

# NETWORK

THE NEWSLETTER OF THE INTERNATIONAL NETWORK FOR CANCER TREATMENT AND RESEARCH



Volume 1, Number 2, Autumn 2000 Inside this issue: INCTR Forms Global Alliance for the Cure of Childhood Cancer - 4 Regional News - 5 Partner Profile-NCI in Cairo - 8 Invitation to Attend Annual Meeting - 10

## THE PRESIDENT'S MESSAGE

### CAPACITY, COMMUNICATION AND COORDINATION - LEITMOTIFS OF THE INCTR'S STRATEGY

by Ian Magrath

"Cancer control" refers to the process of reducing illness and death caused by cancer through intervention (prevention or treatment) based on evidence. This principle applies as much to countries with limited resources as to those with extensive resources, although the problems in developing countries—as well as the patterns of cancers—are very different. Consequently, the slate of interventions and the relative priorities given to each cancer may differ markedly from one country or world region to another. The efficient control of cancer requires the availability of sufficient capacity (human and financial) and communication among the various participants in the process, to permit the establishment of coordinated programs that maximize available resources. The need for capacity is self-evident, but the primary importance of human capacity is worth emphasizing. Money makes things possible, but it is the quality of *human* capital that determines the success or failure



Attending INCTR's Governing Council meeting in Brussels were (standing, left to right) Kishor Bhatia, Tahir Shad, Anslim Narinesingh, Ian Magrath, Louis Schoofs. (Seated) Barbara Scheffler, Aziza Shad, Sultan Al-Sedairy, Dennis Wright, and Guy de Thé.

of any enterprise. Moreover, funds are more likely to be acquired when donors can be reassured that their contributions will be used wisely and efficiently,

Communication, for present purposes, refers to the use of information to enable or influence activities—for example, the use of information to determine where maximal impact can be made and to inform those with the ability to enact change. The exchange of information and the dissemination of the results are critical to cancer control. Information that is collected but not acted upon serves

no purpose. Cancer registration data, for example, that provides information about the incidence of cancer in a given region is only as valuable as the uses to which it is put. In conjunction with knowledge of how best to control specific cancers, information on the incidence of various cancers permits the development of policy—how, for example, available resources can best be used and what kinds of additional resources or programs may be required. It also may stimulate research into the genetic or environmental causes that produce a particular pattern of cancer.

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In countries in which communication is well-developed, access to the information needed to decide policy is good, as are facilities for conducting health programs. Even so, within the USA, the President's advisory panel has noted the "insufficient application of discoveries about cancer and inadequate access to appropriate cancer care" within the USA. How much more difficult is the situation in developing countries, where research is rarely conducted, where the necessary resources for clinical data collection may not be available, and where data that is collected is often of poor quality, not used at all, or used sub-optimally? There is often no coordination between those who collect data and those responsible for the early detection of cancer or the delivery of cancer treatment. Often, facilities for one or more of these activities are lacking. Even when excellent facilities for cancer care exist, primary care physicians and/or the public may be unaware of the signs of cancer so that patients are either not diagnosed

or are diagnosed only after an inordinate delay. In such circumstances, cure is impossible, or at best, requires the dedication of more resources and results in greater risks and inconvenience to the patient.

While cancer registration has been given a great deal of attention, data is still collected only from certain regions in approximately 50 of the more than 180 countries in the world. Limited though this information may be, it is more substantial than data on available resources for cancer control. The collection of such information alongside data on the incidence of various cancers would greatly facilitate the development of a rational and coordinated policy for building capacity for cancer control. The development of a comprehensive, coordinated, and durable strategy also will require information regarding the existence and quality of training programs in various cancer-related disciplines, the degree of involvement and funding from government departments of health, and the existence,

constitution, and goals of various cancer organizations. Cancer control, even in affluent nations, is usually conducted with less than optimal cooperation between the public and private elements. At the most basic level, and excluding primary prevention for the moment, there are three stages that need to be addressed: diagnosis of the patient, access to adequate care, and outcome measures (see Figure 1).

