The original documents are located in Box 2, folder "9/27/74 - Breast Surgery (1)" of the Sheila Weidenfeld Files Files at the Gerald R. Ford Presidential Library.

Private dinner before visit to hospital.

THE WHITE HOUSE

WASHINGTON

Dinner at the White House

Saturday, Sept. 29th

Cocktails 5:30

Dinner 6:P.M.

President Ford

Jack Stiles

Susan

Gardner Britt

Gayle and Michael

Janet Ford

David Kennerly

Robert Mayer

THE WHITE HOUSE

WASHINGTON

Menu

Broiled Sirloin steak

Fresh Broccoli

Baked Potatoes

Tomato and Watercress Salad

Desert by choice.

THE WHITE HOUSE

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Douglas

Thurs am - 10:30 - reg gyn - Knab chf dept Ob & gy

Thurs nite - Lukash exam

BF in WH - Fouty & Thistlethw there. -

3-4 days before final pathol report - pt of lymph[?] tissue

right breast - cntr -

vital signs - bld pressure - normal

1:30 was still in recov rm

she has many friends who've had same operat

tumor 2 cnts round - less than an inch - recovery 76% if hasn't spread - (in stnd radical masectomy)

Dr Jouty

THE WHITE HOUSE

WASHINGTON

She's not been on trang or any specif medication - normal post op care, inc dpg, pain

depres normal react 3-4 days after

hoped this wld help on early tes

Patho Repts

Dr. Henry Jason Norris
chf, gynec + breast
armed Frces Pathology
Institute of (not here)

Cmdr Robt Karnei - head
anatomical + surgical
pathol div at BNH

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anesthe - ① Capt Robt Van Houten
chmn dept anesthes BNH

② Lt Cmdr Myer Rosenthal

Dr. Fauntz, This,

③ Dr Herbert Steinel
asst to Dr fauntz - on
surg staff at WH

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Barbara Manfuso (a classmate of Susan's at Holton Arms) who was a guest at the dinner in honor of President Leone last Wednesday.).

THE WHITE HOUSE

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Briefing – 12:25

? Lukash –
c Fouty – chief of Surgery. Wn.
Thistlewaite – J. Richard
civ. con. Beth. – P/ Sur.
Roberts. G.W. Med. Sc

Fouty – Sur.
nodule – Malignant
Sw. one of breast.

B/ V. well
procedure. highly satisfactr
prognosis excellent.

inner strength
close family. doctrs.

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7 - opn. suite

8 - sup

15 mins remns
path.

Surgeon for breast.

complete 11:15.

B/F. Thur. a.m
conn eye exam

Capt. Douglas Knab.

decided no duels

1 yr - 7 mos ago.

B/F not aware 1 problem.

THE WHITE HOUSE

WASHINGTON

Dr. Fouty —

re: excision & biopsy.

2nd opinion - Thistlewaite.

7 p.m. W.H. Thu

examined & confirms

P. & B/F enter hosp. Fri p.m.

Rec. Rm. Dr. Herb Steinel.

THE WHITE HOUSE
WASHINGTON

Gen. Anesthesia.
Capt. Robt Van Houten.

Dr. Henry Jason North
Cmdr. Robt. Carney

Removal primary tumor in breast tissue
Lymph nodes 2 centimeters in size
subsperiory condition

Lymph bearing
Mastectomy - standard radical
Muscle + lymphoid tissue.
anterior chest wall
just under arm -

all gross tumor

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WASHINGTON

favorable early detection.

Last exam in March
developed since then.

---

in Hosp.

Opn. 2½ hrs.

into Wachael -
gas & drugs -

---

approx 10 days in hospital
not at present time

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WASHINGTON

B/F. close friends -

P. IT Rec. RW.
discussed -

B/F awake - Found told Res.
and are before Surgery.

Routine examination for tumor.

average size

further therapy

pathological exam

Patient comfortable.

Major operation

3 - 4 wks convalescence.

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WASHINGTON

Age no real bearing -

no - cancer detection.

biological activity of tumor

---

early detection

NO - bi monthly examination

self - breast examination.

7 mos -

physical exam.

Breast

medial. pectoral muscles

lymphs. under arm.

---

lymphoid tissue outside breast

pathological.

prognosis - favorable.

THE WHITE HOUSE

WASHINGTON

Right side of breast
close to center - upper part
of right side.

Carcinoma recur?
very individual -

---

routine gyn exam
Dr. Douglas Krab. Hosp.
Chm. Obstetrics & Gynecology.

—

B/F. green light.

no specific medications

---

normal convalescence
written am - 11 a.m.

THE WHITE HOUSE

WASHINGTON

exceedingly well

no

B/B stable

vital signs —

quite satisfactory

W. H.

2 continuous - round.

Little less than an inch.

Recovery Room - 1 P.M.

Recovery 76°: if no spread.

3 of 4 chance of survival.

THE WHITE HOUSE

WASHINGTON

3 - 4 days.

Final pathological report for spread

60 to 70,000 each year

---

tumor in lymphoid tissues.

no evidence of spread.

---

final report will give involvement.

Pdpath'on ex

Forty - ohio st. U. Med.

46

San Diego. N. Hosp

active duty 18 yrs

9 yrs Bethesda.

100

THE WHITE HOUSE

WASHINGTON

Thurs - a.m. 10:30 -

on no standard medication.

patients - 2 others.

w/o th. Conf.

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WASHINGTON

Susphcious
intuhion

Pat

Dr. Henry Jason Norris
ch. gyn - Breast
AFIP -

Cmdr. Robt. Warner
Hd. An... & Surg. Div
Beth

---

anesth -

Capt. Robt. Van Houten
ch. Dpt. of anes
Lt/Cmdr. Myer Rosenthal
cmdr. Herbert Steinel - sur
surg. staff.

THE WHITE HOUSE

WASHINGTON

R.N — called
Last night.

THE WHITE HOUSE

WASHINGTON

Myer - Prentiss Clinic
Detroit

Phone 295-1094

Cdr. Robert A. W. Williams
Commandant of Hosp.

THE WHITE HOUSE

WASHINGTON

Surgeon Dr. William Fouty
Gen. Surgeon.

Nurses: 7 AM - 3
Lt. (J.G.) Kathy Stoessel

3 PM - 11
Lt. (J.G.) Jeanie Stouffer

11 PM - 7 A.M.
Lt (J.G.) Katherine Rodrigue LA.

Lt. Joanne O'Brien - Seattle
VIP Telephone desk -
W.H. Nurse -
With Dr. Burch.

8:30 A.M.

Lt. HARRELL

Miss Angela Danza - Corps Wave.

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WASHINGTON

8:05 a.m. into Surgery -

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[illegible]

[illegible] [illegible]. [illegible] [illegible] [illegible]

R/R is [illegible] [illegible].

M [illegible]..

[illegible] [illegible] [illegible]. 12:30
not sw.

[illegible] B/F.. 11?

Lv. w/H.

[illegible] op is [illegible]
Bi[illegible] - [illegible] [illegible].

H/s family —.
[illegible] [illegible]. [illegible] [illegible] wake-up
suite 7:10
no. 8:05 [illegible]

checked in March. Res. Zaoli.
B/F awoke at 6 - sitting room.

THE WHITE HOUSE
WASHINGTON

B/F. before leaving suite.
Spirits - great.
Laughed - giggled about
w/ shootings.

Susan

Mike Reo -

No Breakfast.
Louise / Peter.
Mrs. Abbruzzi - Little girl

5:55 - checking.
Katherine 2fl:2. (for B/F)
6 1402

Suite.
Williamsburg blue - yellow accents.
B/ Beige -
all flowers from Pam
3 bouquets.

THE WHITE HOUSE

WASHINGTON

Pres. calling ?

Rev. Billy Zeoli.

Susan: 6 a.m.

?

involve football.

Dallas

sports - players.

"Evangelist"

young people

up-dated version

printed for young people

Grand Rapids -

THE WHITE HOUSE

WASHINGTON

T.V.

Ohio speaking.

[illegible].

~~Mitch~~ – & Jack.

not of this line

Phone Janet Ford.

G. Rapids

this p.m.

THE WHITE HOUSE

WASHINGTON

check-up in March

~~Dr. Wm. Lundgren.~~

family doctor, don't

Joy. WROW. Albany
Mr. Robbs.
518 462-6474

noon
Aaron Shepherd

Judy –

Bobbie A.

THE WHITE HOUSE
WASHINGTON

"Reserpine"
Medication for High Blood Pressure –

Rep. Zeoli [for press].....

Bill – pls. call Ric Sando.

Hilton –
Auditorium.
Main Bldg.

Bill's page 602

"Ty" Roberts – 10 mins
229-4269

THE WHITE HOUSE

WASHINGTON

Pres. departed. 11 a.m.

Signed 114.....

THE WHITE HOUSE

WASHINGTON

21 Bouquets of flowers have been received at the hospital since Saturday Morning.

Among those sending flowers are:

Ambassador Orfila of Argentina,

Ambassador Ardeshir Zahedi of Iran,

Ambassador T.N. Kaul of India

Ambassador Takeshi Yasukawa of Japan.

Judge and Mrs. Homer Ferguson

Miss Nancy Hanks

Frankie Welch

Ann Spaeth (former Manager of the Congressional Club)

THE WHITE HOUSE

WASHINGTON

Approximately 500 telephone calls from well wishers have been received by the white House operators since Mrs. Ford underwent surgery Yesterday Morning.

All cards and letters have been sent to the East wing of the white House and a tabulation will be made To-Morrow.

Mrs. Ford awoke at 6:00 a.m. She walked across to the sitting room where Nancy, Col. Sardo and others were. She was laughing and in great spirits. She joked about her white hospital stockings. She was taken down to the suite at 7:10. Entered surgery at 8:05 had no breakfast. Her suite is a large bedroom in Williamsburg blue, with a soft yellow carpet, ceiling to wall blue and beige striped draperies, with blue and beige on the chairs. In the room were three bouquets of flowers, all sent yesterday with the President and were in the room on her arrival. They were lovely fall chrysanthemums in mixed colors.

Rev. Billy Zeoli is from Grand Rapids, and is a great friend of the family. He is an Evangelist, who works with young people and is very involved with sports. His wife heard it on the television last night, got in touch with him. He was in Ohio speaking. He spoke with Nancy Howe when he heard it. Decided to come becsuse of his affection for the family. Arrived this morning.

Jack and Steve have been notified, but are not coming at this time. The President's sister-in-law, Janet Ford is coming and is arriving some time this morning.

Bios on doctors

Surgery Concluded
at 11:15 AM

Taken to Recovery Room
at 11:45

[redacted]

Gnes. saw her briefly
after surgery, declined
a full report fm.
Lukash.

Usual practice to keep
in O.R. until recovery
fm. anesthesia.

Visit brief because
she was not fully
conscious.

FOR IMMEDIATE RELEASE SEPTEMBER 27, 1974

Office of the White House Press Secretary

THE WHITE HOUSE

STATEMENT BY RON NESSEN

Mrs. Betty Ford was examined at Bethesda Naval Hospital on Thursday morning (September 26, 1974) for a regular medical check-up. During the process of that examination, a small nodule was detected in her right breast. After further medical consultation, it was recommended that the nodule be surgically removed and a biopsy be performed to determine whether it was benign or malignant.

Mrs. Ford has entered Bethesda Naval Hospital for preparation for the surgery which will be performed Saturday.

Mrs. Ford entered the hospital at 5:55 p.m. She was accompanied by Mrs. Nancy Howe, Special Assistant to Mrs. Ford.

Dr. William Lukash informed the President Thursday (yesterday). Later yesterday the President and Mrs. Ford decided that Mrs. Ford would enter the hospital tonight and that the surgery would be performed tomorrow.

The purpose of the surgery is to determine through a biopsy whether the nodule is benign or malignant. Should it prove to be malignant, surgery would be performed to remove the right breast.

Surgery will be performed by Navy Captain William Fouty, Chief of Surgery at Bethesda. He will be assisted by J. Richard Thislethwaite, civilian consultant to Bethesda Naval Hospital and Professor of Surgery at the George Washington University Medical School. Dr. Lukash will be in attendance. Mrs. Ford was in good spirits when she entered the hospital.

Further announcements regarding Mrs. Ford's condition will probably be made sometime Saturday afternoon.

# # #

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Ambassador Takeshi Yasukawa of Japan
Judge and Mrs. Homer Ferguson
Miss Nancy Hanks
Frankie Welch
Ann Spaeth (former manager of the Congressional Club)
Barbara Manfuso (a classmate of Susan's at Holton Arms who was a guest at the dinner in honor of President Leone last Wednesday.

"Self-control is more often called for than self-expression"

NEWS SUMMARY
September 27, 1974
Friday nets, wires

The Major Stories:

-- First Lady Betty Ford Has Entered Bethesda Naval Hospital for Surgery Saturday to Determine if She Is Suffering From Breast Cancer.

-- White House Press Secretary Ron Nessen reported "a small nodule was detected in her right breast" during a regular medical check up Thursday. The purpose of the surgery is "to determine through a biopsy whether the nodule is benign or malignant." Should it prove malignant, the breast will be removed. The operation will be performed by Navy Capt. William Fouty, chief of surgery at the hospital. He will be assisted by J. Richard Thistlethwaite, a professor of surgery at George Washington University Medical School. Mrs. Ford is 56.

-- Mrs. Ford entertained Mrs. Lyndon B. Johnson at the White House at tea Friday afternoon. Mrs. Johnson was accompanied by her daughters Luci Nugent and Lynda Bird Robb, and her son-in-law, Charles Robb. Mrs. Ford served tea in the yellow oval room in the family quarters then escorted the Johnson family to the children's garden on the south lawn which the Johnsons had created.

-- Woodward, Okla., (AP). -- A statement by the nation's first lady that the high price of beef has brought about substitutes at the White House shows she had bad information, says the wife of an Oklahoma rancher. "You have contributed to the disaster of all cattlemen in their desperate attempt to feed the nation," Mrs. Phil Ferguson wired Mrs. Ford. "You evidently were ill-informed or misled in your statements about the cost of beef."

-- Economic Conference.

-- CBS and ABC led with reports on the President's economic conference. NBC led with the kidnapping of Barbara Hutchison, chief of the U.S. information service, the Dominican Republic.

-- Gaylord Shaw (AP): Delegates to the Economic Summit Conference bluntly told President Ford today he should find new policies and advisers and make certain the poor don't bear the brunt of the anti-inflation fight.

President Ford to Testify: Members of Congress expressed "praise and concern" over President Ford's decision to testify to a House subcommittee investigating Ford's pardon of Richard Nixon, Chancellor said.

Ray Scherer reported the subcommittee was "completely surprised" at the President's decision to testify in person. Chairman William Hungate (D., Mo.) "had not asked for him and did not expect it, but he was pleased," Scherer said. "Even so, some Democrats warned not to be so charmed with the President the questions would go soft."

Rep. George Danielson (on film) said, "I would say beware of Presidents who come with a broad smile because Mr. Ford's charm is so great that I'm fearful that in the explanation that this was all done in the spirit of mercy, we may subsume this whole concept of preserving the Watergate story in a great warm feeling of camaraderie."

"I urge you to question Mr. Ford closely and with all due respect to the President and the Presidency, your personal allegiance in questioning Mr. Ford is not to the Presidency or to political politeness, but to the American people," said Rep. Fortney Stark (on film).

Rep. Lawrence Hogan said he did not think it was fair "to issue those kinds of warnings."

Hungate said the questions to the President should be limited to circumstances surrounding the pardon, Scherer said.

"He sees no great danger his subcommittee will be charmed into making its questions too hard," Scherer reported. As Hungate put it, 'We don't want to treat the President as a monarch, nor as a notary public either'."

Pesticides: Chancellor reported the Environmental Protection Agency banned the pesticides aldrin and dieldrin because they present a high cancer risk to man.

Mrs. Ford and breast cancer: Chancellor said Mrs. Ford's doctors report she is making an excellent recovery from her Saturday operation.

In a 2:30 minute report, NBC reported six times as many women are seeking breast cancer checkups as a result of Mrs. Ford's operation. The feature detailed many cancer-finding procedures. One woman was shown on film saying the news about Mrs. Ford had reminded her to get a check-up.

Betty Rollin, in New York, said: "The terror women feel about breast cancer is not unreasonable. What is unreasonable, is that many women still turn their terror inward. They think if they avoid investigating the possibility that they have the disease, they'll avoid the disease. But as cases of such prominent women as Betty Ford become known, other women are turning their fear into the kind of action that can save their lives."

Flu: John Chancellor reported the National Center for Disease Control had warned a relatively new and highly dangerous form of flu -- the Port Chalmers flu -- will hit most of the United States this winter. He said it will be worse than the London flu which caused 1,000 deaths a week in 1972 and 1973.

Military aid: The Senate Tuesday got into its first big fight with President Ford, Chancellor reported. The dispute came over military aid to Turkey. After the Senate had voted to shut off aid to Turkey, the President threatened to veto the foreign aid bill. However, Chancellor said, "The Senate did not respond. In fact, just after receiving the veto threat, the Senate voted to suspend all military aid to Chile."

Argentina: NBC reported on political terrorists in Argentina.

Dominican Republic: Chancellor reported leftist guerrillas are still holding Barbara Hutchison, U.S. Information Service Chief in Dominican Republic.

Cuba: Chancellor quoted a State Department spokesman saying the weekend trip by Sens. Jacob Javits and Claiborne Pell to Cuba was "not reflective of any change in attitude in the United States toward Cuba."

China: Celebrating the 25th anniversary of the Communist takeover, China "was described as brimming with revolutionary vigor and joy and forgiveness for wayward comrades," said Chancellor.

ABC COMMENTARY - HARRY REASONER

Some of the changes toward openness and permissiveness of the past few years strike me as more licentious than admirable. But there is no doubt that it is a healthy and good change which permits such frank discussion of cancer when it strikes a public figure.

A lot of us are old enough to remember when "cancer" was such a forbidden word that it might well have been spelled with four letters. People would sicken and suffer and die with what was wrong with them scarcely being mentioned.

Talking about it does not make cancer any less horrible, but it probably makes it a little less terrifying, a little less lonely.

And the case of Betty Ford shows even more dramatically how far we have come because we are not only talking about cancer, we are talking about a breast, and that used to be a word only a little less taboo than cancer.

It is probably also good, although less completely clearly good, to have such wide information on what is wrong with public figures and their families. The amount of attention given to the Kennedy boy's amputation, to Mr. Nixon's phlebitis, to George Wallace's paralysis, and to Mrs. Ford's cancer, likely has something of the morbid in it, but that is overbalanced by proper human concern and,in some cases, by the legitimate interest the public has in conditions which may affect the behavior and attitudes of its servants. It might have been useful, for instance, during Franklin Roosevelt's last year.

It is interesting to remember that it is all recent. It was begun really by Dr. Paul Dudley White and Press Secretary James Hagerty with their very full reports on Dwight Eisenhower after his heart attack. They set a good precedent.

Such openness, of course, makes hard demands on the public figures. To live this way without becoming rancorous or maudlin requires a deep dignity and identity. The Fords seem to have it.

Nixon health: Harry Reasoner reported Nixon physician, Dr. John Lungren, said the blood clot in the former President's right lung has begun to clear and tests show no new clots.

Mrs. Ford's health: Reasoner reported Mrs. Betty Ford is making an "excellent recovery" from cancer surgery. He said the First Lady is stronger and is increasing her activities.

Foreign aid: Smith reported that despite the threat of a Presidential veto, the Senate reaffirmed its support of an amendment to cut off military aid to Turkey. The Senate then passed the foreign aid bill.

Bob Clark reported from Capitol Hill 14 Republicans voted for the amendment. The amendment's sponsor, Sen. Thomas Eagleton, said on film: "If we continue on a policy of acting illegally,...subverting our own statutes and tilt towards Turkey, we will inescapably further drive Greece away from us."

Sen. John Tower, (on film) said: "I think the best chance for a Cypriot settlement that is favorable to the Greeks is for us to maintain a position in which we can negotiate with Turkey and I think this tends to undermine that position."

Clark reported that a Presidential veto, which would only come after "some hard twisting of Republican arms" would leave some government agencies without operating funds.

Federal pay raise: Reasoner reported the President "reluctantly" ordered a 5.5 per cent pay raise for three and one-half million federal employees.

Economic Policy Board: Herbert Kaplow reported the President's Economic Policy Board at its first meeting discussed proposals from Economic Summit Conference and anti-inflation measures which the President soon will send to Congress. Kaplow said Ford's plans are believed to contain tax relief for the poor and energy conservation proposals, although the White House refused to comment on whether the energy programs would be mandatory.

Treasury Secretary William Simon (on film) at a morning press conference said: "The U.S. still consumes more energy than is required for sound economic growth." Simon said that despite domestic supplies of potential energy, the United States has no "leverage per se" over the Arab nations.

Try to persuade the producers it is in their own interest to roll back prices now, then raise them, year by year, until in a decade they will be at the present high level. That will give everybody time to adjust..

The oil producers would suffer no disadvantage. They cannot possibly spend the huge present influx of money this swiftly. By insisting on doing so, they are dealing ordered civilization a worse blow than anything this century, including the Russian revolution. And they, too, conservative nations, will be hurt by it.

Such a proposal put by Kissinger, backed by rich and poor victims nations united -- might carry weight. In any case, it ought to be tried because there is not much else to try.

CBS EVENING NEWS

Mrs. Ford's Condition: Walter Cronkite reported on Mrs. Ford's condition with special reports from Connie Chung at the hospital and William Roberts at the White House.

Javits and Pell Return from Cuba: Marya McLaughlin met Senators Jacob Javits and Claiborne Pell at Andrews Air Force base as they returned from a 2-1/2 day visit to Cuba, including a session with Premier Fidel Castro. They said they brought no messages from Castro to President Ford or Secretary Kissinger.

Javits (on film) said the Cuban government and Castro "were interested in working for better relations with the United States." Pell said he and Javits will not make public any recommendations until they can give their proposals to the Senate Foreign Relations Committee. Pell said they went to Cuba as individuals and engaged in no negotiations. Miss McLaughlin said Javits refused to say whether his and Pell's recommendations would include a proposal for full diplomatic recognition of Cuba.

