Pergamon

European Journal of Cancer Vol. 31A, No. 11, pp. 1723–1729, 1995
Elsevier Science Ltd
Printed in Great Britain

International Cancer News

From the Globe:

Smoke-free Skies Closer to Reality

Jetliners plying the skies over Europe, in common with much of the world, are more and more likely to be smoke-free, thanks to the combined pressure from passengers, flight crews and international health and aviation agencies.

In 1992, the International Civil Aviation Organisation (ICAO) of the United Nations issued a resolution calling for a total smoking ban on international commercial flights by 1 July 1996. Although not legally binding, the ICAO's recommendations are normally taken into account by governments of member states. The action followed a call by the World Health Organization for member states to ban smoking in public conveyences.

Progress toward smoke-free skies worldwide has been piecemeal, but the pace has picked up considerably in the last couple of years, trend-watchers say.

While accurate statistics are difficult to come by, Andrew Hayes of the European Cancer Leagues, Brussels, said he believes most domestic flights in Europe are now smoke-free. A small-scale 1994 survey by the London-based pro-smoking group FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco) found that smoking was banned on 71% of domestic flights in 63 countries and 22% of international flights out of Britain.

Most flights in Europe are international, Hayes added, so that the ICAO-recommended ban would have far-reaching effects there. (A progress report on the implementation of the ban was scheduled for September, after this issue's press date.)

An editorial in *Tobacco Control* (Spring 1994) summarised the problem:

> Nowhere is environmental tobacco smoke (ETS) exposure a greater risk than during a flight where many bodies are squeezed for long hours into a tiny space in which the tobacco smoke is recirculated. A billion air travellers every year are at risk, especially frequent flyers [and] children... An aircraft is also a workplace for hundreds of thousands of people. Flights expose flight crew and attendants to ETS for many hours at a time. The low humidity of the pressurised environment in today's aircraft magnifies tobacco smoke irritations of the lung, throat, nose, and eyes of those operating the controls...

In addition to the direct threat to passengers' and workers' health and comfort, the ICAO resolution notes that build-up of tar and other smoke constituents may adversely affect oxygen masks and contaminate environmental control systems.

AMONG RECENT DEVELOPMENTS IN SMOKE-FREE FLIGHT (COMPILED BY ASH FROM NEWS REPORTS):

- Smoking will be banned on all international flights from **Australia** by July 1996. The U.S.A., Canada and Australia had already agreed to ban smoking on all flights between these countries from March 1995. **New Zealand** may also join the agreement.
- **Icelandair** has banned smoking on all flights from 26 March 1995. The airline claims to be the first transatlantic carrier in Europe to ban smoking entirely.
- From the end of October 1995, the Dutch airline **KLM** will ban smoking on all its flights on European, North American and Australian routes. A spokesman said the decision to implement a complete ban on smoking on all but 200 of its 1300 weekly flights was in response to customer demand.
- The Irish airline **Aer Lingus** has extended its no-smoking policy to its transatlantic routes. In 1988 the airline implemented a no-smoking policy on all domestic and Irish Sea flights.
- **Lufthansa** airlines is introducing smoke-free flights between Frankfurt and Washington and between Munich and Chicago, adding to its existing smokeless flights to New York, San Francisco and Canada.

- Smoking is now banned on all **Air France** flights under 2 hours, and allowed only at special bars on long-haul flights.
- Smoking has been banned on U.S. carrier **Northwest Airlines'** transatlantic flights from London Gatwick to Boston and Minneapolis.
- **British Airways** is to ban all tobacco advertising from its in-flight magazines and in-flight interactive entertainment, in response to complaints from passengers. Revenue from tobacco advertising has been declining for some time in BA's in-flight magazines.
- All flights on Britain's **Virgin Atlantic** airlines, except those on the London–Tokyo route, have been made smoke-free.
- **New Zealand Air** has banned smoking on all flights from Europe after 80% of passengers in a survey demanded it. Almost 90% of the airline's flights are non-smoking.
- **Crossair,** a subsidiary of Swissair, has banned smoking on all flights after passenger polls convinced the airline the move would be popular.
- **The Federation of Tour Operators** have agreed to ban smoking on all flights from the U.K. of less than 6 hours, beginning in November 1995. Members of the federation control about 95% of all chartered flights from the U.K. to continental Europe. The smokers' rights group FOREST has urged smokers to boycott these flights in protest, and claims that package tour business is down as a result.
- **Singapore Airlines** has designated 90% of its flights smoke-free, including all flights except those to and from Japan.

