THE CANCER LETTER

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Ovarian Cancer Screening Unnecessary For Most Women, Consensus Panel Says

Ovarian cancer screening of asymptomatic women who do not fall into a high-risk familial syndrome should be done only in the context of clinical trials, a consensus panel meeting at NIH last week concluded.

Screening of the general population in a "haphazard" fashion with the serum tumor marker CA-125 or transvaginal ultrasonography could

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In Brief

FDA Issues Uterine Cancer-Tamoxifen Warning; Fisher Declined Invitation To Speak At AACR

FOOD & DRUG Administration last week issued a stronger warning to women and doctors that tamoxifen poses an increased risk of cancer of the uterus. Despite the increased risks, the agency said, latest results of studies have reaffirmed that tamoxifen can delay or prevent relapse in patients who have undergone surgery for breast cancer. The drug continues to be indicated for the treatment of breast cancer, the agency said in an April 8 statement. An updated warning placed on the drug's package insert will include data from large randomized trials. The manufacturer, **Zeneca Pharmaceuticals,** is sending the labeling information in a "Dear Doctor" letter to 380,000 oncologists and health care professionals. Women taking tamoxifen (Nolvadex) face a risk of uterine cancer about two to three times higher than the risk for women without breast cancer in the general population, according to results of recent studies, FDA said. This includes the B14 trial of the National Surgical Adjuvant Breast & Bowel Project, as well a Swedish study. . . . **The FDA warning** was issued days before a Congressional hearing on the NSABP. The April 13 hearing, called by Rep. John Dingell (D-MI), was expected to focus on the NCI-NSABP Breast Cancer Prevention Trial, which is testing tamoxifen to prevent breast cancer in high-risk women. . . . **AMERICAN ASSOCIATION** for Cancer Research issued a statement regarding the invitation to NSABP to speak at the AACR meeting this week in San Francisco, as reported in **The Cancer Letter** March 18. According to the April 1 statement, "At the request of the National Cancer Institute, the American Association for Cancer Research invited Drs. Bernard Fisher and Carol Redmond to present the reanalysis of the NSABP breast cancer study data at the 1994 annual meeting in San Francisco. This presentation was to be given a place on the program as a public service. Subsequently, Dr. Fisher declined the invitation to speak. Since the reanalysis is still in progress, there will be no presentation at the AACR annual meeting."

Panel Finds Ovarian Cancer Screening May Harm, Not Help

(Continued from page 1)

result in more harm than good by subjecting women with false positive results to treatment including exploratory surgery, said panel chairman Vicki Seltzer, head of the obstetrics and gynecology at Long Island Jewish Medical Center.

"Routine screening has resulted in unnecessary surgery with its attendant potential risks," said the panel in its consensus statement.

Instead of screening, the panel recommended that all women have a careful family history taken by their primary care physician to pinpoint those who need further tests because they are in the small subset of women with a familial cancer syndrome.

The 14-member panel included Jennie Batson, an ob/gyn in private practice in Everett, WA, who is an ovarian cancer survivor.

Panel Conclusions

In addition to its findings on screening, the panel also came to the following conclusions:

- Platinum and Taxol (paclitaxel) have been shown to be optimal first-line chemotherapy following primary debulking surgery, and many US oncologists are now using this regimen. Nevertheless, an "unqualified endorsement" of this regimen awaits more conclusive data.
- For a woman with recurrent ovarian cancer resistant to platinum who has not already received Taxol, Taxol is the best salvage therapy currently available.
- Women with stage 1A grade 1 ovarian cancer do not need adjuvant chemotherapy following surgery. Many other stage 1 patients do require chemotherapy, but these subsets need to be more clearly defined.
- Women with stages II, III and IV ovarian cancer (other than tumors of low malignant potential) should receive chemotherapy after surgery.
- Second-look laparotomy should "not be employed as routine care for all patients." Instead, it should be reserved for patients in clinical trials or those in whom the surgery will have a major impact on clinical decision-making.