Dan Rather (from Havana) reported on the big rally there Saturday night where Castro blistered President Ford. Rather said Javits and Pell did not attend the rally, "because they did not want to be seen on the same platform with Castro, and Castro did not want them there."

Rather said some diplomats and military people said it was the most aggressive anti-American speech made by Castro in five years. Others interpreted it as a sign from Castro that he wanted better relations with the United States. Others called it rhetorical bombast, necessary for Castro's followers and to maintain his image in the Communist world.

Ford had been given until the end of the day Monday to reply to 14 questions posed by two members of Congress asking the background to Nixon's unconditional pardon.

The pardon angered Congress, and Reps. Bella Abzug (D.,-N.Y.), and John Conyers, (D., Mich.), introduced resolutions of inquiry demanding an explanation.

"I am impressed by President Ford's desire to set the record straight personally," said Judiciary Subcommittee Chairman William Hungate. "It is consistent with the frankness and openness he displayed as a Congressman. I trust his appearance will make a positive step toward putting the final chapter of the Watergate affair on the public record, so we may at last close this book."

NBC EVENING NEWS

Mrs. Ford: John Chancellor reported on Mrs. Ford's condition. White House Press spokesman Bill Roberts (on film) said Mrs. Ford's doctors "remain optimistic for her prolonged survival." Roberts said special diagnostic studies will be performed during the post-operative period to determine the kind of therapy needed for maximum treatment.

Gordon Graham reported President Ford had said his future political plans would be determined by the rate and degree of Mrs. Ford's recovery. So far, "all we know is that the President was pleased with this latest report," Graham said.

Cancer Treatment: Ford Rowan reported a National Cancer Institute task force made tentative findings there is some reason to hope that breast cancer surgery may not have to be as extensive as now.

Watergate Trials: Chancellor said John Erlichman believes the "true guilty party" in the coverup is Richard Nixon and Erlichman "is not alone" in that feeling.

Carl Stern reported that on the eve of the trial, "the wall of loyalty to Richard Nixon has begun to crumble." Stern said Erlichman has filed an affidavit pointing the finger at Nixon for the coverup plan. Stern said the affidavit contains statements by Erlichman of recollections of conversations with Nixon "never before made public."

At least one other defendant is known to be angry at Mr. Nixon and disinclined to protect his interests, said Stern. This defendant asked Mr. Nixon, in accepting his pardon, to state that his aides had merely followed orders. Nixon's failure to do so "further eroded the loyalty of his former aides," said Stern.

to the State Department. Because of poor weather conditions at Camp David, some 70 miles northwest of Washington, it was impossible to fly the participants by helicopter.

Washington (UPI) -- President Ford promised Saturday to porpose a sweeping anti-inflation program within ten days, and he asked citizens to send to the White House their own do-it-yourself ideas for conserving energy and combating the rising cost of living.

In an emotional address to the windup session of his "inflation summit" meeting, Ford indicated that the new government actions would include more public service jobs and tax breaks to encourage citizens to spend less and save more.

Washington (UPI) -- President Ford signaled Saturday that his tax program may include tax breaks for personal savings and for those hit hardest by inflation such as the jobless and the poor. Ford also indicated he may seek increased business tax breaks to stimulate the economy and may support a public jobs program to provide work for those put out of work by the current economic slowdown.

Although Ford mentioned no specifics in his closing address to the summit conference on inflation, one paragraphs of his speech offered strong clues as to his thinking on possible moves to combat inflation.

Washington (AP) -- President Ford consolidated government economic policy-making and formed a blue ribbon labor-management committee on Saturday, then exhorted Americans to join in a citizens crusade to whip inflation.

Ford came from the bedside of his wife, who had just undergone surgery for breast cancer, to address the conclusion of his two-day economic summit conference. "Betty would want me to be here," he said to the applause of the 1,800 delegates and spectators after reporting that doctors said "she came through the operation all right."

Washington (AP) -- Trimming the federal budget without cutting off needed programs was the principal theme advanced to President Ford in Saturday's windup of the economic summit conference.

The next most popular suggestion was a vigorous enforcement of anti-trust laws to break up monopolies and bring down prices. This was coupled with recommendations that the so-called fair trade laws which legalize price fixing be abolished.

CBS Evening News

Mrs. Ford: CBS did a 3 1/2 minute report on Mrs. Ford's operation. It included film of the President arriving at the hospital, the press comments of Dr. William Lukash, the President's opening remarks at the Economic Summit Conference, and the President's remarks to reporters after his second hospital visit.

Robert Pierpoint said "Dr. William Fouty, who performed the operation, said it will be 3 or 4 days before a full pathology report on the tissues involved will reveal the extent of the cancer. It may be years before it is clear if the operation produced a cure. Mrs. Ford will remain hospitalized for about 10 days, will convalesce several more weeks. President Ford has cancelled his public schedule for the next few days. Nelson Rockefeller will replace him at appearances in Utah and California next week."

Dean reported Richard Nixon telephoned Mrs. Ford, wished her well.

Mrs. Birch Bayh: Mrs. Bayh, who had a similar operation in 1971, was interviewed on her experiences. She told of the lift she received from a person who had the same operation.

Economic Summit: Morton Dean said President Ford "enlisted the nation in the fight on inflation and said his own plan is on the way." Nelson Benton said:

President Ford told the summit he will unveil his anti-inflation plan within 10 days, including a proposal to get the national budget at, or under, $300 billion. He will propose a National Energy program soon. Today he asked Americans to become Inflation Fighters and Energy Savers.

NBC EVENING NEWS

Mrs. Ford: Tom Brokaw and John Cochran reported on Mrs. Ford's breast cancer operation. The President was shown on film for 1:45 minutes discussing his wife's condition.

Brokaw said Mrs. Ford's "chances of recovery seemed favorable but (doctors said) they cannot be sure all of the cancer was removed. President Ford was optimistic, saying "Our faith will sustain us.'"

Cochran said, "Two days ago, Mrs. Ford spoke to a consumers group and seemed happy to get a present, a wooden elephant. Just a few hours earlier, she had learned she might have breast cancer," Cochran reported.

"She and the President decided to keep it a family secret until after she entered the hospital last night. This morning while Mrs. Ford was still in the operating room, the President arrived with their son Mike. Earlier former President Nixon had called to say he hoped everything would be all right.

"After the three-and-one-half-hour operation, Mr. Ford spoke with his wife who was awake but groggy. Then the President went ahead with his commitment to give the wrap-up speech at the summit conference on inflation," Cochran said. The President was shown on film bringing word from the hospital.

"At the hospital, the surgical team said Mrs. Ford was in satisfactory condition, but they also said it was much too early to give her a clean bill of health," Cochran said. "Mrs. Ford will be here in the hospital for about 10 days. During that time, tests will be completed to make sure the malignancy has been checked." Cochran said.

"At this point, her doctors believe she has at least a 75 per cent chance of full recovery. The doctors also believe the breast removal will not cause Mrs. Ford any serious psychological problems. Some of her friends have had the same operation, and one of her doctors said she has the necessary insight and sophistication to handle this."

"It is true that many of the speakers chose to set their own positions rather than explore alternatives, but at least those positions were set out for all ot hear. The President and his advisers have been exposed to the clash of ideas and opinions that will not make their decisions any easier. But that's all right too, because if there is one question which all can agree, it is that the nation's economic problems will not be solved by the wave of a wand, whether the wand is held by a President, a banker, or a labor leader."

ABC then ran a clip showing Dr. William Lukash reporting on Mrs. Ford's condition. Steve Bell at Bethesda Naval Hospital said, "We were told that members of the family are holding up well, that they have been sobered by the experience, by the unfavorable prognosis on the original tumor, but that they are optimistic that the surgery will work out for Mrs. Ford."

Saying he probably should not have referred to the summit conference as a "Tower of Babel -- signifying nothing," Reynolds said he thought it was "very good to have this clash of opinions."

Kaplow said "There certainly would be a concentrated effort on the part of all the parties to at least start together. But there are some very broad areas of disagreement and they are not going to be negotiated easily. There is the whole question of cutting the budget. Everybody agrees you ought to cut the budget, but where?"

"Well," responded Reynolds, " you know, there is a substantial body of opinion that cutting the budget is not necessarily the prime task of the federal government in meeting this threat of inflation."

"Except in the sense that if it is possible to take $5 billion out of the $305 billion which is presently programmed for this current year, then that removes $5 billion from competing for credit in the market," Kaplow responded. "And that, theoretically, the economists tell us, should ease the high interest problem a bit."

"Well the President said that he pledged again -- this is not new -- to hold the '75 fiscal budget to at or under $300 billion," said Reynolds.

Mrs. Ford: Mudd reported that Mrs. Betty Ford entered Bethesda Naval Hospital Friday for an operation to determine if a nodule in her right breast is malignant. If it is found to be cancerous, Mrs. Ford's right breast will be removed, Mudd said.

Magdalene: Bruce Morton reported on the National Gallery of Art's acquisition for $2.5 million of the Repentant Magdalene painting by George de la Tours.

Natural Gas: "President Ford today reduced the import fees from all natural gas products. The White House said the action will increase the supply and help stabilize the price of natural gas," said Mudd.

United Nations: "The U.N. General Assembly's Credentials Committee voted Friday not to accept the delegation from South Africa because of its apartheid policy," said Mudd.

Mudd said it was the first time in U.N. history the black African members had been able to put together a majority. The vote may mean the South African delegation will be excluded from the work of the Assembly's current session, he said.

Babies: Steve Young presented a 5:30 minute feature on the practice of finding adoptable babies for couples willing to pay exorbitant fees.

"In an age of shortages, perhaps one of the cruelest shortages of all is the shortage of babies," said Mudd.

Young concluded: "Only uniform action at the federal level will prevent babies from going to the highest bidder."

NBC NIGHTLY NEWS

Hutchison kidnap: John Chancellor reported on the kidnapping of Miss Barbara Hutchison. He said Miss Hutchison's five kidnappers were demanding one million dollars and the release of 38 leftists imprisoned in the Dominican Republic. Chancellor reported that in a phone interview, Miss Hutchison was a "model of calm."

Economic Summit: Chancellor reported the White House Economic Summit opened with the presentation of "many conflicting views and no concrete proposals."

Film showed President Ford's opening remarks. "There are no quick and easy solutions," Ford said. "No miracle cure has emerged from the pre-conference meetings."

This Copy For _____

N E W S C O N F E R E N C E #39

AT THE WHITE HOUSE

WITH RON NESSEN

AT 7:14 P.M. EDT

SEPTEMBER 27, 1974

FRIDAY

MR. NESSEN: I will read you a statement.

Mrs. Betty Ford was examined at Bethesda Naval Hospital on Thursday morning for a regular medical check-up. During the process of that examination, a small nodule was detected in her right breast. After further medical consultation, it was recommended that the nodule be surgically removed and a biopsy be performed to determine whether it was benign or malignant.

Mrs. Ford has entered Bethesda Naval Hospital for preparation for the surgery which will be performed Saturday. Mrs. Ford entered the hospital at 5:55 p.m. She was accompanied by Mrs. Nancy Howe, Special Assistant to Mrs. Ford.

Dr. William Lukash informed the President yesterday afternoon. Later yesterday, the President and Mrs. Ford decided that Mrs. Ford would enter the hospital tonight and that surgery would be performed tomorrow.

The purpose of the surgery is to determine, through a biopsy, whether the nodule is benign or malignant. Should it prove to be malignant, surgery would be performed to remove the right breast.

Surgery will be performed by Navy Captain William Fouty, Chief of Surgery at Bethesda. He will be assisted by J. Richard Thistlethwaite, civilian consultant to Bethesda Naval Hospital and Professor of Surgery at the George Washington University Medical School. Dr. Lukash will be in attendance. Mrs. Ford was in good spirits when she entered the hospital.

Further announcements regarding Mrs. Ford's condition will probably be made sometime tomorrow afternoon.

Q Will the President go out there tonight?

MR. NESSEN: The President's plans are to have dinner with Susan and we will keep you informed after that.

Q Do you have a time for surgery, Ron?

MR. NESSEN: Sometime tomorrow.

Q Morning or afternoon, do you know?

MR. NESSEN: We don't know.

We will give you 15 minutesto file and then we will have some answers for you.

(AT 7:17 P.M. EDT)

# # # #

7:24 P.M. EDT

MR. NESSEN: Let me say the President will go to the hospital this evening, and he will be leaving shortly. The pool for traveling to the hospital will be the AP, UPI, AP photographer, UPI photographer, NBC and Maggie Hunter.

Now, I will take your questions right up until about five minutes before he leaves.

Q Is the President going to spend the night at the hospital?

MR. NESSEN: Not that I know of. I don't think so.

Q What time is she going to be operated on tomorrow?

MR. NESSEN: We don't know.

Q Are you going to brief out there tomorrow?

MR. NESSEN: There will be a briefing out there tomorrow. Bill Roberts is running the press set-up out there.

Q Where will it be there?

MR. NESSEN: There is an auditorium out there.

Q What time, do you know, Ron?

MR. NESSEN: I have to guide you into thinking that we won't have a briefing until after the operation.

Q When is it scheduled?

MR. NESSEN: There is no scheduled time that I know of.

Q Can you say whether it is in the morning or the afternoon?

MR. NESSEN: I don't know, Russ.

Q Ron, on the biopsies, in most instances, you can find out almost instantly --

MR. NESSEN: Well, that is what the statement says, Tom.

Q Will we be told as well?

MR. NESSEN: You are going to have a briefing with the doctors and I assume they will tell you what they discovered.

Q Are any other members of the family coming home?

MR. NESSEN: I am told that Mike is coming down tonight.

Q From where?

MR. NESSEN: He lives in Massachusetts, and goes to school there. Steve and Jack will not be coming as far as I know.

Q Will this affect the President's plans to preside at the summit?

MR. NESSEN: The plans, as far as we know, are for him to stick to his schedule.

Q Will he be at the hospital during the operation?

MR. NESSEN: Well, we don't know what time the operation is going to be. As you know, he is scheduled to be over there until about one o'clock.

Q What is the First Lady's age?

MR. NESSEN: The First Lady's age is 56.

Q Has she ever had cancer before?

MR. NESSEN: I just talked to them out there and I am told that she has never had surgery for cancer.

Q Ron, has she ever had any breast condition or breast operation before?

MR. NESSEN: I didn't get into that much detail.

Q Ron, would the operation for the removal of the breast take place immediately after the operation to determine whether it is cancerous?

MR. NESSEN: That is what the statement says.

Q While she is still on the table?

MR. NESSEN: That is my understanding of the procedure.

Q Ron, has there been any preliminary diagnosis based on heat and cold or anything like that?

MR. NESSEN: The doctors say that they will not know whether it is benign or malignant until after they have performed the biopsy.

Q No indication at this time, or can't you say?

MR. NESSEN: The doctors say the only way to determine whether it is binign or malignant is to perform the biopsy.

Q Ron, was there any evidence that she experienced any pain or discomfort or notice any symptoms like that?

MR. NESSEN: I understand she had no symptoms at all and did not know anything about the nodule until her examination yesterday.

Q Who was the examining doctor? Was it Lukash?

MR. NESSEN: The examination was performed by the gynecological department of Bethesda Naval Hospital.

Q How did Mrs. Ford spend the day today?

MR. NESSEN: Mrs. Ford stuck to her schedule today. She went to the tree planting at the Johnson Grove. She had a meeting with Mrs. Johnson at 4 o'clock, and dropped by the Salvation Army luncheon.

Q She invited Mrs. Johnson, apparently, to the tree planting, didn't she?

MR. NESSEN: Yes.

Q She was very gay at the tree planting.

MR. NESSEN: Yes, she was, and she was all day and she was in good spirits when she entered the hospital.

Q Ron, did she know this all day?

MR. NESSEN: She was told, as I said in the statement, yesterday.

Q What did she and Mrs. Johnson do today, just sit and talk, or what?

MR. NESSEN: I don't have any report on their meeting. I wasn't there. There is Helen.

Q They had tea upstairs in the Oval Room and they went to the third floor and the second floor and they left after about an hour and twenty minutes.

Q Was Mrs. Johnson informed that Mrs. Ford would be going into the hospital?

Q Not to my knowledge.

Q The statement, Ron, says that further announcements regarding Mrs. Ford's condition will probably be made sometime Saturday afternoon.

MR. NESSEN: Yes.

Q Can we therefore divine that the operation is going to be sometime around mid-day?

MR. NESSEN: I simply don't know the time of the operation, but I think you should look for announcements and briefings, and so forth, in the afternoon.

Q Ron, on another subject, does he have an appointment tomorrow with Mr. Healy, of Great Britain?

MR. NESSEN: The schedule is going to be posted shortly, Sara.

Q How do they know they will have to remove the whole breast?

MR. NESSEN: That is the procedure, as I understand it, from Dr. Lukash. In case it is malignant, that is the procedure you follow.

Q As far as you know, Mike is the only one of the children that is coming down?

MR. NESSEN: Susan is already here, as you know.

Q Did the doctors say it was necessary to do this right away?

MR. NESSEN: The statement says that Dr. Lukash talked to the President yesterday and that Mrs. Ford and the President decided that she should enter the hospital tonight and that the surgery would be performed tomorrow.

Q Ron, do you have any idea how long this kind of surgery -- the initial part of the surgery -- would last?

MR. NESSEN: I don't know that. I think you are going to get a full medical briefing tomorrow where you can bring up some of the more detailed medical questions.

Q Ron, are we talking about something that could happen now?

MR. NESSEN: I wouldn't even guess at that. I don't know.

Q Has Mrs. Ford been in good health prior to this discovery?

MR. NESSEN: As far as I know.

Q Does she undergo regular physical examinations?

MR. NESSEN: Her last gynecological check-up was six months ago. That is the regular schedule for women, and at that time, all reports were normal.

Q Have you talked to her about this?

MR. NESSEN: No, I have not.

Q She didn't discover it herself? It was discovered by the doctor?

MR. NESSEN: That is right.

Q What is the gynecologist's name?

MR. NESSEN: That did the examination? It was the department out there. I think you will get a lot of names of people tomorrow.

Bob Pierpoint has pointed out to me that the statement is not as clear as I thought it was on the timing of the operation to remove the breast in case it is malignant. The plan, according to Dr. Lukash, would be to perform that surgery immediately after the results of the biopsy are known, if it is malignant.

Q And would that be a matter of minutes, or a few hours, or a few days?

MR. NESSEN: Immediately after, Bob, or --

Q In other words, she would stay in the operating room until --

MR. NESSEN: I don't want to get into that detail, but it would be performed tomorrow.

Q Ron, is Susan going out with him tonight?

MR. NESSEN: I believe so.

THE PRESS: Thank you, Ron.

END (AT 7:37 P.M. EDT)

FOR IMMEDIATE RELEASE SEPTEMBER 27, 1974

Office of the White House Press Secretary

THE WHITE HOUSE

STATEMENT BY RON NESSEN

Mrs. Betty Ford was examined at Bethesda Naval Hospital on Thursday morning (September 26, 1974) for a regular medical check-up. During the process of that examination, a small nodule was detected in her right breast. After further medical consultation, it was recommended that the nodule be surgically removed and a biopsy be performed to determine whether it was benign or malignant.

Mrs. Ford has entered Bethesda Naval Hospital for preparation for the surgery which will be performed Saturday.

Mrs. Ford entered the hospital at 5:55 p.m. She was accompanied by Mrs. Nancy Howe, Special Assistant to Mrs. Ford.

Dr. William Lukash informed the President Thursday (yesterday). Later yesterday the President and Mrs. Ford decided that Mrs. Ford would enter the hospital tonight and that the surgery would be performed tomorrow.

The purpose of the surgery is to determine through a biopsy whether the nodule is benign or malignant. Should it prove to be malignant, surgery would be performed to remove the right breast.

Surgery will be performed by Navy Captain William Fouty, Chief of Surgery at Bethesda. He will be assisted by J. Richard Thislethwaite, civilian consultant to Bethesda Naval Hospital and Professor of Surgery at the George Washington University Medical School. Dr. Lukash will be in attendance. Mrs. Ford was in good spirits when she entered the hospital.

Further announcements regarding Mrs. Ford's condition will probably be made sometime Saturday afternoon.

# # #

September 28, 1974

Office of the White House Press Secretary

NOTICE TO THE PRESS

HOSPITAL BULLETIN #1 -- 6:30 PM

Mrs. Ford's condition stabilized nicely in the recovery ward and she was returned to the suite at 3:00 p.m. Her blood pressure, pulse and respiration are normal. She is experiencing some post operative discomfort which is quite normal for the operation she has undergone. Mrs. Ford is alert and spent a few minutes with the President and her family. She will remain on intravenous fluids and under close observation throughout the night. Her condition is satisfactory. The next report on Mrs. Ford will be given at 11:00 a.m. tomorrow, simultaneously here and at the White House.

# # #

FOR IMMEDIATE RELEASE SEPTEMBER 28, 1974

OFFICE OF THE WHITE HOUSE PRESS SECRETARY
(Bethesda, Maryland)

THE WHITE HOUSE

PRESS CONFERENCE
OF
DR. WILLIAM LUKASH, PHYSICIAN TO THE PRESIDENT
CAPTAIN WILLIAM FOUTY, CHAIRMAN OF SURGERY, NATIONAL NAVAL MEDICAL CENTER
J. RICHARD THISTLETHWAITE, CIVILIAN CONSULTANT, FOR BETHESDA NAVAL HOSPITAL AND PROFESSOR OF SURGERY, GEORGE WASHINGTON UNIVERSITY MEDICAL SCHOOL

NATIONAL NAVAL MEDICAL CENTER
AUDITORIUM

12:32 P.M. EDT

MR. ROBERTS: Ladies and gentlemen, we have available now for the briefing the three physicians who were involved in the surgery this morning.

At the right, Dr. William Lukash; center, Captain William Fouty, Chief of Surgery, Bethesda; and on the left here, J. Richard Thistlethwaite, who is civilian consultant for Bethesda Naval Hospital and Professor of Surgery at George Washington University Medical School.

