THE CANCER LETTER

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Health Reform Plans Offer Difficult Choices For Patients, Researchers, Practitioners

With health care reform advancing to the top of the nation's political agenda, Washington lobbyists who represent cancer interests are struggling to solve an equation with two variables:

- First, they have to determine the relative merits of the competing health reform packages now in circulation on Capitol Hill.
- Second, they have to face the political expediency of endorsing one package over another.

(Continued to page 2)

In Brief

William Paul To Head AIDS Research Office; Schachman Is NIH Extramural Ombudsman

WILLIAM PAUL has been appointed director of the NIH Office of AIDS Research, NIH Director **Harold Varmus** announced last week. Paul, chief of the Laboratory of Immunology at the National Institute of Allergy and Infectious Diseases, takes over the office with strong support from AIDS activists and new powers conferred by Congress. Last year, Congress passed legislation centralizing authority over NIH AIDS research programs to the office. The office will disburse the $1.3 billion NIH AIDS research budget to the institutes, develop an annual strategic research plan, coordinate AIDS research activities and develop consolidated budget estimates. In addition to being director of OAR, Paul will be the NIH associate director for AIDS Research. A national advisory council will be established to advise the office, and Paul will have use of a $100 million discretionary fund for emerging scientific opportunities. The Treatment Action Group, a New-York based activist organization, praised the appointed of Paul, a noted immunologist. TAG member **Derek Hodel** served on the search committee that recommended Paul's appointment. . . . **HOWARD SCHACHMAN** has been named an ombudsman for the NIH extramural community. Schachman's role will be to visit universities and listen to problems, answer questions, and report findings to the NIH director. Schachman is professor emeritus, Dept. of Molecular and Cell Biology, Univ. of California at Berkeley. . . . **LARRY DELUCAS**, former astronaut, has been promoted from deputy director to director of the Univ. of Alabama at Birmingham Center for Macromolecular Crystallography. The center was established at UAB in cooperation with NASA in 1985, and DeLucas served on a shuttle mission in June 1992. He succeeds **Charles Bugg**, who became CEO and board chairman of BioCryst.

Four Plans, Many Variables, Confront Cancer Organizations

(Continued from page 1)

These are not easy choices, lobbyists say.

"If only we could take an amalgamation of all these bills, I think we could come up with a comprehensive set of benefits that people with cancer can feel comfortable with," Ellen Stovall, executive director of the National Coalition for Cancer Survivorship, said to **The Cancer Letter**.

Leading Reform Proposals

The four leading health reform proposals are:

- **Health Security Act**, the Administration's package, introduced in Congress as HR 3600 and S 1757. The bill's sponsors on Capitol Hill are Sen. George Mitchell (D-ME) and Rep. Richard Gephardt (D-MO).

- **American Health Security Act**, HR 1200, introduced by Jim McDermott (D-WA). Like the Administration's bill, the McDermott measure provides for universal coverage, abolishes exclusion based on pre-existing conditions and establishes a tax on tobacco products. Unlike the Administration's package, HR 1200 establishes a single-payer system funded through taxes. Both bills include drug price controls.

- **Managed Competition Act**, HR 3222 and S 1579, developed by Rep. Jim Cooper (D-TN). Though the bill is strong on reimbursement for mammography screening and patient care in clinical trials, it does not mandate universal coverage. The bill has the support of the Business Roundtable and the Chamber of Commerce, but is unlikely to get the support of major patient groups.

- **Health Equity and Access Today Reform Act**, S 1770, introduced by Sen. John Chafee (R-RI). The bill contains a provision for a medical research trust fund financed through voluntary donations. Neither the Cooper not Chafee measure includes drug price controls.

Clinical Trials

Consider one of the dilemmas, the question of reimbursement of routine care for patients involved in clinical trials.

An argument can be made that this is the most important issue for all cancer-related interest groups, including patients, physicians, basic scientists and drug companies.

And, undeniably, the resolution of the issue is close at hand, since the four health reform alternatives provide for reimbursement of patient care in clinical trials.

