

NETWORK

THE NEWSLETTER OF THE INTERNATIONAL NETWORK FOR CANCER TREATMENT AND RESEARCH

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MESSAGE FROM THE PRESIDENT

A NEW ORGANIZATION FOR A NEW CENTURY

by Ian Magrath

As I sit at my desk in the new INCTR office suite, overlooking the fields and stables behind the Institut Pasteur in Brussels, I feel strongly the sense of being in the right place at the right time.

My personal journey began in Uganda in the early 1970s, where I first learnt something of the problems faced in developing countries and developed a lifelong interest in Burkitt's lymphoma. Burkitt's lymphoma, of course, is a wonderful example of a human tumor model—one which has provided a wealth of information relevant to the epidemiology, pathogenesis and treatment of many other tumors, as well as non-neoplastic diseases. But Burkitt's lymphoma serves as a model in another sense. The pioneers who demonstrated that this disease could be cured by chemotherapy alone not only saved the lives of hundreds of children in Africa, but provided enormous encouragement to those specialists who, against the prevailing opinion of the time, believed that widespread cancer might ultimately be cured by drugs.

There are numerous other ex-



Patients outside the Uganda Cancer Institute where Dr Ian Magrath worked from 1970-1973.

amples of how work conducted in developing countries has contributed not only to improving the lot of patients with cancer in those countries, but to the global cancer knowledge base. Alas, because of the prevailing socioeconomic circumstances, many patients with cancer in developing countries receive little or no treatment, not even palliative care, and only a tiny fraction of global research on cancer takes place outside the affluent nations. Yet slowly but surely, cancer, already the second highest cause of mortality in affluent nations, is becoming a priority health problem in developing countries. This presents

tion than the handling of infectious diseases. While prevention may prove to be less expensive, this is a solution for the future, and will not help patients suffering from cancer today.

However great the challenge, it is also an opportunity for learning. Helping patients with cancer in developing countries will require building capacity for cancer treatment and research in these countries. Such efforts, which must be accompanied by research to determine the nature of the problems faced and the effectiveness of the solutions posed, will produce much new information of value to patients everywhere. It is often stated

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that research is a luxury that developing countries cannot afford—a statement made, naturally enough, by persons fortunate enough to enjoy the advantages of the efficient health care systems of affluent nations. Such a statement is patently wrong. We cannot afford *not* to take advantage of research opportunities in developing countries—both for the sake of the people in those countries and for the sake of cancer patients everywhere. It is the certainty of mutually assured benefit that underpins the process which must take place if cancer in developing countries is to be effectively addressed—collaboration between resource-rich and resource-poor nations.

Words like capacity-building and sustainability have become clichés, so widely are they heard in the context of human development. But they do get to the very nub of the problem—how to transfer knowledge and technology in such a way that it will permanently benefit the people of the recipient countries. Some of the requirements are an existing foundation, however small, upon which to build, a plan of what is going to be built, and the means to construct the



edifice. A second personal note is illustrative. In 1976, soon after I joined the National Cancer Institute in the USA, I was visited by Drs Shanta and Krishnamurthi—pioneer oncologists from Madras, India. They were concerned that their results in the treatment of children with leukemia were very poor compared to those achieved in Europe and the USA. After exchange visits, a more intensive protocol, purposely designed for the setting in which it would be used and accompanied by strenuous efforts to improve supportive care, was introduced. Since then, a long-standing collaboration in the treatment of lymphoid leukemias and lymphomas has been built with the Cancer Institute in Chennai (Madras), which rapidly spread to several other centers in India and Egypt.

