National Institutes of Health

National Cancer Institute

NATIONAL CANCER ADVISORY BOARD

Minutes of Meeting

February 1-3, 1982
Building 31
Conference Room 6
NIH Campus
Bethesda, Maryland

Department of Health and Human Services
Public Health Service
National Institutes of Health
National Cancer Advisory Board

Minutes of Meeting*
February 1 - February 3, 1982

The National Cancer Advisory Board convened for its 41st regular meeting at 8:30 a.m., February 1, 1982, in Conference Room 6, Building 31, National Institutes of Health, Bethesda, Maryland. Dr. Henry C. Pitot, Chairman, presided.

Board Members Present

Dr. Ames
Dr. Amos
Dr. Henderson
Dr. Hickey
Dr. Katterhagen
Mrs. Kushner
Dr. Leffall
Dr. Pitot
Dr. Powers
Dr. Rowley
Mr. Samuels
Mr. Schrier
Dr. Seitz
Dr. Selikoff
Dr. Shubik

Ex Officio Members

Dr. Victor Alexander, Labor
Dr. Hollis Boren, VA
Dr. Allen Heim, FDA
Dr. Richard Marland, EPA
Dr. F. Kash Mostofi, DOD
Dr. Denis J. Prager, OSTP
Dr. David Rall, NIEHS

Representatives of the President's Cancer Panel

Dr. Amos
Dr. Fisher
Dr. Hammer

Board Members Absent

Ann Landers
Mrs. Lombardi
Dr. Wogan

Liaison Representatives

Mr. Alan Davis, Vice President for Governmental Relations, American Cancer Society, New York, New York.

Dr. Hugh R.K. Barber, Director, Department of Obstetrics and Gynecology, Lenox Hill Hospital, New York, New York, representing the Society of Gynecologic Oncologists.

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* For the record, it is noted that members absented themselves from the meeting when discussing applications: (a) from their respective institutions, or (b) in which conflict of interest might occur. This procedure does not apply to "en bloc" actions.

Liaison Representatives (continued)

Dr. Antonie Blackler, Division Director, Physiology, Cellular, and Molecular Biology, National Science Foundation, Washington, D.C.

Dr. J.W. Thiessen, Acting Deputy Associate Director, Office of Health and Environmental Research, Department of Energy, Washington, D.C., representing Dr. Charles W. Edington.

Dr. Edwin A. Mirand, Associate Institute Director of Administration, Roswell Park Memorial Institute, Buffalo, New York, representing the Association of American Cancer Institutes.

Members, Executive Committee, National Cancer Institute

Dr. Vincent T. DeVita, Director, National Cancer Institute
Dr. Richard Adamson, Director, Division of Cancer Cause and Prevention
Mr. Philip D. Amoruso, Executive Officer, NCI
Mrs. Barbara Bynum, Director, Division of Extramural Activities
Dr. Bruce Chabner, Acting Director, Division of Cancer Treatment
Dr. Peter Fischinger, Associate Director, NCI
Dr. Peter Greenwald, Director, Division of Resources, Centers, and Community Activities
Dr. Jane Henney, Deputy Director, NCI
Dr. Alan S. Rabson, Director, Division of Cancer Biology and Diagnosis

In addition to staff, participants, and invited guests, 12 registered members of the public attended this meeting.

I. Call to Order and Opening Remarks--Dr. Henry Pitot

Dr. Henry C. Pitot called the meeting of the National Cancer Advisory Board to order, and welcomed members of the Board and members of the President's Cancer Panel, liaison representatives, guests, and observers. Dr. Pitot welcomed members of the public and announced that anyone wishing to express views regarding items discussed during the open session could do so by submitting written statements to the Executive Secretary of the Board within ten days after the meeting. Any statement by members of the public will receive careful consideration.

II. Consideration of Minutes

The minutes of the October 5 and 7, 1981, NCAB meetings were approved with no changes; the minutes of the November 30-December 2, 1981 meeting were also approved.

III. Future Board Meeting Dates

Future NCAB meeting dates that were confirmed were: May 17-19, 1982, October 4-6, 1982, November 29-December 1, 1982, January 31-February 2, 1983, and May 16-18, 1983.

