National Institutes of Health

National Cancer Institute

NATIONAL CANCER ADVISORY BOARD

Summary of Meeting
May 14-15, 1984
Building 31
Conference Room 6
National Institutes of Health
Bethesda, Maryland

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

Minutes of Meeting*
May 14-15, 1984

The National Cancer Advisory Board (NCAB) convened its 50th regular meeting at 8:30 a.m., May 14, 1984, in Conference Room 6, C Wing, Building 31, National Institutes of Health (NIH), Bethesda, Maryland. Dr. Tim Lee Carter, Chairman, presided.

Board Members Present

Mr. Richard A. Bloch
Dr. Roswell K. Boutwell
Dr. Victor Braren
Dr. Ed L. Calhoon
Dr. Tim Lee Carter
Dr. Maureen M. Henderson
Dr. Robert C. Hickey
Dr. Geza J. Jako
Dr. J. Gale Katterhagen
Mrs. Rose Kushner
Ann Landers
Dr. LaSalle D. Leffall
Dr. William E. Powers
Mr. Sheldon W. Samuels
Mr. Morris M. Schrier

President's Cancer Panel

Dr. Armand Hammer
Dr. William P. Longmire, Jr.
Dr. John A. Montgomery

Ex Officio Members

Dr. Elizabeth Anderson, EPA
Dr. Hollis Boren, VA
Dr. Bernadine Bulkley, OSTP
Dr. Jean French, NIOSH
Dr. Allen Heim, FDA
Dr. F. Kash Mostofi, DOD
Dr. David P. Rall, NIEHS
Dr. Ralph E. Yodaiken, LABOR

Absent

Mrs. Angel Bradley
Dr. Janet D. Rowley
Dr. Irving J. Selikoff

* 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

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

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

Ms. Margaret Foti, Executive Director, American Association for Cancer Research, Temple University, Philadelphia, Pennsylvania, representing the American Association for Cancer Research.

Dr. Raymond Lenhard, Jr., Associate Professor of Oncology and Medicine, Johns Hopkins Medical Institute, Baltimore, Maryland, representing the American Society of Clinical Oncology, Inc.

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, Jr., Director, National Cancer Institute
Dr. Richard H. Adamson, Director, Division of Cancer Etiology
Mr. Philip D. Amoruso, Associate Director for Administrative Management, National Cancer Institute
Mrs. Barbara S. Bynum, Director, Division of Extramural Activities
Dr. Bruce A. Chabner, Director, Division of Cancer Treatment
Dr. Peter J. Fischinger, Associate Director, National Cancer Institute
Dr. Peter Greenwald, Director, Division of Cancer Prevention and Control
Dr. Jane E. Henney, Deputy Director, National Cancer Institute
Dr. Alan S. Rabson, Director, Division of Cancer Biology and Diagnosis
Ms. Iris Schneider, Director of Staff Operations, National Cancer Institute

In addition to NCI staff members, meeting participants, and guests, a total of 12 registered members of the public attended the meeting.

I. Call to Order--Dr. Tim Lee Carter

Dr. Carter, Chairman, called the meeting to order and welcomed members of the Board, the President's Cancer Panel, liaison representatives, guests, staff of the National Cancer Institute (NCI), and members of the public. He expressed his appreciation to those members of the Board whose terms of service have been extended, and welcomed to the Board Dr. Bernadine Bulkley, alternate representative from the Office of Science and Technology Policy, Executive Office of the President. Dr. Carter also welcomed Mr. Henry Neil, Staff Assistant of Representative William Natcher, and announced that Mr. Neil would speak to the Board about the appropriations process. He then introduced the liaison representatives.

Dr. Carter announced that the Tuesday, May 15, session of the Board would be open from 8:30 a.m. until approximately 10:45 a.m., with the rest of the day devoted to the closed session.

Procedures for the conduct of Board meetings were reviewed. Members of the public who wished to express their views on any matters discussed by the Board during the meeting were invited to submit their comments in writing to the Executive Secretary of the NCAB within 10 days after the meeting. Dr. Carter emphasized the importance of having a quorum of 12 members present for each occasion when a vote is taken.