For your information, the surgery was performed by Captain Fouty, assisted by Dr. Thistlethwaite and Dr. Lukash was in attendance. I think Dr. Lukash will open with a statement.

DR. LUKASH: Good afternoon, ladies and gentlemen. I am sorry to have to report today that the nodule in Mrs. Ford's breast was found to be malignant and as a result, surgical removal of that breast was required.

On some happier tone, Mrs. Ford withstood the surgery very well and the results and procedure was highly satisfactory. I am optimistic that the overall prognosis will be excellent.

I might add from a personal note that throughout this ordeal, Mrs. Ford exhibited an atmosphere of confidence, and more interestingly, I thought that she demonstrated a kind of inner strength that sustained the First Family, her close staff, but I think the doctors.

Mrs. Ford was up this morning at six o'clock. She spent some time with her children, Michael Ford and Susan, along with a close family friend, Reverend Zeoli. And at 7:00 a.m., she was taken down to the operating suite. The surgery was started at 8:00 a.m. In about 15 minutes, the nodule was removed and the pathological report was that of malignancy.

MORE

The surgical removal of that breast then took place, and Dr. Fouty will describe that in more detail, and was completed around 11:15.

I would like to review the whole clinical course as it started. Mrs. Ford visited the Naval Hospital Thursday morning to have her annual gynecologic exam, her last having been one year ago. She was examined by Captain Douglas Knab, the Chairman of the Department of Gynecology. During this exam, he detected this nodule in her right breast.

It is interesting that her breasts were examined a year ago and also seven months ago at which time no abnormalities were noted. Mrs. Ford was not aware of this problem and denied any symptoms referable to her breast.

After finding the nodule, Dr. Fouty was called in for consultation and his clinical impression was that the nodule was suspicious and he recommended that an incision and biopsy be performed. He then notified me and it was decided that another opinion from Dr. Thistlethwaite be made and perhaps this could be done at my White House office later that evening.

I called the President early noon that day and told him of the meeting we would be having. So, about 7 o'clock at the White House, Dr. Thistlethwaite examined Mrs. Ford and confirmed the nodule and we then discussed it with the President and the First Lady and it was decided that she would enter the hospital Friday evening for the tentative surgery.

Basically, that is the story up to now and I think I would like to turn over the rest of the discussions and questions to the surgical team.

As mentioned, Dr. Fouty is Chairman of the Department of Surgery at Bethesda. In addition, he has an academic appointment as Professor of Surgery at George Washington.

Dr. Thistlethwaite has been a big help at our hospital as a consultant in surgery. He is also a full Professor in Surgery at George Washington University, and the third assistant, who is attending Mrs. Ford in the recovery room is Dr. Herb Steimel, on Dr. Fouty's staff, and he is a Commander.

Dr. Fouty.

DR. FOUTY: Ladies and gentlemen, this morning the biopsy was performed under general anesthesia, which was performed by Captain Robert Van Houten, and Lt. Commander Meyer Rosenthal. There were no problems with the anesthesia.

A biopsy was performed and a diagnosis of the malignancy was confirmed by pathologists, Dr. Henry Jason Norris, who is the Chief of the Breast Division at the Armed Forces Institute of Pathology, and Commander Robert Karnei, head of our Anatomical and Surgical Pathology.

Once having the diagnosis confirmed, of malignancy, we proceeded with removal of the primary tumor in the breast and lymph-bearing tissue under the right arm. The surgery went well. There were no technical problems and Mrs. Ford is currently in satisfactory condition.

Q How large was this tumor?

DR. FOUTY: This tumor measured approximately two centimeters in size.

Q Why do you call it primary? Explain that.

DR. FOUTY: A primary tumor is a tumor in the breast tissue.

Q Does that describe the grade of malignancy?

DR. FOUTY: No, ma'am.

Q What is the grade of the malignancy and what is this operation called?

DR. FOUTY: The grade of the malignancy will not be determined until the final pathology report, until we examine the entire breast and the lymph-bearing tissue. This will take some considerable time. The procedure performed is a mastectomy. The standard radical mastectomy.

Q Doctor, is it a standard radical mastectomy? I thought when you got into the muscle tissue that went beyond what they called a modified radical and this is the most serious mastectomy that you did. Aren't there three levels of mastectomy and this is the most radical?

DR. FOUTY: There are different types of mastectomy. The standard procedure, and accepted procedure, for carcinoma of the breast of this type would be removal of the breast with the muscle and the lymphoid tissue.

Q Quite often, aren't there mastectomies without going, however, into the muscle tissue? Quite often isn't there just the breast, itself, removed? Are you talking about the muscles that have to do with the arm and the shoulder?

DR. FOUTY: We are talking about the muscles on the anterior chest wall.

Q Did you remove the pectoral muscular tissue? Did you remove the pectoral muscles?

DR. FOUTY: Yes, sir, the pectoralis muscles.

Q Did you go under the arm all the way?

DR. FOUTY: Just under the arm, yes.

Q Dr. Fouty, are you convinced at the present time Mrs. Ford has been relieved of all malignancy?

DR. FOUTY: I don't think one can make the statement that she has been relieved of all malignancy. We removed all gross tumor. There was no evidence of any remaining tumor.

Q How far was the tumor in the breast?

DR. FOUTY: I think this was a very favorable early lesion.

Q Early detected? Early what?

DR. FOUTY: Early detected.

DR. LUKASH: It was detected early and small in size.

Q Was there any consideration to doing a less radical procedure on Mrs. Ford, either a simple mastectomy --

DR. FOUTY: No.

Q In the span of time you speak of before this final determination was made, are you speaking of days, weeks, what?

DR. FOUTY: I don't think one can give you an answer of days or weeks.

Q There is not a point at which you make that determination?

DR. LUKASH: I would think since the last examination in March. It must have developed sometime within that period.

Q I meant, Dr. Lukash, in reference to his speaking that you then go to see how --

DR. LUKASH: I think she is talking about the pathology report.

Q -- about the grade of malignancy, yes. You mentioned it would take a certain length of time. I am trying to find out what kind of time we are talking about.

Q You said considerable time, Doctor.

DR. FOUTY: By considerable time, I meant a few days.

Q How long will she be in the hospital and also, how long did the biopsy take? So, actually, what was the operation, three hours and ten minutes? How much in between?

DR. FOUTY: The operation took approximately 2-1/2 hours, the major operation.

Q What kind of anesthesia?

DR. FOUTY: It was general endotracheal anesthesia.

Q You mean she inhaled gas? How would the layman know it?

DR. FOUTY: It was with gas and drugs.

Q How long will she have to stay in the hospital?

DR. FOUTY: Approximately ten days.

Q Then what?

DR. FOUTY: Then she will be followed as an out-patient.

Q Will she undergo medication or any kind of cobalt or any x-rays?

DR. FOUTY: Not at the present time.

Q There is some thought this is a very severe psychological blow to women and that quick visits by other women who have had similar operations are an important part of the patient's recovery. Is there any such follow-up -- I know there are a number of groups around the country. Are any of these visits planned for Mrs. Ford?

DR. FOUTY: Many patients today are aware of friends who have undergone a similar procedure and there is frequently no need to call anybody in to help them out psychologically.

DR. LUKASH: I might add Mrs. Ford has some close friends who have had this operation, so I think she has that necessary insight in to help her handle this.

Q Doctor, have you talked to the President after the operation?

DR. LUKASH: Yes. He came down to the recovery room and visited with the First Lady and we discussed in a short period there that everything was successful, and he will return later this afternoon, and I hope we will get an opportunity to talk about it a little more in depth.

Q Was she awake when the President talked with her?

DR. LUKASH: Yes.

Q Does she know what has happened?

DR. FOUTY: Yes, sir.

Q Who told her?

DR. FOUTY: I did.

Q What was her response? Did she have any?

DR. FOUTY: Mrs. Ford was well aware of the procedure that might have to be performed prior to surgery.

Q So, what was her reaction?

DR. FOUTY: There was no real definite response.

Q Was this tumor discovered by any new method in that she was apparently completely unaware of it, herself?

DR. FOUTY: The tumor was discovered by a routine examination.

Q Is the size of the tumor relatively routine in this type of case? Larger or smaller?

DR. FOUTY: There is no routine size of tumors. They are all individual.

Q Is this larger or smaller than most you have dealt with?

DR. FOUTY: I would say average.

Q Do you plan to follow on this with radiotherapy or perhaps chemotherapy?

DR. FOUTY: Further therapy, again, will depend upon the final pathological diagnosis and the patient's condition post-operatively in follow-up.

Q What will happen now? What kind of treatment will she get when she remains in the hospital?

DR. FOUTY: This will be mainly supportive treatment, immediate post-operative care, treatment to keep the patient comfortable, to watch the wound.

Q Will this sort of put her out of traveling and social and the official things she would want to do normally?

DR. FOUTY: I would say this would be similar to any major operative procedure and the patient will require three to four weeks of convalescence.

Q After she gets out of the hospital?

DR. FOUTY: Yes.

Q Does the removal of these muscles under the arm, does that cause any sort of permanent -- I don't like to use the word "crippling" -- does that mean there will be a permanent weakness there of any sort?

DR. FOUTY: No.

Q If I could go back to a question earlier. This is the most serious mastectomy, the most extensive mastectomy?

DR. FOUTY: No, it is not the most extensive mastectomy and it is not the most serious. It is a standard way of dealing with carcinoma of the breast that has been well accepted through the years.

Q This is not a very conservative approach. You really are not taking any chances. I gather you went quite deeply in. Often when breasts are removed, you do not go quite so deeply in to the surrounding tissue, muscle tissue; is that correct? In this case, you are being extremely cautious?

DR. FOUTY: Not any more extremely cautious than in any other individual case.

Q Is her age in her favor? Statistically?

DR. FOUTY: It has no bearing.

Q In other words, you are saying this is your standard procedure for cancer of the breast?

DR. FOUTY: Each case is individualized. This is basically my standard procedure for this disease, yes.

Q Is there any chance you might have to call her back in to remove more tissue from the breast?

DR. FOUTY: No.

Q There were no signs that the malignancy had spread to the other breast?

DR. FOUTY: No.

Q Does this fit into the American Cancer Institute's idea of early detection and so forth? Was there anything she could have done before?

DR. FOUTY: No.

Q Doctor, had it not been detected, say, on Thursday, what could have been the result? How long before it would have been a really serious situation?

DR. FOUTY: Again, one cannot give you definite times. This depends upon what we call the biological activity of a tumor. This may be individual to a particular patient, the rapidity of growth.

DR. LUKASH: Could I have one question from Dick regarding this problem of early cancer detection? What is the standard recommendation by the American Cancer Society on this to women?

DR. THISTLETHWAITE: I think that is a good point because medically, we like to stress early detection. I think self-examination is something we like to stress. Usually at monthly or bi-monthly intervals by the patients, themselves. The American Cancer Society has literature available to people, groups, so forth, stressing methods for self-breast examination.

Q Could this have been detected by her had she gone through that procedure?

DR. THISTLETHWAITE: I think we are all trying to stress that this was a rather early detection, we feel, in this case.

Q Yes, but it had been only seven months since she had a physical.

DR. THISTLETHWAITE: You must realize she had absolutely no symptoms. It was just part of her physical examination when this was detected.

Q How long does it take a tumor like this to grow? Seven months ago she underwent an examination and there was no sign of a tumor. And she is obviously getting examinations more frequently, I would think. Most women do not have an examination every seven months. If she had done self-examination, would it have been one month earlier, two months, five months? Is there any way of guessing or estimating that?

DR. THISTLETHWAITE: I think that would just be a guess. Captain Fouty stressed that biological activity of a tumor is so individualized.

Q Excuse me. Can you please tell me just exactly what you removed from the patient?

DR. FOUTY: The breast, the underlying pectoral muscles and the lymph-bearing tissue under the right arm.

Q Dr. Fouty, you said it would be several days before you could determine if the problem has been completely handled. Could you be more specific as to what you are looking for in the next several days?

DR. FOUTY: What I meant by that is all the gross tumor was confined to the breast. When the tissue is removed, as tissue is repaired, fixed, numerous microscopic slides are made to determine the exact extent of the tumor within the breast and whether any lymphoid tissue outside the breast is involved.

Q In this case, there was no lymphoid tissue involved?

DR. FOUTY: We cannot give you that answer today because this is part of the pathological examination.

Q What is the general prognosis now for someone who is in this situation?

DR. FOUTY: I would say the general prognosis is favorable.

Q What do you mean, she will live out a normal life?

DR. FOUTY: I would hope that she would, yes.

Q Where was the location of the nodule?

DR. FOUTY: The nodule was at the right side of the breast towards the upper part of the right side but close to the center.

Q If indeed your further pathological examinations show that there has been some malignancy in lymphatic tissue, this would be an ominous sign, or is that too much?

DR. FOUTY: This would not be particularly an ominous sign. It would not be particularly a bad sign. People do respond to further therapy. There would be no more surgical procedures done because all of this tissue would be removed.

Q What is the likelihood that the carcinoma could recur either at that location or in another organ, let's say.

DR. FOUTY: Well, then we are talking about general statistics. The likelihood of recurrence of breast cancer, again, is so very individual that I would hate to give you a figure at this time.

Q Doctor, doesn't the American Cancer Society have a figure that falls within what they regard as the early detection frame, and if you know that, could you tell that to us? My recollection is 85 percent, or something like that.

DR. FOUTY: Basically, if a patient has a lesion within a breast, early detection contained to the breast, under certain size, no lymphoid involvement, we are talking about probably an overall 76 percent, ten-year survival.

Q Can you tell us why Mrs. Ford was undergoing an examination at this time?

DR. LUKASH: This is her routine gynecologic exam. That is standard recommendation for all women.

Q Who was her doctor?

DR. LUKASH: As I mentioned, Dr. Douglas Knab, here in Bethesda Hospital.

Q What is this doctor's title?

DR. LUKASH: Chairman of the Department of Obstetrics and Gynecology.

Q Did Mrs. Ford have any choice? Did she have any say before as to what would happen?

DR. LUKASH: She was in discussion with us when we all met with the President at the White House, and she was in full agreement.

Q And she gave a green light for any --

DR. LUKASH: Yes, sir.

Q She was told of the different procedures that were possible and was she told some doctors believe that simple mastectomy may be enough?

DR. FOUTY: Yes.

Q So, she won't be on any specific medication, or she will be?

DR. FOUTY: She will be on no specific medication currently, that is correct.

Q But she will be given sleeping pills, that kind of thing?

DR. FOUTY: Yes.

Q When will the next scheduled briefing be?

DR. LUKASH: Our procedure at this time is, I think it is now just a period of normal convalescence. I would think most appropriate just a written announcement every morning at 11 o'clock after the doctors get a chance to evaluate the patient.

Q Dr. Fouty, for those of us who really do not have any medical knowledge, could you give us some words to say -- what I am seeking is whether the operation went normally or well, and what the condition of the patient is keeping in mind it was a massive operation, in non-medical terms.

DR. FOUTY: The operation went exceedingly well. During the procedure, there were absolutely no problems that occurred. The patient is presently -- her blood pressure is stable, pulse is stable, respiration is stable. She is awake. There is no evidence of any bleeding and her condition is quite satisfactory.

Q These interim reports, will they be issued out of Bethesda or out of 1600 Pennsylvania Avenue?

DR. LUKASH: Through the hospital information.

Q Can we have it also at the White House? Would it be possible to get it simultaneously because we might not be able to be everywhere.

Q And can we get some more today to just wrap up the first day here?

DR. LUKASH: No. I think we will wait until 11:00 tomorrow morning.

Q You won't give any more medical information until 11:00 tomorrow morning?

DR. LUKASH: No.

Q I think we should have a later one -- 7:00 -- just as to how she got through the post operative period.

DR. LUKASH: We will discuss that.

Q Two centimeters as the size of the nodule, is that two centimeters round or two centimeters long?

DR. LUKASH: Two centimeters round.

Q How big is it?

DR. FOUTY: Two centimeters is a little less than an inch. An inch is two and one-half centimeters.

Q Is it oval shaped or round?

DR. FOUTY: Round.

Q About the size of what, a dime or nickel?

DR. FOUTY: No.

Q A quarter.

Q Will you be attending her for the rest of the day, both of you?

DR. LUKASH: Yes. Dr. Fouty will actually stay in the suite all night to be close.

Q Is she still in the recovery room?

DR. FOUTY: Yes.

Q Will she remain there likely the rest of the day, in the recovery room?

DR. FOUTY: No.

Q Doctor, you talked about the percentage here for a very normal situation and earlier you described her situation in terms that seemed to fall within that normal pattern. Consequently -- just so we are accurate here -- is it fair and safe to say that knowing what you know now about her early detection and the size of the nodule, if it has not spread then her chances of recovery are 76 percent?

DR. FOUTY: I would say in general that would be true.

Q By recovery you mean the difference between living and dying?

DR. FOUTY: Yes.

Q So three out of four people -- again stressing that you do not find any spread -- at this point from what you know you are optimistic that she has three out of four chances of survival?

DR. FOUTY: That is correct.

Q When you said that is in general, would you say she has better than three out of four?

DR. FOUTY: Again I would like to come back to the point, we can talk about statistics but we are only talking about general population statistics, and when it comes down to the individual case, one cannot give you an exact statistic on a survival of an individual.

Q If, sir, there had been spread, what does that do to the statistics?

DR. FOUTY: It depends on the amount of spread and this would, in general, again, lower the statistics.

Q You have not determined whether there is spread?

DR. FOUTY: This will not be determined until the final pathology report is returned.

Q Do you have any idea how many women have this a year?

DR. FOUTY: Approximately 66,000 to 70,000 cases are diagnosed each year, new cases, 60,000 to 70,000.

Q That undergo this operation or undergo a breast operation?

DR. FOUTY: They have discovery of a breast cancer, yes.

Q The American Cancer Society says 90,000 for 1974. Would you rectify these?

DR. FOUTY: Yes, sir.

Q Is that 90,000 cases or 90,000 breast operations?

DR. FOUTY: That would be 90,000 cases.

Q How many would be operable?

DR. FOUTY: Again, I would say the majority of these cases today would be operable because there is much earlier detection.

Q You said three or four days for the pathology report?

DR. FOUTY: Yes.

Q I gather that the pathologists are going to be working over the weekend on this.

DR. FOUTY: The process takes fixing. The tissue has to be put into special solutions, so it is not a matter of rushing the procedure through. It is just it has to be done that way.

Q Doctor, why do you take out the lymphatic tissue and the muscle if you do not at this point know whether the cancer has spread to those areas?

DR. FOUTY: Because I don't have microscopic eyes. You cannot tell that the tumor is not in the lymphoid tissue. This is why it is best to remove the tissue.

Q Are there other cases where you might not have taken it out, so in this case there was some sign you saw that led you to make a decision to make it more radical?

DR. FOUTY: No. This would be my procedure for this type of cancer of the breast.

Q By the same thinking, you do not know, then, whether it has spread to other areas of the immediate vicinity of the body, either, do you?

DR. FOUTY: There is no evidence that it has.

Q But your final report will perhaps indicate that?

DR. FOUTY: No. The final report will indicate the involvement in the breast, in the lymphoid tissue. There is no symptom or other evidence to indicate there is any distant disease nor do I expect there to be any at this time.

Q How was it detected? Was there an x-ray?

DR. FOUTY: This was detected by a standard method, physical examination. It is a general policy of our Obstetrics and Gynecology Department, when a female is examined, she also has a breast examination.

Q In other words, it was a visual examination rather than x-ray or some other type?

DR. FOUTY: Actually, an examination by palpation.

Q Say that again?

DR. FOUTY: By palpation.

THE PRESS: Thank you very much.

END (AT 1:00 P.M. EDT)

SEPTEMBER 28, 1974

FILL BY
BILL ROBERTS

MR. ROBERTS: To answer your questions, the surgery concluded at approximately 11:15 this morning.

Q What time did it start?

MR. ROBERTS: Approximately 8:05. The usual practice is to keep the patient in the operating room until she begins recovering from the anesthetic. She was taken to the recovery room at about 11:45.

Now, I have a statement. The President was given a full report on his wife's condition after the operation by Dr. William Lukash. The President visited briefly with Mrs. Ford immediately after the operation. The President and his family are optimistic on the outcome of the operation.

Let me say, as far as all reports on her condition and medical facts, this will be available at 12:30 when Dr. Lukash and the two surgeons who did the operation will be available.

Q Did he visit her in the operating room or the recovery room?

MR. ROBERTS: I believe he visited her in the recovery room.

Q She is still in the recovery room?

MR. ROBERTS: He has left the recovery room.

Q She is still there.

MR. ROBERTS: She is still there.

Q Has he left the hospital?

MR. ROBERTS: I came here from the recovery room area and he has left.

Q You said he visited her briefly. How long is briefly, five minutes, ten minutes?

MR. ROBERTS: What will happen, Dr. Lukash probably will make a statement in five minutes or so describing the operation and giving her condition. Then, we will refer to the two surgeons for whatever questions about the operation you have.

# # # # #

SEPTEMBER 30, 1974

Office of the White House Press Secretary

NOTICE TO THE PRESS

The doctors attending Mrs. Ford issued the following pathology report:

The final pathology report was made available about 4 p.m. today. Mrs. Ford had cancer in the right breast at the location previously described. Examination of the tissue in the lymph bearing area removed at surgery showed microscropic involvement of cancer in only two out of thirty nodes. There was no involvement in local blood vessels. Considering that only two of the lymph nodes were involved, and that there is no clinical evidence of cancer spread to other areas, her doctors remain optimistic for a prolonged survival. During Mrs. Ford's post-operative recovery period, special diagnostic studies will be performed to determine whether x-ray therapy, hormonal therapy, or chemotherapy should be instituted in order to ensure maximum treatment of this cancer.

The President was informed of the pathology report by Dr. Lukash and Mrs. Ford was informed of the report by Dr. Fouty.

The doctors said the President and Mrs. Ford were pleased by the optimistic outlook.