Tom Reynolds

Smokers' rights groups such as FOREST scoff at such concerns, and indeed at the notion that secondhand smoke poses any danger to health or even to non-smokers' comfort. FOREST's publications claim that poor air conditions in aircraft cabins are caused, not by smoking, but by other factors including low humidity and flight crews operating ventilating systems at less than full capacity in order to save fuel.

The pro-smoking lobby appears to be having some effect, at least enough to cause concern among their opponents: a memo circulated by the co-ordinator of the International Non-Governmental Coalition Against Tobacco warned members that "there is some worry that a major lobbying effort has been going on to undermine final implementation of this [ICAO] ban". FOREST also claims that some European airlines have relaxed smoking bans after passengers protested.

Overall, though, it appears that FOREST and its ilk are paddling against the current.

In 1990, smoking was prohibited by law on all flights within the continental United States (99% of all U.S. flights, excluding only the longest flights to Alaska and Hawaii). Canada in 1994 became the first country to ban smoking on all domestic and international flights, while passage of a similar measure has stalled in the U.S. Congress.

Amanda Sandford of Action on Smoking and Health (ASH) in London said the trend toward smoke-free skies is "growing all the time... nearly every week we hear of another airline that has banned smoking on more of its routes. But unlike the U.S. where the ban was legislated, here it's the airlines that are taking the initiative". Many airlines have conducted consumer preference surveys, and the results show that most travellers would like to see in-flight smoking eliminated, she added.

Discussions aimed at a total smoking ban on transatlantic flights are under way. Representatives of eight airlines who fly these routes met in May and are planning future talks, although the airlines have to get a special waiver of anti-trust laws from the U.S. government just to meet. Delta Airlines has banished smoking from all transatlantic flights, while British Airways, American, and United have been widening their experiments with non-smoking flights.

Most respondents to a 1995 survey by the International Air Transport Association said they would favour a smoking ban on all flights. A majority of travellers from all regions supported a total ban, but Europeans were the most divided with 60% in favour, compared with 78% of North Americans and 72% of Asia-Pacific residents. Probably due to increased public sensitivity, even smokers may be willing to forego their habit while in the air: a 1989 survey by the American Association of Respiratory Care found that 58% of smokers supported the U.S. law in force at that time which banned smoking on flights of 2 hours or less.

The smokiest flights are transcontinental ones, particularly to and from Japan, Sandford said. Japanese men are both heavy smokers and heavy business travellers, and airlines aim to please their frequent flyers—whether smokers or not.

The rules are changing so fast that both smokers and non-smokers need to check constantly to find out which airlines will cater to their preferences, and on which routes. FOREST last year published a booklet listing airlines' smoking policies.

"It was quite a useful guide for both smokers and non-smokers, but it's already out of date", Sandford said.

Tom Reynolds
London, U.K.

Australia to Host First World Conference for Staff of Cancer Organizations

The first international conference to focus on the professional development of staff and volunteers in cancer leagues and societies will be held from 4 to 7 March 1996 in Melbourne, Victoria, Australia.

This World Conference for Cancer Organizations will be hosted by the Anti-Cancer Council of Victoria under the long-standing chairmanship of Dr Nigel Gray. The conference is sponsored by the UICC-COPES-Programme (Campaign, Organization, Public Education and Patient Support), which is dedicated to helping the development of member organisations' cancer control endeavours worldwide. It is hoped that the event will break new ground in a programme offering workshops and skills training aimed at people involved in community approaches to cancer control.

Formal keynote addresses will be given by some of the world's foremost cancer specialists, political lobbyists, policy makers, strategists, cancer educators, researchers, fundraisers and patient supporters. The overall theme of the conference will emphasize that fighting against cancer into the 21st century will be "everybody's business", and that effective organisation is necessary for success. The format of the meeting is intended to allow everybody to pursue a chosen theme at their own level and in a variety of styles.

A full conference brochure will soon be available. For more information contact: Dr. David Hill, Conference Secretariat, Anti-Cancer-Council of Victoria, 1 Rathdowne Street, Carlton South, Victoria 3053, Australia. Fax: +612-3-279-1250. (Based on press releases by UICC and Anti-Cancer Council of Victoria.)