II. Future Board Meeting Dates

Future Board meeting dates were confirmed as follows: September 24-26, and November 26-28, 1984; February 4-6, May 13-15, October 7-9, and December 2-4, 1985.

III. Consideration of NCAB Minutes of January-February, 1984

The minutes of the January-February 1984 meeting of the National Cancer Advisory Board were approved without objection.

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

Dr. Hammer reviewed the Panel's new directions for its meetings: as announced at the January-February 1984 Board meeting, the Panel will focus on the cancer centers throughout the country and will consider current undertakings in cancer research, plans for the future, and particularly how the centers can effectively meet the needs of their communities.

Since the last Board meeting, the Panel has held two highly diverse meetings on the topic of the cancer centers. The first meeting was hosted by Panel member Dr. John A. Montgomery at the Southern Research Institute in Birmingham, Alabama. As starting points for discussion, questions were raised on the role of the cancer centers in the community and on the number of cancer centers needed nationwide to obtain the goals established for the year 2000. Special problems pertaining to cancer treatment in the South were

discussed: the area is sparsely populated; the proportion of people with college degrees is only one-third that of the national average; and, 25 percent of the population of the region lives below the poverty level. The issue of establishing cancer centers at minority institutions was also discussed.

The second Panel meeting was held in Los Angeles, California, at the University of Southern California Comprehensive Cancer Center. There are two comprehensive cancer centers in Los Angeles and three basic science centers. The Panel learned of the unique problems in the Southern California area, specifically, the great mix of ethnic populations, blacks, whites, Hispanics, Asians, and American Indians; the resulting communications problems because of the diversity of languages; and the problems of poverty and the lack of education. The issue of the involvement of the cancer centers with minority institutions was raised and discussed, as was the question of the support of minority students, scientists, and clinicians.

The Panel's next meetings are scheduled for San Francisco in September and Seattle in October.

Dr. Hammer announced that the American Cancer Society has agreed to match his contribution of $75,000 to sponsor jointly a study of the construction needs of the Nation's cancer research community. He has sent letters inviting contractors to submit proposals, which the American Cancer Society will evaluate.

Dr. Hammer offered the Panel's congratulations to Dr. Robert Gallo and to NCI for the discovery of the connection between the human cancer virus and acquired immune deficiency syndrome (AIDS).

Dr. Hammer reported on the encouraging progress in developing a human monoclonal antibody, called antimalignant antibody (AMA), using mouse lymphocytes.

V. Director's Report, National Cancer Institute--Dr. Vincent T. DeVita, Jr.

Dr. DeVita also welcomed the members of the Board whose terms of service have been extended, Dr. Bulkley, and Mr. Neil.

Announcements

(1) The scientific community was saddened by the recent death of Dr. Henry Kaplan, who had been a major contributor to the cancer program.

(2) Dr. Janet Rowley has been elected to the National Academy of Sciences and has received the Hussain Makki Al Juma International Prize.

(3) Dr. John D. Boice has been appointed as Chief of the Radiation Epidemiology Branch in the Epidemiology and Biostatistics Program in the Division of Cancer Etiology.

(4) Ms. Rosemary Romano has been named Chief of the Information Projects Branch in the Office of Cancer Communications.

(5) The Low Level Radiation Branch has been transferred into the Radiation Epidemiology Branch.

(6) Dr. Gregory Curt has been selected as Special Assistant for Clinical Affairs to the Director of the Division of Cancer Treatment.

(7) Mr. Michael Goldrich, former Administrative Officer for the Division of Cancer Treatment, has been named Executive Officer for the National Institute of Allergy and Infectious Diseases.

(8) Mr. Robert Namovicz, who was Deputy Executive Officer for NCI, has been selected as the Executive Officer for the National Heart, Lung, and Blood Institute.

(9) Dr. Saul Schepartz, Deputy Director of the Division of Cancer Treatment, has taken the position of Associate Vice President for Industrial and Academic Affairs at the Medical and Dental University of New Jersey.

Followup Items

(1) The Outstanding Investigator Grant Award received NIH and Department approval for a 7-year award. Over 100 letters of intent have been received. The deadline for receipt of the final grant applications is July 15; the first awards may be expected in January 1985.