However, pinpointing the bill that addresses the issue best is anything but straightforward.

The Administration's bill says the health alliances "may cover an investigational treatment" at their discretion. (Sec. 1128).

The White House has assured the American Society for Clinical Oncology that reimbursement of patient care will be provided, Stacey Beckhardt, ASCO's director of government relations, said to **The Cancer Letter**.

"The Clinton language is written in a fashion that is open to misinterpretation," Beckhardt said.

According to ASCO, the most precise language on the issue in contained in the Cooper bill.

"The Cooper language does a better job of defining what patient care costs are by requiring all plans to pay for all treatments required by the protocols," Beckhardt said.

The bill states: "Coverage of routine medical costs associated with the delivery of treatments shall be considered to be medically appropriate only if the treatment is part of an approved research trial."

Routine medical costs are defined as "services required to provide treatment according to the design of the trial." These do not include the cost of the investigational agent and the cost of managing research. (HR 3222, Sec. 1302.)

THE CANCER LETTER

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Screening vs. Broader Agendas

The Cooper plan, which covers annual mammography screening of asymptomatic women, is more generous than the President's plan, which covers screening mammography every one to two years for women over 50.

The Cooper plan also covers annual fecal occult blood tests and screening flexible sigmoidoscopies, which are not expressly covered in the Administration's plan. The McDermott plan does not specify the frequency of screening. Instead, it calls for creation of a commission that would establish a benefits package.

In recent months, HHS and the voluntary groups have been trying to avoid getting bogged down in controversy over mammography screening, concentrating instead on developing a strategic approach to breast cancer.

Following the HHS summit on breast cancer Dec. 14, an ad hoc group appointed by HHS Secretary Donna Shalala was expected to outline areas of consensus on screening mammography. However, the group, which included members of voluntary organizations as well as government officials, is yet to produce a consensus document.

Similarly, the strategic plan that was to be developed as a result of Shalala's conference remains to be released. At the conference, Shalala said the plan would be completed before Feb. 1 (**The Cancer Letter**, Jan. 7).

Advocates Not Locked Into Demands

Patient advocacy groups are not necessarily locked into demanding annual mammography screening or screening for women under 50. The American Cancer Society and the National Breast Cancer Coalition, for instance, are calling for a clinical trial to settle all controversies over screening.

However, patient advocacy groups are less likely to be flexible on the issue of universal access to health care. A related criterion in the voluntary groups' selection of plans is prohibition of denial of coverage based on preexisting conditions.

The Chafee and Cooper plans allow for denial of coverage of treatment of preexisting conditions. The President's plan and the McDermott plan prohibit such discrimination.

Thus, while major business groups are backing the Cooper bill, the trade unions, the National Association of the Retired Persons and the National Health Council are likely to be left choosing between the President's plan and the McDermott plan.

Other issues of interest to cancer researchers and patient advocates include:

● **Reimbursement for off-label indications.** The Administration bill mandates reimbursement for drugs listed in the three compendia and for indications supported by peer review literature.

The Cooper bill mandates coverage for uses contained in the compendia and gives health plans the authority to rely on peer-reviewed literature for coverage decisions. The McDermott plan calls for creation of a national board that would list all approved drugs and control their prices.

The Chafee plan does not include explicit coverage for off-label uses.

● **Excise taxes on tobacco** are mandated only in the President's and McDermott's bills. The Administration calls for a 75-cent tax for every pack of cigarettes. The McDermott bill calls for a $2-per-pack tax.

Medical Research Trust Fund

The Republican bill is the only measure to call for voluntary donations to fund medical research. (S. 1770, Sec. 3201).

The Republican bill lags the Cooper alternative in attracting endorsements from the major business groups.

However, the fate of the trust fund does not hinge on the future of the Chafee package.