Oral Contraceptives For Prevention

In terms of prevention, the panel concluded that the risk of ovarian cancer can be lowered by use of oral contraceptives, which reduce incessant ovulation. In addition, women in a high-risk familial cancer syndrome can reduce their risk of ovarian cancer by having their ovaries prophylactically removed after childbearing or at age 35.

If a woman is undergoing pelvic surgery, removal of her ovaries at that time will reduce the risk of ovarian cancer, the panel said. However, the panel cautioned that if the woman is still menstruating, her physician should discuss estrogen replacement therapy with her prior to removal of her ovaries.

It is crucial for the woman to understand that if she does not take estrogen, the risk of premature menopause—with its potential for heart disease and osteoporosis—could outweigh the potential risk-reduction benefits obtained through removal of the ovaries, the panel said.

The panel estimated that in 1994, 24,000 new cases of ovarian cancer will be diagnosed in the US, and 13,600 women will die of the disease. Because symptoms are often silent until ovarian cancer is advanced, it is diagnosed at advanced stages in about two-thirds of the cases.

THE CANCER LETTER

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Intramural Cuts Expected; Gallin To Head Clinical Center

An NIH advisory panel has recommended reducing the Institutes' $1.2 billion intramural research program, including a 50 percent cut in the number of beds at the NIH Clinical Center, sources said.

The committee of extramural advisors, in a report submitted last month to Michael Gottesman, NIH deputy director for intramural research, recommends cutting the number of inpatient beds from about 500

to 250, sources said last week.

The report also is expected to recommend that funding for the intramural program be held to a fixed percentage—probably about 10 percent—of the Institutes' budget. In the past two years, the intramural program has averaged 11.3 percent of the NIH budget, according to an internal background paper.

NIH Director Harold Varmus is reviewing the report in preparation for House Appropriations Committee hearings this month, sources said. The report, written by a committee chaired by Paul Marks, president of Memorial Sloan-Kettering Cancer Center, and Gail Cassell, chairman of the microbiology department at Univ. of Alabama at Birmingham, will be made public at the June 2 meeting of the NIH Director's Advisory Committee, a spokesman for Varmus said.

In another development, John Gallin has been selected to head the NIH Clinical Center, **The Cancer Letter** has learned.

Gallin, director of the National Institute of Allergy & Infectious Diseases Div. of Intramural Research, is expected to take the post May 1. He replaces Saul Rosen, who has been acting director of the Clinical Center for about three years. Gallin was recommended by a search committee led by NIH Deputy Director Ruth Kirschstein.

Gallin also will be given the title of NIH Associate Director for Clinical Research, a new position, sources said to **The Cancer Letter**. By establishing the position in the NIH Director's Office, Varmus may be indicating a desire to support and strengthen clinical research, sources said.

Smaller Program, Higher Quality

The recommended reductions in the intramural program were expected for many months, sources said. In fact, NIH has been under a hiring freeze for two years, and intramural program budgets throughout the Institutes have been shrinking. That tightening may help focus the science, optimists say.

"The intramural program is going to be smaller and higher quality," an NCI administrator said to **The Cancer Letter**. "It is going to force us to use the intramural program for high-quality, fundamental science, in close proximity to the clinical science."

Others say NCI's clinical program will take larger reductions than any other program, primarily because NCI has the largest clinical program of all the Institutes. NCI, the major user of the Clinical Center, currently is assigned about 100 inpatient beds, which are full about 70 percent of the time, sources said. Overall, the Clinical Center's occupancy rate for FY93 was 53 percent.

Ability To Accrue Patients Quickly

Cancer patients from all over the U.S. travel to the Clinical Center to take part in NCI protocols. Patients entered into trials receive free medical care while at the center, and travel reimbursement to and from the center. The ability to accrue patients to trials quickly, even those with rare cancers, has been an important aspect of NCI's clinical research program, sources said.

"We can do a clinical trial as indicated by the science, without worrying about the third-party payors or the patient's ability to pay," an NCI physician said. "If you are interested in patient subsets, you can accrue as many patients to a trial here in a year or two as would take an entire career anywhere else."