Presently, most of the available resources are put into treatment rather than primary prevention. Behavioural modification of the public and of the relevant industries requires a quite separate approach. To meet the needs of patients with cancer, there must be centers where a reasonable standard of cancer care can be delivered. Patients needing intensive chemotherapy, sophisticated surgery, or radiotherapy can be treated only in specialized centers, but smaller units may be able to deal with early stage cancers and palliative care. Yet in all developing countries, the fact that patients present with much more advanced disease than is the case in resource-rich countries is only too evident, and directing some resources at early detection would greatly relieve the overload on cancer care providers. Indeed, if cancer could be detected earlier, more patients would survive even without any enhancement of existing services for treatment. Early detection programs can be specific, i.e., screening programs with broad population coverage for particular cancers, but only a small number of cancers are amenable to such programs. There is no substitute for education of the public and of the health care providers that the public will first approach for help. Indeed,

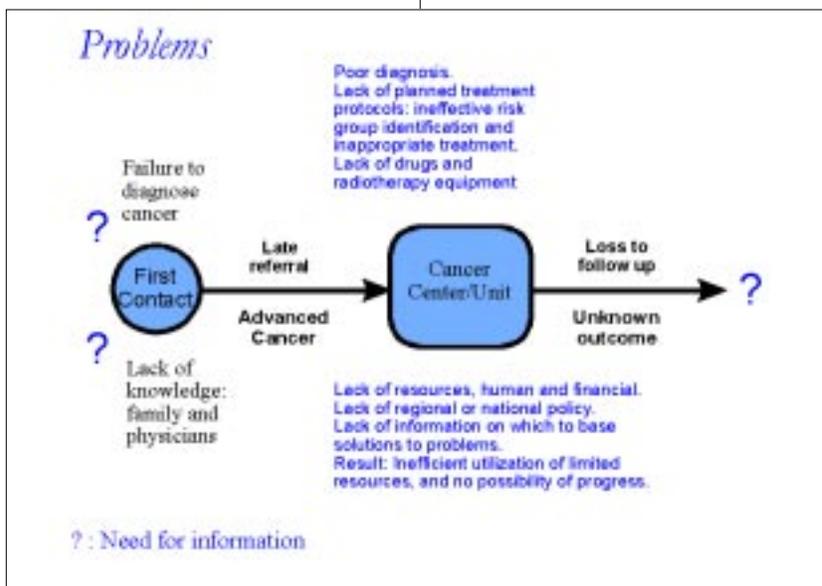
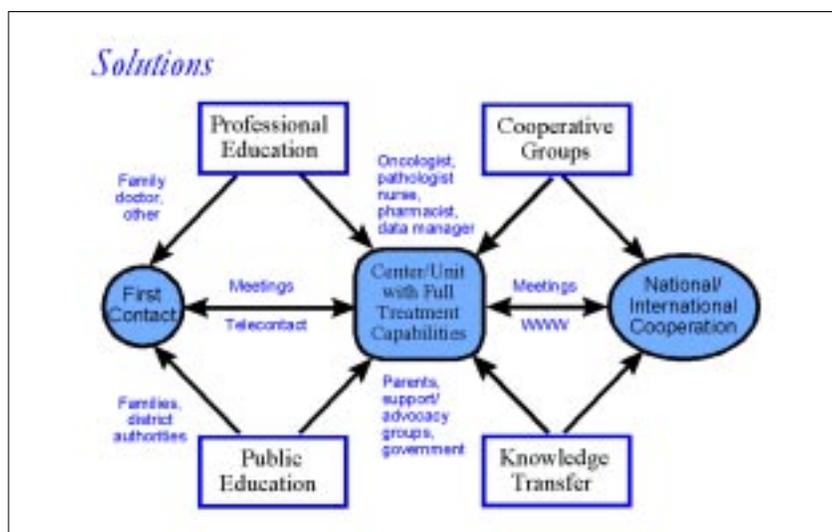


Figure 1. Problems



**Figure 2. Solutions**

one of the benefits of screening programs is that they raise awareness of cancer among the population at large and non-specialist members of the medical profession. Since the goal is to detect cancers at a curable stage, screening programs also carry the implicit message that cancer can be cured—an important message to transmit if individuals who suspect that they may have cancer are to be persuaded to act quickly. Equally important, this message needs to be received by primary health care providers, and by those responsible for the development of health policy.