On Feb. 24, Sens. Tom Harkin (D-IA) and Mark Hatfield (D-OR), who have been pushing for creation of the fund since last summer, are scheduled to introduce a measure that would require a mandatory surcharge on premiums to be used to fund research (**The Cancer Letter**, June 4, 1993).

Drug Pricing, Innovation

The pharmaceutical and biotechnology industries are opposed to price controls included in both the President's and McDermott's plans.

However, lobbyists for the two industries have not endorsed either the Cooper or the Chafee plan. Also, from their statements it appears that they prefer the Administration package over McDermott's.

Last month, in a statement on health care reform, the Pharmaceutical Manufacturers Association said the overhauled system should include three features:

—"Coverage for prescription drugs should be provided just like coverage for medical treatments."

—"Competition in the market can and must be relied on to control costs, without federal government price regulations and anti-competitive government intrusion in the market."

—"The discovery of new cures must be encouraged as the best way to maintain and improve the quality of care for patients and to contain health care costs."

PMA said the pharmaceutical industry was troubled by several features of the Clinton plan, including the HHS Secretary's authority to deny Medicare coverage for drugs found to be "excessively priced" and creation of an advisory council on breakthrough drugs.

Similar concerns have been outlined by the Biotechnology Industry Association (**Cancer Economics**, February 1994).

Wyden's Proposal

Several major players in the cancer drug industry are expected to back a proposal by Rep. Ron Wyden (D-OR) to give companies incentives to sponsor clinical trials comparing new technologies to existing ones.

Wyden is expected to introduce the amendment in the next few weeks. His goal is to include these incentives in whatever health reform plan clears the House.

"Rep. Wyden has proposed a very constructive amendment that would provide additional market exclusivity to companies willing to sponsor comparative trials or studies in special populations," said Dan Kiser, partner with Fox, Bennett & Turner, a Washington law firm that represents two pharmaceutical companies that were targets of Wyden's investigations: Bristol-Myers Squibb Co. and Sandoz Pharmaceutical Co.

Now, it appears, Wyden may be working in a new climate.

"Mr. Wyden's proposed amendment is an important step in the right direction," Kiser said.

Under Wyden's bill, manufacturers would be able to earn added exclusivity for products involved in studies that focus on high priority areas of clinical research.

In addition, manufacturers of products found to be superior would be allowed to use the government's findings in their marketing activities, while Medicare and Medicaid would be obligated to review reimbursement and coverage barriers for such products.

Uterine Cancer Is Associated With Tamoxifen In B-14 Study

NCI has alerted physicians testing the drug tamoxifen (Nolvadex) that 25 women enrolled in a clinical trial have developed uterine cancer while taking the drug to prevent a second occurrence of breast cancer.

Six of the women who developed uterine cancer have died; four of the deaths were attributed to the disease, NCI's Cancer Therapy Evaluation Program said. Of the four, two were identified as endometrial cancer and one was carcinosarcoma.

The cancers occurred in women enrolled in the National Surgical Adjuvant Breast & Bowel Project study B-14, a randomized, placebo-controlled trial testing whether tamoxifen prevents cancer in the opposite breast in women with estrogen receptor positive, node negative breast cancer. The trial compares five years of tamoxifen versus placebo and 10 years of tamoxifen versus five years.

Reacting to the findings, CTEP instructed researchers conducting trials of tamoxifen to revise informed consent forms to notify patients of the risk of contracting or dying from uterine cancer.

In another reaction to the findings, the National Women's Health Network said the occurrence of uterine cancers in B-14 should preclude NCI from proceeding with another, larger trial, which is testing tamoxifen in asymptomatic women.

Even if the benefits of tamoxifen in preventing breast cancer outweighed the risk of uterine cancer, NCI could not condone using tamoxifen in healthy women as a public health measure, said Cynthia Pearson, executive director of the National Women's Health Network.

"NCI knows with certainty that healthy women will be killed by this drug," Pearson said to **The Cancer Letter**. "Tamoxifen may prevent as many as 120 cases of breast cancer in the 8,000 women who will get randomized to the drug. But NCI knows it will cause 50 to 60 cases of endometrial cancer, and 10 to 12 deaths as a result."