IV. Report of the President's Cancer Panel--Dr. Armand Hammer

Dr. Hammer reported on the progress made in implementing his cancer research award proposal. At the last Panel meeting, he announced that a special committee of the Armand Hammer Foundation would be formed to make grants and prize awards totaling $2 million to scientists who may help find a cure for cancer within the next 10 years. The matter is under study by the Foundation, and the special committee of experts will be formed soon. Response to the proposal has been overwhelming.

Two major points were discussed at the December 3 Panel meeting: the grant review process and NCAB appointments. The Panel will hold meetings in several cities across the country in the next 18 months to discuss the grant review process with members of the scientific community. The series of meetings will begin with the next Panel meeting of March 19 in Boston; a second meeting has been scheduled for June 22 in Los Angeles. Later dates and sites will be determined in the near future.

Dr. Hammer attended the semiannual meeting of the Association of American Cancer Institutes (AACI) on January 24 and 26. AACI members are especially concerned about the Federal budget, particularly for the core program of NCI, but they were reassured that, although no final budget figures are available, the NIH and NCI budgets will not be cut in 1983.

AACI members are also concerned about the upcoming reauthorization of the National Cancer Act. Dr. Hammer urged NCAB members to contact the members of

the House and Senate committees who are involved in upcoming hearings on the Act, requesting that the legislation continue the provisions of the Act, especially the authority granted to NCI in certain areas.

Questions and Answers. A question was asked about the activities of the Panel. The response was that the Panel was established to serve as a liaison between the NCAB, the NCI, and the President. Although the three-member Panel has recently been inactive, it is resuming its responsibilities. A board member asked about the Panel's recommendations on the methods of selecting members, especially consumer members, of other boards. Dr. Amos replied that no specific recommendations had been made.

V. Report of the Director, National Cancer Institute--Dr. Vincent DeVita

Dr. DeVita announced the January 28 appointment of Dr. Jane Henney as the Deputy Director of the National Cancer Institute. He then introduced other NCI staff: Dr. Peter Fischinger, Associate Director; Mr. Philip Amoruso, Associate Director for Administration; and Dr. Elliott Stonehill, Assistant Director. Dr. DeVita also noted the death of Dr. Margaret Sloan, Chief of the Occupational Medicine Branch. Dr. John McDonald, Associate Director for the Cancer Therapy Evaluation Program of the Division of Cancer Treatment, is leaving NCI to enter private practice; Dr. Daniel Hissner will be Acting Director.

Six NCAB members will be leaving: Dr. Henry Pitot, Chairman; Dr. Bruce Ames, Dr. Harold Amos, Mrs. Marie Lombardi, Dr. Frederick Seitz, and Dr. Philippe Shubik. Dr. DeVita thanked them for the contributions they made during difficult times for NCI, and presented each retiring member with a certificate of appreciation.

Budget. President Reagan mentioned in his State of the Union address that some increase of NIH funds is planned for 1983. Definite figures would not be available, however, until February 8, at which time the President was scheduled to submit the budget to Congress.

The transfer of the bioassay program to the National Institutes of Environmental Health Sciences will complicate interpretation of the final 1983 budget. Another complicating factor is that the 4 percent cut absorbed in 1982 has come from an elevated funding level, not from the actual 1981 base of $989 million. The 4 percent cuts were made from the lower of the two congressional budget levels, which was $1.3 billion. Although the proposed 1982 amount was reduced, many grantees, even with the reduction, received an increase over what they had received in the previous year.

The current budget is a continuing resolution, which expires March 31. Therefore, Congress must act again before the end of the fiscal year. In working with cuts in grant amounts (especially the R01 and P01 grants) NIH generally acts in unison as the budgets, and suggestions for cuts, come from the Department of Health and Human Services. A decision is usually "trans-NIH," since many grantees and institutions work side-by-side.

There has been a 4 percent reduction in the entire non-competing grant pool. Grantees with early start dates, who were notified of 12 percent reductions, have been contacted and their budgets readjusted up to the 4 percent reduction. This is true for all grants, except for a few whose reductions are slightly more; for instance, the Clinical Cooperative Group Program took a 5 percent reduction.

Type 2 grants are being negotiated at recommended levels less 4 percent, or the current level plus 8 percent. New awards are being granted at 4 percent below the level recommended by the Study Section. This year, a sliding scale will not be used in awarding grants, since adjustments relating to priority scores, science, and budget manipulations already take into account the quality of the grant. Other grant programs, for example core grants, have been handled in the same way as others in the grant pool.