It was that accrual ability that allowed Charles Myers, who recently left NCI, to test the activity of the drug suramin in prostate cancer within a relatively short time by selecting pateints with soft tissue cancers.

That advantage could be lost if the current funding trends continue, sources said.

"I hate to see the Clinical Center get smaller when we haven't cured the disease, but we have to face the fiscal realities," said another NCI source. "In the extramural community, it's tough as well."

NCI has had to decrease the number of new patients this year because of reductions in the budget for patient travel, sources said.

"We are looking seriously at our protocols," the source said. "We are trying to [make the cuts] so that we do not harm the most innovative parts of the program, the new therapies."

The Clinical Center this year will cut about 87 staff positions. Some of the effect on patient care has been minimized by the ability of the Institute to request exemptions in cuts of patient care personnel. Administrators are trying to consolidate units and increase efficiencies.

"Beyond a certain point, it becomes very difficult," the NCI physician said. "When a surgeon leaves, you can't get a biologist to perform surgeries."

The need for replacement of the Clinical Center has been recognized for many years. In 1991, the U.S. Army Corp of Engineers concluded that a new building would be the most economical solution, since

any attempt to renovate the 40-year-old building would result in a loss of about a third of the building's space to bringing utility systems up to current standards. NIH has yet to convince Congress to provide the $1.4 billion to $1.6 billion estimated for a "total replacement facility."

By itself, downsizing the inpatient beds does not necessarily mean losing the ability to serve patients, the NCI physician said.

"If you built a 250-bed hospital, you would actually maintain our current services," an NCI physician said. The reason is that the Clinical Center is relying more on outpatient care. NCI's Day Hospital alone logs 10,000 outpatient visits a year.

The Clinical Center also contains 2,000 research laboratories, accounting for almost half the research space on the Bethesda campus, housing about 40 percent of the NIH workforce, according to the report of an internal NIH committee that was submitted to the extramural advisors.

The basic science laboratories are adjacent to patient areas to enable physicians and basic scientists to talk to each other, the report said. That arrangement, while less efficient, aids the translation of basic science advances to clinical care, sources said. It is not clear whether this arrangement would continue in a new facility.

"If we lose the Clinical Center, the intramural program loses its ability to do translational science," the physician said.

AMA Begins Anti-Tobacco, Smoking Cessation Program

The American Medical Association has begun its largest and most comprehensive anti-tobacco and stop-smoking program.

The initiative includes the National Wellness Stop Smoking Campaign, a program to help Americans quit smoking. It also includes federal legislation to regulate tobacco products, and new direct efforts to ban smoking in public places throughout the US.

How to Quit, part of the National Wellness Stop Smoking Campaign, represents a new method of smoking cessation, the AMA said. It is the first to employ "telemedicine" to bring proven methods and group support directly into smokers' homes.

"For decades, the tobacco industry has bombarded the public with marketing campaigns to lure people into smoking," said Randolph Smoak, AMA trustee. "The AMA is now striking back by using the power of television to enable them to quit and stepping up our efforts to protect non-smokers and the young from this deadly habit."

The AMA also called for federal action to fully regulate tobacco as a drug delivery device for nicotine. Smoak cited news reports that tobacco companies allegedly alter the nicotine levels in cigarettes to maintain addiction among smokers.

"Cigarettes are no different than syringes," Smoak said. "Cigarettes deliver nicotine, the most addictive drug we know. They should be fully regulated, just as we regulate heroin."

The physicians' group noted that the US Surgeon General has declared passive smoke a deadly carcinogen. The AMA will therefore apply pressure at local, state, and federal levels to protect non-smokers from the cancerous effects of passively inhaled cigarette smoke.

The AMA's How to Quit program costs $69.95. It includes an instructional video tape and companion handbook, audio tapes for both stress management and support, a weekly performance calendar, and a smoker's diary. The kit also features a stop-smoking contract and letter to enlist support of employers, as well as specific instructions to prevent relapse and weight gain. There is also a 24-hour toll-free support line.