# # #

September 30, 1974

Office of the White House Press Secretary

NOTICE TO THE PRESS

HOSPITAL BULLETIN #3

Mrs. Ford had a much more restful night, awakening only once for medication. She has been sitting in a chair and walking for short intervals and is taking fluids this morning. She has had some mild temperature elevation, typical of a post operative course. The operative site is in excellent condition and all laboratory data and vital signs are within normal limits. The post operative course has been normal and uneventful thusfar. Her condition is good.

# # #

October 1, 1974

Office of the White House Press Secretary

NOTICE TO THE PRESS

Mrs. Ford's doctors, Dr. William Fouty and Dr. William Lukash, report that the First Lady had a very favorable day. They say she is regaining her strength and has been sitting in a chair, reading, watching TV, and visiting with members of the family. She had chicken noodle soup, crackers and tea for lunch. Her temperature has returned to normal and all other vital signs continue normal. Her spirits are excellent.

# # #

Jack Sheehan, Legislative Director, U. S. Steel Workers of America

This Copy For_____

N E W S C O N F E R E N C E #49

AT THE WHITE HOUSE

WITH RON NESSEN

AT 4:18 P.M. EDT

OCTOBER 11, 1974

FRIDAY

MR. NESSEN: This is not a full briefing. Some people asked me if I would provide some material on Mrs. Ford on the helicopter and so forth, which I will.

Before that, I wanted to say that the President met for 40 minutes this afternoon with the President of Somalia, Mohamed Siad Barre, who is also the Chairman of the Organization of African Unity. The President took this opportunity to underline the importance he attaches to strengthening and expanding American ties with black Africa, and his desires for improved relations with Somalia.

They reviewed a range of international issues, including the Middle East and general African issues. The President reaffirmed America's desire for mutually beneficial relations with Africa and steady and peaceful progress toward self-determination in Africa.

You saw the President leave and the helicopter landed on the helicopter pad at the hospital. He went by car, through the side entrance and up on the elevator to the little hallway outside the suite, and in the hallway the nurses and corpsmen who had cared for Mrs. Ford were lined up on both sides and he went around and shook hands with each of them and thanked them and had a few words with each one for caring for Mrs. Ford.

When he walked in, he said, "How is the patient?" Then he shook hands and then when that little ceremony was over, he said, "I hope she has behaved herself. I cannot express adequately our gratitude. You made her feel a great deal better," and then he said, as a joke, "This is a nice place, but I don't think she wants to hurry back."

And then he went into her room for about 15 minutes or so and then they walked out together. You saw how she was dressed and so forth when she arrived. There was no wheelchair or anything. She walked to the elevator, down the elevator and down those little steps on the side.

She stopped at the microphones and said a few words. You have to get that from your colleagues. I did not have a chance to write down everything she said, but basically it was how happy she was and how well she felt. But you can get your quotes from the others who could hear better.

Then they got in the car and drove to the helicopter and got on the helicopter and he sat in his usual seat and she sat across from him. There was a little joking about this was an occasion that called for champagne.

Q On the helicopter?

MR. NESSEN: There was no champagne.

Q The talking was on the helicopter?

MR. NESSEN: Everything I say now is on the helicopter. Then, as the helicopter took off, they both waved out of the window. There were about 75 people who had come to the helicopter to wave goodbye.

Then, as they lifted off, they kept waving after they were in the air for a while, and then she said, "It is a beautiful day." Dr. Lukash leaned over and said, "She looks super," and then they passed over the Mormon Tabernacle, the Mormon Temple, and commented on how beautiful that was, and at one point they flew over a high school where there was football practice going on, and she said, "There is a football game down there," and the President said, "They are just practicing."

Then the President -- he looked out -- pretty much the whole flight was taken up with identifying the landmarks and Nancy Howe, if I did not mention it, was on the helicopter -- Lukash, Kennerly, myself, Colonel Blake -- one of the Air Force aides, and the Secret Service agents.

When we were just about here, the conversation turned around to this dress she was wearing, which was a new dress, and she said something about, "I guess he did not notice my new dress," and the President said, "I will notice it when the bill comes."

Q Was she speaking of the President or --

MR. NESSEN: It was sort of general conversation. I do not have the precise quotes, but that was the general idea.

Q Do you perhaps know the fabric of that dress? Was it suede or --

MR. NESSEN: Why don't you call over to Nancy Howe or somebody on the other side. I amnot a great one for dress fabrics.

She had her hair done yesterday, and then once she got off the helicopter I think you saw everything that went on here, didn't you?

Q Can I ask about her recovery? When she went in the hospital, they told her she would be up there ten days, two weeks, something like that, and she would have a limited convalesence. Can you give us any idea --

MR. NESSEN: As to what her plans are?

Q How will she be physically restricted during the next several weeks?

MR. NESSEN: I did not check with the doctors precisely on that. We will get Bill Roberts to check that out for you.

Q What kind of treatment will she get now?

MR. NESSEN: I don't know that they have decided that she needs any treatment. The idea of these tests were to determine whether she needed any treatment. I don't know what decision has been made yet.

Q Ron, are you going to have a briefing tomorrow?

MR. NESSEN: Saturday? Why would we?

Q You have that meeting, the citizens' group meeting.

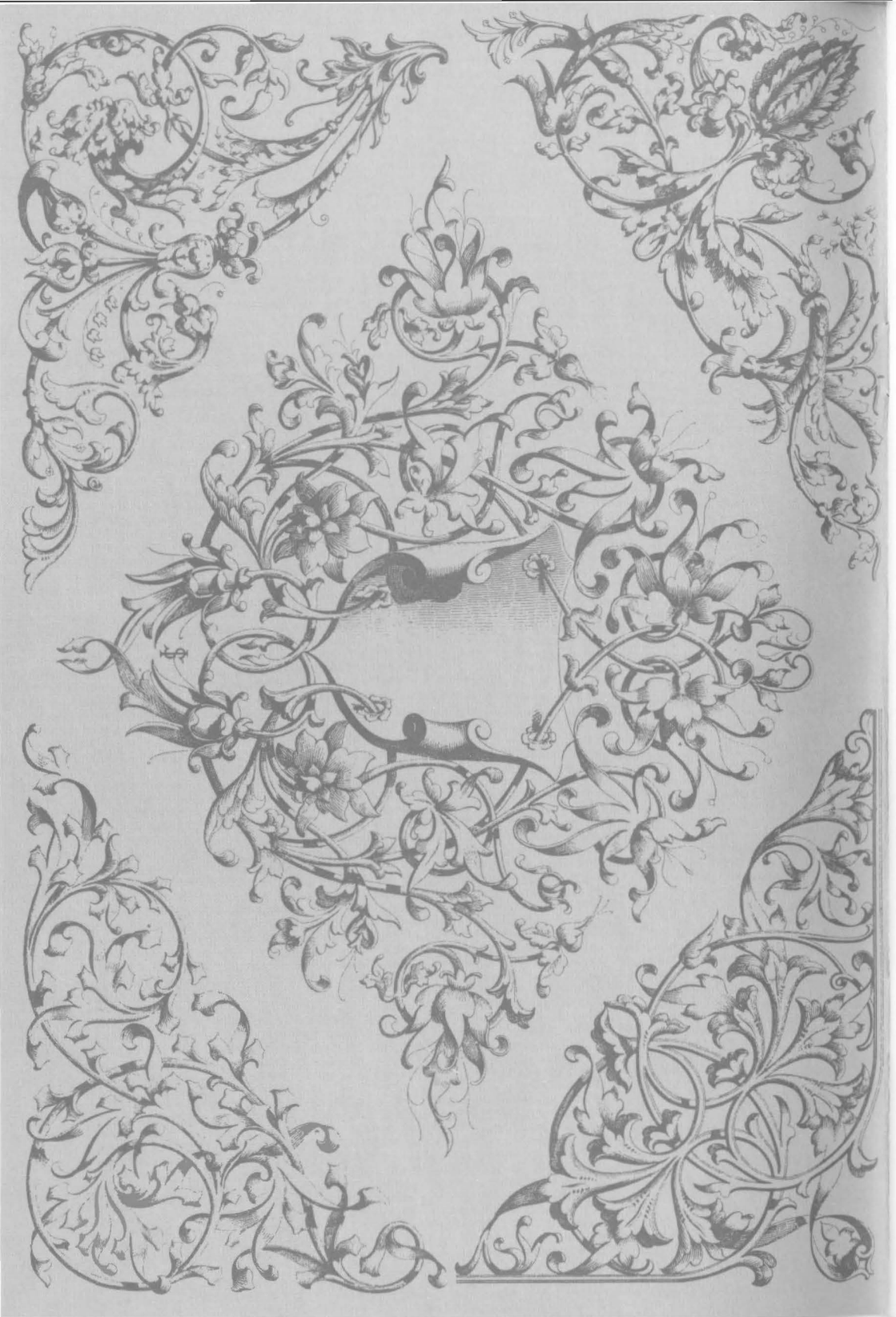
MR. NESSEN: What time is that?

Q Two o'clock.

MR. NESSEN: Do you want a briefing on that?

Q It is the only story going.

MR. NESSEN: Somebody will be here to try to help you out with that.



Reach To Recovery
by
Terese Lasser
National Consultant and Coordinator
of the
Reach To Recovery Program
of the
American Cancer Society, Inc.

Contents

Foreword

We physicians tend to guard our patients and protect them from the nonprofessionals. We assign responsibility to physicians, nurses and members of the allied health professions. It was our custom to discourage patients from discussing their operations with other patients. Our motivation was good. We believed we were acting in the best interests of the woman who had expressed her confidence in our surgical skills by relying on our judgment while she was under anesthesia.

But attitudes have changed—many of them the result of one remarkable woman. Back in 1952, Terese Lasser had a mastectomy. During her recuperation, it became clear to her that not enough was being done for the woman whose life had changed so drastically within the space of a few hours. Through trial and error, she gradually learned how to adapt to her new life style. It was not easy by any means. She learned a basic philosophy, which turned out to be a useful approach to the problems of the mastectomy patient.

For she discovered through personal experience that, as a former mastectomy patient who had adjusted well to her own operation, she could provide psychological assistance to other women on a woman-to-woman basis. How right she was! All one need do is to see the look in the eyes of a recently operated mastectomy patient when she first meets an attractively dressed, active and personable woman who says, "I have had the same operation. You are not alone. Can I help you?"

That was the beginning of REACH TO RECOVERY.

Terese Lasser overcame the obstacles of reluctant acceptance at hospitals, the naysayers who gave nothing but discouragement, impossible travel schedules and the limits of physical tolerance in her one-woman campaign.

Through her determination, the REACH TO RECOVERY Program began to catch on. The more Terese Lasser extended herself, the more one saw the women she had trained carry her message of rehabilitation to hospitalized patients and to those patients who had left the hospital some time before without ever receiving assistance.

By 1969, the potential of the rehabilitation endeavor became clear to the officers of the American Cancer Society, and we merged with the REACH TO RECOVERY Program. The Society was able to offer its nationwide organizational structure of 58 Divisions, 3,000 Units and more than 2,300,000 volunteers. We could help Terese Lasser build further on the solid foundation she had laid.

If we had one complaint about the merger, it would be this —Terese Lasser puts us to shame with her constant enthusiasm, tireless energy and abounding optimism! She is a rare woman indeed.

Arthur I. Holleb

Arthur I. Holleb, M.D.
Senior Vice President for Medical Affairs and Research
American Cancer Society, Inc.

Introduction

I, too, have had the same surgery, and, in 1952, during my own first frightening days and nights in the hospital, the outlook seemed bleakly hopeless.

Overwhelmed by anxieties so acute and so bewildering that I all but drowned in them, my mind surged with questions—some very practical but with no practical answers forthcoming, some rather foolish but nevertheless terribly serious to me, and some so highly personal I could not even bring myself to put them into words. How I ached to talk to another woman who had had the same experience and come through it, and so could counsel, and reassure, and understand!

But no such woman was available.

When I was told to start exercising, "What sort of exercise?" I asked my surgeon, a brilliant specialist and a very busy man.

He told me that my nurse would show me.

"Exercise of any kind," the nurse suggested, "just so that you move your arm."

But exercise was just part of what I had to REACH for. I had to find out—sometimes by painful trial and error—how to cope with all the problems of dress and wardrobe adjustment that breast surgery makes us face. To begin with, I had to discover where to shop for an artifical breast form. I didn't even know it was called a prosthesis—or even how to pronounce the word [pross-thees-is]. Well, it wasn't easy, and I'm happy that things are better organized now.

A few months after my surgery I heard that Helen Kelley (that's not her real name), with whom I'd once worked in the Red Cross, had just undergone this operation and was so profoundly depressed that she refused to talk to anyone and would see no visitors.

A mutual friend suggested that I might be able to get through to this woman something of what I had been learning about RECOVERY after a mastectomy, and perhaps give her morale a boost.

At first I resisted the suggestion. It was so soon after my operation that I had not yet resolved all my own problems of RECOVERY, either emotionally or physically. Helen Kelley was not a close friend; there was no reason she should want to see me, or trust me, or listen to anything I had to say.

But later I did decide to phone the hospital with my request to visit her. I mentioned to the nurse that Mrs. Kelley and I had had the same surgery and, coincidentally, the same surgeon. Early the next morning the same nurse phoned to say that the surgeon, learning of my call, had urged Helen to see me. Now the question was, how to make the most of this opportunity?

When I walked into the hospital room a few hours later, I was wearing a formfitting knit dress and my makeup was very carefully applied. The nurse left us alone. The woman in bed looked at me without, apparently, any recognition whatsoever. When I spoke she did not reply.

Then I remembered my own feelings, lying in just such a bed.

I drew up a chair and sat down and began to talk quietly, almost at random, concerned less for the words than for the thought behind them—that it's possible for a woman to discover within herself wellsprings of strength that she did not know she possessed, tenderness and perception far beyond anything she had ever known before. Rather than being less a person after this operation, I said, a woman's femininity can be enhanced, her ability to love increased, her awareness of her womanhood heightened. I said I was finding all this to be true, myself.

And from Helen Kelley—no response. No movement. No sound. Nothing even to indicate she had been listening.

I stood up.

"I'm running late, Helen. I've been on the go since seven this morning." Slowly her head turned on the pillow. I went on, "A regular merry-go-round! Eighteen holes of golf, then a quick swim, and you can't imagine what it was like driving in here fighting that awful traffic." At long last, a reaction—her eyes were widening in a kind of entranced disbelief. "I'd stay longer," I added, "but I really must get home to change for a cocktail party."

She spoke then, in a choked whisper. "You haven't gone through what I have. They didn't do to you what they've done to me."

"Yes," I said, "Yes, my dear. they did."

I stepped back and waited.

She started to speak and could not. Her eyes filled with tears. Color came into her face, and a glow into her eyes that could only be hope coming alive. She motioned for my hand, and pressed it against her cheek. At that precise moment, I think, the idea for REACH TO RECOVERY was born.

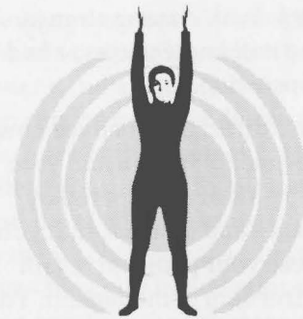
With the help and encouragement of my late husband, J. K. Lasser, I published the first edition of this manual (which has since been translated into many languages and is in use around the world). I worked entirely alone for the first few years. Then volunteers came forward to aid in the work, and have been trained—6,500 at this writing and probably more by the time you read it. They are now helping new patients through this traumatic experience in more than 2,500 U.S. hospitals. When the program merged with the American Cancer Society in 1969, I became a "dollar a year" Volunteer—National Coordinator and Consultant to REACH TO RECOVERY.

I am amazed, looking back, at the great strides that have been made in rehabilitating breast patients in less than two decades.

One further note: REACH TO RECOVERY is not a club. There are no dues. There are no charges. It is a free service of the American Cancer Society available—with her physician's approval—to any woman who has had breast cancer surgery.

Terese Lasser

Terese Lasser
National Consultant and Coordinator of the Reach to Recovery Program, American Cancer Society, Inc.



You, your man, your family

You Are Not Alone

I tell you this not because misery loves company; but because hundreds of thousands of American women who have gone through the same surgery as you are alive and well and living life to the fullest. Among strangers, no one will know you ever had this operation.

It is difficult to believe now, while you are in pain and your movements are hampered by bandages and stitches, that you will lose your pain and regain your freedom of movement. You will be able to drive, swim, play golf, cook, write, sew—do anything you did before. You will be able to wear practically all of the same clothes you wore.

You are not alone, because you have your family and your friends. But it is most important to remember that your experience is not unique; there are several hundred thousand women who have gone through a similar experience and surgery, and have come out of it, back to their homes, lives, families, jobs, avocations. And you are more fortunate than those who underwent this experience 20 years ago—before there was a REACH TO RECOVERY. Then it was truly frightening; then you were truly alone; then there was no practical help or information. Today all that is changed.

Thousands of REACH TO RECOVERY volunteers will visit in hospitals more than a half of all American women who have had breast surgery this year to offer moral support, practical help—and this booklet.

Volunteers are carefully selected and trained by the ACS, and you can be sure that each one cares about you and your recovery. Visits are arranged by your local ACS office.

"Why me?"
Why did this happen to me?
What did I do to deserve this?"—

These may be some of the unbearably painful thoughts you are having right now.

"Your scar is hidden—no one need know"

You probably know that your physician chose surgery for you because he wanted to give you the very best chance of cure.

It's natural for you to feel angry or depressed or sad right now. You have lost an accustomed part of your body.

But *you are more important than any one part of yourself.*

You are the same woman you always were . . .

You will be able to continue your everyday life . . .

Love, friends, a job, swimming, pretty clothes—whatever you enjoyed before you can enjoy now.

There are ways—tried and tested and proved among thousands of women—of assuring that all of these things will come true for you.

You are holding in your hand the fruits of my own first lonely and desperate—REACHING. For that is the key—the physical REACHING that gave me back strength and confidence in my body. And the spiritual REACHING out to others, to life. In helping others, I helped myself, and that is what thousands of REACH TO RECOVERY volunteers have found out for themselves. This is what REACH TO RECOVERY is all about.

For yours is a hidden scar. If you REACH to help yourself, if you understand and *truly believe that you can, no one need know* that you have had a mastectomy unless you choose to tell them. And those who do know—your husband, children, people you love—they will have a chance to love you even more because you are so special to them.

The day will come when you will go on to other things and forget about your hidden scar—if you *love yourself* and believe in yourself. That's being healed within and without.

Love Yourself

We all grow up somehow believing that our bodies will never change. Our self-image is based on this—when we lose a body part, it destroys our image

of who we are. To rebuild that image is an essential part of getting well. *You will find that your greatest strength will come from being able to give to others.* This is what I learned when I founded REACH TO RECOVERY. And all of our 6,500 Volunteers—and of the many thousands of women they have helped—have discovered the same thing.

Time after time I have seen the damage that can be done to a woman if she belittles or hates herself after a mastectomy. The only way to achieve physical and mental well-being is to stand on your own two feet, and this takes the confidence that comes out of loving yourself and life. Remember these lines from Shakespeare . . .

"Our doubts are traitors, and make us lose the good we oft might win, by fearing to attempt . . . "

Don't let the treason of doubting yourself enter your mind. Indeed, women who have had breast surgery have a chance to prove that genuine love is not based solely on physical attributes. They can grow in the love of others. They can show woman's great capacity to give love and warmth.

There is no reason to feel inferior because you have had an operation. You are the same woman you were before. Only you are probably safer, healthier and better able to face the challenge of an even more rewarding tomorrow—if you learn to *love yourself.*

"Love yourself" is really another way of saying that you accept yourself. On the day you really look at your incision and see it in the light of your own true worth—then you will have learned this vital lesson. Believe me, it gets easier as time passes.

Sexuality and Femininity

Almost invariably, every woman who has faced what you are now facing has two primary concerns. The first is her life—will she be cured of cancer? But nearly as important is the

question of femininity, of sexuality, of desirability. One woman asked her husband for a divorce the day she learned she was going to have surgery. She was certain that he would not desire her any more, and she wanted to avoid that by ending the relationship immediately. She was wrong, of course.

And many who have mastectomies are single, divorced, or widowed. They may have boyfriends, or no men in their lives. In any case, there is no commitment; they feel desperately lonely. Their concern about their femininity is perhaps even more urgent than that of a married woman.

These worries are normal. But they are often based on mistaken expectations. The relationship between husband and wife, or between lovers, is almost invariably much deeper than sexual attraction based on visual stimulation. *After my operation,* the shell of emptiness loomed agonizingly close. *I did something very wrong. I underestimated the man in my life.* I was afraid to trust the love that was there for me. For months I undressed in the closet, sure that my husband would prefer it that way. I was really shutting him out, not allowing him to give of his warmth and understanding.

What I was doing was shutting myself out, holding at arm's length the very love and warmth I needed so desperately.

This is a mistake I hope you will not make.

The Man in Your Life

More than anyone else, your man can make you feel needed and wanted. And by doing this he will not only help you regain confidence as a woman, but he will also be able to take pride in his manhood.

I did not realize this for a very long time. I forgot that *a man falls in love with more than your body.* The real you—your sense of humor, the life you've shared with him, your way

of looking at things are all intact. Expression of love-enjoyment has sustained your man's sexual ardor and that will still be true.

Nothing has lessened your ability to love, your womanly capacity for devotion. Nurture that capacity and be proud of your womanhood. Keep in mind as you prepare to face the future that your man is quite sensitive and perceptive enough to respond to your womanhood as he did before—provided that you remember that you're still the woman he loves and behave that way. Passivity or unresponsiveness on your part could build a great barrier between you. But if you eagerly re-affirm your femininity, take pride in it, the future can be better than the past. This is not just talk. It is based on the experience of thousands of women all over the world.

For the Woman Who Is Single . . .

A mastectomy is no bar to romance, to love, and to marriage. *Hundreds of unmarried women have married for the first time after breast surgery.* And large numbers of widows and divorcees remarry after mastectomy, and these marriages are usually better than average.