Senate hearings for the 1983 budget will be held February 22; House hearings will be on March 2. NCI will testify first at both hearings. Dr. DeVita has begun planning for the 1984 budget with the Acting Director of NIH.

The SEER Program. Information from the Surveillance Epidemiology End Results (SEER) Program indicated that relative survival rates for whites was 46 percent, and for all of the races combined was 45 percent for the years 1973-1979. These figures were compared to Public Health Service Report Number 5, an accumulation of data from 1967-73, which lists a relative survival rate of 41 percent. The comparison is weak, since the two data bases are not comparable. In the future, NCI will be able to compare the results of SEER to previous SEER data. It was explained that the relative survival rate is an estimate of the probability of escaping death from cancer if all other causes are inoperative. This calculation is a better indicator of the overall curability of cancer than is absolute survival, which takes into consideration death from all causes. NCI tends to use conservative estimates of survival rates. A full review of the SEER Program is scheduled for the May Board meeting.

Legislation. The Small Business Innovation Research Act of 1981, S. 881, passed the Senate 91-0 on December 8. The Bill is in the House awaiting consideration by the Energy Development Subcommittee. The House Bill proposes a 30 percent set-aside. NCI members have also met with members of the House Subcommittee on Health and Environment and the Senate Labor and Human Resources Committee about the reauthorization of the National Cancer Program and the National Heart, Lung, and Blood Institute.

NCI has sought advice concerning the legality of conducting research with cancer control funds. Nothing in the National Cancer Act prevents this.

Dr. Greenwald has announced new Cancer Control Research Units, which will support the development of research units in defined population areas. These will help NCI set a national goal of reducing disease mortality, improving surveillance, and improving screening.

In February the NCI Executive Committee will set priorities for the 1983 budget.

Frederick Cancer Research Facility. Dr. Fischinger is now manager of the Frederick contract.

Core Grants. There has been concern at the AACI about support for the core grants. Despite a 9 percent budget cut in NCI funds, the money for core grants increased by 6.6 percent.

Protocol Data Query. A committee is examining the NCI's information system and the International Cancer Research Data Bank (ICRDB), which includes all NCI management protocols, to evaluate the possibility of converting them to an interactive system available to patients and doctors. The system, known as Protocol Data Query, will contain the best available information on curability of a particular type of cancer by stage, patient management, sources of information, and references. The system will be partially operational within 12 weeks. The program could work on a national scale and any doctor with a computer in his or her office would be able to interact with these data. The system will not give highly detailed treatment protocols, but rather it will provide general information on treatment, where the treatment is being done, and references to contact for specific treatment protocols. Ultimately, all NCI information systems could be pooled and a separate unit set up to keep the information updated. The current program will be remodeled to accommodate these new data.

Oversight Functions. The Task Force on Drug Development conducted a thorough investigation of NCI clinical trials and drug development programs, and the report has been submitted to the Assistant Secretary for Health, Dr. Edward Brandt. A Government Accounting Office investigation of the same subject has also been initiated. The NIH Director's Advisory Committee has asked the NCAB to look at the costs of biomedical research, especially the indirect costs of the grants, and the cooperative research relationship with for-profit companies. For-profit organizations may now apply for grants, which is one way of interacting with the private sector.

News Clips. A study conducted by four institutions, supported by the NCI, found that Laetrile has no value and is not without toxicity. There has been considerable public outcry regarding the NCI study. An article on Karposi's sarcoma indicates association with various viruses, certain carcinogens, and hepatitis; it responds very well to interferon treatment.

Questions and Answers. A question was asked whether there had, in fact, been any increase in the NCI budget since 1974 in terms of constant dollars. The response was that there has been no real increase since 1974 or 1975. Despite this, NCI has started an impressive number of new programs over the past two to three years. The clinical proof of interferon's effectiveness as a treatment for cancer, and the reasons why data are unavailable was also questioned. The response was that although interferon may have been proven effective, the lead time necessary to publish research articles can delay the dissemination of the information. In addition, many companies performing the research are private businesses, which are covered by the Trade Secrets Act. The Division of Cancer Treatment is presenting to its Board a special Request for Application (RFA) that will attempt to conduct organized clinical trials on interferon. Further NCI involvement in validation and dissemination of interferon effectiveness was urged.