(2) The President's Cancer Panel document on the peer review process has been forwarded to NIH, with suggestions for improving the peer review system. An internal review of the site visit process for the P01 grants has been completed. Both documents conclude that a major difficulty is that of obtaining senior scientists to review grants, either on site visits or on regular study sections. A possible remedy might be to require those who receive grants to serve the system to some degree.

(3) On March 6, 1984, Secretary Margaret M. Heckler announced the Institute's Prevention Awareness Program. Phase I will end in June with further media events. Several workshops are being held around the Nation in preparation for Phase II, which is to develop regional plans to address special audiences.

(4) Dr. Robert Gallo's work on AIDS has been published in Science; two additional papers with confirming information are ready for publication. The next steps are to make a general diagnostic test for AIDS available, to take preparatory steps for developing a vaccine, and to investigate the virus further in the search for antiviral agents that may prevent infection.

(5) Major meetings since the January-February Board meeting were:

- International Adjuvant Therapy Conference, Tucson, Arizona; Dr. Sydney Salmon was present to summarize the results for the Board.

- Joint Meeting of the American Society of Clinical Investigation and the American Association for Cancer Research, Toronto, Canada.

(6) Regarding the review of cancer centers, the NCI Grants Administration Branch is conducting an administrative review of centers; the Planning Group has been reviewing the centers and reported to the Board at the meeting; and the President's Cancer Panel is discussing the centers' roles in the community, as reported earlier.

A key issue is that of the basic science centers versus the clinical centers, and whether they should be divided into separate budget pockets and whether their rates of growth should be shown separately.

Another key issue pertains to providing for underserved areas, e.g., by awarding core grants for historically black institutions so they may better serve their particular communities. The issue is whether to allow a temporary exception to the guidelines for establishing centers which would remove the requirement for the presence of $750,000 worth of basic research at each center. The Coalition of Minority Health Professional Schools has sent a letter of intent asking for a planning grant to approach the development of such grants.

The Board unanimously approved a motion that the Board approve the concept of a planning grant for the study of cancer in minorities to be conducted primarily at a minority institution, and that if a meaningful or viable program comes from the planning grant, revisions in the cancer center guidelines be made so that core grant funding can be obtained for that program.

Budget

Basic research continues to be the Institute's top funding priority, which includes the R01 and P01 research grants, the Young Investigator Award, the R-23's, and the intramural program. Next in importance are the cancer centers, clinical trials, and contracts to support the other three categories.

The President's 1985 budget for NCI is $1,101,069,000, an increase of $23,790,000 or 2.2 percent over the current 1984 appropriation. Because of a required fixed level of support to the NIH 5000 grant pool, the research project grants (R01's and P01's) received a $26,490,000 increase over their 1984 funding level. Since this addition was $3 million greater than the Institute's overall increase, reductions for other budget items were necessary. The centers' budget was reduced from $79 million to $78 million. Because there was no competing business in the Clinical Education Program in 1984, its funds were reallocated. Additional funds were moved from the contracts area.

Allocation of monies within budget categories will follow consistent funding policies. Noncompeting R01/P01 grants will be funded at about 2.9 percent below study section recommendations. Competing renewals and new grants will receive about 3.8 percent less than recommended levels; nonetheless this level represents a substantial increase over 1984 funding, since

the average recommended increase was 25 percent. Overall, intramural programs receive a smaller increase than extramural programs.

For the centers, competing grants will be reduced by 2 percent of 1984 levels, and noncompeting grants will increase by 2 percent. The cooperative groups have a 2.5 percent increase for noncompeting grants and a 10 percent decrease from 1984 funds for the competing pool.

The reduction in the number of full-time staff positions at NIH requires NCI to reduce its employment ceiling by about 100 positions.

Several trends in funding over the past decade are apparent. The research project pool, supporting the basic research priority, has received the most sustained and significant increases. The clinical cooperative groups have received increases, but they have tended to flatten out over time. Although funds for cancer control had dropped markedly at one time, with the expansion of the Cancer Prevention Program, allocations have now risen. Research and development contracts received major reductions over the period, as some contracts were replaced by less expensive grants, and improvements in technology reduced the need for research and development resources.