One other element in the equation is often overlooked in developing countries—ensuring that patients are followed-up so that the efficiency of the interventional measure can be evaluated. Without such evaluation, the possibility always exists that precious resources are being wasted on ineffective measures. Educational attempts that do not reach their target audience, incorrect diagnoses, treatment that is ineffective or incomplete, and the collection of inaccurate infor-

mation may all compound problems. Moreover, just as cancer registry data provides a foundation for research into the causes of cancer and for the development of cancer control policy, so information on the efficacy of cancer treatment is essential if present endeavors are to provide a foundation on which to build. In countries with limited resources, not only the overall cancer pattern, but the pattern of subtypes within a disease entity, the accuracy of the diagnosis, the availability and quality of treatment, the tolerance of the patient for therapy, and the quality of supportive care may differ markedly from one country to another, and between resource-poor and resource-rich countries. It will be necessary to address each of these issues in order to optimize cancer control. Clearly, controlling cancer is an enormous task, but one more likely to be accomplished by a coordinated approach. The major points for intervention are shown in Figure 2.

The INCTR plans to work with colleagues in developing countries to establish programs designed to obtain information on available re-

sources, and on the reasons for late patient referral and loss to follow-up after treatment. With this information in hand, it should be possible to better utilize existing cancer services and to expand their resources in a fashion consonant with local needs. Initially, a series of pilot programs in the areas of public and professional (specialist and non-specialist) education, early diagnosis and treatment (in the form of internationally conducted clinical protocols) will be undertaken. In order to boost limited local resources the INCTR will institute consultation programs, visiting professorship programs and staff exchanges, and will utilize modern communications, including telemedicine, teleconferencing and teleimaging in training and education. It will be important to stimulate cooperation within countries and between countries—cooperation that starts with the major cancer centers or hospitals, but is spread, over time, to more peripheral hospitals. In addition, the INCTR will invite other major organizations to work with it in the development of its programs, utilizing their strengths and experiences, and helping to ensure that their knowledge and expertise are as accessible as possible.

This is no small task and success will be dependent upon building capacity as well as enhancing communication and coordination of effort. Globalization, in the economic sense, has been criticized because it enhances the ever-increasing gap between the rich and the poor. Global sharing of knowledge and experience, on the other hand, is the surest way to diminish inequalities, to build capacity, and to bring the benefits of modern science and technology to all, rather than to a fortunate few. ■

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## INCTR FORMS GLOBAL ALLIANCE FOR THE CURE OF CHILDHOOD CANCER

Representatives from the European Organization for Research and Treatment of Cancer (EORTC), the International Agency for Cancer Research (IARC), the International Society of Pediatric Oncology (SIOP), the National Cancer Institute (NCI), the Monza International School of Pediatric Oncology (MISPHO), the International Consortium for the Cure of Childhood Cancer in China (CURE) and the Oncology Center, Antwerp, gathered at the INCTR offices in Brussels on 4th December to discuss working together as a Global Alliance for the Cure of Childhood Cancer. The International Union Against Cancer and the St Jude Outreach Program also have expressed an interest in participating. In his introductory remarks, Dr Magrath described the concept of the Global Alliance as one in which organizations whose members have different expertise and experiences work together to develop an active program to identify the problems faced in developing countries in dealing with children with cancer, and to develop a coordinated strategy to overcome them. The combined strengths of the organizations would create an alliance encompassing a broad range of knowledge and experience as well as one of great credibility. Its mission would be to increase cure rates in children with cancer in developing countries.