Pearson said her organization is preparing a letter to HHS Secretary Donna Shalala questioning the ethics of continuing the NSABP Breast Cancer

Prevention Trial, the study of the drug in asymptomatic women. The network supports the use of tamoxifen as adjuvant therapy for women who already have breast cancer, she said.

NSABP began the prevention trial in May 1992. Evenually, the trial will randomize 16,000 women to tamoxifen or a placebo.

Two Cases Per 1,000

NSABP scientists said the risk of uterine cancer caused by tamoxifen is not higher than was expected, and is equivalent to that seen in women taking estrogen replacement therapy. The NSABP had previously reported that the risk of uterine cancer was about 2 cases per year per 1,000 women, Lawrence Wickerham of the NSABP said to **The Cancer Letter**.

Women selected for the prevention trial have a much higher than average risk of developing breast cancer, and the trial's informed consent process makes clear that there are some tradeoff risks, NSABP Chairman Bernard Fisher said to **The Cancer Letter**.

"This is just an update of what we have been telling investigators all along," Fisher said. "We now have quantified the risk of endometrial cancer better than it had been previously."

Informed consent forms for the prevention trial and other clinical trials using tamoxifen will be rewritten to advise patients of the risks, and patients will be questioned for any gynecologic changes, Wickerham said.

Acts Like Estrogen

Researchers say that, in breast tissues, tamoxifen acts against the effects of estrogen, believed to enhance breast cancer.

At the same time, tamoxifen acts like estrogen in other parts of the body. This may cause beneficial effects similar to the effects of estrogen replacement therapy, such as a lowering of blood cholesterol and a slowing of bone loss that may lead to osteoporosis, according to an NCI description of the BCPT.

Women taking estrogen replacement therapy are not eligible for the BCPT unless they have been off therapy for three months.

"Estrogens are known to increase the risk of endometrial cancer, and there are reports from several large clinical trials showing that breast cancer patients taking tamoxifen have an increased risk of endometrial cancer," according to an NCI "Q and A" paper about the BCPT. "Endometrial cancer frequently causes bleeding and is usually diagnosed in its early stages—when treatment by surgery alone is effective.

"The endometrial cancers that have occurred during studies of women taking tamoxifen have all been found in very early stages."

Notification Of All Patients Required

According to a CTEP alert sent to the NCI-funded clinical cooperative groups, the NSABP gathered data on three groups of breast cancer patients enrolled in the B-14 trial: the control group, which did not receive tamoxifen; the randomized patients using tamoxifen for five or more years; and patients taking tamoxifen for five or more years who registered for the five-years versus 10-years portion of the trial.

In the randomized group, there were 15 cases of uterine cancer. Five of the patients died; three of these were attributed to uterine cancer (two endometrial and one carcinosarcoma).

In the registered group, there were eight cases of uterine cancer, including one death. The patient who died was diagnosed with uterine cancer after nine months of tamoxifen, raising the question of a pre-existing condition, CTEP said. In five cases, the uterine cancer diagnosis occurred after less than one year of tamoxifen.

In the control population, there were two cases of uterine cancer. In both cases, the patients had been put on tamoxifen by their physicians following protocol events, CTEP said.

This rate was lower than the seven cases of uterine cancer that would have been predicted.

NCI instructed the cooperative groups conducting trials of tamoxifen to:

- Rewrite the toxicity sections of informed consent forms, including the risk of uterine cancer and the possibility of death, and a recommendation that physicians evaluate any pelvic complaints in patients taking tamoxifen,
- Obtain re-consent of all patients taking tamoxifen on any treatment trial,
- Notify all patients who have ever taken tamoxifen on any treatment trial,
- Modify and submit to institutional review boards the sections on toxicity and informed consent for all active protocols in which patients receive tamoxifen,
- Require on-study pelvic exams with yearly follow-up.