If you are dating, remember that no one need know about the surgery unless you choose to tell. It's up to you. Don't feel you must talk about your surgery as soon as you meet someone. You don't normally discuss important, intimate subjects until you know a man well. But don't feel that what you may ultimately tell him is a shameful secret. You have been treated for a medical condition. Talk about your surgery only when you are ready and prepared to *give a man some adjustment time and understanding.*

When two people know each other, and are in love, they can discuss intimacies without fear. Your man will have problems and doubts to confide in you. You won't think less of him for that—you'll feel special to be permitted

into his most intimate confidence. He will feel the same about you. In fact, he'll probably revere you for your courage and candor. It is only when you can begin talking freely together about such things that you truly start to build a lasting relationship based on trust, without which romance cannot endure.

Sexual Relations

As your physical health returns, you and your man may experience fears and uncertainty about resuming sexual relations. Talk about it, and problems can be resolved. *Sometimes a change of position can be helpful*—a lessening of weight pressure. Possibly, because your chest may be tender, you may instinctively flinch. Please don't let your husband interpret this as rejection of his affection. Help him understand by telling him that this is just temporary and has nothing to do with your feelings for him.

And the incision . . . remember that it took a little while for you to be able to look at it and accept it—give your man time to do the same. It won't take long. If it was natural for you to undress in front of him before, relax and continue. There will be a natural acceptance if you act naturally.

The way you think of yourself is the way the man in your life will think of you. And, he'll probably think you're great.

Your Family

There are few threats so frightening to a family as the imminent loss of a beloved member, and your family has just faced that peril. It is behind them now, happily, but it will have left its mark.

Don't be surprised, therefore, if they aren't quite at ease with you at first, or that you are very much center stage for a while. What you do, what you say, how you act will be your family's cues for what they do and say, and how they act.

"Children often have fears they can't express"

Children of all ages have fears they often can't express, but as a mother, you know when something is troubling them. The fact that you have been in the hospital has caused them alarm. Explain it in terms you're sure they'll understand. Better than words are attitudes and actions. Show them you love them as you always have. Give them the chance to show their love for you—help you to do little things—let them bring you a book or make a batch of cookies. Most parents don't undress in front of their children—the children need never see your scar. It's up to you to let them know that you are still very much their mother and you know how to do that in the warmest way possible.

The same is true of other relatives. There will be expressions of dismay because all feel menaced when the family becomes vulnerable to a threat. *Your future relationships with your family can be warmer and closer than those of the past;* you can offer reassurance, gratitude for their concern.

How to reach your way to recovery in hospital and at home

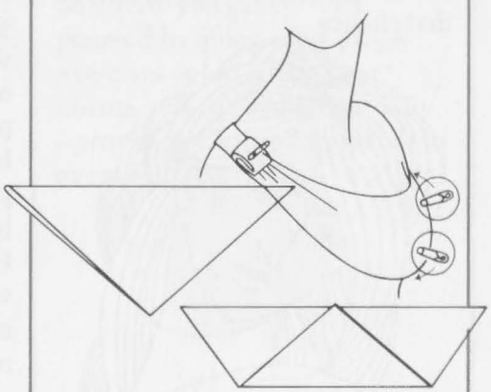
Hospital Helpfuls

(with doctor's permission)

How to:

(1) *Make a walking aid or arm support*—with the help of the nurse or REACH TO RECOVERY Volunteer roll six double or 12 single pads such as hospital "Chux" over a small amount of absorbent cotton and tie with a 2" bandage, 5" from each end, to be placed under your operated arm. An additional two pieces of 27" bandage to go over your opposite shoulder should be tied to each of these ties. This support can be used repeatedly if you will cover it with plastic and soft fabric.

(2) *Make support for breast*—ask the nurse or Volunteer to help you make this simple "uplift"—especially for a pendulous breast. It can give you better balance while walking. Take a large arm fracture bandage, fold ends under one another over 2" by 4" pads in the collarbone area. Pin securely with large safety pins, making a tight cup for the breast with these pins (see circles).



"Reach to Recovery" exercises

Going Home

After a few days in hospital, one tends to become accustomed to the reliable professional routine, as a security blanket.

Meals have been served to you. People have been taking care of you. Leaving all that, no matter how anxious you are to go home, can be upsetting, even frightening. There's a good possibility that you will find yourself tiring easily during your first days at home. *Give yourself a chance to catch up, take it easy, don't force yourself.* Soon you will feel better. But you must give yourself that chance.

Why Exercise?

The meaning of REACH TO RECOVERY is implicit in its name. It includes a system of exercises that will help you RECOVER the physical well-being and activity that you had before surgery. Since you do the exercises yourself, there is also a strong feeling of achievement and a sense of emotional fulfillment at winning your way back from surgery.

Exercises are generally begun before leaving the hospital. But they should never be started without prior consultation with your doctor. Since there are various ways in which your operation may have been performed, it is of the utmost importance that you follow your physician's directions carefully before undertaking any exercises. He alone is qualified to tell you which you may do, when you may begin, and how far you may go.

General Rules of Exercising

Exercise need not be a cause of strain. If when you begin exercising, you feel pain, STOP, take a *slow* deep breath in through your nose, hold it for a few seconds to expand your chest fully—then let all the air out through your mouth. Afterward, let your chest and shoulders sag. You may find it necessary to do this several times to achieve full muscular relaxation—but this exercise will relax you.

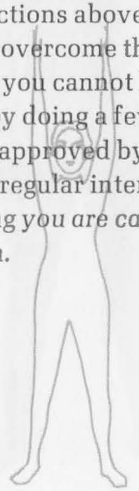
If, when exercising, you feel a slight pulling sensation, STOP, HOLD THE POSITION—breathe deeply until the pull disappears—then try to REACH a little farther, until you feel only a *slight* pull.

Do not expect all stiffness, heaviness or tautness to be gone in a few weeks. But if, about six weeks after your operation, when all stitches have been removed and your wound has healed, you still do not have as much range of motion as you would like—discuss this with your surgeon. Never try to be your own doctor in exercise or in anything else.

For information on relieving tautness of skin on chest, see p. 41.

Exercise to Recovery

The exercises that follow have been perfected over many years to help you REACH your way to RECOVERY. There is a variety of exercises which you can do safely so you may avoid the monotony of repeating the same movements. Some will be painful at first, but by following the instructions above, you will be able to overcome this. *Do not be afraid:* you cannot hurt yourself by doing a few proper exercises approved by your doctor, at regular intervals daily *—providing you are careful not to overstrain.*

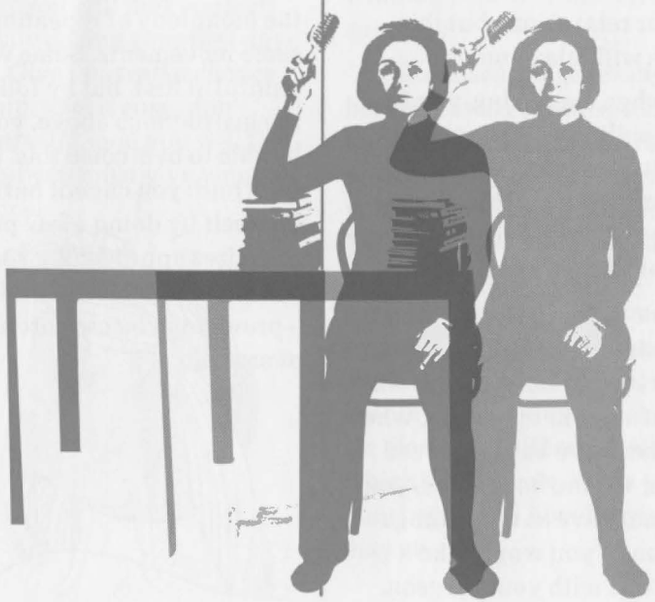


Note: *In all following exercises, the arm to be used is always the one on the same side as your operation, unless otherwise stated.*

Hair Brushing Exercise
(in hospital)

Sit at your night table. Elevate your arm on a few books (in order to rest it). Start combing and brushing your hair, keeping your head *erect*. Start by brushing only one side of your head.

Little by little, work around to the other side until you are completely REACHING the entire head. Rest whenever you feel that you really need to. Don't overdo but be persistent. (Your hair will benefit from this too!)



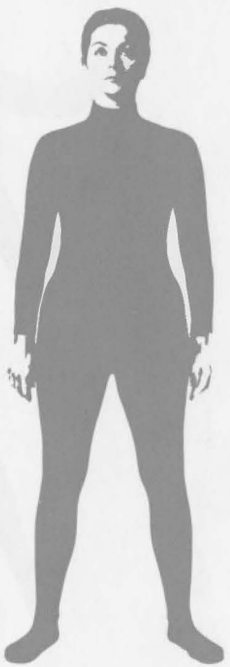
Paper Crumpling Exercise
(in hospital)

Place about 10 sheets of newspaper 10" x 15" in a flat pile. Rest your forearm comfortably on a table. Put your hand on one corner of the pile. Start crumpling the sheets one at a time. Discard each sheet in turn after it is completely crumpled. This exercise strengthens the muscles in the hand and forearm.

Standard Exercise Position

For our standing exercises wear flat shoes, or go barefoot; the standing position is head erect, chin in, arms at sides; weight on the balls of the feet, knees slightly bent and relaxed.

Feet should be apart about the width of the hips—or a wee bit more. This will give you balance and you will not be likely to totter from side to side. Keep eyes straight ahead for all but the ball exercises.



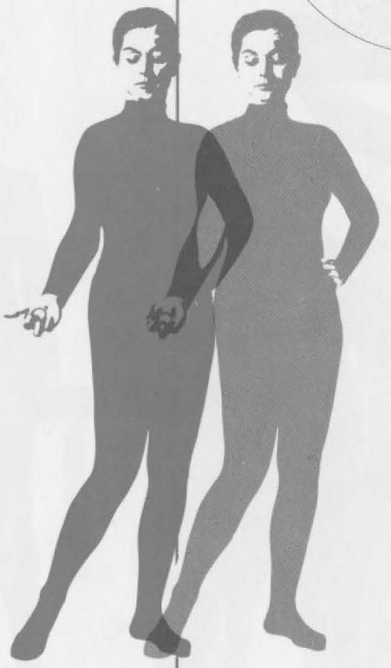
At first, do as many exercises as possible in front of a mirror.

The basic principle of all these exercises is, of course, to REACH. The following exercises have been found to be most helpful (for fun, perhaps you will invent some of your own, too). It is important to keep working at them day by day. Level your shoulders—hold your head erect—chin in—relax—now begin . . .

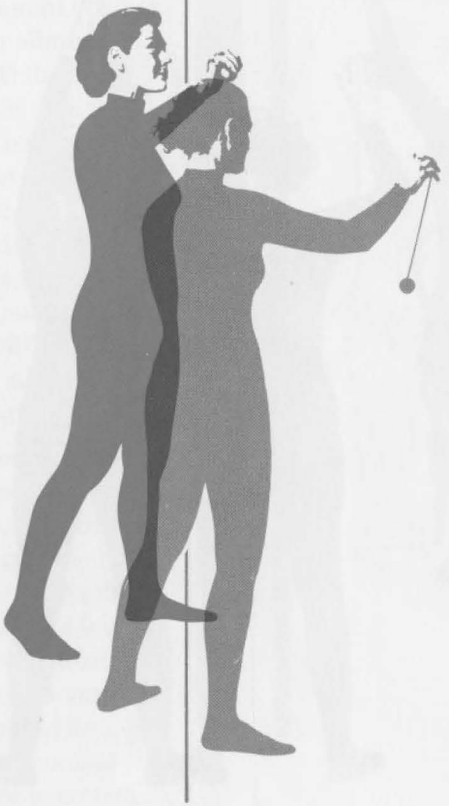
Rubber Ball Exercises

(in hospital—at home)

a) Hold a rubber ball cupped in your hand, alternately squeezing and relaxing. You should feel this throughout your arm. Keep the ball in your robe pocket and repeat this as often as possible.



b) You have a rubber ball with an elastic attached in your REACH TO RECOVERY kit. Tie a small loop in the elastic about 9" from the ball. (Leave about 2" of extra elastic so you can retie and lengthen the elastic easily if necessary. Cut off excess so it won't interfere with the exercise.) Slip the loop onto your middle finger. Throw the ball easily in any direction, moving your arm from the shoulder. Throw it farther and farther each day. This is important. It does not matter whether you catch the ball or not—but it is important that you REACH out to try to catch it. The other hand may help to retrieve the ball. Start by doing this five times in the morning and five times in the evening, working up to about 20 times morning and evening. Use your full arm bent, not the wrist or elbow.

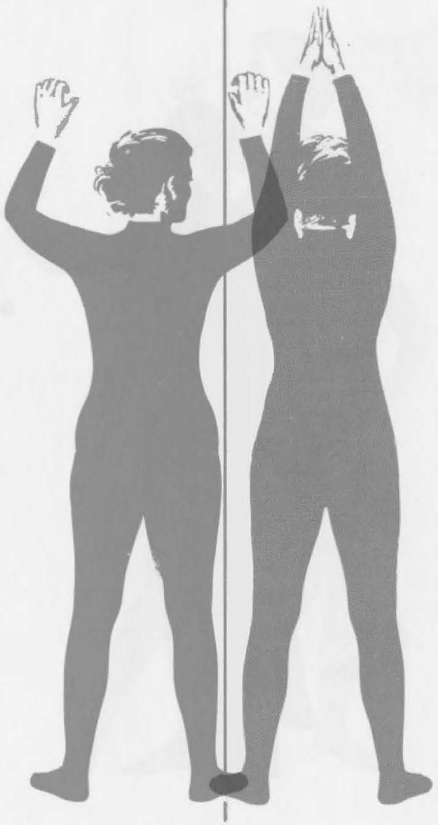


Wall Reaching Exercise

(in hospital—at home)

With feet well apart for balance, stand comfortably close to and facing a wall, forehead resting against the wall, and begin crawling and REACHING with hands *slowly* up the wall, above your head. Slide your hands down to shoulder level, before starting the exercise again. This should be done *slowly* several times a day. Each time mark the spot you've REACHED with pencil or scotch tape to show where you REACHED. Your next mark should be just a little higher. Eventually you should be able to extend your arms up to full length with *elbows straight,* bringing your arms in close to your head, with the palms of your hands touching. Many patients are not able to do this while still in the hospital. A great deal depends upon the type of surgery, your determination, emotions, and many other factors. Do not set unreal goals or comparisons for yourself.

WE WOULD LIKE TO HELP YOU GET BOTH ARMS STRAIGHT UP, CLOSE TO YOUR HEAD AS SOON AS POSSIBLE.

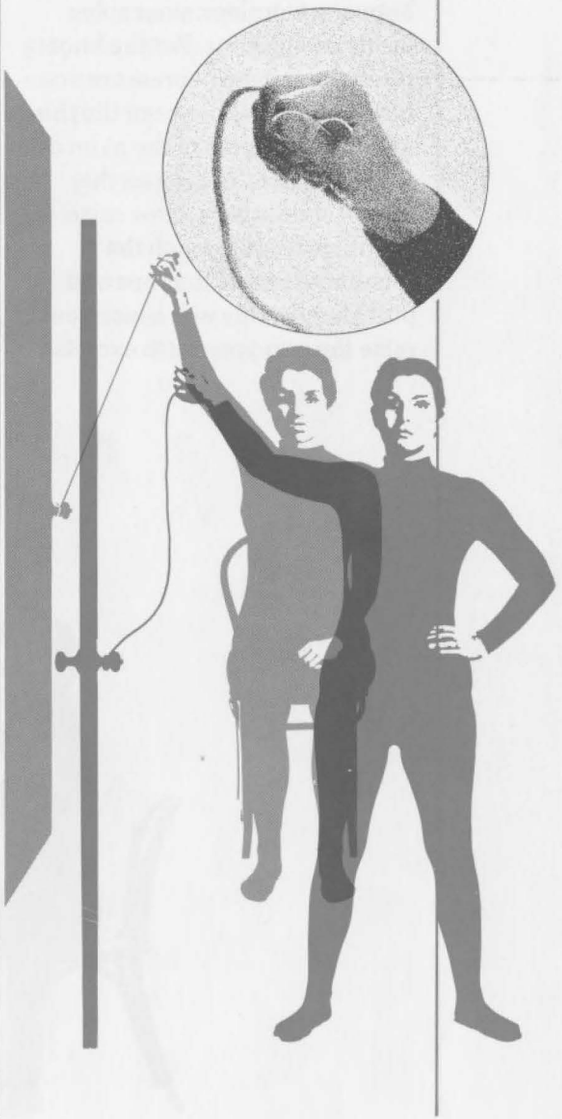


Rope Exercise

(in hospital—at home)

Attach one end of the rope from your kit to a doorknob or to a handle on a piece of furniture. Put the knot (with the tongue depressor) between the third and fourth fingers in the palm of the affected hand. Stand alongside the rope at right angles, looking straight ahead, with the other hand on your hip and feet apart and knees flexed. Start to make small circles with the rope, MOVING THE ENTIRE ARM FROM THE SHOULDER. This exercise can be done seated just as well. There should be a small amount of slack in the rope, and your elbow should be relaxed. At the beginning, you may be able to make only small circles. To make a larger circle, move in closer to the doorknob. Be sure not to compare yourself with someone operated on at the same time who may be able to make larger circles. Remember, different surgical techniques may make a tremendous difference.

The exercise should be done at first five times in one direction and five in the other, with the circle becoming progressively larger. If you feel pain, take deep breaths, hold, relax, rest a few moments until the pain subsides and then start again. It is very natural that there should be some pain. But your doctor has said that you are ready for exercises; therefore you need not be disturbed about slight pain. You must be persistent and work your way out of it. It will usually disappear. Exercise in the morning and evening, *slowly* working up to a total of 20 times in each direction.



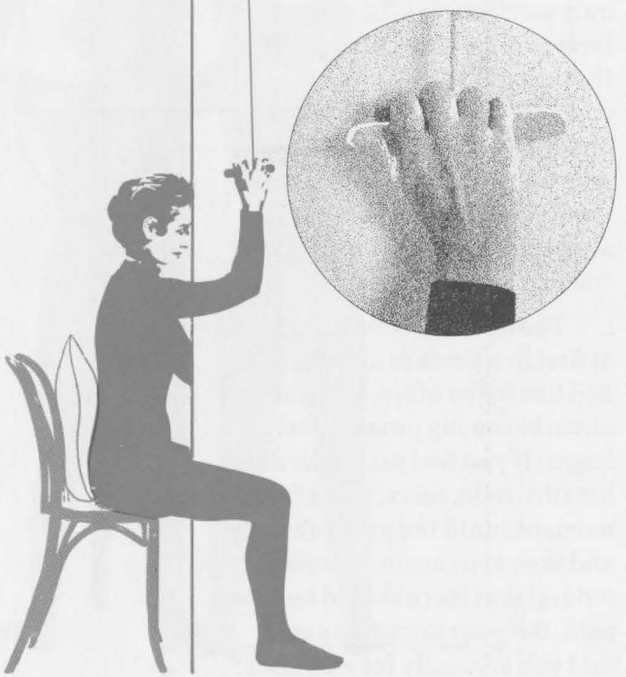
Rope Pulley Exercises

(in hospital—at home)

Throw the rope in your REACH TO RECOVERY kit over the door, screen, shower rod, etc. Sit erect on the front edge of a chair, under the rope pulley arrangement, with the screen or door between your legs, your soles firmly on the floor. Put the knot (with the tongue depressors inside the knot) between the third and fourth fingers in the palm of your hand on your lap on the side of the surgery. Now raise the other hand to catch the remaining end of the rope and pull *slowly*. This will cause you to raise the arm you are to exercise.

Do this very gently and very carefully. Raise your affected arm as high as possible the first time. Keep the pulley close to your nose; in this way the arms will be brought up, with elbows straight, close to your ears, which is one of the purposes of this particular exercise. Breathe deeply while doing this five times each morning and evening, until you are able to get full arm elevation with the pulley on the needed side.

You can also do this exercise in reverse— throwing the rope over a door hook, for example, if you find it more comfortable. Turn your chair with its back to the door . . . and follow through with the same procedure.



(at home)

If you are of slight build you may use the shower rod over the bathtub for this exercise. Sit straddling the edge of the tub, your back touching the wall to which the rod is attached, with one foot in the tub and the other on the floor. Sit on a pillow, it's more comfortable.

At home, as an alternative, have someone drive a large nail into the top edge of a closet door, about six inches in from the outside corner (see circle). If the door is hollow, use an expansion bolt. Be sure nail is driven in at least one inch. This will prevent the door from closing. The nail will not damage the door and it can be removed after you have mastered the exercise. The hole on top cannot be seen.

Sit with legs hugging both sides of the door closely in this exercise, soles firmly planted on the floor.

REMEMBER—ALL EXERCISES SHOULD BE DONE VERY, VERY SLOWLY.

P.S. Equivalent household activities

- ☐ Hanging clothes on a line
- ☐ Putting up curtains
- ☐ Washing windows
- ☐ Rearranging things on high shelves, etc.

Looking your best after surgery

Everything You Need to Know About Breast Forms

They're Washable

First thing that you should know about your REACH TO RECOVERY temporary breast form (prosthesis)—it's washable. You can take the filling out (try to keep it in one piece) and wash it by hand; dry it by putting it in a towel and wringing it out. At home, for machine washing and drying, put the form in its cover inside the foot of an old stocking, knotted at the ankle to keep the fluff from flying all over. If the form is too large for the stocking foot, use the leg, knotting it at the ankle and at the top. After the form dries, gently pull apart to regain shape.

If you don't want to bother with laundering, wear your form inside a thin plastic bag. The pins can go right through the plastic. Wipe with a damp cloth.

How to Insert

To pin the REACH TO RECOVERY form in your bra: when you are alone, stand in front of a mirror, find the low level of the other breast and follow that as the low level of the breast form. Tilt the narrow end of the form at a very slight angle up toward the underarm—make sure that the protrusion is on an equal line with the nipple of your breast and as full in the cup.

Remember, the REACH TO RECOVERY breast form is only temporary.