All organizations expressed an interest in participating in the Alliance, and indicated areas in which they were already active in childhood cancer in developing countries, or areas in which they would be willing to

contribute. There was considerable discussion on the necessity of collecting data on existing resources for the diagnosis and treatment of pediatric cancer in developing countries in order to identify needs and to develop an overall strategy. Dr Eva Kramarova of the IARC proposed that an initial approach to the development of such information might be to utilize the existing network of cancer registries in developing countries which report to the IARC. This suggestion was well-received. Other areas of endeavor would include early diagnosis, which would necessitate programs of non-specialist and public education, specialist education, support for cooperative groups conducting clinical trials, and improvement of follow-up.

The participants agreed that a Steering Committee, with representation from each organization, would be responsible for coordinating

projects undertaken jointly by members of the Alliance, and for deciding upon the structure of the Alliance in the context of projects that it might undertake—e.g., the formation of specific subcommittees. The immediate goal would be to produce a detailed document spelling out the goals and mission of the Alliance, approaches to be used in reaching its goals, and measures of evaluation. A draft document prepared by the INCTR was provided. Each organization will comment on the document, propose modifications, and provide information regarding areas to which it would be best able to contribute. It was agreed that the document would be completed within three months, and a date was fixed for a meeting of the Steering Committee—immediately after the INCTR annual meeting, on April 21, 2001. ■

### NEW ASSOCIATE MEMBERS OF INCTR

Al-Sabeen Pediatric Hospital	Sanaa, Yemen
Avalon Pharmaceuticals	Gaithersburg, Md., USA
College of Medicine, Dept. of Child Health	Al-Khodh, Oman
Deutsches Krebsforschungszentrum	Heidelberg, Germany
Eli Lilly and Co, Lilly Oncology	Indianapolis, Ind., USA
Hammersmith Hospital, Div. Of Investigative Science	London, England
Lombardi Cancer Center, Georgetown University	Washington, DC, USA
Queen's University of Belfast, Dept. of Oncology	Belfast, Ireland
Saint Bartholomew's Hospital	London, England
Sanchette Hospital and Cancer Institute	Jodhpur, India
S Gerrado Hospital, Dept. of Pediatrics	Monza, Italy
Shaukat Khanum Memorial Cancer Hospital and Research Center	Pakistan
Sheba Medical School	
Dept. of Pediatric Hematology Oncology	Tel-Hashomer, Israel
Singapore General Hospital, Dept. of Pathology	Singapore
Texas Tech Medical Center	Amarillo, Tex., USA

## BARTS JOINS INCTR AS ASSOCIATE MEMBER

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St Bartholomew's Hospital School of Medicine, London, (Barts), has recently become an associate member of INCTR. Dr Ama Rohatiner, newly elected to serve on the Governing Council of the INCTR, also will serve as the INCTR liaison with Barts. It is proposed that an INCTR office be established in London, a likely venue being the East Africa Research Project (headed by Dr Arthur Levin, also an INCTR Governing Council member) at Barts.

It is hoped that staff members of Barts will take an increasingly active role in INCTR research and educational projects. Some collaborative activities are in the planning stages, or already underway, in Africa and the Middle East. In Egypt, bladder cancer accounts for approximately 25% of the patients seen at the National Cancer Institute in Cairo (see Partner Profile, in this edition of NETWORK). Dr Dan Berney, from the Department of Pathology at St Bartholomew's Hospital, is collaborating with Dr H. Khaled, Dr N. Gad el Mawla, and Dr Nadia Moktar in Cairo, in studying molecular tumor markers as prognostic factors in bladder cancer patients. The objective is to determine whether such markers correlate with clinico-pathological features of the disease at presentation (e.g. stage), and/or with prognosis.

Some years ago, Dr Levin and others described familial Burkitt's lymphoma in Tanzania. Further studies into the presumptive genetic nature of familial Burkitt's lymphoma are planned.