While this may represent a small contribution to the control of cancer in these countries, its effects go beyond the immediate benefits to the patients suffering from leukemia and lymphoma. We have worked for many years with numerous colleagues in developing countries on the design of protocols, the problems encountered in managing the patients, the collection, quality control and analysis of data, the publication of results, and the identification, based on previous results, of specific issues for future research. Moreover, many young physicians have been involved in the work, some of whom are now in charge of oncology programs in other

Agfa-Gevaert, a manufacturer of medical imaging products, donated two digital cameras to INCTR for documenting the extent of disease in patients with retinoblastoma in Mexico and Brazil. The cameras may prove useful in the early detection of this disease.

centers where they continue to apply the principles they have learned. The dissemination of results has demonstrated to others who work in similar resource-poor settings that tangible improvements in the results of treatment can be achieved, encouraging them to join in the effort in order to benefit their own patients. There are doubtless other effects, many of which are difficult to measure—the broader impact, for example, of improvements in diagnostic facilities, supportive care, and the general principles of structuring treatment programs upon the management of other patients with cancer. Long-term collaborations of this kind will be an essential element of all INCTR programs.

There have, of course, been other kinds of efforts to transfer knowledge about cancer treatment to developing countries. Physicians from developing countries, for example, are often brought to major meetings of western-based professional societies, or workshops are held within the developing countries themselves. Both are valuable, but their benefits are limited by the brevity and consequently, superficiality of the interactions, coupled to the lack of local resources and therefore the ability to effectively apply new knowledge. A second, frequently utilized approach to deal with the paucity of well-trained physicians and scientists in developing countries, is to establish fellowship training programs, whereby young persons from developing countries are given opportunities to study in affluent countries. Unfortunately, many such individuals never return to their own countries, simply because of the limitations in opportunities there—the reason for leaving their country in the first place. Thus, helpful though such programs can sometimes be,

much of the potential benefit to developing countries literally leaks away and the consequence is that affluent nations permanently profit from the transfer of the brightest and most motivated physicians and scientists from developing countries to their own pool of professionals.

An alternative approach, the establishment of training programs within developing countries which make use of visiting experts from affluent nations, has several advantages: it is considerably less expensive, and young people learn in the midst of the problems they must face in their own countries. Moreover, visiting experts reach many health professionals in developing countries, whereas only the one trainee who goes to the USA or to Europe benefits from the experience. It is with these considerations in mind that the INCTR has decided to emphasize in-country training and educational programs wherever possible.

The INCTR, of course, cannot hope to deal with the many-faceted problems of improving cancer control in developing countries alone. Fortunately, it is not the only organization



At the Inaugural Meeting (from left to right): Dr Louis Denis, Dr Ian Magrath, Melissa Adde, Dr Ketayun Dinshawe, and Louis Schoofs.

Clinical Sciences and numerous friends and colleagues at the National Cancer Institute in

with an interest in this problem. *Challenge* and ICEDOC are both organizations that have been created recently to address this issue, albeit in rather different ways, and other organizations, such as the International Union Against Cancer (UICC), view cancer in developing countries as a problem of increasing urgency. It is this quite recent recognition that there is a problem to be dealt with that suggests that the timing of the creation of INCTR is entirely appropriate. International cooperation has never been greater. It is for us to ensure that at least some of this spirit of cooperation is focused on the problem of cancer in developing countries. To this end, the INCTR plans to work closely with other organizations—either informally or through the development of consortia such as the Global Alliance for the Cure of Childhood Cancer, which will be described in the next edition of this newsletter—to achieve its goals.

It remains for me, in this first of many messages, to thank at least some of those who have made this venture possible. The support and encouragement provided by the Office of the Director, the Division of

Bethesda have been instrumental. The kindness and hospitality of our Belgian friends, who have given so generously of their time as well as providing us with a home, have been essential. The support of the UICC, which listened to the idea and helped to make it happen, has been providential. But ultimately, our success in this venture depends upon the willingness of our friends and colleagues in developing countries to join us in accomplishing our mutual goals, for none are more acutely aware of the needs of patients with cancer in their own countries than they. ■

INCTR CONVENES IN ANTWERP

The inaugural meeting of the INCTR, held in November 1999, took place at the beautiful Elzenfeld Conference Center in Antwerp. The meeting drew 80 participants from 20 countries, and included scientific sessions, largely related to work previously accomplished in collaborative programs with the National Cancer Institute, and presentations on various aspects

Did you know...