VI. Human Hybridoma Research--Dr. Henry S. Kaplan

Dr. Kaplan cautioned that any information on hybridoma antibodies would refer to potentials, not actuality, and that very little hard data exist. Several types of hybridomas have been produced. The first involved the fusion of mouse B-lymphocytes to mouse myeloma cells which produced the first monoclonal antibodies. However, these are heterologous and likely to be destroyed in the human body in clinical use. Rat lymphocytes coupled to mouse myeloma cells have the same disadvantage on the clinical level. An attempt was made to create human-mouse hybridomas, but the human chromosomes were selectively lost from the hybrid cells, with a high probability that they would lose the chromosomes making the human antibody, and thus stop secretion. Another group has used chimpanzee lymphocytes to mouse myeloma cells. Dr. Kaplan and Dr. Leonard Olson have created the first human-human hybridomas; two other research groups have replicated their results.

The biggest problem was the technical difficulties of obtaining a reliable and efficient procedure for generating the cultures. Human myeloma cells were fused with cells from spleens removed from Hodgkin's disease patients, and, through this procedure, human monoclonal antibodies were produced. In the second step, sheep red blood cells were presented to Hodgkin's spleen cells, and IgM antibody against sheep red blood cells was produced, indicating the process could be done in vitro as well as in vivo. In the third stage, endotoxin was presented to normal peripheral blood lymphocytes, again resulting in IgM antibody production. However, IgM antibody is of low affinity, unlikely to be of any real clinical use. Therefore, the process has been demonstrated in principle, but has no immediate practical usefulness.

Among the problems in this research are the shortage of available myeloma cell lines, the need to conduct experiments in vitro rather than in vivo because of ethical considerations, and the toxicity of the fusion step. The immunosuppression regimen is highly complex, and scientists are now searching for a more efficient methodology.

The idiotype on B-cells seems to be the closest approximation to a true tumor-specific antigen in man. Differentiation antigens of many types are present on all other tumors, which may eventually lead to a way of destroying tumors without harming the patient.

Drs. Kaplan and Olson found that when monocytes were present, there is a great increase in growth in the culture vessels. After cloning they biosynthetically labeled the hybrids and the parental myeloma cells, took the culture foods which contained the secretions of those cells, and carried out SDS Polyacrylamide gel electrophoresis to determine the products and their size. Evidence indicates that the hybridoma is indeed producing a new monoclonal antibody. Dr. Olson has recently succeeded in obtaining hybrids that are reactive with human T-cells.

There are two approaches to making actual anti-cancer monoclonal antibodies in the human-human hybridoma system: the autologous approach which uses the patient's own tumor and lymphocytes, and the allogenic approach. However, it will be necessary to enhance the activity of these antibodies by linking them either to toxic materials, drugs, or alpha particle emitters. Problems with the process include: tumor cells are heterogeneous with respect to antigen

expressions, so that a tiny cohort in every tumor will fail to express enough antigen to bind antibody; some tumors shed antigen only after contact with antibody; and the tumor may move to sites such as the brain where the antibody cannot move.

Extensive research is needed before it will be possible to generate the broad spectrum of types of antibody needed to attack the 100 or more different kinds of cancer. The strategy should focus on those cancers which can be readily induced to go into complete remission, but in which there is a high frequency of relapse.

Questions and Answers. In response to a question from a Board member, Dr. Kaplan noted that the length of time needed to generate antibodies makes it impossible to work with a patient's own cells. It will be necessary to improve the binding strength of antibodies so that they will react with multiple cancers of a given type.

VII. NIH International Cooperation: Opportunities, and Magnitude Report--Dr. Claude L'Enfant

The Fogarty International Center. The Center, created in 1968, has four programs. The International Coordination and Liaison Program fosters research in foreign countries, and represents NIH to the State Department, U.S. embassies abroad, foreign embassies in the U.S., and international health organizations. A majority of the foreign research activities are conducted under bilateral agreements. Funding comes from regular NIH funds, and totaled $58 million in 1981.