Lack of adequate follow-up of cancer patients, as mentioned in the

President's Message, is a serious problem in developing countries. In collaboration with Dr D. Arjarim, Dr A. Al Kofide, Dr A. Belgaumi, Dr M. Shoukri and Dr S. Brown of the King Faisal Specialist Hospital and Research Centre, Riyadh, Dr Levin is developing a project to monitor follow-up of lymphoma patients. The objective is to identify the problems and to develop approaches to ensure that treatment is completed, and that its outcome is accurately assessed. ■

## INCTR FORGES NEW TIES IN LATIN AMERICA

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Preliminary discussions have been held with pediatric oncologists in Lima, Peru (Dr Anthony Wachtel and Dr Ivonne Guerrero of the Instituto de Enfermedades Neoplasicas) and Bolivia (Dr Yolanda Ernst, Dr Maria Raquel Bravo and Dr Martha Alicia of the Instituto Oncologico del Oriente Boliviano) regarding future INCTR activities in these countries. In Peru, discussions have focused on retinoblastoma and virus-associated cancers. In Bolivia, discussions focused around the development of programs directed toward earlier diagnosis. A local support group, *Salvame*, is interested in working with the INCTR in this area of endeavor. The INCTR already has strong relationships with the Boldrini Children's Cancer Center in Brazil and the Instituto Nacional de Pediatria in Mexico, so that, at least in the area of pediatric oncology, Latin American links are strengthening. These countries all have a high incidence of cervical cancer, a disease which will be a focus for discussions in the next INCTR Annual Meeting, and which is also likely to become a focus of the US Branch. ■

## NEWS FROM THE NORTH AMERICAN BRANCH

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Barbara Scheffler has joined INCTR (USA) as a Board member and treasurer. A statistician by training, Scheffler has extensive experience in the development of new therapies for cancer. Now President of the Scheffler Group, which provides consulting services to the pharmaceutical industry, she previously served as Senior Vice President of U.S. Biosciences, with responsibilities for development and regulatory affairs activities.

The US Branch is planning to develop projects in Latin America pertaining to uterine cervical cancer.

We are pleased to report that the International Oncology Division of Bristol Myers Squibb has made a generous financial contribution to support the activities of the organization. ■

## INCTR-RELATED ACTIVITIES IN CHINA

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Drs Yaoping Wang and Jin Yang Tang are pediatric oncologists who practice at the Shanghai Children's Medical Center. For some years they have successfully treated childhood leukemia according to protocol MCP 841, which has been used extensively in India and Egypt by other INCTR collaborators. More recently, they have been instrumental in the formation of a small pediatric oncology group in Shanghai. The first protocol adopted by the group is for the treatment of pediatric non-Hodgkin's lymphoma. The INCTR has agreed to provide support for the development of this group, including the training of a data

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manager. Dr Rong Bu, a physician who recently gained his Ph.D. in Shanghai, is undergoing additional training in the molecular characterization of acute lymphoblastic leukemia in the INCTR-associated unit at the King Fahd Children's Medical Center in Riyadh, Saudi Arabia, under the supervision of Dr Kishor Bhatia. When Dr Bu completes his training, he will return to the Shanghai Children's Hospital and develop a laboratory program in leukemia studies to supplement the clinical program. ■

## INCTR HOLDS REGIONAL MEETING IN RIYADH

The first regional meeting of the INCTR, held jointly with the Research Center of the King Faisal Specialist Hospital, took place in November at the King Fahd Children's Medical Center (KFCMC) in Riyadh, Saudi Arabia. The meeting was organized by Dr Abdallah Al-Nasser, a consultant pediatric oncologist from the Department of Pediatric Oncology at the KFCMC, and made possible by the Director of the Research Center, Dr Sultan Al-Sedairy. Attending were delegates from 13 countries—Bahrain, Egypt, Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, UAE, and Yemen. The purpose of the meeting was to encourage the formation of a Middle Eastern Cooperative Group for Pediatric Oncology. A representative from each country was invited to provide information on the pattern of pediatric cancer at their own institution or within their country, and to comment on available resources. Didactic sessions were held on translational studies, acute lymphoblastic leukemia,

## VISITORS

This fall, the INCTR hosted several important visitors. Among them were:

**Prof. Mufunda**, from the University of Zimbabwe Medical School  
**Dr Jon Pritchard**, from the Institute of Child Health, London  
**Dr Sultan Al-Sedairy**, from King Faisal Specialist Hospital and Research Center  
**Dr Hussein Khaled**, from National Cancer Institute in Cairo  
**Mr Kenneth Kemper and Robert Martino**, from the National Cancer Institute, USA

## RECENT MEETINGS IN BRUSSELS

The INCTR held several meetings at its Brussels headquarters. Among them were:

Strategy Group for Childhood Osteosarcoma – August 17-20, 2000  
Corporate Liaison Committee – October 2, 2000  
Global Alliance for the Cure of Childhood Cancer – December 4, 2000  
Annual General Assembly – December 8, 2000  
Governing Council – December 9, 2000

palliative care, specialist education and training (including the role of the INCTR in such programs), then group discussions were held on four potential areas of activities for the new group—acute lymphoblastic leukemia, osteosarcoma, retinoblastoma, and infections in the immunocompromised host.

All delegates expressed strong interest in joining the group and in participating in one or more of the initially selected topics. It was decided to focus on further information gathering in the context of ALL, a clinical trial for patients with metastatic disease in osteosarcoma, collecting information on the reasons for late presentation in retinoblastoma, and to develop guidelines that would be used within the region for febrile

neutropenic patients and other aspects of supportive care. It was further decided that Dr Abdallah Al-Nasser would function as coordinator. An INCTR office will be established within the KFCMC for Dr Al-Nasser and a small staff. Further meetings will be held, but dates have yet to be decided. ■

## OSTEOSARCOMA STRATEGY GROUP

A meeting of this group was held in Brussels on August 18 and 19. The purpose of the meeting was to discuss a proposed schema for the treatment of metastatic osteosarcoma in children and young adults and to obtain an agreement among the investigators attending this meeting:

- to participate in the conduct of a multi-national protocol;
- to finalize the treatment schema for the proposed protocol;
- to identify potential problems in managing a protocol involving widely dispersed countries with varied resources; and
- to discuss the strategic expansion of the work of the group in the future.

The investigators were from institutions in Brazil, Mexico, Saudi Arabia, India, China, Taiwan and the Philippines.

The rationale for beginning with patients with metastatic disease is to keep annual patient accrual to a manageable number whilst identifying the problems that undoubtedly will be faced in collecting accurate data in a timely fashion from so diverse a

group, and developing strategies to overcome them.

During the meeting, the key elements of the protocol were discussed. These included:

- study objectives;
- the treatment schema;
- eligibility and exclusion criteria;
- ethical considerations;
- data management; and
- special biological and molecular studies.

A timetable for completion of the protocol document was established. A draft of the protocol document has been prepared and reviewed by a scientific panel. Investigators who participated in the development of the protocol have provided their feedback and responses to issues raised by the reviewers. Consultation with

respect to data analysis has been obtained from a biostatistician and an oncology pharmacist has reviewed procedures for the administration of chemotherapy. The revised protocol will undergo review by an INCTR-appointed Ethical Review Committee in January 2001 and it is anticipated that a final draft, incorporating changes stipulated by the Ethical Review Committee, will be available shortly afterwards for review by participating centers. We anticipate that patient accrual will begin in late February or early March. Once satisfactory systems for data collection and quality control are in place, the protocol will be expanded to include non-metastatic osteosarcoma patients, patients from centers associated with the present core group, and additional participating centers from other countries. ■

## APPLICATION FORM FOR ASSOCIATE MEMBERSHIP

We invite your institution/organization to become an Associate Member of the INCTR. If your organization is willing to support this international effort by helping build capacity for cancer research and treatment in developing countries, please complete this form and mail or fax it to the address below.