The 1986 bypass budget projects resources required for 1986 through 1990. This bypass budget was based on NCI staff assessments of resources needed to meet the goal of reducing cancer mortality by 50 percent by the year 2000. It projects an 83 percent increase from 1985 levels, to a total of $2.22 billion, which includes substantial increases for expanding the number of centers and clinical oncology programs, and increasing the capacity of the clinical cooperative groups.

Legislative Update--Dr. Mary Knipmeyer

The Senate bill for the reauthorization of NCI has still not come before the full Senate.

HR 4192, on risk assessment review, has been marked up by one subcommittee and reported to the Science and Technology Committee. The bill now awaits similar action from another subcommittee.

The Compassionate Pain Relief Act is aimed at making heroin available to cancer patients suffering from what is thought to be intractable pain. The Department and NCI oppose this legislation because equally effective formulations of morphine are available. This bill has yet to come before the full House.

In 1983, Congress authorized the purchase of the Visitation Convent located on the NIH grounds. Both the House and the Senate recently passed bills establishing the name of this new NIH facility as "The Mary Woodard Lasker Center for Health Research and Education." Current plans are to use this facility as an education center to introduce medical students to NIH research programs.

The Cigarette Safety Study Act, introduced in October 1983, has to do with the issue of cigarettes causing fires in inflammatory materials such as mattresses and with the feasibility of developing a "safe" cigarette regarding these materials. The Department and NCI are opposed, because their position is that people should not smoke.

The Subcommittee of the House Committee on Science and Technology will hold an informational hearing on the status and implications of oncogene research on June 6, 1984.

VI. Interim Report on Cancer Centers--Dr. Harry Eagle, Dr. Albert Owens, Dr. Ernst Wynder, Dr. Jerome Yates

Dr. Peter Greenwald, Director, Division of Cancer Prevention and Control, introduced the three cancer centers' directors' presentations by noting the cancer centers' role, in partnership with the NCI, in responding to local needs and opportunities, which will aid in meeting the Institute's goals for the year 2000. A committee of the Board, made up of center directors and others, has been working to develop detailed recommendations on the centers' programs.

Dr. Harry Eagle, Director, Cancer Research Center at Albert Einstein College of Medicine, Bronx, New York, focused on the importance of continuing core grant support for the centers that do basic laboratory research exclusively. The core grant mechanism provides support in several critical areas that are covered either inadequately or not at all by the traditional R01 and P01 grants. Core grants help provide large items of equipment, support for shared services and facilities, seed support for new investigators, and crisis interim support for those investigators who may temporarily lose their personal grants. Continued core grant support for laboratory research in all centers remains essential.

Although the socially oriented programs are a direct responsibility of the cancer centers, some centers that do not have either the appropriate orientation or capacity are discharging their societal function by their research activities. Unless incremental funds are provided, these socially oriented activities can only be carried out in the basic cancer centers at the expense of research functions. Dr. Eagle concluded by urging the NCAB to continue its commitment to the undiminished support of basic laboratory research in general and of the laboratory cancer centers in particular.

Dr. Albert H. Owens, Director, Oncology Center, Johns Hopkins University, Baltimore, Maryland, discussed the history, current programs, and future of the center. He began by outlining the history of the oncology center, which began with the Cancer Act of 1971. At that time, the statement of goals focused on research and education in cancer and related disorders, stressing application of new knowledge, patient management, and disease prevention, with a particular focus on human neoplasia. The center is organized into medical services and research laboratories, each of which has shared resources. To maintain a multidisciplinary focus, its organization follows disciplinary lines, e.g., transplantations, lung cancer, and childhood tumors.

About 1,100 to 1,300 new cancer cases a year go to the center; the current caseload is nearly 3,000. There are 60 staff members with primary academic appointments in oncology and many more with secondary appointments. The growing number of part-time faculty indicates active participation on the part of the individuals who come to the center's clinic and attend its meetings, but who also take responsibility in their local hospitals for a cancer program. NCI core grant money represents about 15 percent of the total resources for research and helps provide leadership personnel, shared resources, and money to support young faculty.