The Lancet now "online"

The world's oldest and probably most prestigious medical weekly is available from August 1995 online in fulltext on DataStar. Currently in its 172nd year of continuous publication, *The Lancet* is read and respected throughout the world as an authoritative periodical for the dissemination of high quality news, research and opinion.

The Lancet receives 5,000 articles for publication annually and a similar number of letters. Of these, up to 90% will be rejected, ensuring that articles are of the highest calibre, rich in facts and highly topical. A publication, whose pedigree is unmatched, was further enhanced following its acquisition in 1991 by the leading science publisher Elsevier (now Reed–Elsevier). Since then Dr Richard Horton — at 33 years of age *The Lancet's* youngest Editor since its founder Thomas Wakely — has been appointed, and a New York-based editorial office was opened.

Now that the full text of this vital journal is available in electronic form via DataStar, it will be updated weekly and coverage is from January 1995 onwards. The text of the original publications is given in full, excluding advertisements and situations vacant. *The Lancet* will also be made available on DIALOG later this year. The price will be £40 or 60 U.S. Dollars per hour.

From Europe:

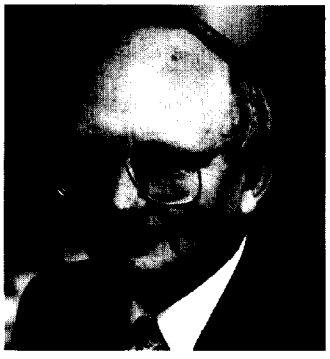
New Presidential Officers for the Federation of European Cancer Societies

It is with pleasure that the Federation of European Cancer Societies (FECS) announces its new presidential officers.

Professor Jean-Claude Horiot will succeed Professor Allan T. van Oosterom as President of FECS while Professor Niall O'Higgins becomes President-elect. Professor van Oosterom will in turn replace Professor Umberto Veronesi as Past-president. All new incumbents will take up their office immediately after ECCO 8 for a period of 2 years.

Professor Jean-Claude Horiot

Professor Horiot has held the position of Professor of Radiotherapy at the University of Dijon since 1972, becoming Head of the Department of Radiotherapy at the Centre GF Leclerc, Dijon in 1983. He is a Past President of the European Society for Therapeutic Radiology and Oncology (ESTRO) and a Board member of the International Society for Radiation Oncology (ISRO). He has also held a number of positions within the European Organisation for Research and Treatment of Cancer (EORTC) and it was mainly due to his efforts that quality assurance procedures covering the clinical aspects of cancer treatment became one of the priority areas of the EORTC treatment division. With his extensive experience in clinical research, fractionation in radiotherapy and long standing involvement in the practical procedures of quality control in patient data and treatment documentation, Professor Horiot is well placed to move FECS forward in a number of areas where its impact has yet to be felt.



Professor O'Higgins

Professor O'Higgins is Senior Professor of Surgery at University College, Dublin. He is a member of the Council of the Royal College of Surgeons in Ireland and is the national delegate for Ireland for the International Society of Surgery

and the Irish representative on the World Federation of Surgical Oncology Societies. Professor O'Higgins also serves as the Director of the Department of General Surgery at the European Institute of Oncology, Milan, and is a member of the Scientific Committee of the European School of Oncology (ESO). He has held visiting professorships in Bahrain, Canada, France, Greece, Kuwait, Malaysia, New Zealand, Saudi Arabia, Singapore and the United States of America. In 1994 he was elected President of the European Society of Surgical Oncology (ESSO). His current interests are in breast and endocrine diseases.

Professor van Oosterom is currently Head of the Department of Oncology, University Hospital and Professor of Oncology at the University of Antwerp. He has held a number of honorary offices in the European Society for Medical Oncology (ESMO) including that of President. He continues to play a major role in the work of EORTC where he is Chairperson of the EORTC Treatment Division. An honorary member of ESTRO, Professor van Oosterom also serves on the councils of the Centre Rene Hugenin, St Cloud, and Institut Gustave Roussy, Villejuif. Professor van Oosterom has a long association with clinical research, mainly focused on chemotherapy, and has made seminal contributions to evaluating the environment in which chemotherapy is applied, toxicity documentation and process description. His current interests include soft tissue and bone sarcomas, genitourinary cancers and new drug developments. During his presidency and under his guidance, FECS established its new base in the same building as EORTC in Brussels and it is to be expected that his major contribution to the development of FECS will continue into his period as Past-president and beyond.