That deaths from cancer exceed those from all infections and parasitic diseases in China? (1,836,000 versus 456,000 in 1998, according to World Health Organization estimates)

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of international oncology.

In a series of workshop sessions, participants outlined their position on cancer control activities, collaboration with other health-related organizations, including corporations, education, and training. These sessions provided vital input to the INCTR from oncologists in developing countries and representatives of the many public and private organizations with which the INCTR will work.

CORPORATE LIAISON

Improving cancer treatment in developing countries will require increasing access to essential products for diagnosis and treatment, including drugs and a broad range of medical equipment. The INCTR is forging cooperative research partnerships with pharmaceutical and other health-related companies in order to accomplish this. By generating credible clinical

trials data, the INCTR hopes to benefit cancer patients everywhere, but a firm principle of all research conducted in developing countries is that it must first benefit local populations.

There may also be scope for developing partnerships with the health and life insurance industry, which might have an interest in supporting preventive programs. INCTR activities partnered with industry will include building local infrastructure and institutional capacity, professional training, public education, and the dissemination of cost-effective treatment, in addition to scientific research.

INDIAN COOPERATIVE GROUP

Based on the success of activities in several major centers in India, which include MCP 841 and 842 protocols for acute lymphoblastic leukemia and non-Hodgkins lymphoma, and the

new randomized clinical trial, MCP 943, now in its pilot phase, the INCTR would like to extend these trials to institutions in Pakistan and other South Asian countries. Workshop participants stressed the importance of standardizing drugs and patient criteria, sharing information through the formation of cooperative groups, and the need for reference laboratories.

EDUCATION

The INCTR, which will focus on professional training, improving access to experts, and collaborations in translational research, can help developing countries reach their potential for cancer treatment and research in many ways, including facilitating communication among centers within specific countries; assisting with data management and quality control of documentation; supporting advanced training in research laboratories; collaborating with professional societies and cooperative groups; and establishing funds for research training for fellows, nurses and data managers.

STRATEGY GROUPS

Meeting participants also discussed a multi-national protocol for the treatment of osteosarcoma, with the goal of increasing the frequency of limb salvage procedures and improving survival rates whilst avoiding difficult-to-manage and particularly expensive protocol elements. An international program in retinoblastoma that includes early detection, epidemiology and treatment was also discussed. Retinoblastoma occurs much more frequently in developing countries than in affluent countries and tends to present with much more advanced disease, sometimes even metastatic disease. ■

NEW STAFFERS

Elisabeth Dupont joined INCTR in June as administrative assistant. Dupont, who was born in France, trained as an interpreter and speaks English and Italian fluently. She has both administrative and management experience and already has had a major impact on the organization of mountains of documents shipped from the United States.

Dr Anslim Narinesingh joins INCTR as Executive Director in August. His background is well-suited to the challenges he will face. He first obtained a graduate degree in biological sciences (medical microbiology and pharmacology) and has laboratory experience in carcinogen testing. He then became a nurse, and obtained his certificate in oncology nursing before adding a certificate in applications programming, an MSc in business information systems and a diploma in management studies. "Slim" managed the Cancer Center at the Hammersmith Hospital in London for four years before becoming a technical officer at the WHO, where he worked in the Cancer Control Program with Professor Karol Sikora. In between, he studied health services (screening for carcinoma of the cervix) in Cuba, earning a Ph.D.

INCTR's next step is to open laboratories in Brussels. Several excellent candidates have applied for the post of senior scientist, and the laboratories should be functional before the end of the year. ■

INCTR OFFICES OPEN IN BRUSSELS

Dr Magrath arrived in Brussels on 30th March, 2000, and the offices located at the Institut Pasteur, Brussels, became operational on 1st April. Dr Magrath was joined by Melissa Adde on 20th April. The suite includes a conference room for committee and strategy group meetings as well as small training workshops. The second meeting of the Governing Council took place on 5th and 6th May—just two days after the installation of the conference table. ■

HOW TO CONTACT US

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INCTR VISITORS

Since opening offices in Brussels, INCTR has hosted several important visitors.