In the future, the center will continue to promote a network of approximately 12 hospitals in the state that provide patient consultation, education, and some clinical protocol research. The center will likely continue as a referral center and plans to develop some alternatives to routine hospital care. Future research activities include cell and molecular biology laboratory efforts, experimental therapeutics, and development of chemoprevention.

Problems include physician/scientists training and entering the pool, initial support for young faculty, and support for new areas of research. A funding void exists in translating new knowledge into practice. Another major concern is the DRG prospective payment system. Because of the extremely high cost of the procedures and treatment carried out at the Johns Hopkins center, the DRG payment would not begin to reimburse the center adequately.

Dr. Ernst Wynder, President of the American Health Foundation, New York, New York, discussed four principles in cancer prevention: 1) cancer is not an inevitable consequence of aging; 2) the mechanism of a disease need not be known to prevent the disease; 3) health education is more than simply providing information; and, 4) common diseases have common causes.

Dr. Wynder discussed obstacles to prevention, particularly the lack of health professionals in prevention programs. Insufficient financial and academic rewards may explain the shortage. A key emphasis in prevention programs is school health promotion, which should be mandatory, graded, and monitored to be most effective. The American Health Foundation has developed the "Know Your Body School Health Promotion Program," which personalizes health messages and risks for each child. The program has succeeded in reducing children's serum cholesterol levels and changing smoking habits over a 4-year period. Another benefit to teaching prevention to children is that parents are likely to learn from the children; moreover, what is taught in school is an entry point to community health education. The cost of adopting this type of program would be between $25 and $35 per student.

The American Health Foundation Cancer Center specializes in prevention and brings together basic research in chemistry, biology, and epidemiology. It was stressed that cancer control units should be led by promotion strategists, rather than by health educators or behaviorists, with specialists, mostly allied health professionals, on the staff. The cancer control units should receive core support from NCI and receive long-term support from third-party carriers.

Dr. Jerome W. Yates, Associate Director, Centers and Community Oncology, introduced Dr. Lucius Sinks, who will be the new Chief of the Cancer

Centers Branch, and then presented some preliminary recommendations related to the centers program. Some of the recommendations made by the ad hoc planning committee will reflect the cross-section of involvement by cancer centers, as shown in the previous reports of three centers. The committee is building a foundation for some substantive changes in the direction of the Core Grant Program. Previous guidelines had excluded support for program leadership in cancer control research. Because the Division of Cancer Control and Prevention changed the approach to cancer control and has stimulated research activities, it became appropriate to treat cancer control as any other program area and provide program leadership support.

VII. Budget and Appropriations Process--Mr. Henry Neil

Mr. Henry Neil, Staff Assistant to the Committee on Appropriations of the U.S. House of Representatives, spoke to the Board about the congressional budget process, the appropriations committee's role in it, and how NIH is affected by the process. Mr. Neil is assigned to the subcommittee on the Departments of Labor, Health and Human Services, Education, and related agencies--one of 13 subcommittees of the House Appropriations Committee. The subcommittee's role is to review the President's annual budget requests for the programs of the Departments and Agencies within its jurisdiction and to recommend the amounts the subcommittee judges should be included in the Annual Appropriations Bill for those Departments and Agencies.

The Agencies and Departments covered by the Labor, Health and Human Services, and Education Appropriation Bill account for $372.8 billion out of the President's 1985 budget of $1 trillion.

The President's budget provides about $29 billion in discretionary appropriations for fiscal year 1985 for the programs funded in the Labor and Health and Human Services Education Appropriation Bill. The National Institutes of Health, with $4.566 billion in the 1985 budget, accounts for 15.8 percent of the total 1985 budget request of $29.968 billion for discretionary appropriations.

About 10 years ago, the Congress became concerned that it was not considering the budget as a whole, but only in bits and pieces: there were 15 or more separate appropriation bills, any number of tax bills, and any number of pieces of legislation creating entitlements, for the budget year and for future years, that would have first claim on the budget.