Professor Veronesi is currently Director of the European Institute of Oncology in Milan. He has spent the majority of his professional career at the National Cancer Institute, Milan, first as a pathologist and subsequently as a surgeon, being appointed Director of the Institute in 1975. Professor Veronesi's career is both long and illustrious. Among the positions he has held, or continues to hold, are President of the European Society of Surgical Oncology (ESSO), President of the International Union against Cancer (UICC), President of the EORTC, President of the FECS, Chairperson of the International Group for the Study of Melanoma of the World Health Organisation (WHO), Chairperson of the Scientific Committee of the European School of Oncology (ESO) and Chairperson of the European Commission's "Europe against Cancer" Programme Committee of Cancer Experts. The success of FECS, and in particular ECCO — the European Cancer Conference, is very much the result of the vision and energy invested in it by Professor Veronesi and similarly minded colleagues since the early 1980s.

The EORTC New Drug Development Programme Restructured

The EORTC in a Board "brain-storming" in Zürich, Switzerland in the summer of 1994, declared the acquisition and subsequent development of new anticancer drugs and approaches as one of its "spearheads" for the coming years. An efficient system has evolved over the past years, linking preclinical scientists and medical oncologists into a coherent network, supported by two scientific offices:

The EORTC New Drug Development Office (NDDO) in Amsterdam, The Netherlands is involved in preclinical research and development activities, as well as early clinical trials up to early phase II; the EORTC Data Center in Brussels, Belgium focuses on late phase II and phase III trials. This recently streamlined EORTC structure safeguards scientific input from expert committees and leading co-operative groups, as well as professional project management.

EORTC launched a special brochure on this topic in summer 1995 to increase the awareness of the important changes in this area. It also successfully introduced a new form of project management in 1994, clearly identifying the timeframe and subsequent steps of drug development. Among others, this has led to the initiation of seven new collaborative agreements of the NDDO with international pharmaceutical industries, both at the preclinical and clinical level.

Moreover, with the support of several Cancer Leagues (especially the Dutch and the Swiss Leagues), as well as with industrial support, a new programme for the development of unsponsored drugs was set up, based on interesting new data via the EORTC screening system. The EORTC Research Division aims to rapidly evaluate the potential value of new approaches coming from basic science. In addition, an EORTC Drug Master File (DMF) on the standard operating procedures for early clinical trials has been submitted to the U.S. Food and Drug Administration (FDA), and important contacts have been set up with the newly established European Medicines Evaluation Agency (EMEA) in London, heading for the development of respective Pan-European guidelines.

Obviously, these efforts are aimed at increasing Europe's contribution to global drug development in the near future. The EORTC feels increasingly confident to set future standards for rapid high quality new drug development via its unique network.

The NDDO is pleased to periodically report on these important evolutions in the "News" and in the scientific sections of the EJC.

Coen Van Kalken
Amsterdam, The Netherlands

The Protocol Review Committee of the EORTC: Changes and Opportunities

Many physicians would regard someone who enjoyed committees as showing signs of either existential confusion or of mental instability. I share this opinion but every now and then a committee is formed on which it is exciting to work because its purpose is scientific; membership is then a pleasure. I have participated in only three committees of this kind and the latest is the Protocol Review Committee (PRC) of the EORTC.

Over the years the EORTC has, through its working parties, developed considerable expertise in the design and execution of treatment trials in cancer. Its studies have become highly regarded and some of them are a major contribution to the science of cancer treatment. This has not happened overnight since the role of working parties and the way in which they work and develop protocols has evolved slowly. In recent years the Data Center in Brussels has expanded and increased its data management and statistical capacity. We now expect the EORTC studies to represent the highest standard of cancer care and to address the most pertinent areas in cancer management.

Although it has not been the only factor driving forward this

process of improvement and refinement, the PRC has certainly played a central role. I believe that the general public and their political representatives would be impressed and reassured if they understood the way in which the committee works and the manner in which trials are generated and monitored.