The program video features a series of "house calls" by a team of medical experts led by Edward Taub, a family physician and smoking cessation advocate from Mount Carmel, IL. Additional support classes will be telecast on American Medical Television on CNBC, the first time smoking cessation classes will telecast nationally.

How to Quit is co-sponsored by campaign creator, Orbis Direct, LLC, and General Nutrition Centers, the national sponsor and exclusive retailer of the kit. Kits will be available by mail, at the more than 1,500 GNC stores nationwide, and through a half-hour "infomercial" to air on local stations across the country.

NCI, Other Cancer Meetings Listed For April, May, Future

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.

Symposium on the Role of Psychosocial Factors in Human Health—Boston, MA. Contact Jessie Gruman, Center for the Advancement of Health, Tel. 202/775-8826.

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.

AIDS: Current Challenges and Future Directions—April 21, Hood College, Frederick, MD. Contact Patti Hall, Foundation for Advanced Cancer Studies Inc., Tel. 410-658-2882.

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.

ECC/ESMO Postgraduate Course on Controversies and Recent Advances in Medical Oncology—April 20-23, Academic Medical Center, Amsterdam. Contact European Cancer Center, phone 0031-20-644-4500/4550, fax 0031-20-644-4551.

Biologic Therapy of Cancer—April 22, Philadelphia, PA. Contact Univ. of Pennsylvania Cancer Center, Tel. 215/349-8387.

American Roentgen Ray Society Annual Meeting—April 24-29, New Orleans, LA. Contact the society, Tel. 703/648-8910.

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

Hereditary Breast, Ovarian and Colon Cancer—April 27-29, Washington, DC. Contact Andrea Brooks, Tel. 301/565-4020.

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

Oncology Nursing Society Annual Congress—May 4-7, Cincinnati, OH. Contact ONS, Tel. 412/921-7373.

NCI Div. of Cancer Prevention & Control Board of Scientific Counselors—May 5-6, Bethesda, MD.

National Conference on Breast Cancer—May 8-13, Palm Desert, CA. Contact American College of Radiology, Tel. 703/648-8952.

American Society for Clinical Oncology—May 14-17, Dallas, TX. Contact ASCO, 312/644-0828.

Future Meetings

Genetic Predisposition to Cancer—June 14-15, NCI, Bethesda, MD. Contact Leslie Pearson, General Motors Cancer Research Foundation, Tel. 212/418-6229.

The Endocrine Society Annual Meeting—June 15-18, Anaheim, CA. Contact the society, 301/571-1835.

Histopathobiology of Neoplasia—July 17-24, Keystone, CO. Contact American Assn. for Cancer Research, Tel. 215/440-9300.

The Metcalf Forum: Polyfunctionality of Hemopoietic Regulators—Sept. 7-9, Dublin, Ireland. Contact Dr. Ann Murphy, AlphaMed Press, Tel. 513/293-8508.

Molecular Biology for Clinical Oncologists—Sept. 11-15, Ascona, Switzerland. Contact ESMO Conference Secretariat, Tel. 41-91-57-5411, fax 41-91-57-5744.

American Cancer Society National Conference on Prostate Cancer—Sept. 29-Oct. 1, Philadelphia, PA. Contact Jackie Wilbourne, ACS, Tel. 404/329-7604.

American Assn. for Cancer Education Annual Meeting—Nov. 17-20, Louisville, KY. Contact Dr. John Spratt, Tel. 502/852-5592, fax 502/852-7799.

European Society for Medical Oncology 19th Congress—Nov. 18-22, Lisbon, Portugal. ESMO Conference Secretariat, Tel. 41-93-63-2774, fax 41-93-63-2937.

Chromosomes in Solid Tumors—Feb. 19-21, 1995, Tucson, AZ. Contact Nancy Rzewuski, Arizona Cancer Center, Tel. 602/626-2276.

The Human Genome Project: Commercial Implications—Feb. 28-March 2, 1994. San Francisco, CA. Contact Cambridge Healthtech Institute, Tel. 617/487-7989.