NIH Limits Salaries Allowed On Grants And Contracts

NIH has informed grantees and contractors that the salary limitation imposed on awardees will remain in place again in fiscal year 1994, for the fifth consecutive year.

The HHS Appropriations Act for FY 94 restricts the amount of direct salary an individual under a grant or applicable contract issued by the NIH to a rate of $125,000 per year. Direct salary is exclusive of fringe benefits and indirect costs/general and administrative expenses. The salary limit of $125,000 has not increased from the FY 93 level.

NIH will continue to apply the limits to all grant and applicable contract awards and all funding amendments to existing awards made with FY 94 funds. Therefore, NIH grant and applicable contract awards for applications/proposals that request direct salaries of individuals in excess of a rate of $125,000 per year will be adjusted in accordance with the legislative salary limitation.

According to the notice, other points relating to NIH grants and contracts are:

o An individual's base salary is not constrained by the legislative provision. An institution may supplement an individual's salary with non-federal funds.

o The salary limitation does not apply to payments made to consultants under an NIH grant or contract although, as with all costs, such payments must meet the test of reasonableness.

o The salary limitation provision does apply to those subawards/subcontracts for substantive work under an NIH grant or contract.

In addition, the following three paragraphs apply to grant applications/awards only:

o Competing grant applications submitted to NIH may continue to request funding at the regular/actual rates of pay of all individuals for whom reimbursement is requested, even when these rates exceed the salary limitation. NIH staff will make necessary adjustments to requested salaries prior to award.

o There is a change in the way that NIH is treating salaries in excess of the limit for any future years beginning with competing grant awards funded with FY 94 funds. Based upon experience and the expectation that the salary restriction will continue in future appropriations (although the amount of the limitation may change with future appropriations), NIH awards for competing applications will reflect adjustments to all years of a project, including future years, so that no funds are awarded or committed for salaries over the limitation.

o Non-competing continuation grant applications submitted to NIH should request funds for salaries at rates of pay that do not exceed the salary limitation. If the current committed level includes funds for salaries at a rate that exceeds the salary limitation, the excess may not be rebudgeted for any other purpose, and NIH staff will delete it from the award.

RFA Available

RFA OH-94-001

Title: **Occupational Radiation and Energy Related Health Research**

Letter of Intent Receipt Date: April 1

Application Receipt Date: May 18

The Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH) is soliciting grant applications for research projects relating to occupational safety and health concerns associated with occupational exposures to radiation and other hazardous agents at Department of Energy (DOE) facilities and in other energy-related industries.

Studies in the nuclear power industry and deliberate exposure of human subjects in radiation experiments are outside the scope of this RFA.

Eligible applicants include domestic and foreign non-profit and for-profit organizations.

Research support may be obtained through applications for a regular research grant (R01). Applicants for R01s may request support for up to three years.

For fiscal year (FY) 1994, approximately $500,000 is available to fund projects ranging in amount from $25,000 to $200,000 in total costs.

The Secretary, Department of Health and Human Services (HHS) and the Secretary, Department of Energy (DOE) signed a Memorandum of Understanding (MOU) transferring the authority and resources to manage and conduct energy-related analytic epidemiologic research from DOE to HHS.

This includes the authority, resources, and responsibility for the design, implementation, analysis, and scientific interpretation of analytic epidemiologic studies of the following populations: workers at DOE facilities; other workers potentially exposed to radiation; and workers exposed to potential hazards resulting from non-nuclear energy production and use.

The focus of grants should reflect: (1) retrospective

occupational exposure assessment, (2) radiation measurement issues, (3) non-cancer morbidity and mortality outcomes, (4) meta-analysis and combined analysis methodologies, (5) uncertainty analysis, and (6) effects of measurement error on risk estimates.

Direct requests for the RFA, inquiries regarding programmatic issues, and address the letter of intent to:

Roy M. Fleming, Sc.D. National Institute for Occupational Safety and Health Centers for Disease Control and Prevention, 1600 Clifton Road NE, Building 1, Room 3053, Mail Stop D-30, Atlanta, GA 30333, Tel: 404/639-3343.

