over with no evidence of benign prostatic hyperplasia or no carcinoma on digital rectal examination.

Participants will receive finasteride for seven years, and will have prostate biopsy at the end of the seven year period.

NCI expects accrual to begin in August or September, Ford said.

Will Proscar get "bad press" the way tamoxifen did? Kardinal asked.

"My theory is that the problem with tamoxifen is we know too much," Ford said. Clinical experience with tamoxifen involves 41,000 women. "There's not another drug including aspirin for which we have so much data," she said. Proscar is marketed by Merck for BPH.

"We need to set up a whole new accrual process" for the prostate trial, Kardinal said.

"I'd go after the husbands of your breast cancer ladies," Ford said. An advantage would be "mutual pill-taking reinforcement" among the couples.

CCOPs Budget Under $30 Million

NCI's budget for the CCOPs program is $29.3 million this year, compared to $30 million in FY92. The budget is entirely from the prevention and control line item.

CCOPs funding will be $12.5 million, MB-CCOPs will get $2.3 million. The rest of the funding is set aside for chemoprevention supplements, research bases, and the tamoxifen and Proscar trials.

CCOPs are involved in 47 prevention and control protocols active or approved; 38 have closed, three have temporarily closed, and nine are under revision.

Accrual to treatment trials has fallen over the past two years for two reasons, Ford said. First, NCI was funding 56 CCOPs and 12 MB-CCOPs in 1990-91 and now is funding 51 CCOPs and 10 MB-CCOPs. Second, some large adjuvant trials have closed.

NIH Responding To Executive Order To Reduce Number Of Committees

NIH and NCI officials are in the process of responding to an executive order from President Clinton that requires government-wide reduction of the number of advisory committees by one-third.

The Feb. 10 order applies to all federal advisory committees whether or not they are mandated by law. The agencies have until the end of the 1993 fiscal year, Sept. 30, to comply.

The Dept. of Health and Human Services has 300 of the 1,200 federal advisory committees; about 230 of those are within NIH. About 175 of those are peer review committees. NCI has 17 chartered committees.

NIH has several internal task forces preparing a response to the order, according to Barbara Bynum, director of NCI's Div. of Extramural Activities.

The executive order asked each agency to submit "a detailed justification for the continued existence, or a brief description in support of termination, of any advisory committee not required by statute; and a detailed recommendation for submission to the Congress to continue or to terminate any advisory committee required by statute."

"It is not clear what 'mandated in statute' means," Bynum said to **The Cancer Letter** last week. "Since we are required to empanel peer review committees prior to awarding grants, and since the director of each institute is empowered to constitute panels, it can be implied that the panels are 'mandated in statute.'

The National Cancer Advisory Board is specifically mandated in the National Cancer Act of 1971, Bynum noted.

"If we are faced with the possibility of retiring or replacing committees that are not specifically mandated in that fashion, it would present a challenge for us to figure out, for example, how to do non-conflicted peer review," Bynum said. "It will test our ingenuity.

President Jimmy Carter made a similar order during his term. "At that time, we collapsed some committees into others, forming mega-study sections under a broad discipline rubric," Bynum said.

It costs NCI about $15,000 to hold one meeting of a typical study section or a site visit.

"There might be some savings if we actually do abolish committees and discontinue the services of committee members," Bynum said. "But for peer review, until the influx of applications which must be reviewed is reduced, the requirement to review will continue unabated. I'm not smart enough to figure out where the savings will come from."

Bynum is NCI's representative to the NIH Extramural Programs Management Committee, which is coordinating the NIH response to the order, through the office of the NIH Deputy Director for Extramural Affairs, John Diggs.

Cancer Education Program To Open To Investigator-Initiated Ideas

NCI's Cancer Training Branch plans to open its Cancer Education Program (R25 grants) to investigator-initiated research, rather than relying on tightly focused components and Requests for Applications.

"Our intent is to provide greater flexibility for curriculum driven programs for health professionals and students," branch chief Vincent Cairoli said to **The Cancer Letter**. "Instead of the fixed and limited programs we have now, we will open it to good ideas in cancer education that would impact on cancer incidence, quality of life, and mortality."

The program would support grants in cancer education that could not be supported by other grant mechanisms, Cairoli said.

The branch also has drafted revised NCI supplementary guidelines for the support of institutional National Research Service Awards (T32s).

The guidelines, which will be published in the "NIH Guide to Grants and Contracts" by the end of April, are being revised to "encourage grantees to deal more directly with cancer research," Cairoli said.

A new requirement will be that at least half of the preceptors must be cancer researchers supported by grants from NCI or other organizations such as the American Cancer Society. Also, the grants will require courses in cancer biology and exposure to clinical aspects of cancer research.

Advisors to NCI's Div. of Cancer Biology, Diagnosis & Centers were informed of the revisions at their meeting last week.