Your Permanent Form

Just as soon as your doctor gives his permission, arrange to be fitted with one of the many kinds of breast forms which are available in almost all department stores and specialty shops. If possible, go to a good corsetiere who has had experience along these lines. Your REACH TO RECOVERY Volunteer will be glad to help you. See our "how to" section on page 40 for instructions on how to make a form. Or order a ready-made one by using the Prosthesis List and Fitting Instructions available

at your local REACH TO RECOVERY office of the American Cancer Society.

The Form for You

Please don't be influenced to buy a specific form just because someone you know wears it and vows "It's the very best." Make your own evaluation. Be sure it fills your requirements. Mastectomies are done in a number of different ways and your needs may be different from another woman's.

There are many fine ready-made forms on the market—if you are uncomfortable in one type, or if your prosthesis rides up and makes you self-conscious or uncomfortable, try another.

Types of basic forms:

- ☐ Some are made with soft fluid-like fillings—such as silicone, silastic, viscous fluid or glycerin—all are effective.
- ☐ Some come with weights of various sorts to balance your other side. These include rubber covered steel pellets, sand, bird seed, barley, small beads or flat lead weights, etc.
- ☐ Some are made of all rubber—synthetic or real.
- ☐ Some are filled with air.
- ☐ Some are filled with air and soft fluid-like substances.

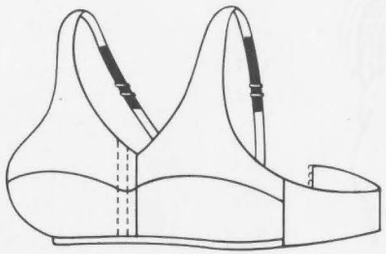
NOTE: Sheepskin pads are available to absorb perspiration.

Fitting Your Form and Bra

When fitting your permanent form, try to wear a dress, sweater or knit that will really hug your chest—stripes are great, or wear anything that will give you a very clear look at the outline of your bosom through clothes. Be sure that your form matches as closely as possible your other breast—from the sides, bottom, front and top. Make sure that the spaces from the front center of your body to each breast are equal, and that the nipples are on an even line. (See illustration above.)

Prices

Prices range from about $1—small forms which can be bought



in stores like the "five and dime" —up to several hundred dollars for individual prostheses made to order.

Incidentally, look into your medical insurance; *some* policies pay for surgical prostheses and special bras.

Income Tax Deductions

- ☐ The cost of breast forms and bras with pockets are *tax deductible* along with drugs and medical expenses.
- ☐ If the corsetiere has to put a pocket in or alter a bra to cover your incision, her charges, too, are deductible.
- ☐ When purchasing such items, be sure that the bills and your checks are marked "surgical".

To insure being able to take a tax deduction of these two items, ask your surgeon to write a prescription for your prosthesis.

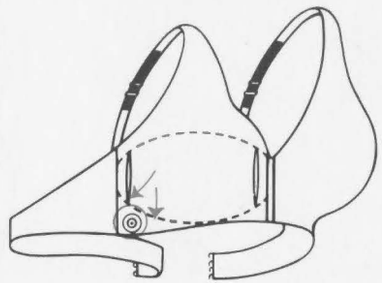
A Good Fit

Remember that a good fit can make a great difference in your comfort and mental outlook. It can help you to forget about your surgery. Unless your bra is well fitted and comfortable, the form won't feel just right, so let's consider the right brassiere for you.

The Right Bra for You

The right bra for you may very well be the one you've always worn. It may help a great deal to use the bra extenders available in any five and dime or notions store to take care of temporary tenderness. Use two extenders or more if necessary. If you are heavy breasted you may find that the shoulder strap on the side of your operation hurts. In the same shop where you found the extenders, you'll probably discover a bra shoulder pad which may help. (See "How to" for other hints on pp. 40-42).

A word of caution: If you are thinking about wearing a wired



bra—check with your physician first. Wear it only with his approval.

Bras that come with sewn-in pockets don't fit most patients properly—be very wary of these.

If you have a bra that is comfortable for you, continue to wear it, but remove the adjuster, and either sew the strap in place, or use the adjuster on the back strap.

Keeping It in Place

Some women find it useful to sew a vertical seam ½" to 1" in from the front center seam of the bra, from top to bottom on the needed side of a short-lined bra, to keep the form from moving towards the center. Begin the new seam about ½ inch from the center of the bra. (See illustration above left.)

In addition to the basic form, some of us require extra "filling in". REACH TO RECOVERY has a basic crescent pattern that you can make in a soft fabric to be filled with fluff (thinning the edges to nothing) and used as an addition along with your prosthesis. It can make a world of difference. Please ask for the pattern. (See "How to" section on p. 40 for details).

Adapting Your Bra

Three different pocket patterns are available through REACH TO RECOVERY. Sew the pocket a little larger than the size of the breast form you've chosen *right down to the bottom* inside the short-lined bra. This will help keep the form on an even line. The pocket should have snaps, either top or bottom, whichever is more comfortable. Many women find it best to sew the snaps on the bottom (see above.) The pocket should also have a small pleat in front, to allow for the depth of the form.

OR use a pocket that doesn't require snaps.

OR don't use a pocket at all—just sew three snaps (in a triangle) on the outside cover of your form and three matching

snaps on the inside of all your bras. Be sure the snaps are large enough to hold and that they match.

Some breast forms are worn close to the skin without any kind of pocket.

Night bras and other bras with fancy names are a story by themselves and deserve a section of their own, which follows.

When You Go to Sleep at Night
Lounging at Home
Doing Housework; etc.

If you've always worn nightgowns or pajamas, don't change. See our "How to" section on p. 41 for instructions about "sleepwear."

If you feel, however, that it is absolutely necessary to wear a breast form at night, lounge-, night- or leisure-bras are available in many stores. These are similar bras under different names. They will be comfortable if large enough not to constrict your body or arms. One has pockets sewn in on both sides: use one for the prosthesis, and remove the other if you like. Some leisure bras are made of very firm, stretch lace for heavier breasts. See our "How to" on p. 41 to make your own night bra from an old bra.

Fashion: Looking Better Than Ever

Home again and wondering about those clothes in the closet and the bras in the drawer?

Wear them!

Thinking about a new outfit?

Go shopping in your favorite store!

Fond of making your own clothes?

Pick out the prettiest pattern in the book—and go to work!

Clothing can and should be as important and exciting to plan, buy or sew, as it was before your surgery. Almost every woman who has had breast surgery can continue to wear her own clothes, and to shop where she always did. You will not need specially

made clothing. You can try things on, as you always did—spend what you spent before.

If you have your surgery in the winter, try to wear soft woolen clothes. They make you feel so much better.

So You Can Lean Over Freely in a Low-Necked Dress

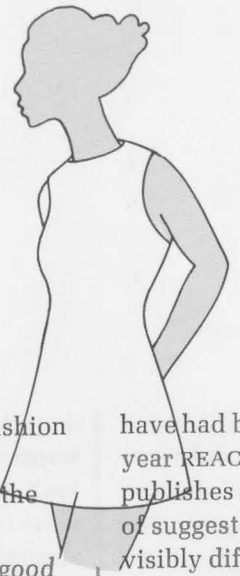
When you shop, look to see whether seams can be let out, and, the shoulder on the needed side can be raised and tightened at a slight slant—a little more at the neck than at the arm to hug the body a bit closer—so you can lean over freely when wearing a low-necked dress or a bathing suit. Sewing several rows of elastic thread shirred, (either round or flat), along the area inside the neckline that you would like still closer to your body, frequently helps. Some dresses and bathing suits may need these slight adjustments.

Sleeveless dresses frequently need reinforcement with a piece of iron-on interfacing ("press-on" tape) or pellon (bought in most department stores) on the lower inside of the armhole to help keep the material from clinging close to the body. Sometimes armholes may have to be enlarged. No one need know of these minor, invisible changes, which can make you feel more comfortable.

Extra Fabric

Occasionally, you may need an extra piece of matching fabric to adjust a dress, suit, or blouse to your needs. In the 20 years since my surgery, I have yet to find a salesperson or anyone who wouldn't cooperate in helping me to get that extra piece of fabric—frequently, at no cost—if the garment is bought early enough in the season. When in need of a small piece of matching fabric and unable to get it, I've used the piece from the underside of a collar (or a hem, or the underflap front of a blouse) to widen an armhole.

In the pages that follow we hope to answer other questions about breast forms, bras, night-



gowns and bathing suits. Fashion is important to a woman's appearance and morale—as the old Chinese proverb says,

"Three-tenth of a woman's good looks are due to nature... seven-tenths to dress."

Swimming with Splash —and Dash!

If swimming has been one of your favorite pastimes, don't think that you have to give it up. It's one of the best exercises for you. In fact, this is a good time to start learning, if you don't know how. Bathing suits need not be made to order. Information on buying and adapting bathing suits follows. For information on making a bathing suit, see p. 42.

Bathing Suits

In all probability you will be able to wear your present swimsuit with very little alteration. Or, if a new one will provide a needed boost to your morale, "big name" designers include in their lines a wide range of styles suitable for women who have had breast surgery. Each year REACH TO RECOVERY publishes a new Bathing Suit List of suggested styles that are not visibly different from those being worn by women who have not had this surgery. They are listed with pictures so you can find the suit best suited to you. Have fun!

Some women are able to wear bikinis—but that's something for each woman to decide on the basis of her figure and age regardless of surgery.

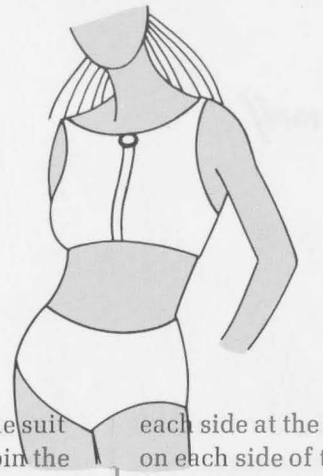
Adapt Your Own Suit

When you are ready for the water, you can adapt your suit by securing a breast form within a pocket; or with several large snaps in the suit, with matching snaps on the breast form cover or the suit's bra, making sure that everything is *well fastened.*

OR you can wear your bra and form under the suit.

OR cut out the bra in the suit and replace it in the suit with your own bra.

OR wear a backless suit with one of your old bras



underneath. Put the suit and your bra on—pin the bra to the front center and the side seams. Then cut the bra on the sides and sew tightly to the side seams of your suit and at the front center. Be sure you leave enough material at the sides to sew the sides *very securely.* Sew the shoulder straps of the bra to the straps of the suit. Wear with any of your old comfortable forms.

OR you may sew a rubber form in the bathing suit or inside a pocket and leave it there.

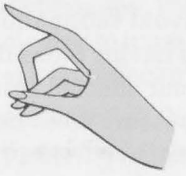
OR inflate an air form and leave it in a pocket in the bathing suit.

Secure Your Bra and Form

Another way to secure a bra to your suit is to sew in five restraints to hold it in place; large lingerie straps will do. Attach one in the center front, one on each side at the seams, and one on each side of the fastener in back. The notions-and-trimmings counters in most department stores stock a tape which has snap fasteners set at regularly spaced intervals; this will serve the purpose. Or, if you wish, you can make your own.

If your breast form is made of rubber, remember when you come out of the pool or surf to squeeze the water out of it. This is easily managed, poolside or on a crowded beach—just use a towel to dry your face and while making a pretense of wiping your eyes, press your prosthesis with your forearm. No one will be wiser! Just squeeze real hard.

For the larger woman who has difficulty in buying a suit, be sure to see "How to" make a bathing suit on p. 42. It is so simple, you will find it hard to believe.



Taking care of yourself

Hand and Arm Care

Ten Practical Pointers

After the type of breast surgery which may include removal of lymph glands in the armpit, there may be a tendency towards swelling of the arm. This swelling may become more severe if your hand or arm is infected or injured. You should therefore take precautions to help prevent this from happening.

In the event of infection, which may appear as redness, pain or swelling—with or without fever or feelings of illness—see your physician promptly. You should also check with a physician if you use cosmetics containing hormones or vitamins. Avoid taking any form of medication without his advice.

Here are some practical pointers about hand and arm care:

☐ Avoid vaccinations, injections or having blood drawn from your affected arm; have blood pressure taken on the unaffected side.

☐ Housework is healthy for you, but ask for help when it comes to lifting heavy things and moving furniture. As for cooking, be wary of burns, use a mitt to cover your hand and arm in the oven.

☐ In manicuring, do not cut the cuticle on your affected hand—lanolin-based cream will help keep the cuticle soft enough.

☐ Take care of cuts and scrapes immediately by washing and covering them with a protective dressing.

☐ Try to carry your purse on your unaffected side. If you must carry it on the side of your operation, avoid shoulder pull by resting it on the forearm, then rest the arm on the hipbone. Or if the bag has a handle, put your arm through it, rest it on the hip and relax your arm by placing your hand on top of the purse. (See above.)

☐ Gloves should always be loose-fitting. Do not wear anything that constricts your hand or arm, such as jewelry or tight sleeves.

☐ When gardening, wear strong work gloves; when sewing, use a thimble, watch out for pinpricks; when washing, avoid harsh detergents; and if you must keep your hands in water, or use steelwool, wear gloves.

☐ To help prevent swelling, try to keep your arm at least shoulder high as much as possible. When seated, rest it on the back of a chair or sofa.

☐ Excessive sunburn may result in swelling. Keep a light scarf or kerchief with you—throw it over your arm from elbow to shoulder if you must be in the sun for prolonged periods. To tan, you can expose the arm gradually, just for short periods, over a number of days.

☐ Any skin area that has had X-ray treatment should be shielded from the sun.

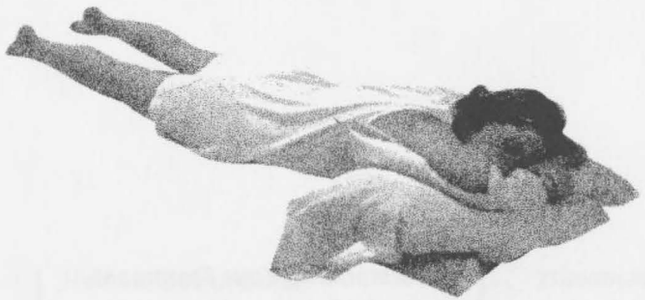
Understanding Your Treatment

Each of us is an individual who deserves the best personal attention. And that is what you have received. With so many thousands of women undergoing breast surgery each year, you may read stories in newspapers and magazines, see programs on television and hear stories from other people. *Do not compare your operation or treatment with anyone else's* because each case is different and therapy varies.

Operations have different names and different purposes. Your surgeon did what his experience taught him was best for you.

Some women receive radiation therapy after their operations. This does not necessarily mean that their tumors were any worse than those of women who weren't given this kind of therapy. It's wrong and damaging to jump to conclusions—ask your doctor.

It's not surprising that there are so many approaches to the



treatment of breast tumors—they go back to earliest times. I'm no historian but of course I'm very interested and you might be too. It is amazing to think that the ancient Egyptians made observations about breast lumps or swellings, while as early as 520 B.C., Atossa, the wife of Darius Hystaspis, was treated by Democedes in the first recorded instance of a breast's being removed that I could find. Of course, the great Hippocrates mentioned breast cancer about 400 B.C. From 30 B.C. to 30 A.D. Aulus Cornelius Celsus was treating breast cancer by surgery.

For Your Well-being

How to:

(1) *Protect your health*—Be sure to keep your followup appointment with your doctor. Every woman who has had this operation should do a quick monthly check of her breast to protect herself. It has been proved that women notice most changes.

Here's how to do the most efficient check. Start in the shower or bath when your skin is slippery and it is easy to feel for any lump or thickening. Do this while raising the arm on the side being checked. Then lie down with a pillow under your shoulder, and feel all parts of your breast with flattened gentle fingers in a rotary motion including area under arm. As a final precaution, check the area over your incision.

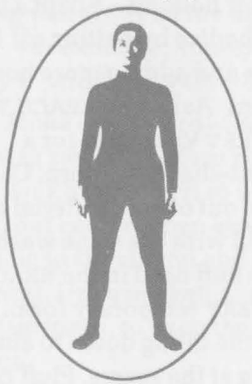
Naturally, anything unusual should be reported immediately to your physician even if you are between visits. Don't be afraid, it will give you peace of mind to know that you are taking care of yourself. Remember, any redness or swelling in your arm should be reported to him.

(2) *Sleep comfortably*—An extra-firm pillow under the affected shoulder usually helps. If you are not too uncomfortable, try to sleep with that arm supported above your head.

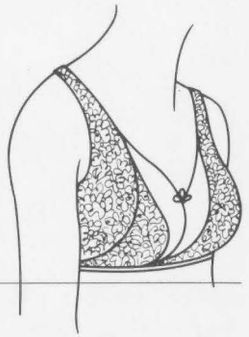
If you are a stomach sleeper, take two pillows, put one on top of the other, then lower the top pillow slightly. With both arms raised, rest your head on the arm opposite the surgery. The elbow on the operated side should be pointed toward the top of the bed, on the turned-under corner of the upper pillow. In this way, it will have the needed elevation. It may take several weeks before you can do this comfortably. *Do not sleep with your head on the arm of the operated side.*

(3) *Look and feel your best*—Include time for rest and relaxation in your day; you do need and deserve it.

- ☐ Watch your diet, avoid weight-gain after your operation.
- ☐ Enjoy being active, gradually return to your favorite sports; keep up with your exercises at home—until you are able to do the REACH TO RECOVERY "YARDSTICK" (see p. 44).
- ☐ Be conscious of your posture to prevent a drooping or raised shoulder on the operated side; stand in front of a mirror to see if your shoulders are lined up evenly—square them by rolling them back and keeping your arms down. Soon you will do this naturally.
- ☐ You will look your best if you feel your best by having a busy life with little time for brooding. Do everything you did before with zest. It's wonderful to be alive, enjoy it!



"Reach to Recovery" how-to section*



Breast Forms, Bras and Skin Color

How to:

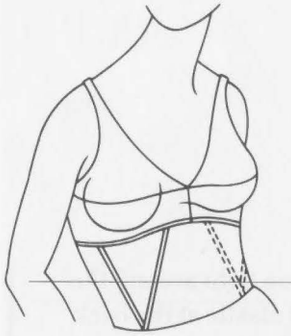
(1) *Make a weighted breast form*—Buy a laminated (glued together) rubber form. Slit a few inches of the top weld or seam and insert cut-up pieces of foam rubber plus any of the following: tiny beads, sand, bird seed, rice, barley or the smallest size upholstery lead weights, to attain the desired weight. The static electricity in the cut-up rubber helps to keep the weighted items more evenly distributed.

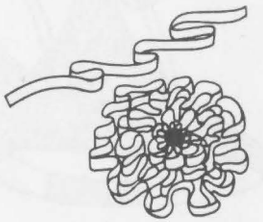
(2) *Make a fill-in for arm and shoulder hollows*—Adapt a dress shield bodice by cutting off the sleeves and adding more hooks in the front. Ask your REACH TO RECOVERY Volunteer for a crescent-shaped pattern. Cut the pattern out of soft material and sew—fill with the same washable dacron fluff used in the REACH TO RECOVERY temporary form. Taper the filling down to almost nothing at the seams. Fluff can be obtained in variety stores or through mail order houses. Attach to shoulder and side seams inside the bodice. (See above.)

(3) *Anchor lightweight forms*—Sew a piece of elastic in a "V" about 2" wide to the bottom front of the bra and attach the point of the "V" with a large hook or garter fastener to the top of your panty or girdle. You may need more than just the one "V"-shaped piece of elastic. (See illustration above right). Regular garters may be used the same way. An additional 2" piece of elastic should be sewn on the back of your bra strap on the operated side to allow for greater mobility.

(4) *Ease a shoulder strap*—If the strap is painful on the operated side lower it and tuck it into the bra; wear a full slip to keep the bra close to the body. Frequently, bra shoulder pads found in the five and dime store will help.

* *Includes supplementary exercises*





Sleepwear

(5) *Cover skin discoloration*—Try a waterproof cream. One of these, "Covermark," is available in seven shades from fair to black. It lasts for 24 hours if used according to directions. Toners and rouge may be used together for more natural tones. If the cream hardens, add one or two drops of baby oil to soften before applying.

(6) *If there is skin sensitivity to form*—Place it in a proper sized plastic "baggie" or have a cotton pocket sewn in bra.

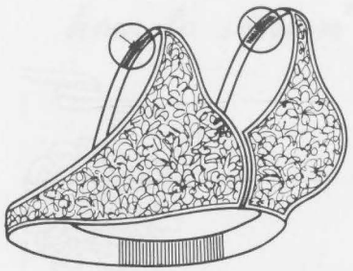
(7) *Make your prosthesis match your skin color*—Dip the form cover in a strong brew of coffee or tea; if that doesn't darken it enough, use a good dye. In general, the dye will not damage the form. You can also tint most of the fluid breast forms the same way.

(8) *Ease tight skin*—Apply lanolin or cocoa butter cream to hands and chest—avoid creams with hormones unless your surgeon has given his O.K.

How to:

(1) *Adjust a nightgown or pajamas*—Sew soft nylon or lace ruching (netting) into a full rose-like shape by gathering it all together and place it in your gowns or pajamas. Cover gathered stitches with a small, thin piece of rubber or soft material over stitches. The yardage will give you the size—for example, approximately 4 yards for size 34B. The width of ruching will give you the desired depth—for example, approximately 2" width for 34B.

(2) *Make a night bra*—Cut an old bra in two, sew a firm ribbon to the back and bring it to within 6" of front center—then sew 6" of elastic to the ribbon and hook it in front. Use a pocket, or a few hooks or snaps, to keep the form in place.

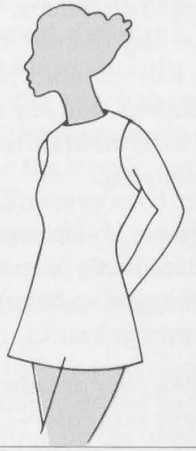


(3) *Adjust a "store bought" night bra*—If too short, cut shoulder seams and insert proper width elastic, adding an extra inch or more on the side of the surgery; if too tight around the body, insert elastic at the back bottom for more width; if too large around the body, make a dart in bottom center back.