The Foreign Scientist Assistance Program provides at least 20 services, fostering scientific exchange by enabling foreign scientists to work with scientists on the NIH campus. Approximately 1,200 scientists participated in 1981 at a cost of $16 million. The International Research and Awards Program supports activities such as the International Research Fellowship Program, the Senior International Fellowship, the Foreign Fellowships for U.S. Scientists, and the Special Foreign Currency Support, also known as the P.L. 480 Program. The Advanced International Studies Program includes the Scholars in Residence Program, the International Conferences Program, and the International Issues Study Program.

An international issue is defined at Fogarty as one that involves more than one country, requires appropriations in the various countries to solve the problem, would benefit the U.S. if solved, and is appropriate to and feasible within the NIH mission. The Center is allotted 2 percent of the NIH budget, a total of $9 million.

VIII. Cancer and Minorities--Dr. LaSalle Leffall

The NCAB Committee on Cancer and Minorities investigates the problem of cancer among minorities. Recent data show that black patients suffer cancer earlier, had a much smaller percentage of localized cancers, and had significantly lower 5-year survival rates for major cancers. According to figures supplied by the

American Cancer Society, 160 minority deaths per week could be prevented by bringing the status of cancer treatment of blacks up to that of white patients' treatment. The Committee, in conjunction with the American Cancer Society, will hold a series of educational workshops and meetings, including the Second National Conference on Cancer and Minorities (April 1983 in Memphis, Tennessee). The primary focus of the Committee will be on finding ways to decrease the burden of cancer among minorities, especially blacks.

The Committee is considering a major review of the geographical pathology of cancer in blacks. The Committee also suggests a study of the statistical data regarding the incidence of cancer among blacks, since misgivings about the validity of current data have been expressed. Both of these studies could be done quite rapidly. A third suggestion is to study the effects and significance of migration. Another study should compare factors in cancer incidence among blacks and whites, with an attempt to minimize economic factors. A detailed investigation of the 4- or 5-year survival, and a study of industrial differences between blacks and whites, are also necessary. Lifestyle factors and the major cancers that kill blacks are the last two studies suggested by the Committee. A total budget of $500,000 was suggested for all nine studies. In addition, a concept statement has been submitted to the Board of Scientific Counselors, DCT, and if it is approved and funded, the project will enable the NCI as a whole to collaborate with DRCCA on extramural investigations to evaluate the determinants of the cancer survival differences between blacks and whites.

Questions and Answers. It was asked if the contract for these research questions would have to be considered by the Board and follow the usual contract mechanisms; the answer was yes. Board members discussed the incidence of breast cancer in black and white populations, and suggested that studies would be appropriate in that area. Dr. DeVita questioned if a $500,000 budget would be sufficient to complete the suggested research. The possible correlation between cancer and alcohol and tobacco use was also suggested.

IX. Minority Training--M.D. Anderson Experience--Dr. Robert Hickey

The University of Texas Comprehensive Cancer Center sponsors summer programs for students in high school, college, medical school, and dental school. No more than half a dozen of the students in these programs were minorities. Dr. Hickey suggested two reasons for this lack of minority participation: first, lack of a role model in the minority population, and second, lack of a strong science background. Dr. Hickey suggested that a program be set up whereby mostly minority universities establish affiliations with Comprehensive Cancer Centers. The universities would send students to the centers for given periods of time for training. This type of program would allow minority students to receive the science training which they had missed.

Questions and Answers. Several Board members questioned whether starting such a program at the university level would be sufficient. They suggested that perhaps the place to try to compensate for inadequate education is in junior and senior high school. A program at the University of California identifies promising high school students with inadequate backgrounds and starts them in summer sessions. Therefore, by the time they enter the university, they are competitive. A program developed by Mt. Sinai Hospital and the New York City

Board of Education takes 80 students per year in a training program that focuses on mathematics and language. In the past year, 80 percent of those students were admitted to college. A suggestion was made to attempt to single out the number of these types of programs available at the college level and at the high school level to determine how they differ and how they are similar.

X. Report of the Ad Hoc Nutrition Subcommittee--Dr. Bruce Ames

Various studies indicate relationships between certain nutrients and cancer incidence. A crucial factor in carcinogenesis seems to be the fat oxidation rate. High oxidation rates occur in the presence of radicals, and generate lipid hydroperoxides, which are known to be carcinogens and mutagens. These in turn break down into radicals, thereby continuing and accelerating the oxidation process. Studies have shown a correlation between a high-fat diet and breast and colon cancer.