Dr Yves Debaille, a Belgian surgeon who has practiced in Latin America and the Congo, and **Professor Raphael Kalengayi**, Rector of the University of Mbuji mayi in Kinshasa, visited on May 16 to discuss possible collaboration between the INCTR and a new Cancer Center that is being developed in Kinshasa.

Prof. Françoise Meunier, Director General of the EORTC, visited on May 25 to discuss EORTC participation in the Global Alliance for the Cure of Childhood Cancer. Professor Meunier agreed to serve on the Steering Committee of this important new program.

Dr Norman Coleman, Director of the Radiation Therapy Program of the National Cancer Institute, and his Deputy, **Dr Frank Govern**, visited between June 4-6 to discuss the NCI's Telesynergy program. It was agreed that INCTR would work closely with the Telesynergy initiative program in establishing a telemedicine program with centers in developing countries. The use of computer technology and the Internet to aid communications and support educational and training programs is likely to be a cost-effective mechanism that will become an essential tool in INCTR's future work. Both Drs Coleman and Govern will serve as members of INCTR's Education Committee.

Dr Surendra Bd. B. Shrestha, Mayor of the Banepa Municipality, which is situated near Kathmandu in Nepal, visited between June 24-26 to discuss the possibility of INCTR collaborating with the Nepal Cancer Relief Society in the development of a network for cancer control. Nepal, a country of 22 million people has, according to estimates made by the International Agency for Research on Cancer in 1990, some 13,000 new cases of cancer each year. Current estimates from Nepal suggest that this number has been considerably augmented in the last decade. Dr Shrestha will discuss this project at the next meeting of the Nepal Cancer Relief Society and prepare a proposal for consideration by INCTR. Nepal, which has very limited capacity for cancer prevention and treatment at present, but is a relatively small country, could become a model program for the INCTR which may then be applied elsewhere. It enjoys good relationships with its neighbors, including Pakistan, India and China, where INCTR has existing collaborative programs. ■

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Editor's Note: In each edition of Network, a case report with particular relevance to developing countries will appear. Readers are invited to send interesting and informative case reports to the editorial offices noted below. The best of the submitted case histories will be published, and the author(s) will receive \$100 toward the purchase of educational materials for their institution. Case reports should be no more than 500 words in length.

The following case report is from the National Cancer Institute in Cairo, Egypt.

The map of liver cancer distribution throughout the world, depicted below, indicates the high concentrations of the disease among male populations in parts of Africa and China. The distribution for females is similar.

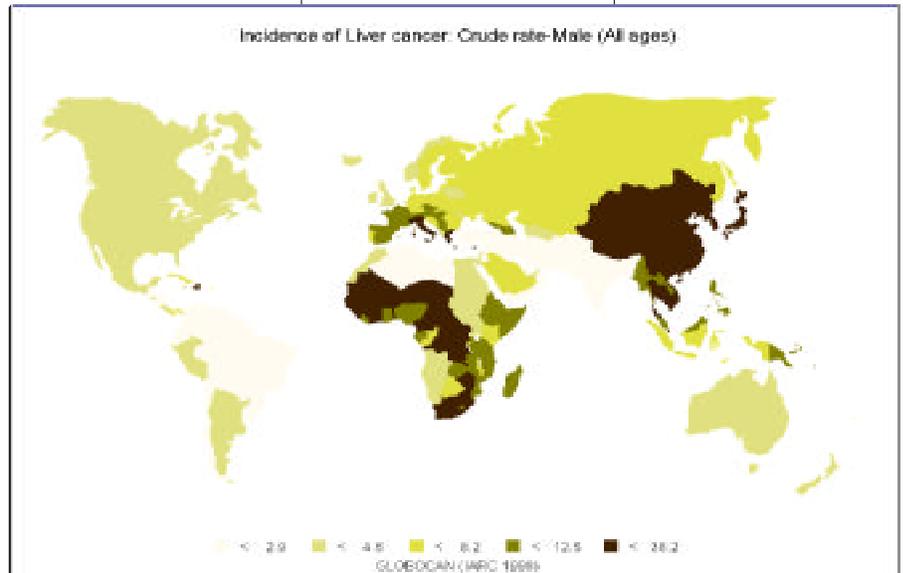
A CASE REPORT OF LIVER CANCER FOLLOWING MELOMA