Name: \_\_\_\_\_

Company/Institution Name: \_\_\_\_\_

Department/Division: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail address: \_\_\_\_\_

INCTR at Institut Pasteur • Rue Engeland 642 • B-1180 Brussels, Belgium  
Tel: 32-2-373-9323/9322 • Fax: 32-2-373-9313

# NETWORK

*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.*

## THE NATIONAL CANCER INSTITUTE IN CAIRO

by Dr Hussein M. Khaled  
Vice Dean, NCI

### HISTORY

The development of modern oncology in Egypt is credited to two great surgeons—Professor Aboul-Nassr and Professor El Sebai. The idea of establishing a National Cancer Institute arose in the 1950s and it was eventually implemented through the determined efforts of Professor Ahmed Lotffi Aboul-Nassr. With the same enthusiasm, Professor Ismail EL-Sebai introduced radical surgery for cancer and trained a large group of Egyptian surgeons. Thanks to their efforts, Cairo University recognised oncology as a separate specialty in 1959.

The National Cancer Institute, including its hospital of 270 beds, opened in 1969.

### THE PROBLEM

In Egypt today, the number of new cancer patients per year is estimated to be 65,000. Accumulated patients represent about three times the number of new cases. This patient load will expand in the future as the population continues to grow and age, and as the prevalence of known etiological factors increases. Egyptian patients with cancer usually present at a relatively advanced stage in their disease, which has a negative impact on treatment results. The three most common cancers encountered are



urinary bladder (30%), breast (14%), and lymphomas and leukemias (12%).

Patients with cancer require repeated hospital visits and hospitalizations, sometimes over the course of several years. A child with acute leukemia requires about 132 hospital visits over ten years while a woman with breast cancer may require more than 20 visits over ten years. Since NCI is the largest comprehensive cancer center in the country, it is overloaded by patient referrals from all over Egypt, although in recent years eight small cancer centers have opened throughout the country. In addition to these cancer centers, six university-based clinical oncology departments operate in various parts of Egypt.

### PATIENT POPULATION

The NCI registry, over a 23-year period (1970-1993), included a total of 1,057,733 patient services, comprising 122,099 new cancer patients, 50,399 admitted patients, and 935,634 outpatient visits. About 38% of patients came from the Cairo metropolitan area, 40% from Lower Egypt, and 22% from Upper Egypt. About

**Cairo's National Cancer Institute, first established in 1969, is the largest cancer center in the Middle East.**

65% of patients are treated free of charge and private patients generally have health insurance which covers their costs.

### FACILITIES

The present hospital of 500 beds is the largest cancer center in the Middle East, and developed in stages. In 1989, the old NCI hospital was renovated at a cost of 6.6 million Egyptian pounds L.E., and in 1993, a new 230-bed hospital was opened, permitting more patients to be served. The total cost of the new hospital was 83.5 million L.E. (44.5 million L.E. from the Egyptian government, 25 million L.E. from foreign grants and 14 million L.E. from public donations). This project received valuable support from the USAID program of the American government, the European Union, and the United Nations Development Program (UNDP). With these successive enlargements, the number of new patients rapidly doubled, while the

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number of outpatient visits increased approximately ten-fold. In 1999, just ten years later, 20,000 new patients were seen at the NCI, and the number of outpatient visits totalled approximately 140,000 visits.

At the present time, the hospital includes a broad array of medical services. There are 14 operating theatres, an intensive care and recovery unit (36 beds), adult and pediatric medical oncology units, a pain control clinic, and a bone marrow transplantation unit. Radiotherapy facilities include three linear accelerators, three cobalt machines, two simulators, one deep X-ray therapy machine, and interstitial therapy after-loading capabilities. There is a nuclear medicine unit and a radiodiagnosis department equipped with standard x-ray facilities, mammography, computerized tomographic scanning, ultrasonography, and magnetic resonance imaging. There is a diagnostic endoscopy unit, several clinical pharmacy units, clinical pathology laboratories, a blood bank, a laboratory of surgical pathology, a laboratory of cytopathology, a cancer registration and epidemiology unit, a department of cancer biology, an electron microscopy unit, and an experimental surgery unit associated with an animal house.

## ACADEMIC PROGRAM AND RESEARCH

NCI offers academic degrees in various oncology specialties, including a master's degree in pain control, and doctoral degrees in surgical oncology, adult and pediatric medical oncology, radiotherapy, pathology, clinical pathology, and cancer biology. A total number of 58 master's degrees and 185 doctoral degrees have been awarded.