Fifth International Congress on Anti-Cancer Chemotherapy—Jan. 31-Feb. 3, Paris, France. Contact Prof. David Khayat, SOMPS, Hpital de la Pitie-Salpetriere, 47, Bd de L'Hopital, 75651 Paris Cedex 13, France.

Komen Foundation Accepting Nominations For Awards

The Susan G. Komen Breast Cancer Foundation is accepting nominations for the 1994 Brinker International Awards for Breast Cancer Research.

Established by Brinker International Inc. in 1992, the awards recognize outstanding individuals for their achievement in the field of breast cancer research; one in basic science and one in clinical science. Both awards are funded by proceeds from the annual Chili's 10K Run and reward outstanding work which advances basic research concepts or clinical application in the field of breast cancer research, screening or treatment.

Each award includes a $10,000 honorarium, a citation and an inscribed limited edition statuette designed by Tiffany & Co. Nomination forms are available from the foundation, Tel. 214/450-1777, and must be postmarked no later than July 1. The awards will be presented at the Foundation's National Awards Luncheon to be held in Dallas, TX, on Oct. 21.

The award recipients will be selected by two panels of jurors. Arnold Levine, chairman of the Dept. of Molecular Biology at Princeton Univ., will head the Basic Research Award jury, and Kent Osborne, interim chief of the Div. of Medical Oncology at Univ. of Texas Health Science Center at San Antonio will head the Clinical Research Award jury.

RFP Available

RFP NCI-CN-45000-46

Title: Evaluation Of Chemopreventive Agents By In Vivo Screening Assays

Deadline: Approximately May 24

NCI's Div. of Cancer Prevention and Control, Chemoprevention Branch, wishes to award Master Agreement (MA) contracts for the evaluation of chemopreventive agents by in vivo screening assays. The required services will be defined by Master Agreement Orders issued during the four year period of performance. This solicitation is the annual announcement to expand the current pool of MA Holders qualified to perform this type of work. All interested offerors must submit proposals to be eligible to compete for future MAO RFPs.

Pursuant to the MAO the Contractor will conduct in vivo screening studies in small rodents using gavage and other routes of administration to administer the designated chemopreventive agents in animal models using any carcinogenic mechanism (that is consistent with the Evaluation Criteria), such as the administration of carcinogens, promoters, hormones, irradiation, cells or other carcinogenic agents. Agents to be tested are potentially hazardous. The animal model systems also involve the use of carcinogens. Laboratory practices that keep any element of risk to personnel at an absolute minimum will be employed. Where indicated, tissue and compound handling must be performed in (at least) Class I laminar flow agents.

It is required that the animal facilities be maintained in accordance with the NIH Guide for the Care and Use of Laboratory Animals, the Animal Welfare Act as administered by the USDA, and the U.S. Government Principals for Utilization and Care of Vertebrate Animals Used for Testing Research and Training. This research will be performed under cost reimbursement and/or fixed price MAO's. The contractor must have all the equipment necessary to accomplish the studies including, but not limited to, animal racks and caging, hazardous chemical storage cabinets and refrigerators, pathology equipment such as microscopes and microtomes and miscellaneous laboratory equipment. The laboratory must have or have access to appropriate terminal and computer facilities and equipment for data collection and storage. It is estimated that four to five Task Orders per year will be issued pursuant to the Master Agreement contracts.

Copies of the RFP may be obtained by sending a written request to: Schuyler Eldridge, Research Contracts Branch, NCI, Executive Plaza South Suite 635, Bethesda, MD 20892, Tel: 301/496-8603.

RFAs Available

RFA CA-94-011

Title: **Breast Cancer Education Initiatives**

Letter of Intent Receipt Date: May 2

Application Receipt Date: June 16

NCI invites grant applications to create new educational programs aimed at reducing the mortality and morbidity of breast cancer. These cancer education programs are intended to disseminate what is professionally known about the prevention, early detection, and treatment of breast cancer to primary care physicians, other health professionals, and the lay community with special attention to minority or underserved populations.