by Professor Hussein Khaled
Vice-Dean, NCI, Cairo

A male patient aged 54 years and known to have chronic, viral C hepatitis presented in March 1996 with a low backache. After an initial work-up, which included laminectomy and excision of a lesion found in the sacral region, he was diagnosed as having a solitary plasmacytoma. The lesion was treated with radiotherapy, which was completed in 1996. Follow-up included bone marrow aspiration, serum protein immuno-electrophoresis, serum immunoglobulin estimation, serum β_2 microglobulin, and Bence Jones' proteins in urine, which remained within normal limits except

for a very mild increase in the level of IgG (1585 mg/dl, normal range 770-1520 mg/dl), which persisted in the course of the next year, and a very minimal increase in β_2 microglobulin level (3.5 $\mu\text{g/dl}$, normal range 0-3.4 $\mu\text{g/dl}$).

In November 1998 the patient developed severe headache. A work-up included brain CT and MRI scans, MRI cervical spine, ophthalmologic, ENT, and dental consultations, but no abnormalities were found. One year later, the patient developed a painful swelling in the right temporal region. Brain CT revealed a right temporal bone lesion, suspicious for neoplasia, and a suspected osteolytic lesion in the midline of the occiput. Another complete work-up revealed the following: (1) a deposit in the right alium of the sacrum, (2) a monoclonal band



in the gamma region, with a concentration of 2.7 g/dl (3) an increase in the IgG concentration, exclusively associated with kappa light chains, (4) a β_2 microglobulin level of 7.8 μ g/dl, and (5) a high serum uric acid level (1.8 mg/dl). A fine needle aspiration of the temporal bone lesion revealed the presence of plasmacytoma.

The patient was treated with 3-4 cycles of the VAD regimen and Aredia, given as an infusion of 90 mg every month, to be followed by high dose therapy and autologous peripheral blood stem cell transplantation if he obtained a CR. While on the VAD therapy, however, the patient developed steroid induced diabetes mellitus, which was controlled by insulin therapy, and elevations in liver enzymes. Given his history of viral C hepatitis, a trial of interferon, 6 million units per day was initiated, but due to severe side effects, which included persistent fever, generalized bone pain and depression, the drug was stopped after 10 days. The patient went on to receive 4 cycles of VAD chemotherapy, but his multiple myeloma progressed. Further investigations at this point revealed the presence of a portal vein thrombosis that involved the main portal trunk, its bifurcation and both right and left branches. In addition, a large hypochoic area of about 10 cm in diameter was found in the right hepatic lobe of the liver and there was minimal ascites. A panel of serum tumor markers demonstrated elevated alpha fetoprotein (84 ng/ml, normal up to 10 ng/ml), and carcinoembryonic antigen (204 u/ml, normal up to 37 u/ml). It was felt very likely that the patient had developed a second malignancy in the liver (hepatocellular carcinoma), but a CT-guided biopsy of the hepatic lesion

was considered a high risk procedure and therefore not undertaken. The patient traveled abroad and a PET scan performed in June 2000 was felt to be compatible with the diagnosis of hepatocellular carcinoma. It also revealed bone lesions at D8 and L1. The patient was treated with palliative therapy, including supportive care and tamoxifen, 20 mg/day. ■

LET US HEAR FROM YOU

In addition to Case Reports, readers are invited to submit letters to *Network* on any topic related to cancer in countries with limited resources for cancer treatment and research. Letters should be no more than 250 words. The newsletter staff reserves the right to edit letters selected for publication.