To deal with this problem, Congress enacted the Congressional Budget Act, creating two new budget committees, one in the House and one in the Senate, and a new staff agency, the Congressional Budget Office. It changed the beginning of the fiscal year from July 1 to October 1, and it established a set of procedures whereby Congress would set overall targets for revenues, budget authority, and outlays within which it would annually produce the spending plan for the Federal Government.

The amount in this spending plan is broken down into an allocation for discretionary programs and an allocation for entitlement programs and it

becomes known as the Section 302 (of the Budget Act) target for the Appropriations Subcommittee. It is expected that in acting on the Appropriations Bill, the Subcommittee will not exceed the discretionary portion of this target. In the years since the Budget Act has passed, the Appropriations Committee has taken those targets very seriously.

Another factor that affects the Subcommittee's deliberations is the status of authorizing legislation. Programs funded in the Labor/HHS/Education Appropriation Bill are authorized by many separate and distinct laws and sections of laws. NIH is somewhat unique in that most NIH programs are covered by the broad research authority contained in Section 301 of the Public Health Service Act, which has neither a dollar limit nor a time limit.

For the National Institutes of Health, aside from the expiration of the National Cancer Act and the National Heart, Lung, and Blood Act, for which Section 301 provides fall-back authority, the most serious authorization problem at the moment relates to research training authorized by the National Research Service Awards Act.

Over the past 10 years, Congress has added a total of $2,840,949,000 over the President's budget request for NIH. The growth of the NIH appropriation in this period from $2.1 billion for 1975 to $4.5 billion for 1984 is accounted for entirely by congressional add-ons. The National Cancer Institute appropriation since 1975 has grown from $691,666,000 to $1,077,279,000. This growth is also more than accounted for by congressional increases totalling $675,292,000 in this period.

VIII. Status Report on Adjuvant Chemotherapy--Dr. Sydney Salmon

Dr. Sydney Salmon, Director, Arizona Cancer Center, reported that adjuvant chemotherapy has been an important thrust in the Clinical Investigation Program of the NCI for more than a decade. Intramural and extramural programs involve a large number of institutions via grants, usually PO1's or cooperative group grants or contracts. Recently the cooperative agreement mechanism has been used for some of the multi-institutional clinical trials.

The adjuvant therapy concept is not limited to chemotherapy, but is a multimodal therapy that brings the early stage of cancer management into a different perspective. Historically, cancer treatments have been given to patients in the order in which they were discovered: surgery was tried first, then radiotherapy, chemotherapy, and finally immunotherapy.

During the past decade or so, this mix of treatments has been taken into consideration in deciding the best sequence and combination to bring to bear on the cancer problem and to apply this formula earlier in the course of the disease. Adjuvant therapy is an approach to cancer treatment in which a second modality is used to make the primary treatment more effective and increase the likelihood of cure or the long-term suppression of cancer. In most instances, the adjuvant treatment is used with the intent of eradicating occult micrometastases of cancer that are responsible for late distant recurrence after locally curative surgery or local radiotherapy.

Dr. Salmon discussed clinical trials in breast cancer, head and neck cancer, small cell lung cancer, gastric, pancreatic, colon, and rectal cancer, and some less common cancers, including testicular cancer and Hodgkin's disease, because they address specific issues that are important in deciding on indications for adjuvant therapy. There has been some recent debate on the successfulness of adjuvant chemotherapy, in part stimulated by conflicting results in osteogenic sarcoma.

Following is a summary of perspectives in adjuvant therapy of cancer:

- Adjuvant chemotherapy is an effective means to delay recurrence and improve survival for some forms of cancer that are at high risk of recurrence after surgery.

- Optimal adjuvant therapy for breast cancer has not yet been defined, and continued clinical research remains important. Nonetheless, in view of significant evidence of effectiveness, community oncologists are justified in using adjuvant therapy for breast cancer as long as they follow the doses and schedules reported for effective programs.

- While adjuvant therapy can significantly delay relapse in some very chemosensitive tumor types (Hodgkin's, testicular), therapy for patients who relapse is usually effective and negates need for adjuvant therapy.