Applications may be submitted by domestic for-profit and non-profit organizations for the NCI Cancer Education (R25) Award. This is a flexible, curriculum-driven program aimed at developing and sustaining innovative and, possibly, unique educational approaches that ultimately will have an impact on reducing cancer incidence, mortality, and morbidity, as well as on improving the quality-of-life of cancer patients. The total project period may not exceed three years. It is anticipated that the average amount of direct costs awarded per grant will range from $50,000 to $130,000 depending upon the proposed program. Indirect costs will be allowed at

the rate of eight percent of total direct costs (exclusive of equipment). The earliest feasible start date for the initial award will be September 1994.

For FY 1994, $1,600,000 in total costs will be available for, it is estimated, some 15 to 20 awards.

The purpose of this RFA is to stimulate breast cancer educational programs among health professionals and the lay public. NCI proposes that Cancer Centers and other organizations with appropriate breast cancer expertise collaborate with educational specialists and other professional and lay groups, particularly those with access to underserved populations, to design and implement programs dealing with one or more of the following target populations for this initiative: primary care physicians, health professional faculty, health professional students, women's groups, minority or underserved groups, employer-based groups, breast cancer patients and their families. NCI also strongly encourages submission of applications from minority health professional schools and from other organizations that have traditionally served minority communities and geographically isolated populations.

Inquiries: Dr. Robert C. Adams, Div. of Cancer Biology, Diagnosis, and Centers, NCI, Executive Plaza North Rm 520, Bethesda, MD 20892, Tel: 301/496-8580, Fax: 301/402-4472.

RFA CA-94-012
Title: **Hospice And Palliative Care Education Programs**
Letter of Intent Receipt Date: May 2
Application Receipt Date: June 16

NCI invites grant applications to create new educational programs to address health professional training in palliative patient care. The intent of this RFA is to emphasize NCI's concern for this neglected area with the expectation that any funded programs will act as catalysts to encourage further interest and development in the medical community. Applications may be submitted by domestic for-profit and non-profit organizations, public and private, for the NCI Cancer Education (R25) Award. The total project period may not exceed three years. The earliest feasible start date for the initial award will be September 1994. It is anticipated that the average amount of direct costs awarded per grant will range from $50,000 to $100,000 depending upon the proposed program. Indirect costs will be allowed at the rate of eight percent of total direct costs (exclusive of equipment).

For FY 1994, $500,000 in total costs will be available for five to seven awards. This RFA proposes to stimulate medical schools, schools of nursing, cancer centers, oncology divisions, and other health professional entities to design methodologies for the education and training of health care professionals in hospice and palliative care. Hospices, either individually or in regional settings in collaborative arrangements with other medical centers are particularly encouraged to submit applications in response to this RFA.

NCI hopes to stimulate multi-disciplinary, team approaches to palliative care by encouraging a variety of educational programs aimed at medical students, physicians, other health professionals, and hospice personnel.

Inquiries: Dr. Robert C. Adams, Div. of Cancer Biology, Diagnosis, and Centers, NCI, Executive Plaza North Rm 520, Bethesda, MD 20892, Tel: 301/496-8580, Fax: 301/402-4472.

Letters to the Editor:

In Letter To Schroeder, Boxer, Love Supports NCI Decision

The following letter was sent by the author to Rep. Patricia Schroeder (D-CO) and Sen. Barbara Boxer (D-CA). The letter refers to Boxer's and Schroeder's questioning of NCI Director Samuel Broder, as reported in ***The Cancer Letter****, March 18.*

I read with some distress your questioning of Dr. Broder from the National Cancer Institute regarding mammography screening in women under 50. Please let me expound on the issues.

There is no question in my mind that we should not recommend routine screening of all women under 50. Nine randomized, controlled studies have failed to show a difference in mortality from breast cancer in women under 50 who had been mammographically screened.

This is not to say that young women don't get breast cancer. They certainly do. The point, however, is that mammography screening is not the best tool for its detection. There are many reasons for this.