Send case reports and letters to Ian Magrath at INCTR in Brussels or to the editorial office of the INCTR at 15200 Shady Grove Road, Rockville, MD 20850. ■

ASSOCIATE MEMBERSHIP OF THE INCTR

The INCTR offers Associate Membership to corporations, academic institutions and other organizations, and individuals interested in participating in the INCTR's mission. Membership fees support INCTR programs, primarily administrative and meeting costs, and permit the INCTR to keep its members informed of its activities. For further information contact the INCTR in Brussels, or the USA Branch, whichever is most convenient. Addresses and telephone numbers are provided on page 5.

Corporate Membership: Corporations are invited to sponsor and to participate in educational and training programs as well as research studies. A Corporate Liaison Committee, including representatives of corporate Associate Members, will meet regularly to discuss how INCTR-corporate partnerships can help to improve access of patients with cancer in developing countries to the drugs and technology necessary for their treatment.

Institutional Membership: Institutions are invited to participate in educational, training, and research programs. An Education Committee, including representatives from institutional Associate Members, will be responsible for assisting in the development of specific professional educational programs, including the design of appropriate curriculae, and the organization of visiting professorship programs and workshops.

Individual Membership: Individuals who cannot otherwise participate in INCTR programs through corporate or institutional membership can become associate members if they make a significant contribution to INCTR programs through support of or participation in an INCTR activity or sponsorship of one or more trainees or patients in one or more developing countries. ■

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Editor's Note: In each edition of Network, a brief article about one of the institutions with which the INCTR collaborates will appear. These articles are solicited by the editorial staff.

CANCER INSTITUTE (WIA), CHENNAI, INDIA

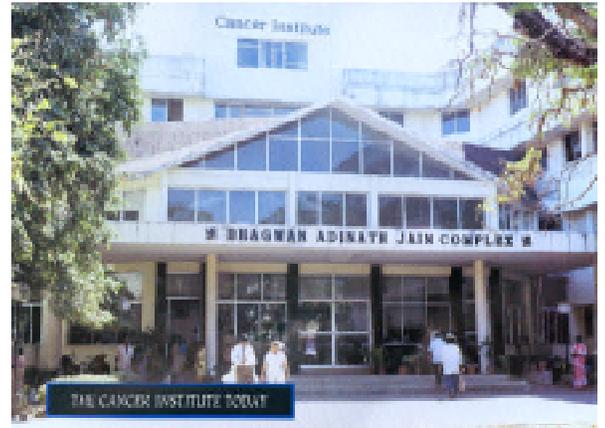
by Dr. V. Shanta
Executive Chairman, WIA

The Cancer Institute (WIA) was established in 1954 by the Women's Indian Association Cancer Relief Fund under the dynamic leadership of the late Dr. Muthulakshmi Reddy, India's first female medical graduate and a pioneer social reformer. It was at that time the first and only cancer facility in the South Indian peninsula and only the second in the country. From its inception, its guiding principle has been the multi-disciplinary care of patients, irrespective of social standing or economic status. It has grown from a few straggling huts and menacing financial insecurity to a comprehensive regional cancer centre of national importance and international interest.

In 1969, the World Health Organization, in conjunction with the Cancer Institute, established the first International Cancer Control Programme in the developing world at Kanchipuram, near Madras.

The Cancer Institute today comprises a 428-bed hospital, a research centre, a centre of preventive oncology and the Muthulakshmi College of Oncologic Sciences. Annually, 70,000 cancer patients from all over India pass through the Institute. Two-thirds of them are indigent, with fewer than one percent covered by health insurance.

The division of radiation oncology is the largest in the country with a



great tradition. It has an array of four linear accelerators, two cobalt-60 units and three remote after-loading brachytherapy units and supporting ancillary facilities such as a treatment planning system, interfaced CT scanner, simulator etc. One of the brachytherapy units is a product of the Institute's engineering and physics department. It was the first indigenous remote after-loading unit in India, built at a tenth of the cost of an imported one. A high dose rate interstitial brachytherapy unit is under development. The Institute pioneered a number of programmes on radiosensitisation of oral and cervical cancers and has collaborated in global international trials with the Medical Research Council of U.K., the IAEA, Vienna and others. It also introduced multi-modality treatment in the management of advanced oral and breast cancers as early as 1958, an evolution born of necessity and which today is the accepted state-of-the-art the world over.