Ideas for studies clearly emerge from knowledgeable and informed experts within the working parties. Worthwhile studies depend on the expertise and scientific imagination of the clinicians who form these groups. It is they who read the literature and they who run their own units and specialise in the new forms of treatment which are emerging. We rely on their judgement to know which treatments are likely to produce advances and which are worth testing, either as exploratory treatments or as major randomised trials in which a new form of treatment is being assessed against a generally accepted standard treatment.

The PRC's task is to evaluate these new ideas, and to decide whether they justify the allocation of time and resources to become EORTC studies. The range of tumours, and the many different kinds of trial design which might be suggested, means that the PRC must have a membership which draws its expertise from a variety of different specialities within cancer. It needs members who are fair-minded, independent of outside influence, and who use their own judgement. The individual membership also needs to reflect the different approaches which may be found in different European countries. At a single meeting, the PRC may, for example, have to consider a Phase I study in metastatic breast cancer, a randomised Phase II study in advanced ovarian cancer, and a large scale intergroup trial in testicular cancer. Is it realistic to expect that a high standard of independent review can be maintained in the face of this diversity?

In the last few years we have begun to refine the process of protocol review. We are now asking the working parties to submit their outline suggestions in a brief document which clearly states the purpose of the study, the way in which it is to be carried out, the eligibility criteria, the statistical guidelines and the likely recruitment. Each member of the PRC receives all of these outline protocols but each is also sent to three or four independent external reviewers for their comments. At the meeting of the PRC the chairmen of the working parties concerned are invited to come and present their ideas to the committee. The committee has the final judgement, which is based on the independent views of the committee members and the external referees. Measured and detailed debate of each protocol ensures, I think, that a fair and reasonable decision is made about whether the basic idea and the design of the study is worthy of development into a full protocol.

If such development is thought desirable, the working party is then asked to draw up a full protocol, but it does this in conjunction with the Data Center who supervise the protocol development. In this way standard procedures are followed for statistical guidelines, toxicity scoring, data monitoring and definition of outcome measures. After the full protocol has been prepared it is sent out for further independent review before the protocol is finally activated. At the point at which the draft protocol is accepted the PRC now has the advice of two additional units within the EORTC; one concerned with quality of life and the other with economic assessment of the results of treatment. This gives two new dimensions to the EORTC studies. Not all trials justify the use of quality of life or economic assessment but, increasingly, such evaluations are secondary, or even primary, endpoints in studies. The methodology of quality of life and economic assessment in trials is still in its infancy but the EORTC is playing an important role in introducing this aspect of trial design and execution.

It requires a certain deftness of touch on the part of the committee, and its long-suffering chairman, to maintain this careful monitoring influence without injecting an unwieldy and frustrating bureaucracy. We probably do this reasonably well having adopted various short cuts in the system of protocol review. For example, we have devised a system of master protocols for use in Phase I and Phase II studies in which the guidelines are clearly set out and can be adapted for a variety of new drugs and treatments. This process is also being refined. The master protocols are themselves being adapted to individual diseases so as to allow still greater standardisation and the avoidance of frustrating delays in assessment. Nevertheless, there is a balance to be struck between efficiency and meticulousness. The PRC has to be the guardian of high standards and, if this takes little time, the working parties have to accept it and live with it.

In the last year, the PRC has accepted a still wider assignment. This has been to assess recruitment into current trials and to recommend review of trials which are not recruiting well, and which should probably be closed, so that working parties can move on to different studies; we do not think it reasonable that a working party puts forward proposals for a new study when it can't complete those it has in progress. This discipline is essential for a well-run trials organisation.

An exciting recent development has been the acceptance by the EORTC that the PRC also begins to define certain aspects of trial design and execution which are still poorly formulated and a source of confusion. We are beginning a series of meetings in which the PRC formulates its ideas and makes recommendations about some key issues of trials design. We plan, for example, to have detailed discussions about the use of randomisation in Phase II studies, the role and constitution of data monitoring committees, and the practical use of stopping guidelines in large studies. These are weighty subjects and ones where, hitherto, the EORTC has not formulated a precise strategy. This is not a criticism of the EORTC, since very few other trials organisations have a clear idea of their attitudes and *modus operandi* with respect to these aspects of clinical trials. We hope that the PRC will help to set standards of excellence and practicability as a result of these detailed reviews.