For Swimmers

How to:

Make a bathing suit—Take one of your own sleeveless dresses or buy a lined sleeveless dress—turn the hem up to proper length. If the dress is unlined. attach a slip inside to the shoulders and side seams before raising hems. Use with two pairs of heavy jersey panties in the appropriate color. Use your own bra. It works out beautifully!



Lifting and Carrying

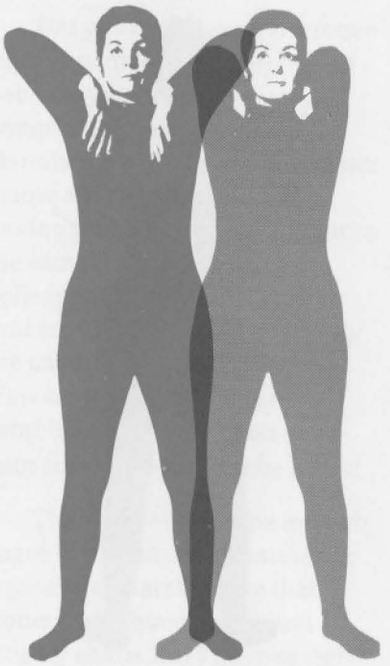
How to:

Lift and carry a baby or heavy package—approach object sidewise. Bend knees. The foot nearest the object should be about 12" ahead of the other foot. Embrace object. Lift, by straightening knees—in other words, you are using your thigh muscles to lift, and putting no strain on your arms or back. Move your shoulders back. Rest the weight of the object as far back as possible on the hip.

Relaxing with Other Exercises (at home)

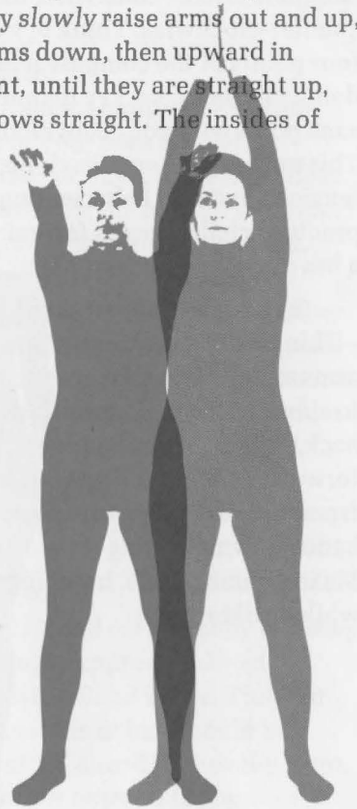
How to:

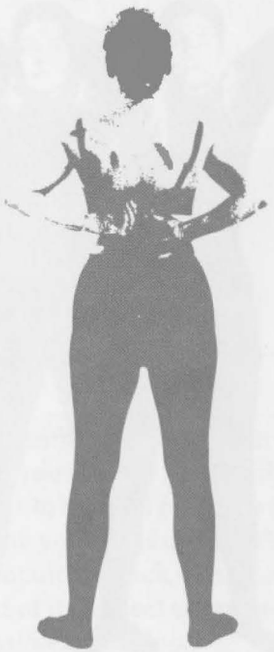
(1) *Relax back, neck and shoulder muscles*—Stand with relaxed knees and shoulders, elbows bent, arms shoulder high, hands hanging loosely. Very *slowly* rotate arms back from the shoulders towards the shoulder blades, round and round, in a complete circle—clockwise, then counter-clockwise. Think of the four points of the compass while doing this exercise. Try to touch each point with your bent elbows. This not only relieves back-neck tensions, but will help meet such practical challenges as fastening a bra or putting up your hair.



(2) *Avoid dropped shoulders*—This is an extra exercise. Keep arms and hands down and close to sides. Roll shoulder blades back, with palms of hands facing forward and thumbs rotating out from the sides. Keep arms and hands down touching sides. Make a game of this, try doing it while walking.

(3) *Check your arm mobility* —This is the REACH TO RECOVERY "yardstick" and should only be tried after leaving the hospital, after you have been doing your exercises regularly. Take the standing R to R exercise position, very *slowly* raise arms out and up, palms down, then upward in front, until they are straight up, elbows straight. The insides of your upper arms should touch your ears. Thrust upward a little more, turn your hands in, touching your palms, and then lower your arms to your sides. Now pretend to tie an apron string and then fasten your bra—when you have met this "yardstick," you can stop formal exercises! Make good posture a habit.





A new beginning

Reach Forward

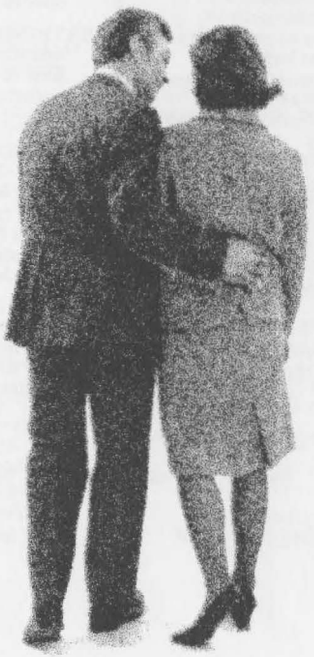
The end of this book can mark a new beginning if you REACH FORWARD to a more vigorous, exciting and fulfilling life than the one you knew before your operation.

Yes, you are a woman who has had a breast removed.

But you are more of a woman than you have ever been before because you have new compassion, grace and understanding. You're the same mother —now a little more patient— having greater awareness. You're the same friend—the same colleague. If unmarried, know that marriages after this surgery are usually better than average. New understanding has been established between you and your man. *Please don't be afraid.*

There never could be enough pages in a manual to contain the hope and understanding that women who have had breast surgery share. But I have saved something for the last—my heartfelt hope that you will truly believe in yourself, with more patient understanding—*and my prayer that you may have blessings always.*

Terese Lasser



Index

Presented To.....

Date.....

Hospital.....

Doctor's Name.....

Reach To Recovery Volunteer.....

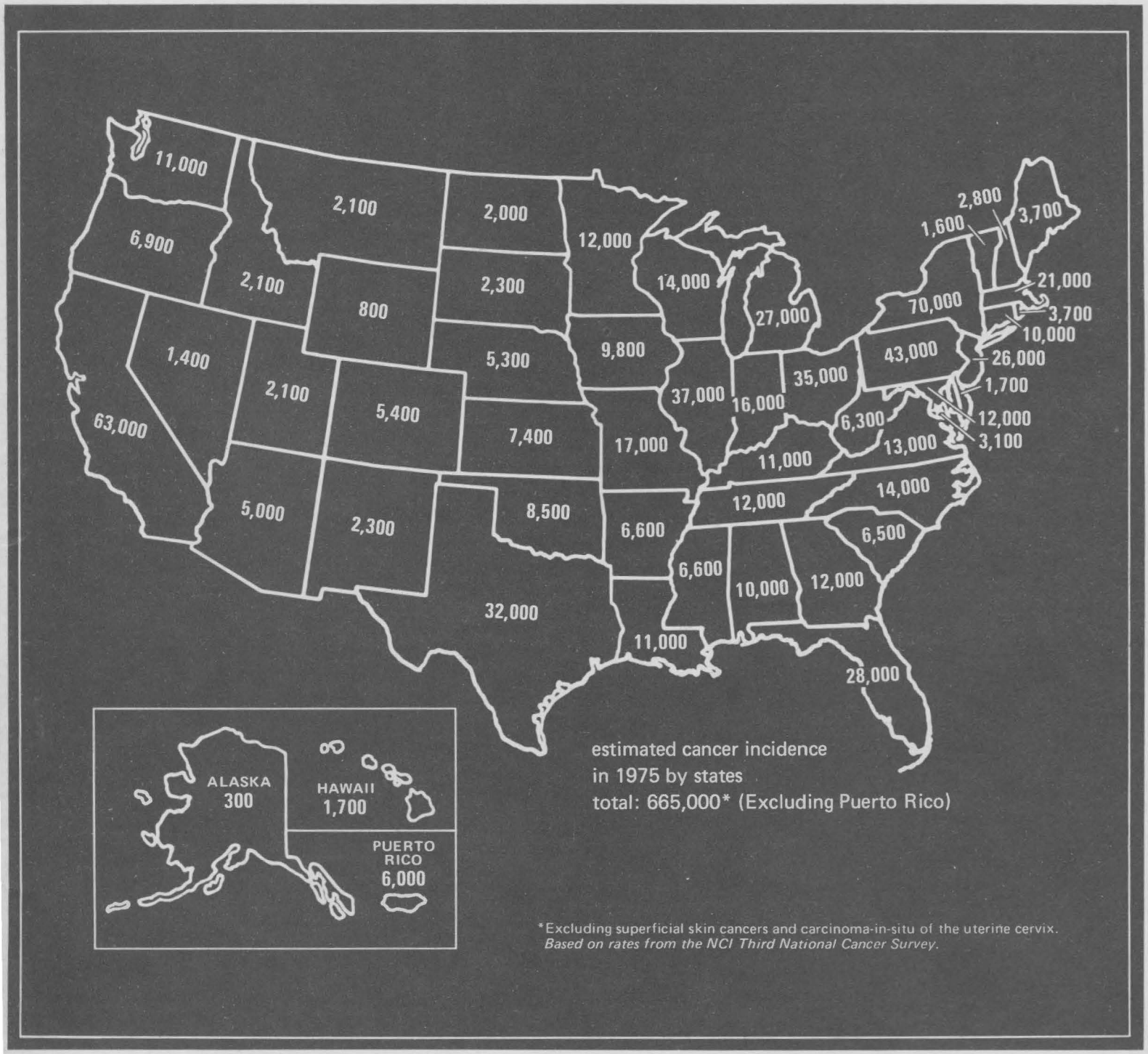
Telephone.....

Hours To Call.....

74 - 100M - 11/74 - No. 4600

'75 CANCER FACTS & FIGURES

AMERICAN CANCER SOCIETY®



estimated cancer incidence
in 1975 by states
total: 665,000* (Excluding Puerto Rico)

*Excluding superficial skin cancers and carcinoma-in-situ of the uterine cervix.
Based on rates from the NCI Third National Cancer Survey.

CONTENTS

CANCER'S 7 WARNING SIGNALS

Change in bowel or bladder habits

A sore that does not heal

Unusual bleeding or discharge

Thickening or lump in breast or elsewhere

Indigestion or difficulty in swallowing

Obvious change in wart or mole

Nagging cough or hoarseness

If YOU have a warning signal, see your doctor!

THE 7 SAFEGUARDS URGED BY ACS

Lung: Reduction and ultimate elimination of cigarette smoking.

Colon-Rectum: Proctoscopic exam as routine in annual checkup for those over 40.

Breast: Self-examination as monthly female practice.

Uterus: Pap test for all adult and high-risk women.

Skin: Avoidance of excessive sun.

Oral: Wider practice of early detection measures.

Basic: Regular physical examination for all adults.

BASIC DATA

What Is Cancer?

Cancer is a disease characterized by abnormal growth and spread of cells. If this malignant process is not controlled or checked, the patient will die. However, many cancers can be cured if detected early in their development and treated promptly.

How Treated?

By surgery, X-rays, radioactive substances, and various drugs, chemicals and hormones.

How Many Are Being Saved?

About 222,000 Americans will be saved from cancer this year. This means that about one-third of all people who get cancer will be saved.

How Many More Could Be Saved?

Another 111,000 cancer patients will probably die in 1975 who might have been saved by earlier and better treatment.

Survival Rate Is One-In-Three

In the early 1900's few cancer patients had any hope of long-term survival. In the 1930's fewer than one-in-five was being saved – that is, alive five years after first being treated. In the 1950's one-in-four was being saved. Now the ratio is one-in-three. The gain from 1-4 to 1-3 currently amounts to some 55,000 lives each year. Of every six persons who get cancer today (exclusive of superficial skin cancer and carcinoma-in-situ of uterine cervix), two will be saved and four will die. Numbers 1 and 2 will be saved. Number 3 will die but might have been saved with early diagnosis and prompt treatment. Numbers 4, 5 and 6 will die of cancer which cannot yet be controlled; only the results of research can save these patients. This means that about half of those who get cancer could and should be saved. Thus, the immediate goal of cancer control in this country is saving 333,000 lives, or half of those who get cancer (other than superficial skin cancer and carcinoma-in-situ of the uterine cervix) each year.

Who Will Get Cancer?

Cancer strikes at any age. It affects children as well as adults, but it strikes with increasing frequency with advancing age.

How Many Will Get Cancer?

About 53 million Americans now living will eventually have cancer; one-in-four persons according to present rates. Cancer will strike over the years in approximately two of three families. In the 70's, there will be an estimated 3.5 million cancer deaths, 6.5 million new cancer cases, and more than 10 million under medical care for cancer.

How Many With Cancer?

This year more than 1 million Americans will be under medical care for cancer.

New Cases Annually

There will be about 665,000 new cancer cases (diagnosed for the first time) in 1975. (This does not include superficial skin cancer or carcinoma-in-situ of the uterine cervix, which have been included in past years.)

These estimates of the incidence of cancer are based upon data from the National Cancer Institute's Third National Cancer Survey (1969-71). The incidence of superficial skin cancer is shown

One important way of improving treatment yield is selective, earlier detection – determining population groups more likely to have cancer and providing frequent and inexpensive checkups for them. Short of a universal screening test that would disclose the presence or absence of cancer, identifying high risk groups can be a most effective step in saving more lives.

The following are the major cancer sites for which some high risk categories have been identified.

Lung Cancer: It is estimated that cigarette smoking causes at least 80% of lung cancer. The highest number of male lung cancers occurs in age group 60-69, in men who have smoked two or more packs a day for 20 years and who started smoking before age 15. A male in this group has a 15 to 20 times greater chance of dying from lung cancer than his counterpart who never smoked. He also has a significantly higher risk of getting cancer of the larynx, bladder and oral cavity.

The largest number of female lung cancers occur in age group 55-64, in women who have smoked one or more packs of cigarettes a day for at least 20 years, inhale smoke deeply and begin smoking before age 20. A woman in this group has a risk of dying of lung cancer 5 to 10 times that of a female who never smoked.

Breast Cancer: High risks in the U.S. are: 1) women over age 35 – risk increases with age; 2) a woman who has never had a child; 3) a woman who bore her first child after age 25; 4) women whose mothers or sisters had breast cancer; 5) women who experienced early menarche and/or late menopause.

Gastric Cancer: A recent study of Japanese (who have a very high incidence of stomach cancer) gives some interesting clues to high risk. The elevated incidence of gastric cancer continues for Japanese who migrate to Hawaii but does not persist among their offspring. Diet is a likely causative factor and evidence for a higher incidence of gastric cancer was observed among frequent consumers of pickled vegetables and dried salted fish, but not for consumers of raw fish and unprocessed vegetables.

Diet has been suggested as the causative factor in all countries with a high incidence of gastric cancer.

Colon-Rectum Cancer: The familial tendency for polyps has been observed and a high incidence of colon-rectum cancer in patients with a history of familial polyposis is documented.

Cancer of the Uterine Cervix: The high risk female for this cancer is of low income background, who never has had a Pap test or regular checkups, has borne children, has a history of early sexual intercourse with multiple partners.

Cancer of the Endometrium: Most cases of this cancer occur in women between the ages of 50 and 64, women with late menopause, postmenopausal bleeding, obesity, a tendency toward high blood pressure, and a history of diabetes.

Other cancers: There is evidence of a relationship between cancer and certain industries, such as asbestos, typography and roofing, plastics – vinyl chloride and arsenic processing. (See page 28).

Practical Controls

The ACS sometimes in cooperation with the NCI, is initiating practical control measures toward improving early case finding. Examples are: the Society's Uterine Cancer Task Force program of having a Pap test for every woman in the country and the Breast Cancer Task Force program, which has already established 27 centers where mammography, thermography, xeroradiography and clinical examinations are being tested.

TRENDS IN CANCER

- The overall age-adjusted cancer death rate for American women has been declining slowly but steadily since 1936. The total drop has been about 13%, largely due to a sharp reduction in mortality from cancer of the uterine cervix, a readily detectable disease.

- The death rate for men since 1930 has risen by over 40%, due mainly to a 2,000% increase for lung cancer, a highly preventable disease.
- Since 1949, more men than women have been dying from cancer each year; in 1975 about 55 to 45.
- Better 3-year survival rates were reported among white Americans since the 1940's for cancers of the bladder, brain, breast, cervix, body of the uterus, larynx, thyroid, prostate, chronic and childhood leukemias, Hodgkin's disease, melanoma and multiple myeloma at the 7th National Cancer Conference, co-sponsored by the ACS-NCI in September, 1972.
- The same report noted "little or no improvement in life expectancy" for patients with lung and pancreas cancer.
- Deaths by age groupings show more than half of all mortality among persons over 65.
- Cancer is the leading cause of death among women age 30 to 54.
- In 1975, cancer will take the lives of about 3,500 children under 15 and about half of them will die of acute leukemia, a cancer of the blood-forming tissues – a notable reduction from the maximum deaths (4,615) recorded in this age group in 1965.
- More school children die of cancer than from any other disease.
- The overall incidence of cancer among men is increasing, but among black men the incidence is substantially higher. The cancer mortality rate per 100,000 population has increased by 50% for black men against 16% for white men. In black women, the mortality rate has been declining, but by 3% while it declined by 9% among white women.
- The increase among men is attributed to higher incidence of prostate cancer as well as lung, and to a lesser increase in colon cancer. The decrease among women is attributed to a drop in cancers of the stomach and rectum, as well as cervix.

Trends in Individual Sites

- Lung cancer: The male mortality rate has increased more than 20 times in 45 years and is going up steadily in women. Incidence has doubled in both men and women, both black and white. It is second in incidence only to colon-rectum cancer overall and first in incidence in men.
- Colon-rectum cancer: Excluding skin cancer, it is the site of the greatest number of new cases estimated for 1975. Slight, if any, recent change in incidence or death rates.
- Breast cancer: It is the leading cause of cancer incidence and death among women today. Leading cause of all deaths among women 40-44 years of age and second leading cause of death for other age groups. No great reduction in mortality rate in the past 35 years. Survival is 85%-90% when found early.
- Uterine cancer: Deaths continue steady decline, now are one-third of rate 35 years ago. Two factors contribute – better programs of education for women and wider use of Pap test for cancer of the uterine cervix.
- Pancreas cancer: Highly fatal, with incidence up 65% in past generation, 200% in the past 40 years. No known reason.
- Larynx cancer: Strikes few women, survival rate among men improved into the '60s but has since leveled off.
- Stomach cancer: Steady decrease, both sexes; about half the death rate of 20 years ago. Reasons unknown.
- Cancers of the bladder, kidney, brain, lip-tongue-mouth: Improvement in survival through the '40s, a plateau since early '50s.
- Prostate and thyroid cancers, Hodgkin's disease: All show some improvement in recent survival information.
- Leukemia: No great change in survival data of chronic forms but acute leukemias show continuing dramatic improvement.