ACS Clinical Awards Available For 1995 Funds, COF On Hold

The American Cancer Society has announced its clinical awards for 1995 funding: the Clinical Oncology Career Development Award (CDA) and the Cancer Control Career Development Award for Primary Care Physicians (CCCDA).

The CDA is a three-year award given to promising junior faculty who will pursue academic careers in clinical oncology. A successful application must describe in detail a supervised program that will develop the candidate's clinical expertise and his/her capacity to perform independent clinical/laboratory research. The annual stipend for the CDA is $25,000 for the first year, and $30,000 and $35,000 for the second and third years, respectively. Approximately 40 new CDAs are funded each year.

The CCCDA was created to develop academic leaders in the primary care specialties who will emphasize cancer control. An application must describe, in the context of a comprehensive primary care setting, a detailed program of clinical, teaching, and research activities planned for the two-year period of the award. It is anticipated that medical school faculty trained under these awards will promote cancer control activities and methodology to students and physicians in the academic setting, as well as to their colleagues in private practice, and enhance the cancer control knowledge base through increased research. The Society annually funds three CCCDAs, which provide a stipend of $25,000 in the first year and $30,000 in the second.

Candidates for these awards must be US citizens or permanent residents. Application deadlines are: Aug. 1 for the Clinical Oncology Career Development Award; Aug. 15 for the Cancer Control Career Development Award.

For application materials, contact Virginia Krawiec, Clinical Awards Program, American Cancer Society, 1599 Clifton Rd. NE, Atlanta, GA 30329-4251, Tel: 404/329-5734, FAX: 404/325-1467.

In a related development, the society has announced that funding for its Clinical Oncology Fellowship program has been suspended due to lack of funds.

The society is in the process of evaluating how to best allocate its limited resources, according to a statement. In the interim, commitments for all current Fellowships will be honored; however, new applications, i.e., for the award period 1995-96, will not be accepted.

A final decision about the status of the Clinical Oncology Fellowship program will be made when this evaluation is complete, the society said.

Cancer Meetings Are Listed For March, April, Future

Monoclonal Antibody Immunoconjugates for Cancer—March 3-5, San Diego, CA. Contact Cass Jones, Tel. 619/565-9921.

American Society of Preventive Oncology Annual Meeting—March 6-9, Bethesda, MD. Contact Judy Bowser, Tel. 608-263-6809.

Biology of Renal Cell Carcinoma—March 7-8, Cleveland, OH. Contact Cleveland Clinic Foundation, CME office, Tel. 216/444-5696 or 800/762-8173.

Workshop: Hereditary Breast, Ovarian, and Colon Cancer—April 27-29, Washington Sheraton Hotel, Washington, DC. Contact Andrea Brooks, Tel. 301/650-7471, or Rii's Conference Dept., Tel. 301/565-4048.

PET and SPECT Imaging in Oncology—March 9-11, Baltimore, MD. Contact Patty Campbell, Johns Hopkins, Tel. 410/955-6046.

NCI-EORTC Symposium on New Drugs in Cancer Therapy—March 15-18, 1994, Amsterdam, The Netherlands. Contact Technical Resources Inc., 800/883-6338.**Symptom Management**—March 17-19, San Francisco, CA. Contact UCSF 415/476-5808.

Viral Pathways to Cancer—March 30-31, Chapel Hill, NC. Contact UNC Lineberger Comprehensive Cancer Center, Tel. 919/966-3036.

Diagnosis and Treatment of Neoplastic Disorders—April 7-8, Baltimore, MD. Contact Johns Hopkins Continuing Education, Tel. 410/955-2959.

American Assn. for Cancer Research Annual Meeting—April 10-13, San Francisco, CA. Contact AACR, Tel. 215/440-9300, FAX 215/440-9313.