From all this it is clear that the PRC is not just another boring committee. It is a part of clinical science and contributes to it. Our intention is to develop the role of the PRC in order to maintain the reputation of the EORTC as one of the world's leading cancer trials organisations.

Robert L. Souhami

From the Nations:

This section will focus on a different country for each issue

Switzerland

The Swiss Cancer League has a new president from summer 1995: Prof. Dr. med. Urs Metzger, Chief of the Department of Surgery at the "Triemli-City-Hospital" in

Zürich. Urs Metzger is a longstanding Consulting Editor to, and manuscript reviewer for, EJC. He is also well known to many EJC readers and EORTC officials by his former position as secretary and later as chairman of the EORTC Cooperative Group on GI-Cancers and his presidency of the Swiss Association for Clinical Cancer Research (SAKK), a position from which he only recently resigned in favour of his new part-time responsibilities with the Cancer League.

How Dangerous are the Health Professions? A recent survey of the Swiss National Accident Insurance Company (SUVA) in approximately 300,000 health care workers in hospitals, medical offices, pharmacies and medical research laboratories in the country, identified a total of 232 cases of "accepted professional injuries" between 1989 and 1992. The leading causes were skin problems (59.9%), followed by musculo-skeletal health problems (22.8%), infections (13.8%) and diseases of the respiratory tract (3%).

It was deduced, that the high rate of skin and infectious problems reflected the relatively high exposure of this working group to chemical and microbial noxes.

After all, the distribution of "injuries" in health care workers is very different to the corresponding one in the general working population of the country: musculo-skeletal diseases (44.6%), followed by skin problems (28.6%), respiratory injuries (9.2%) and infections at work (2.8%). After all the talking and writing about potential health hazards of oncology nurses by the frequent handling of cytostatic drugs, it is reassuring for the oncology nursing community and their hospital directors and medical partners, that no cases of cytostatic drug injury were reported in the 3-year period.

It has to be stated, that Switzerland in 1985 was one of the first countries on the European continent to regulate the safe handling of cytostatic drugs by protective procedures, enforced countrywide by SUVA monitoring.

Swiss Government (Bundesrat) in Bern gets active on Tobacco and Health. After years of cautious, diplomatic delays, the Bundesrat in its weekly session of 16 August 1995 rather suprisingly accepted a package of measures to strengthen smoking prevention and diminish tobacco health damage in the country. These measures include among others: (1) cutting down the number of juvenile smoking beginners, (2) increased support for individuals, willing to quit smoking, and (3) intensified measures against passive smoking in the public and professional environment. Instead of meagre federal 0.6 Mio Sfr. (£300,000) per year as up to the present, 2.5 Mio Sfr. (£1,200,000) shall be spent for smoking prevention, promoting education and research. The Federal Office of Health in Bern is willing to collaborate with all (public and private) forces in the country, which engage in the fight against tobacco health damage.

Although laudable, especially from the oncologist's point of view, this is probably less than 5% of the money, that the national tobacco industry is investing in cigarette advertisements annually! Nevertheless, the national government for the first time publicly admitted, that tobacco-induced health damage represents the largest single health problem of the country, causing more than 15% of annual mortality, 9% of potentially lost years of life under 65, and more than 1 billion Sfr. (£1/2 billion) of health expenditures annually in a small country of 7 million inhabitants.

Hans-Jörg Senn
St Gallen, Switzerland

From the Journal

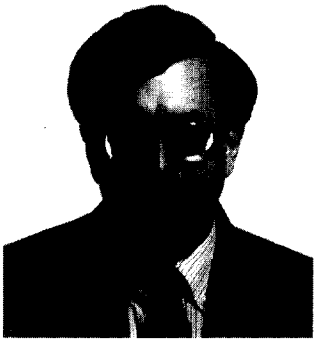
Editor for Experimental Oncology

Professor Ian Hart

Professor Ian Hart, Ph.D., FRCPath, Richard Dimbleby Professor of Cancer Research, United Medical and Dental Schools, St Thomas' Hospital, University of London, U.K. has been the "Science Editor" of the EJC since 1993. He became "Editor for Experimental Oncology" in June 1995 and is solely responsible for this section of the Journal, Professor Hart also represents the interests of the European Association for Cancer Research (EACR).