Surgical oncology, still the solid foundation on which the cure of

The Cancer Institute in Chennai, India, provides the finest in diagnostic and therapeutic oncology to the poorest of India.

many cancers depends, includes teams for head and neck, gastrointestinal, thoracic, breast and gynaecology, genito-urinary and reconstructive (including micro-vascular) surgery.

Medical oncology, introduced as a distinct specialty in 1970, is the most expensive division to maintain because of the ever-widening areas of its application, the spiraling cost of new drugs, the increasing use of colony stimulating factors and wider use of peripheral blood stem cell infusions and marrow transplantation.

These three main clinical divisions are supported by state-of-the-art imaging services, haematology (including blood component therapy) pathology, cytology, cytogenetics, a prosthetic laboratory and a rehabilitation and counseling service.

The focus of research has been on the common cancers in South India,

viz, cancers of cervix, breast, oral cavity and pediatric leukemias. We are involved in identification of molecular aberrations (other than HPV) needed for converting a normal cervical epithelium to a malignant one, including those of the cell cycle regulatory molecules and cytokines. We are using differential display in an attempt to identify genes involved in radio-responsiveness in cervical cancer, and study molecular markers such as Cripto, amphiregulin and C-ErbB4 in cervical, oral and breast cancer in studies of their prognostic value. We are also attempting to develop tar-

geting treatment approaches using monoclonal antibodies raised against Epithelial Growth Factor Receptor in head and neck tumors. Minimum residual disease in T-ALL is being studied using Tal-1 & TCR gene rearrangement as markers. A randomised trial to evaluate the role of hyperthermia in the treatment of cervical cancers is ongoing (IAEA, Vienna & DAE, India).

The Dr Muthulakshmi College of Oncologic Sciences was established in March 1984, the first such college in the country to offer specialty training in surgical and medical oncology. Its alumni are heading various new

oncology centres and oncology wings of medical colleges all over the country. The college also runs the master's training courses for medical physicians and registers students for doctoral and post-doctoral research.

The centre for preventive oncology is a network of programmes rather than a physical entity. It consists of two main components—cancer prevention and early detection, and demographic and hospital registries.

The preventive program is essentially educational at both the public and professional levels. Rural-based educational programmes include the training of village health nurses (VHN) and multi-purpose workers in the detection of an abnormal cervix, and abnormal changes in the mouth and the female breast. Over 750 VHNs and 250 rural medical practitioners have been trained in early detection, including taking Pap smears. Rural training centres and cytology laboratories for screening have been established.

The fully computerized hospital and demographic registries at the Institute are rated highly. The hospital registry has good documentation and the follow-up division has over 80% lifetime followup of patients treated.

The demographic registry has provided the lead for cancer control activity in our area. The rising trend in lung cancer incidence in men and breast cancer incidence in women is ominous.

The registry is collaborating in a number of epidemiologic studies with Japan. A major tobacco survey and the impact of tobacco on mortality is ongoing with support provided by the World Bank, Clinical Trial Service Unit of Oxford, and the World Health Organization. ■

THREE JOIN NORTH AMERICAN BRANCH

Three distinguished cancer experts recently joined the Board of Directors of INCTR's North American Branch.

Carolyn Aldige is President of the Cancer Research Foundation of America and also serves as President of the National Coalition for Cancer Research, an organization dedicated to educating policymakers and the general public about the value of cancer investigations.

Dr. Ronald Barr is a pediatric oncologist, educated at the University of Glasgow and currently Professor of Pediatrics, Pathology and Medicine and Chief of Service, Hematology-Oncology at the Children's Hospital, McMaster University in Hamilton, Canada. Previously, he had been a member of the Faculty of Medicine at the University of Nairobi, assisting in the establishment of the first medical school in Kenya. Dr. Barr also is a member of the Treatment Committee of the UICC and the Committee for Pediatric Oncology in Developing Countries of the International Society for Pediatric Oncology.