On the other hand, research in Japan has indicated that persons who consume large quantities of green and yellow vegetables have lower cancer rates. A possible explanation is that these vegetables contain beta-carotene, which plants generate as a defense against singlet oxygen. Other nutrients which appear to destroy singlet oxygen and hydroperoxides are the enzymes catalyase, glutathione peroxidase, expoxide hydratase, and DT-diaphorase, vitamins C and E, selenium, and uric acid. Research is being conducted on all of these substances, and on the possible carcinogenic effects of the toxic substances which plants manufacture. Studies also show that cooking proteins and fats generates mutagens. Eventually, diet and nutrition may prove to be even more closely related to cancer rates than are environmental carcinogens.

XI. Community Cancer Oncology Program Report--Dr. Peter Greenwald

There has been a great increase in the number of physicians specializing in cancer since 1970, and a resultant increase in community cancer treatment. The Community Cancer Oncology Program (CCOP) is aimed at putting the oncologist in the community to aid in those areas of cancer control that have already been successful, and to increase activity in the important area of toxicity research.

Dr. Greenwald cited the need for a "dynamic continuum" in cancer control programs, with both research and treatment taking place in the community. The Eastern Cooperative Oncology Group recently conducted a study involving 2,600 pairs of patients, one group in community hospitals, the other in the Cooperative's 28 member institutions. The findings indicated that the community physicians had low rates of ineligibility, protocol violation, and inadequate data submission. This showed that community physicians are well able to participate in such research file efforts. Dr. Greenwald also cited an unpublished study by the Southeast Cancer Group, which indicated that patients on protocol may have lower toxicity rates.

These studies and others indicate the potential usefulness of community centers, but CCOP needs to develop clear-cut, measurable objectives. Among them might be monitoring cancer control progress nationwide, testing the diffusion hypothesis of protocol benefit, and reaching communities with this new information.

A CCOP is a medical consortium with a multidisciplinary professional team and administrative cohesion. It would have a written agreement with a clinical research base to which the consortium contributes a minimum of 50 patients a year who are put onto the national protocol.

Questions and Answers. Dr. Greenwald outlined the proposed evaluation plan for CCOP and how community centers negotiate with research bases. Various questions were raised regarding the structure and specifications for community centers; however, Dr. Greenwald cautioned against establishing detailed requirements. It was suggested that the first group of centers be limited to 20 and that the costs per patient, which are estimated to be approximately $1,000, be determined. Board members also discussed the long-term role of the CCOP in clinical research and the method of patient protocol selection.

Several Board members questioned the value of the CCOP, and asked to review the draft RFA before it is issued. However, this review could possibly result in disqualification of institutions whose representatives had seen the draft. Dr. Powers suggested that a letter and background document on the RFA be sent to the Board; the Board was amenable. By motion, it was agreed that Dr. Katterhagen's subcommittee would meet to discuss the RFA material before the meeting of the full Board in May, but a motion to delay the RFA until after the May Board meeting was defeated.

XII. Status Report of the Frederick Cancer Research Facility--Mrs. Barbara Bynum

Twelve proposals for operating the Facility have been received. The technical merit review will take place March 15, and the agenda for that meeting was outlined. It is necessary to avoid any appearance of favoring the incumbent in the evaluation procedures. The Source Selection Group's final meeting should be held in August.

In the comments following the report, it was noted that two years ago, the Board had agreed that recompetition of the program would take place at a 20 percent lower funding level, but the present plan calls for a 29 percent decrease. The funding should not exceed $25 million. It was explained that the apparent discrepancy resulted from rearrangement of laboratory facilities, support services, and staff assignments.

XIII. Motion of Gratitude to Dr. Philippe Shubik

The following motion was passed unanimously by the Board:

"The National Cancer Advisory Board, in acknowledging the contribution of members whose terms end with this meeting, wishes to express its recognition of a special debt to Dr. Philippe Shubik. Dr. Shubik has served the Board with distinction and, at times, under unusually difficult circumstances. The members of the Board wish to affirm for the public record their support of Dr. Shubik, whose integrity and high standards have proved invaluable to the deliberations of this body."