Symposium To Honor Werner Kirsten Scheduled For June 2 In Frederick

NCI's Frederick Cancer Research & Development Center will hold a symposium in memory of Werner Kirsten on June 2 at Hood College in Frederick, MD.

Kirsten, director of FCRDC for the past five years, died last December (**The Cancer Letter**, Jan. 1).

Guest lecturers at the symposium include Murray Gardner, Robert Gallo, Peter Vogt, Janet Rowley, Donald Rowley, Dennis Slamon, Edward Prochownik, Larry Arthur, and Stephen Hughes.

Comments and introductions will be delivered by

NCI Director Samuel Broder, Div. of Cancer Etiology Director Richard Adamson, Hollings Oncology Center Director Peter Fischinger, former NCI director Vincent DeVita, George Vande Woude, and Raymond Gilden.

Contact Margaret Fanning at 301/846-1089 to reserve a seat for the symposium.

AACR To Honor Five With Awards At Annual Meeting Next Month

American Assn. for Cancer Research will honor five cancer researchers during its annual meeting in May in Orlando, FL.

Wuan Ki Hong, M.D. Anderson Cancer Center, will receive the Richard and Hinda Rosenthal Foundation Award, which is given to a physician scientist under age 51 to recognize research which has made or gives the promise of soon making a notable contribution to improved clinical cancer care. Hong is cited for his contributions to treatment and prevention of aerodigestive malignancies, including the successful implementation of alternatives to laryngectomy and the use of 13-cis-retinoic acid as a therapeutic agent.

Tom Curran, Roche Institute of Molecular Biology, will receive the Cornelius P. Rhoads Memorial Award recognizing meritorious achievement in cancer research by a person under age 41. He was chosen for his discovery of the fos oncogene and the elucidation of its interactions with the jun oncogene and their related proteins.

Stuart Yuspa, chief of NCI's Laboratory of Cellular Carcinogenesis & Tumor Program, will receive the Clowes Memorial Award in recognition of outstanding accomplishments in basic research. Yuspa was chosen for his use of the mouse skin model in defining the mechanism of tumor promotion at the cellular and molecular level.

Joseph Fraumeni, director of NCI's Epidemiology & Biostatistics Program, will receive AACR's newest award, the American Cancer Society Award for Research Excellence in Cancer Epidemiology and Prevention. Fraumeni was selected for his "unstinting dedication to cancer epidemiology which has yielded fundamental contributions to our understanding of cancer etiology and prevention."

Victor Ling, Ontario Cancer Center, will receive the Bruce F. Cain Memorial Award, recognizing outstanding preclinical research leading to the discovery of a significant new therapeutic agent for the improved care of cancer patients. Ling will be honored for his contributions to the understanding of the mechanisms of drug resistance, particularly the identification of P-glycoprotein.

In Brief

Moore Celebrates 10th Year At ONS; Structural Biologists Move To Seattle

(Continued from page 1)

. . . .**PEARL MOORE**, executive director of the Oncology Nursing Society, is celebrating her 10th year with the society. Moore was one of the first oncology clinical nurse specialists in the nation at the Montefiore Hospital at Univ. Health Center of Pittsburgh. She was a founding member of ONS in 1975 and became executive director in 1983, when there were 3,000 members. Today ONS has 23,000 members. . . . **BARRY STODDARD**, formerly of the Univ. of California (Berkeley), has moved to Fred Hutchinson Cancer Research Center to develop a new program in structural biology, funded by a $700,000 grant from the M.J. Murdock Charitable Trust. Also joining the center's program is **Jefferson Foote**, of the Laboratory of Molecular Biology in Cambridge, England. Foote's research involves analyzing the structure of antibodies. With the addition of **Lee Hood** at Univ. of Washington recently, the Seattle area will be an "important force" in structural biology, Stoddard said. . . . **CLINICAL RESEARCH MEETING** will be held April 30-May 3, in Washington. This is the annual gathering of the American Federation for Clinical Research, the American Society for Clinical Investigation, and the Assn. of American Physicians. For information contact Slack Inc., phone 609/848-1000. . . . **NEWS TRIVIA:** Name the former member of the National Cancer Advisory Board who this week took what some are calling "the toughest job in American business." Answer: Louis Gerstner Jr., new chief executive officer of International Business Machines Corp., was appointed to the NCAB in 1988 and served until 1989. Gerstner, then also a member of the Memorial Sloan-Kettering Cancer Center board, resigned from both boards when he left his job as president of American Express Co. to head the tobacco and food company RJR Nabisco. The NCAB urged regulation of tar and nicotine content of cigarettes in 1974 and earlier this year called for a $2 federal excise tax on cigarettes. . . . **WIVES OF** the Philadelphia 76ers, with the help of Fox Chase Cancer Center, will offer mammography screening for breast cancer on April 4 when the 76ers play the Sacramento Kings. A mobile mammography van will provide screenings for $25 for women age 40 or older. The collaboration between the wives and Fox Chase began as part of the NBA Wives Save Lives program initiated by NCI and the NBA.