The NCI is the nation's first to receive international research grants to study cancer problems of particular importance to Egypt. During the past two decades, seven NCI staff members have received the National Research Award.

## COMMUNITY OUTREACH

NCI recognises its role in community health and maintains a positive attitude toward all cancer-related problems. It has active programs in cancer prevention and early detection through public education. It also plays an important role in educating doctors throughout Egypt who serve in various health care sectors via its visiting residency programs, continuing education programs, and staff visits to satellite clinics.

## INTERNATIONAL COLLABORATION

The institute has an active program of scientific collaboration with a number of international cancer centers which at various times have included the National Cancer Institute, Bethesda, USA; Institute Gustave Roussy and Lyon Hospital, France; the National Cancer Institute, Holland; Guy's Hospital, London; Karolinska Hospital, Stockholm, Sweden; and Health Care International, Scotland. Currently the NCI is an active member of the European Organization for Research and Treatment of Cancer (EORTC) in Brussels, Belgium, and participates in treatment protocols for cancers of the breast, GIT, and lung as well as lymphomas. The NCI has been recognized by the World Health Organization as a collaborating center in bladder cancer and head and neck cancer.

## PIONEER ACHIEVEMENT

- NCI is the world's first in bladder surgery (16,000 cases).
- Egypt's first to perform bone marrow transplantations (1988).
- Egypt's largest hospital computer network and integrated Hospital Information System (1992).
- Egypt's first to use computers in radiotherapy dosimetry (1992).
- Egypt's first Cytology Laboratory (1973).
- The nation's first Medical Oncology Department (1970).
- Egypt's first to use Iridium implants (1973).
- Egypt's first Tumor Markers Laboratory (1982).
- Egypt's first to screen anti-cancer activities of Egyptian plants in experimental animals. ■

## LET US HEAR FROM YOU

We welcome letters and case reports from our readers on topics related to cancer in countries with limited resources. Send your submissions to:

INCTR - Institut Pasteur  
Rue Engeland 642  
B-1180 Brussels, Belgium  
tel: 32-2-373-9323/9322  
fax: 32-2-373-9313

or

INCTR (USA)  
P.O. Box 7515  
St. Davids, PA 19087-7515  
tel: 610-527-4605  
fax: 610-527-3810

Visit our web site: [www.inctr.org](http://www.inctr.org)



## Please join us for our Annual Meeting

April 18-21, 2001

Hilton Hotel, Brussels

Program will include:

- Reports on INCTR activities
- An educational workshop on clinical trials methodology
  - Cancer in Africa
  - Cervical Cancer
  - Childhood Cancer
- Round Table Discussions on present and future programs

For additional information, please contact Bénédicte Chaidron or Elizabeth Dupont at:

Tel: +32 2 373 93 23 \* Fax: +32 2 373 93 13 \* e-mail: [edupont@inctr.org](mailto:edupont@inctr.org)

The INCTR web site, <http://www.inctr.org>, will be updated periodically with program information and includes an application form. If you prefer, you may complete the following form and return it by fax to the INCTR office in Brussels. Your quick response will assist us in planning the meeting. Please cross out what does not apply, and use one form for each person.

I **plan/do not plan** to attend the INCTR Annual Meeting.

Limited support will be available for participants. Please indicate below whether this will be needed.

I **shall/shall not** need support for travel.

I **shall/shall not** need support for accommodation.

I **shall/shall not** be accompanied by a non-participating companion.

I shall require a **double/single** room.

(Unfortunately, travel support and additional accommodation costs for non-participants cannot be provided.)

Name \_\_\_\_\_ Title/Position \_\_\_\_\_

Institute \_\_\_\_\_

Address \_\_\_\_\_

Country \_\_\_\_\_ Tel: \_\_\_\_\_

Fax: \_\_\_\_\_ e-mail \_\_\_\_\_

Please fax this form to INCTR at +32 2 373 93 13.