XIV. Subcommittee Report on Nutrition--Dr. Maureen Henderson

Dr. Henderson asked that discussion of the Ad Hoc Subcommittee's Report on Nutrition and Cancer be put on the agenda of the May Board meeting. The report recommended more extensive research in the area of cancer and nutrition, and suggested implementation of an NCI-wide program to establish and communicate program goals in the scientific community. The conclusions of the report were: scientists from other disciplines should be recruited to expand the study of dietary carcinogenesis; chemoprevention trials should be emphasized less than biochemical epidemiology; and more work should be done with animal models, representative patient studies, and toxicity in an effort to upgrade and expand NCI research in diet, nutrition, and cancer. Also, scientists from disciplines tangential to cancer research should be more actively recruited.

The report also recommended that more funds be earmarked for nutrition and that these funds be used to promote NCI-wide coordination of nutrition research. A "Nutrition Cancer Task Force" was proposed to implement the recommendations, to document and establish a national research agenda for the cancer and nutrition field, to oversee recruitment of new scientific investigators to the field, to identify critical research areas, and to solicit, screen, and review grant applications. The task force was proposed as a 2- to 4-year body.

Questions and Answers. Discussion revealed some skepticism about earmarking funds for this area, since this type of research is already covered by R01s. Discussion of the Subcommittee's efforts and report was scheduled for the May meeting.

XV. Subcommittee Report on the Organ Site Program--Dr. William Powers

The report opened with discussion of the Ad Hoc Subcommittee Report on Organ Site Program Review, copies of which were submitted to the Board for discussion March 31-April 1, prior to the submission of recommendations by the Organ Site Subcommittee at the May Board meeting. The report was critical of clinical and basic research, but "congratulatory" regarding administration and recruitment. Dr. Powers reviewed several organ sites and the degree to which research on them was covered by the Organ Site Program. For the large bowel and the pancreas, slightly over 25 percent is done in the Organ Site Program; for the bladder and prostate, almost 75 percent of all investigations are carried out in the Organ Site Program. The following recommendations were offered: organ site research is valuable and deserves continued support, and decentralization and reduction of headquarters staff should be complemented by increased emphasis on basic science and improved communications.

By motion, the report was accepted (not endorsed) as a Subcommittee report, subject to amplification prior to the May meeting. Dr. Janet Rowley recommended that outside leadership of the program be continued and offered several other suggestions for the deliberations of the Subcommittee regarding program leadership. A motion was tabled to emphasize the Subcommittee's belief that all grants should fall under DRG.

XVI. Budget and Planning Committee Report--Dr. Frederick Seitz

NCI will operate under a continuing resolution until March 1, at which time an extension may be effected. A 4 percent budget cut and minor changes in allocation (an administrative reduction of $2 million and a transfer from the National Institute of General Medical Sciences (NIGMS) of about $4 million) will put 1982's appropriations at about $943 million, as opposed to $947 million for 1981. Research funds for both years represented about three-fourths of the total budgets (about $772 million each year). Source development was $119 million for 1981, and $115 million for 1982. Figures for cancer control were $55 million and $56 million for 1981 and 1982, respectively. It was noted that allocations for investigator-initiated research have grown from about 56 percent of the total budget in 1976 to 75 percent of the total budget in 1981. The phase-out period for R01 grant research has been changed to 3 months; however, only grants that could have fallen within the previous year's payline are eligible. For Center grants (P30), the phase-out period has been reduced from 75 percent to 50 percent of current levels for 12 months.

Until the President presents his 1983 budget on February 8, no predictions for NCI's budget can be made. However, the President did state that he hoped to add $100 million to the total NIH budget; NCI hopes to share in that. General comments on the possibility of a 1983 budget increase and 1984 bypass budget were made. A survey instrument, requesting that the Planning and Budget Subcommittee rank NCI's programs, will be prepared; on the basis of these results, NCI will draft the 1984 bypass budget. The NCAB will review a second draft of the budget in May. The usefulness of the bypass budget as a means of conveying NCI's priorities to OMB, the President, and Congress was questioned, but the report was accepted by motion.

XVII. Message from the Retiring Members of the Board

On behalf of the six retiring members of the NCAB, Dr. Pitot expressed gratitude to the NCI staff and other Board members.

XVIII. Adjournment

The meeting was adjourned at 11:47 a.m.

Henry C. Pitot, M.D., Ph.D.
Chairman
National Cancer Advisory Board