Dr. Elmer Huerta received his medical education in Peru before completing a fellowship in oncology and a master's degree in public health at the Johns Hopkins School of Hygiene and Public Health. He subsequently completed a fellowship in Cancer Prevention and Control at the National Cancer Institute. Dr. Huerta is director of the Cancer Risk Assessment and Screening Center at the Washington Cancer Institute. His popular radio program "Cuidando su Salud" (Taking Care of Your Health) is broadcast on more than 70 radio stations in the United States and Puerto Rico. He also serves as President and Founder of Prevencion, Inc., a not-for-profit organization dedicated to providing educational materials to the Latino community in the United States. ■

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REGIONAL NEWS

Middle East

The INCTR Collaborating Unit in Saudi Arabia presently consists of three molecular biologists—Drs Marina Gutierrez, Vandy and Colin Hodgkinson—a research physician, Dr Assar Hussein, and a technician, Khalid Siraj. Dr Kishor Bhatia, who supervised Dr Magrath's Laboratory at the National Cancer Institute for more than 10 years, will become the Director of the laboratory program. Dr Robert Hewitt will become the Director of the Tissue Bank for the Research Center of the King Faisal Hospital, with joint appointments in the Department of Pathology and the INCTR laboratory. This is a strong group that should enable INCTR to couple molecular profiling to clinical trials, and make a major contribution to the study of the geography of neoplasia. With our long-standing collaboration with the National Cancer Institute in Cairo, which we hope will go from strength to strength, the INCTR has excellent representation in the Middle East and should be in a good position to develop new educational and research programs in this region.

South Asia

A new randomized study designed to examine the role of cranial radiation in the prevention of central nervous system disease in Indian patients (up to 21 years of age) with acute lymphoblastic leukemia (ALL) is in its pilot phase. The majority of patients with ALL in India still receive cranial irradiation, and since they tend to have more extensive disease than their counterparts in the USA and Europe, as well as different clinical features, it was decided to study the need for cranial irradiation by randomized clinical trial. The trial will be initiated later this year.

Southeast Asia

The Department of Pathology of Singapore General Hospital is soon to become an INCTR Collaborating Unit. Dr Ivy Sng, the head of the Department, will undertake the training of technicians and pathologists from Indonesia in preparation for the development of a SE Asian network for the characterization and treatment of non-Hodgkin's lymphoma.

China

Dr Rong Bu, MD, PhD, who is presently working in the department of Hematology/Oncology at Shanghai Children's Medical Center, will undertake additional training at the INCTR Collaborating Unit in King Fahd National Children's Medical Center, on the molecular characterization of

acute lymphoblastic leukemia (ALL) and its relevance to treatment. At the completion of his INCTR fellowship, Dr Bu will return to Shanghai to work with Drs Wang and Tang in the characterization of childhood ALL in China.

Latin America

Dr Sidnei Epelman has developed a protocol for the treatment of osteosarcoma which does not entail the use of high dose methotrexate. A pilot study conducted in both Brazil and the USA (in conjunction with the Children's Cancer Study Group) gave similar results to protocols which do use high dose methotrexate. High dose methotrexate is both expensive and difficult to handle in developing countries. In August, an INCTR Osteosarcoma Strategy Group meeting will take place in order to plan for the implementation of this or a similar protocol in several other countries.

Africa

Meetings will take place later this year with the Dean of the Faculty of Medicine of the University of Zimbabwe, Dr J Mufunda, to discuss the development of an INCTR Collaborating Unit in Harare. ■

FUTURE DATES

Meetings of the Steering Committee of the Global Alliance for the Cure of Childhood Cancer, the Education Committee, and the Corporate Liaison

Committee, to be held in Brussels, are planned for later this year. Look for details in the next newsletter edition.

A meeting to establish a Middle Eastern network will be held in Saudi Arabia from November 18-21, 2000. ■