Professor Hart was trained in Bristol, U.K., with extensive additional research training at the NCI Cancer Research Facility in Frederick, Maryland, U.S.A. thereafter being a principal staff scientist at the ICRF Laboratories in London, U.K., before moving to his present position in 1993. He is also Co-Editor-in-Chief of the journal *Cancer and Metastasis Review* and is a Visiting Professor at the Division of Biomedical Sciences at King's College in London, U.K. as well as a member of numerous national and international cancer research associations.

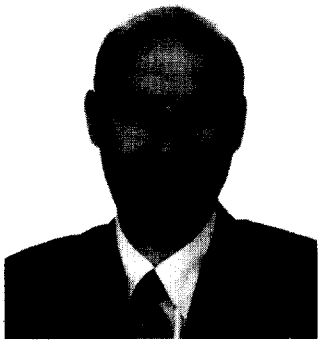
New Associate Editors



Dr Daniel C. Ihde

Dr Daniel C. Ihde, M.D. From 1978 to 1984, he was Editor-in-Chief of the *Journal of the National Cancer Institute.* From 1984 to 1986 he was Editor-in-Chief of the NCI's PDQ Editorial Board. Since 1994, he has served as Chief, Medical Oncology, Washington University School of Medicine, St Louis, Missouri, U.S.A. Since assuming this position, he has been working to strengthen the Unversity's medical oncology department and to develop a broad range of services. Since 1991, Dr Ihde has been on the Oncologic Drugs Advisory Committee of the U.S. Food and Drug Administration. Throughout his tenure at the National Cancer Institute, where he served as Senior Investigator at the NCI-Veterans

Administration Medical Center and later as Deputy Chief (clinical) and Head, Clinical Investigations Section, NCI-Navy Medical Oncology Branch at the NCI, Dr Ihde has been acknowledged as a creative and rigorous clinical investigator. Prior to assuming his post at Washington University, he served the NCI as Deputy Director.



Professor Silvio Monfardini

Professor Silvio Monfardini, M.D. serves as Scientific Director of the Centro di Riferimento Oncologico of the Italian National Cancer Institute Branch in Aviano, Italy. He is also the centre's Head of Medical Oncology and a frequent lecturer in medical oncology at Udine Medical School, Italy and has previously been a longstanding senior staff member at the National Cancer Institute in Milano, Italy.

Silvio Monfardini joined the EJC as Associate Editor for Geriatric Oncology (Cancer in the Elderly) — an ever growing health problem — in June 1995, being the chairman of the EORTC Cooperative Group on Cancer in the Elderly. He is also an organiser and moderator of oncology courses and, as a faculty member with the UICC and ESO, the editor of UICC's manual on Medical Oncology and a previous president of the European Society of Medical Oncology.

Dr Jon Pritchard

Dr Jon Pritchard, FRCPath is a consultant paediatrician at the Department of Haematology and Oncology, Great Ormond Street Hospital for Children in London, U.K. He became the first full time oncologist at this world-famous paediatric institution in 1977.

Jon Pritchard joined the Editorial Board of the EJC to enhance the coverage of Paediatric Oncology in early 1995, and became an Associate Editor in June of this year.

Jon Pritchard's principal laboratory interests are the molecular pathology of childhood solid tumours and the pathogenesis of histiocytosis. Over the past 15 years he has been the co-ordinator of national and international trials on paediatric solid tumours and a founder of the European Neuroblastoma Study Group, as well as the SIOP paediatric liver trials and chairman of the Nikolas Symposia on the Histiocytoses. He is also an enthusiastic advocate of clear and concise communications in medicine.

The Scientific Editor

Dr Delphine Purves

Delphine Purves, Ph.D., started her present position as the "Scientific Editor" of the EJC in summer 1993. Having trained and worked in experimental pathology, toxicology and microbiology — and having acquired extensive additional experience in biostatistics computers and databases — Delphine Purves is well qualified to run the EJC's extremely busy Editorial Office, together with Brad Timms, Editorial Assistant. She is mainly responsible for the assessment of the scientific validity of manuscripts, the commissioning of reviews and editorials, the organisation of the "running orders" of the journal issues, together with the Editor-in-Chief.

Delphine Purves clearly is a central person in the whole editorial logistics of the Journal and stays in direct and constant contact with our publisher, Elsevier Science Ltd in Oxford, U.K. as well as with the EJC's Editor-in-Chief in St Gallen, Switzerland.