American Cancer Society National Conference on Skin Cancers—April 14-16, Phoenix, AZ. Contact Jackie Wilbourne, ACS, Tel. 404/329-7604, Fax 404/636-5567.

Cancer Patient Education in a Changing Environment—April 15, Pittsburgh, PA. Contact 301/468-MEET.

Breast Cancer Education Summit—April 20, Los Angeles, CA. Contact Dr. Phyllis Rideout, Tel. 213/224-6416.

Controversies and Recent Advances in Medical Oncology—April 20-23, Amsterdam, The Netherlands. Contact Robbert F. M. van Bokhoven, Tel 31-20-617-2903, FAX 31-20-615-5904.

American College of Oncology Adminstrators Third Annual National Symposium—April 21-23, Boston, MA. Contact ACOA, Tel. 313/540-4310.

American Radium Society Annual Meeting—April 22-26, Bermuda. Contact Office of the Secretariat 215/574-3179.

Ohio Cancer Symposium—April 22, Columbus, OH. Conact Georgette Haydu, Tel. 614/466-2144.

Genes and Cancer: Potential for Early Diagnosis and Identifying Genetic Susceptibility—April 22, Memphis, TN. Contact Dr. James Hamner, Tel 901/448-6354.

Experimental Biology Meeting—April 24-28, Anaheim, CA. Contact FASEB 301/530-7010.

The Clinical Research Meeting—April 29-May 2, Baltimore, MD. Contact Slack Inc. Tel. 609/848-1000.

First Announcement Of Future Meetings

Immunoglobulin Gene Expression in Development and Disease—July 13-17, Montreal, Canada. Contact New York Academy of Sciences, Tel. 212/838-0230, FAX 212/838-5640.

Cell Cycle Regulation—July 15, Hood College, Frederick, MD. Contact Patti Hall, Foundation for Advanced Cancer Studies, Tel. 410/658-2882.

EORTC Breast Cancer Working Conference—Sept. 6-9, Amsterdam, The Netherlands. Contact Conference Secretariat, Bureau PAOG Amsterdam, Tafelberweg 25, 1105 BC Amsterdam, The Netherlands.

Biology, Prevention and Treatment of Head and Neck Cancer—Sept. 8-11, Arlington, VA. Contact Meeting Planner, Tel. 507/285-1523.

Radioimmunodetection and Radioimmunotherapy of Cancer—Oct. 6-8, Princeton, NJ. Contact Lois Gillespie, Tel. 201/982-4600, FAX 201/982-7047.

National Lymphedema Network Conference—Oct. 21-23, San Francisco, CA. Contact NLN, Tel. 800/541-3259, FAX 415/921-4284.

American Endocurietherapy Society—Dec. 7-10, Fort Myers, FL. Contact AES, Tel. 215/574-3158.

Letters to the Editor

NCI Mammography Statement Recognizes Patient Autonomy

To the Editor:

I believe the publication of letters similar to that of Daniel Kopans (**The Cancer Letter**, Feb. 11) is not useful. Dr. Kopans is obviously committed to a point of view which prevents his objective evaluation of the exchange between Dr. Broder and Mr. Waxman in the Feb. 4 issue, which must be very painful to Dr. Broder, since he is being accused of opinions and attitudes that he quite clearly does not have.

For example, Dr. Kopans accuses Dr. Broder of not understanding the difference between a screening mammogram and a diagnostic mammogram, when, in fact, the interview quite clearly expresses Dr. Broder's clear understanding of this difference.

Dr. Kopans goes on and on about a situation that can be summarized quite simply by stating that there is no clear evidence of benefit for mammographic screening for women ages 40-49, and that the informed consent process which NCI advocates for mammograms in the younger age group is fully consistent with both ethical and legal recognition of patient autonomy, though it appears to be unacceptable for paternalistic academic physicians who continue to believe that patients are not capable of understanding simple statistics, and, even more important, that the average doctor is similarly intellectually beclouded.

Dr. Kopans needs to reflect at adequate length on the self-referent pertinence of his concluding sentence.

David Wishart
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