One is that young women often have denser breasts on mammography, less suited for x-ray visualization. In addition, the incidence of breast cancer is lower. This means many more women would have to be submitted to the risks of radiation, extra biopsies, and extra anxiety to find very few cancers.

It has been estimated that, even if mammography worked as well in women under 50 as in older women (where it reduces the mortality rate by 30 percent), you would have to screen 1,000 women yearly for ten years to save one woman's life.

For every 1,000 mammograms there will be 700 extra procedures and/or biopsies to find 15 breast cancers and miss seven. This just isn't a cost effective tool.

The other argument used by enthusiasts is that

mammographic technology has improved, so if older studies were repeated today, they would show a difference.

This is unlikely. Every study has shown that mammography screening in women over 50 works well. It consistently decreases the mortality from breast cancer by 30 percent.

What is interesting is that this figure of 30 percent is the same whether the study was done in the 1950's or more recently, with improved technology.

It is likely that there is a subset of women who can benefit from mammography screening (about one third) and improvements in technology won't alter this figure very much.

This is a case where more is not necessarily better. We need to be lobbying for a tool which will work in women under 50, not fighting for something which doesn't work very well. And, where this tool has been shown to be life-saving, we need to make sure that every woman over 50 has access to free mammography.

Susan Love
Director, Breast Cancer Center
Univ. of California, Los Angeles

Bernard Fisher And The NSABP: Controversy Cannot Tarnish A Career That Helped Millions

To the Editor:

Having read the recent reports about the National Surgical Adjuvant Breast & Bowel Project, I was moved to express my personal sense of profound sadness at this unfortunate turn of events.

I know that I express both personal feelings and objective scientific and intellectual facts when I state that I can think of no physician-scientist who has contributed more to our understanding of the basic biology of cancer, to its management, and to the benefit of the literally millions of individuals with cancer and their families than Dr. Bernard Fisher.

I know that my views are shared almost uniformly and universally by physicians and scientists around the world.

In 1993, our institution joined the legion of others in honoring Dr. Fisher for his scientific and intellectual contributions by awarding him the Jeffrey A. Gottlieb Memorial Award. This award recognizes physicians and scientists who have made signal contributions to cancer therapeutic research and it honors a young, brilliant physician-scientist who died at the age of 35 in 1975 from the disease we have all worked so hard to contain.

It is certainly not necessary for me to recite the honors that have been bestowed upon Dr. Fisher for the qualities of scientific integrity, brilliant intellect, fluent communication, both verbal and in writing, and joyous, positive, expansive personality to match the intellect that goes along with it.

Dr. Fisher, as an individual, has had a profound impact on the entire body of the knowledge which relates to the biology of cancer. His recognition of the fundamental importance of the systemic nature of localized cancer is a milestone in our understanding of the behavior of tumors.

I am confident that current events could not possibly tarnish the brilliant, creative, and productive career of this great person and I personally certainly hope that it will not interfere with his ability to continue to play a leadership role in advancing our knowledge of the biology of cancer and its ultimate control.

Emil J Freireich
Director, Adult Leukemia Research Program
Univ. of Texas M.D. Anderson Cancer Center

A Lesson In Ethics?

To the Editor:

A Fisher's Tale

Once upon a time they apprehended a slovenly pickpocket in the far reaches of the kingdom with a fresh-picked wallet in his hand. They called the king's ministers who ordered him tapped on the wrist of his misguided extremity. They forbade him to put his hand in any pocket for a full eight days. Then, after confiscating the wallet, they ordered the owner executed for not shouting "Stop, thief!" loud enough.

Thus they taught the citizenry that pickpockets are bad—they spoil the reputation of the kingdom and embarrass the king. And, as for owners, well...

James Holland
Distinguished Professor of Neoplastic Diseases
Mount Sinai Medical Center

The Cancer Letter welcomes Letters to the Editor on subjects of interest to readers. Letters may be sent by mail to PO Box 15189, Washington, D.C. 20003, by fax to 202/543-6879, or by E-mail to Kirsten Goldberg, CompuServe ID# 73322,2044.