- Adjuvant therapy is ineffective in chemoresistant tumors such as colon cancer and remains investigational in this disease.

IX. Subcommittee Reports

Planning and Budget Subcommittee—Dr. Robert Hickey

Dr. Robert Hickey presented the subcommittee report in the absence of Dr. LaSalle Leffall, subcommittee chairman. On May 14, the subcommittee, with Dr. DeVita in attendance, met on the budget for 1985 and projections for 1986, 1990, and 2000. The subcommittee recommended that the bypass budget of $1.445 billion be approved. A breakdown of figures consistent with NCI's year 2000 goals will be developed and returned to the subcommittee for review before the next meeting. The Board accepted the subcommittee report.

Subcommittee on Innovations in Surgical Oncology--Dr. Ed L. Calhoon

Dr. Calhoon reported on the subcommittee's meeting of May 14, when Dr. William Longmire reported on a Surgical Oncology Research Development (SORDS) meeting in New York, and Dr. Calhoon reported on a meeting with the executive committee of the Society of Surgical Oncology, also in New York.

Discussion on contacting institutions and their component surgical societies seeking favorable and mutually agreeable programs for training surgical oncologists led to the decision that more qualified surgeons should

be on study sections and review teams. The subcommittee decided that Dr. Bruce Chabner and key members of the subcommittee should make a presentation concerning the subcommittee's activities to a meeting of surgical and surgical subspecialty department chairmen. A planning meeting of members of the subcommittee will be developed, and recommendations of this meeting will be presented to NCI.

X. AIDS Task Force--Dr. Peter J. Fischinger and Dr. Robert C. Gallo, Jr.

Dr. Peter Fischinger reported on the events that led the AIDS Task Force to discovering the probable cause of this disease. The team of NCI scientists, headed by Dr. Robert Gallo, Dr. Samuel Broder, and Dr. Fischinger, began the search 14 months ago at the request of NCI's Executive Committee. The Task Force involved all the Divisions of the Institute and brought together scientists from other agencies throughout the United States and abroad who were working on retroviruses and AIDS. The data from NCI's AIDS studies were documented recently in four separate papers in Science magazine.

The next steps for the AIDS Task Force, now that the probable causative agent has been found, fall into two areas of concern: primary prevention and the possibility of providing immediate help to the AIDS patient.

A major related activity within the Department is the development of a test for AIDS that will involve serum and blood banks. Although NIH has the ability to do the test, and the technology is not complicated, the amount of antigen that would be required is not available at this time.

Dr. Gallo explained why the Task Force focused on the human T-cell leukemia virus (HTLV) group of viruses and traced the chronology of events that led to the discovery that the retrovirus HTLV III is the probable cause of AIDS. When work was begun, the group felt that they could find the answer to the AIDS question within a year-and-a-half; the results came sooner than expected. It appears that, like many other microbial diseases, a large dose of the virus (from a blood transfusion, for example) can cause AIDS, whether or not any other infections exist in the system. Although the cause of the disease appears to have been identified, the scientists believe that cofactors exist that may increase the risk of developing it.

An adequate animal model for AIDS has not been identified, but the task force does not believe that such a model would add to or subtract from the argument for the etiology, although such a model would be important for therapy--for vaccines and experimentation.

The HTLV virus is most prevalent in the southeastern United States, Central America, South America, throughout the Caribbean, Israel, southern Japan, and Africa. Clusters of the disease occur where infection is prevalent. Prevalence of infection varies by country, region, age, and race. Infection is more likely to be found among close relatives. The pattern suggests that it is not highly contagious. Transmission of the virus occurs through close contact, such as sex, blood transfusions, and possibly an insect vector.

The virus is believed to have originated in Africa where it came into Old World primates, including man, then spread from Africa to the Americas via slave trade and then to the southern islands of Japan by the Portuguese involved in trade by way of the tip of Africa.

XI. Adjournment--Dr. Tim Lee Carter

The 50th meeting of the NCAB was adjourned at 10:55 a.m., on Tuesday, May 15, 1984.

AUG 13 1984

Date

Tim Lee Carter, M.D.
Chairman
National Cancer Advisory Board