Estimated Cancer Deaths for All Sites, Plus Major Sites, by State — 1975

State	All Sites		Major Sites								
	Number of Deaths	Death Rate per 100,000 Population	Breast	Colon-Rectum	Lung	Oral	Uterus	Prostate	Stomach	Pancreas	Leu-kemia
Alabama	5,600	155	425	550	1,300	125	250	350	175	375	200
Alaska	200	60	15	20	50	5	10	10	10	10	10
Arizona	3,000	151	225	300	700	70	50	150	100	150	125
Arkansas	3,700	183	225	400	900	75	100	275	125	250	200
California	34,500	161	3,200	4,300	7,700	750	1,000	1,600	1,400	1,800	1,400
Colorado	3,000	128	275	400	600	60	70	175	100	175	150
Connecticut	5,500	171	500	800	1,100	175	125	250	250	325	250
Delaware	950	163	70	125	225	25	20	40	30	50	30
Dist. of Columbia	1,600	213	175	200	325	60	60	90	60	80	40
Florida	16,600	236	1,200	2,100	4,400	350	400	900	600	950	500
Georgia	6,600	136	550	650	1,600	150	275	375	250	350	275
Hawaii	900	104	60	90	150	30	20	30	90	60	50
Idaho	1,100	145	90	125	200	20	25	80	40	70	70
Illinois	20,100	171	1,900	2,900	4,300	450	700	1,000	850	1,100	900
Indiana	8,800	160	800	1,300	2,100	175	325	450	250	500	350
Iowa	5,400	183	500	900	1,100	100	125	350	175	250	275
Kansas	4,100	172	375	550	850	90	125	275	100	225	200
Kentucky	5,800	175	425	800	1,400	150	200	300	150	325	275
Louisiana	6,000	154	475	600	1,600	150	200	325	250	300	250
Maine	2,200	211	175	300	475	40	60	125	90	100	80
Maryland	6,600	159	600	900	1,700	175	200	325	200	325	200
Massachusetts	11,400	189	1,200	1,700	2,300	300	300	500	525	600	400
Michigan	14,500	153	1,400	1,900	3,200	300	425	800	525	700	550
Minnesota	6,600	163	600	950	1,100	125	125	450	300	375	275
Mississippi	3,600	153	275	400	850	70	125	250	150	225	200
Missouri	9,200	190	800	1,200	2,100	175	275	550	275	475	400
Montana	1,300	177	100	150	250	25	30	70	50	80	60
Nebraska	2,800	180	250	425	500	60	70	175	100	175	150
Nevada	800	153	60	80	200	15	20	25	10	60	30
New Hampshire	1,500	193	150	250	350	30	50	80	40	80	70
New Jersey	14,300	189	1,400	2,200	3,000	300	400	600	650	800	500
New Mexico	1,300	116	100	125	250	20	30	60	50	70	50
New York	37,700	194	4,000	5,800	7,800	800	1,000	1,600	1,700	2,100	1,400
North Carolina	7,300	137	600	800	1,700	175	300	400	225	425	350
North Dakota	1,100	167	90	150	175	15	25	70	60	80	50
Ohio	19,100	170	1,800	2,700	4,200	425	650	900	700	900	750
Oklahoma	4,700	177	350	550	1,100	80	125	300	150	275	200
Oregon	3,900	179	325	500	850	80	100	225	125	200	200
Pennsylvania	23,500	193	2,300	3,600	4,800	500	750	1,200	950	1,200	950
Rhode Island	2,000	200	200	350	450	60	50	90	100	90	60
South Carolina	3,600	131	300	375	800	80	150	225	100	250	150
South Dakota	1,200	170	80	175	200	20	40	100	50	90	80
Tennessee	6,600	161	550	750	1,600	150	225	400	200	400	275
Texas	18,000	150	1,400	2,000	4,500	375	600	900	650	1,100	900
Utah	1,100	95	100	150	175	20	30	80	50	50	60
Vermont	850	181	70	150	175	20	30	60	30	50	40
Virginia	7,200	147	650	900	1,800	175	250	375	225	425	275
Washington	5,800	162	500	700	1,500	125	150	350	225	325	275
West Virginia	3,500	195	250	400	900	70	125	200	125	200	125
Wisconsin	7,800	167	800	1,200	1,300	175	200	450	350	400	325
Wyoming	500	142	40	60	100	10	10	40	15	30	20
United States	365,000	170	33,000	49,000	81,000	8,000	11,000	19,000	14,000	20,000	15,000
Puerto Rico	3,000	105	125	175	250	175	200	175	425	100	125

Estimated New Cancer Cases for All Sites, Plus Major Sites, by State — 1975

State	All Sites*	Major Sites								
	Number of Cases	Breast	Colon-Rectum	Lung	Oral	Uterus (Invasive)	Prostate	Stomach	Pancreas	Leu-kemia
Alabama	10,000	1,100	1,100	1,400	350	1,000	1,000	300	400	300
Alaska	300	50	50	60	15	20	20	15	10	20
Arizona	5,000	600	600	800	150	350	450	150	200	150
Arkansas	6,600	600	800	1,000	200	500	800	200	250	300
California	63,000	8,700	8,700	8,700	2,300	3,900	4,700	2,300	2,100	2,000
Colorado	5,400	750	800	650	150	350	550	150	200	200
Connecticut	10,000	1,400	1,700	1,300	450	550	750	400	350	350
Delaware	1,700	200	300	250	70	100	100	50	50	40
Dist. of Columbia	3,100	450	400	350	200	250	250	90	80	60
Florida	28,000	3,300	3,900	5,000	1,100	1,600	2,700	1,000	1,000	700
Georgia	12,000	1,500	1,400	1,800	450	1,100	1,100	400	350	400
Hawaii	1,700	100	200	200	80	80	60	150	60	70
Idaho	2,100	250	250	250	50	100	250	70	70	100
Illinois	37,000	5,100	5,800	4,800	1,300	2,700	3,000	1,400	1,200	1,200
Indiana	16,000	2,200	2,700	2,300	450	1,300	1,400	400	500	500
Iowa	9,800	1,300	1,800	1,300	300	650	1,100	300	300	400
Kansas	7,400	950	1,100	1,000	250	650	800	150	250	300
Kentucky	11,000	1,200	1,400	1,600	400	900	900	250	350	400
Louisiana	11,000	1,300	1,200	1,800	450	850	950	400	350	350
Maine	3,700	500	600	500	125	250	400	150	150	100
Maryland	12,000	1,600	1,800	1,900	500	900	950	350	400	300
Massachusetts	21,000	3,200	3,500	2,500	850	1,200	1,500	850	600	550
Michigan	27,000	3,700	3,900	3,600	900	1,800	2,300	850	800	750
Minnesota	12,000	1,600	2,000	1,300	350	600	1,300	500	450	400
Mississippi	6,600	750	800	950	200	700	750	250	250	300
Missouri	17,000	2,100	2,500	2,400	500	1,200	1,700	450	550	550
Montana	2,100	250	300	250	70	150	200	80	80	80
Nebraska	5,300	700	900	550	150	300	500	150	200	200
Nevada	1,400	150	150	250	50	60	90	15	50	40
New Hampshire	2,800	350	500	400	100	200	250	70	80	100
New Jersey	26,000	3,800	4,500	3,400	850	1,600	1,700	1,100	900	700
New Mexico	2,300	250	250	300	60	150	200	80	70	70
New York	70,000	10,700	12,000	8,500	2,400	4,300	4,700	2,800	2,300	2,000
North Carolina	14,000	1,600	1,400	1,900	500	1,200	1,200	350	450	500
North Dakota	2,000	200	300	200	50	80	200	100	80	70
Ohio	35,000	4,800	5,600	4,800	1,200	2,500	2,700	1,200	1,000	1,000
Oklahoma	8,500	950	1,100	1,300	250	600	900	250	300	300
Oregon	6,900	900	1,000	950	200	500	650	200	250	300
Pennsylvania	43,000	6,300	7,400	5,400	1,400	2,800	3,400	1,600	1,300	1,300
Rhode Island	3,700	550	700	500	200	200	300	150	90	80
South Carolina	6,500	800	750	950	250	700	650	150	250	200
South Dakota	2,300	250	350	250	50	150	300	80	90	100
Tennessee	12,000	1,500	1,600	1,800	450	1,000	1,100	300	450	400
Texas	32,000	3,800	3,700	5,000	1,000	2,300	2,700	1,100	1,200	1,200
Utah	2,100	300	300	200	50	200	250	80	60	80
Vermont	1,600	200	300	200	60	100	200	50	50	60
Virginia	13,000	1,800	1,700	2,000	500	1,000	1,100	350	450	400
Washington	11,000	1,400	1,500	1,600	350	700	950	350	350	400
West Virginia	6,300	650	800	1,000	200	600	600	200	200	150
Wisconsin	14,000	2,200	2,500	1,500	450	850	1,300	600	450	450
Wyoming	800	100	100	90	20	60	80	20	30	30
United States	665,000	89,000	99,000	91,000	23,000	46,000	56,000	23,000	22,000	21,000
Puerto Rico	6,000	350	275	300	425	700	300	500	100	125

*Does not include carcinoma-in-situ of the uterine cervix or superficial skin cancers. These estimates are offered as a rough guide and should not be regarded as definitive. They are calculated according to the distribution of estimated 1975 cancer deaths by state. Especially note that year to year changes may only represent improvements in the basic data.

Estimated Cancer Deaths and New Cases by Sex for All Sites – 1975*

SITE	ESTIMATED DEATHS TOTAL	MALE	FEMALE	ESTIMATED NEW CASES TOTAL	MALE	FEMALE
All Sites*	365,000	199,000	166,000	665,000*	334,000*	331,000*
Buccal Cavity & Pharynx **(Oral)**	8,200	5,900	2,300	23,300	16,600	6,700
Lip	225	200	25	4,000	3,700	300
Tongue	1,950	1,400	550	4,500	3,100	1,400
Salivary Gland	650	400	250			
Floor of Mouth	525	400	125	8,400	5,000	3,400
Other & Unspecified Mouth	1,250	800	450			
Pharynx	3,600	2,700	900	6,400	4,800	1,600
Digestive Organs	101,700	53,800	47,900	167,800	87,800	80,000
Esophagus	6,500	4,700	1,800	7,400	5,500	1,900
Stomach	14,400	8,500	5,900	22,900	14,000	8,900
Small Intestine	700	350	350	2,200	1,200	1,000
Large Intestine **(Colon-Rectum)**	38,600	17,900	20,700	69,000	31,000	38,000
Liver	10,600	5,900	4,700	30,000	17,000	13,000
Pancreas	9,800	4,800	5,000	11,500	5,700	5,800
Other & Unspecified Digestive	19,500	10,900	8,600	21,500	12,000	9,500
Respiratory System	1,600	750	850	3,300	1,400	1,900
Larynx	85,700	67,150	18,550	102,600	81,600	21,000
Lung	3,250	2,800	450	9,100	8,000	1,100
Other & Unspecified Respirator	81,100	63,500	17,600	91,000	72,000	19,000
Bone, Tissue and Skin	1,350	850	500	2,500	1,600	900
Bone	8,600	4,900	3,700	15,300	7,800	7,500
Connective Tissue	1,900	1,100	800	1,900	1,100	800
Skin (Melanoma)*	1,700	900	800	4,400	2,400	2,000
Breast	5,000	2,900	2,100	9,000*	4,300*	4,700*
	32,900	300	32,600	88,700	700	88,000
Genital Organs	42,700	19,800	22,900	127,900	60,300	67,600
Cervix, Invasive* **Uterus**	7,800	–	7,800	19,000*	–	19,000*
Corpus Uteri **Uterus**	3,300	–	3,300	27,000	–	27,000
Ovary	10,800	–	10,800	17,000	–	17,000
Other Female Genital	1,000	–	1,000	4,600	–	4,600
Prostate	18,700	18,700	–	56,000	56,000	–
Other Male Genital	1,100	1,100	–	4,300	4,300	–
Urinary Organs	16,500	11,000	5,500	43,200	30,000	13,200
Bladder	9,400	6,500	2,900	28,700	21,000	7,700
Kidney & Other Urinary	7,100	4,500	2,600	14,500	9,000	5,500
Eye	400	200	200	1,700	800	900
Brain & Central Nervous System	8,500	4,800	3,700	10,700	5,900	4,800
Endocrine Glands	1,650	650	1,000	9,000	2,600	6,400
Thyroid	1,150	350	800	7,900	2,100	5,800
Other Endocrine	500	300	200	1,100	500	600
Leukemia	15,200	8,500	6,700	21,200	12,000	9,200
Lymphomas	18,600	10,000	8,600	28,800	15,700	13,100
Lymphosarcoma & Reticulosarcoma	7,800	4,200	3,600	10,200	5,500	4,700
Hodgkin's Disease	3,500	2,100	1,400	7,100	4,200	2,900
Multiple Myeloma	5,100	2,700	2,400	7,800	4,000	3,800
Other Lymphomas	2,200	1,000	1,200	3,700	2,000	1,700
All Other & Unspecified Sites	24,350	12,000	12,350	24,800	12,200	12,600

Note: The estimates of new cancer cases are offered as a rough guide and should not be regarded as definitive. Especially note that year to year changes may only represent improvements in the basic data. ACS six major sites in **boldface.**

*Carcinoma-in-situ of the uterine cervix and superficial skin cancers not included in totals.

INCIDENCE ESTIMATES ARE BASED ON RATES FROM N.C.I. THIRD NATIONAL CANCER SURVEY.

Reference Chart: Leading Cancer Sites, 1975*

SITE	ESTIMATED NEW CASES 1975	ESTIMATED DEATHS 1975	WARNING SIGNAL IF YOU HAVE ONE, SEE YOUR DOCTOR	SAFEGUARDS	COMMENT
BREAST	89,000	33,000	LUMP OR THICKENING IN THE BREAST.	ANNUAL CHECKUP. MONTHLY BREAST SELF EXAM.	THE LEADING CAUSE OF CANCER DEATH IN WOMEN.
COLON AND RECTUM	99,000	49,000	CHANGE IN BOWEL HABITS; BLEEDING.	ANNUAL CHECKUP INCLUDING PROCTOSCOPY, ESPECIALLY FOR THOSE OVER 40.	CONSIDERED A HIGHLY CURABLE DISEASE WHEN DIGITAL AND PROCTOSCOPIC EXAMINATIONS ARE INCLUDED IN ROUTINE CHECKUPS.
LUNG	91,000	81,000	PERSISTENT COUGH, OR LINGERING RESPIRATORY AILMENT.	PREVENTION: HEED FACTS ABOUT SMOKING, ANNUAL CHECKUP. CHEST X-RAY	THE LEADING CAUSE OF CANCER DEATH AMONG MEN, THIS FORM OF CANCER IS LARGELY PREVENTABLE.
ORAL (INCLUDING PHARYNX)	24,000	8,000	SORE THAT DOES NOT HEAL. DIFFICULTY IN SWALLOWING.	ANNUAL CHECKUP.	MANY MORE LIVES SHOULD BE SAVED BECAUSE THE MOUTH IS EASILY ACCESSIBLE TO VISUAL EXAMINATION BY PHYSICIANS AND DENTISTS.
SKIN	9,000***	5,000	SORE THAT DOES NOT HEAL, OR CHANGE IN WART OR MOLE.	ANNUAL CHECKUP, AVOIDANCE OF OVEREXPOSURE TO SUN.	SKIN CANCER IS READILY DETECTED BY OBSERVATION, AND DIAGNOSED BY SIMPLE BIOPSY.
UTERUS	46,000**	11,000	UNUSUAL BLEEDING OR DISCHARGE.	ANNUAL CHECKUP, INCLUDING PELVIC EXAMINATION WITH PAP TEST.	UTERINE CANCER MORTALITY HAS DECLINED 65% DURING THE LAST 35 YEARS. WITH WIDER APPLICATION OF THE PAP TEST, MANY MORE LIVES CAN BE SAVED, ESPECIALLY FROM CERVICAL CANCER.
KIDNEY AND BLADDER	43,000	17,000	URINARY DIFFICULTY. BLEEDING – IN WHICH CASE CONSULT DOCTOR AT ONCE.	ANNUAL CHECKUP WITH URINALYSIS.	PROTECTIVE MEASURES FOR WORKERS IN HIGH-RISK INDUSTRIES ARE HELPING TO ELIMINATE ONE OF THE IMPORTANT CAUSES OF THESE CANCERS.
LARYNX	9,000	3,000	HOARSENESS – DIFFICULTY IN SWALLOWING.	ANNUAL CHECKUP, INCLUDING MIRROR LARYNGOSCOPY.	READILY CURABLE IF CAUGHT EARLY.
PROSTATE	56,000	19,000	URINARY DIFFICULTY.	ANNUAL CHECKUP, INCLUDING PALPATION.	OCCURS MAINLY IN MEN OVER 60, THE DISEASE CAN BE DETECTED BY PALPATION AND URINALYSIS AT ANNUAL CHECKUP.
STOMACH	23,000	14,000	INDIGESTION.	ANNUAL CHECKUP.	A 40% DECLINE IN MORTALITY IN 20 YEARS, FOR REASONS YET UNKNOWN.
LEUKEMIA	21,000	15,000	LEUKEMIA IS A CANCER OF BLOOD-FORMING TISSUES AND IS CHARACTERIZED BY THE ABNORMAL PRODUCTION OF IMMATURE WHITE BLOOD CELLS. ACUTE LEUKEMIA STRIKES MAINLY CHILDREN AND IS TREATED BY DRUGS WHICH HAVE EXTENDED LIFE FROM A FEW MONTHS TO AS MUCH AS TEN YEARS. CHRONIC LEUKEMIA STRIKES USUALLY AFTER AGE 25 AND PROGRESSES LESS RAPIDLY.		
			IF DRUGS OR VACCINES ARE FOUND WHICH CAN CURE OR PREVENT ANY CANCERS THEY PROBABLY WILL BE SUCCESSFUL FIRST FOR LEUKEMIA AND THE LYMPHOMAS.		
LYMPHOMAS	29,000	19,000	THESE DISEASES ARISE IN THE LYMPH SYSTEM AND INCLUDE HODGKIN'S AND LYMPHOSARCOMA. SOME PATIENTS WITH LYMPHATIC CANCERS CAN LEAD NORMAL LIVES FOR MANY YEARS.		

*All figures rounded to nearest 1,000.
**If carcinoma-in-situ is included, cases total over 86,000.
***Estimates vary widely, from 300,000 to 600,000 or more, for superficial skin cancer.

INCIDENCE ESTIMATES ARE BASED ON RATES FROM N.C.I. THIRD NATIONAL CANCER SURVEY

Trends in Age-Adjusted Cancer Death Rates Per 100,000 Population 1949-51 to 1969-71

Sex	Site	1949-51	1969-71	Percent Changes	Comments
Male	All Sites	129.8	156.1	+ 20	Steady increase mainly due to lung cancer.
Female	All Sites	119.8	107.8	– 10	Slight decrease.
Male	Breast	0.3	0.3	*	Constant rate.
Female	Breast	22.0	22.8	+ 4	Slight fluctuations: Overall no change.
Male	Colon & Rectum	19.6	18.9	– 4	Slight decrease in both sexes.
Female	Colon & Rectum	19.1	15.3	– 20	
Male	Lung	18.2	47.1	+ 158	Steady increase in both sexes due to cigarette smoking.
Female	Lung	3.9	9.5	+ 144	
Male	Oral	4.8	4.9	*	Slight fluctuations: Overall no change in both sexes.
Female	Oral	1.2	1.5	*	
Male	Skin	2.4	2.4	*	Slight fluctuations: Overall no change in both sexes.
Female	Skin	1.6	1.5	*	
Female	Uterus	19.0	9.4	– 51	Steady decrease attributed in part to widening acceptance of regular checkup with "Pap Test".
Male	Esophagus	3.7	3.9	*	Slight fluctuations: Overall no change in both sexes.
Female	Esophagus	0.9	1.1	*	
Male	Stomach	18.4	8.2	– 55	Steady decrease in both sexes: Reasons unknown.
Female	Stomach	9.8	3.9	– 60	
Male	Pancreas	6.4	8.6	+ 34	Steady increase in both sexes: Reasons unknown.
Female	Pancreas	4.1	5.1	+ 24	
Male	Prostate	13.2	13.2	–	Fluctuations all through period: Overall no change.
Female	Ovary	6.9	7.6	+ 10	Steady increase.
Male	Kidney	2.7	3.6	+ 33	Steady slight increase.
Female	Kidney	1.6	1.7	*	Slight fluctuations: Overall no change.
Male	Leukemia	6.3	7.2	+ 14	Early increase, later leveling off.
Female	Leukemia	4.4	4.5	+ 2	Slight early increase, later leveling off.

*Percent changes not listed because they are not meaningful.

CANCER AROUND THE WORLD

Age-Adjusted Death Rates Per 100,000 Population for Selected Cancer Sites for 40 Countries — 1968-1969

	ALL SITES		ORAL		COLON & RECTUM		LUNG		BREAST	UTERUS	SKIN		STOMACH		PROSTATE	LEUKEMIA	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	FEMALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	MALE	FEMALE
United States	153.0 (18)	106.7 (18)	4.84 (7)	1.42 (10)	18.94 (15)	15.74 (13)	44.04 (9)	8.28 (8)	22.18 (12)	9.67 (27)	2.35 (8)	1.42 (13)	8.68 (38)	4.31 (39)	13.66 (12)	7.41 (3)	4.74 (10)
Australia	150.9 (19)	98.8 (27)	3.66 (14)	1.28 (14)	19.08 (14)	16.92 (9)	40.26 (14)	4.98 (20)	19.28 (16)	7.89 (35)	4.67 (1)	2.47 (2)	15.01 (34)	8.08 (34)	15.25 (8)	6.30 (15)	4.30 (16)
Austria	191.2 (3)	128.1 (5)	3.26 (20)	0.80 (30)	20.84 (11)	15.22 (14)	51.61 (7)	6.25 (14)	17.59 (21)	14.07 (12)	1.94 (14)	1.68 (9)	37.97 (4)	20.62 (5)	14.46 (10)	5.85 (20)	4.04 (18)
Barbados	127.6 (28)	104.1 (21)	1.94 (32)	0.32 (40)	10.58 (25)	8.72 (25)	7.59 (37)	3.57 (34)	17.71 (20)	28.79 (2)	0.87 (32)	0.86 (31)	28.53 (14)	13.44 (15)	16.01 (4)	4.97 (25)	1.38 (38)
Belgium	186.9 (5)	117.9 (12)	3.08 (21)	0.67 (32)	22.38 (3)	18.39 (7)	53.13 (6)	4.47 (26)	21.90 (13)	11.01 (19)	1.65 (21)	1.09 (25)	24.46 (17)	12.70 (18)	15.37 (7)	6.14 (16)	4.39 (15)
Bulgaria	132.7 (25)	84.1 (32)	2.23 (29)	0.66 (34)	8.01 (30)	6.41 (33)	34.59 (19)	6.37 (13)	10.15 (29)	7.15 (36)	1.53 (24)	1.23 (21)	34.61 (7)	21.18 (3)	6.51 (31)	4.67 (27)	3.75 (23)
Canada	149.9 (20)	109.9 (15)	4.28 (10)	1.21 (15)	21.63 (8)	18.75 (5)	37.09 (16)	5.86 (15)	23.54 (9)	9.48 (28)	1.90 (16)	1.38 (16)	15.40 (33)	6.99 (36)	13.50 (14)	7.05 (8)	4.59 (12)
Chile	154.3 (17)	138.5 (1)	2.13 (30)	0.92 (27)	6.66 (33)	7.28 (29)	16.81 (30)	4.98 (21)	11.49 (26)	14.33 (9)	1.53 (23)	0.95 (28)	59.41 (2)	35.62 (1)	10.05 (24)	4.21 (30)	3.32 (29)
China (Taiwan)	100.3 (36)	70.5 (36)	6.00 (4)	2.64 (6)	7.14 (31)	6.89 (30)	11.21 (36)	5.45 (17)	3.70 (39)	14.24 (10)	1.50 (26)	0.98 (27)	22.44 (21)	11.52 (24)	0.83 (40)	2.90 (36)	2.30 (35)
Denmark	159.2 (14)	131.6 (2)	1.93 (33)	1.20 (16)	22.10 (6)	19.29 (4)	40.32 (13)	7.66 (9)	24.34 (6)	15.64 (8)	2.60 (4)	1.95 (5)	17.69 (29)	9.79 (29)	12.88 (15)	7.22 (5)	4.67 (11)
Dominican Rep.	35.5 (40)	35.9 (40)	1.31 (38)	0.77 (31)	3.19 (38)	3.08 (39)	3.77 (40)	1.54 (39)	3.06 (40)	8.17 (33)	0.26 (39)	0.30 (38)	4.46 (40)	1.93 (40)	3.68 (35)	1.20 (40)	1.11 (39)
England & Wales	186.6 (6)	118.0 (11)	3.05 (22)	1.38 (12)	21.69 (7)	17.68 (8)	72.08 (2)	11.60 (4)	25.34 (3)	9.77 (26)	1.50 (27)	1.24 (20)	21.74 (24)	10.62 (25)	11.90 (18)	5.80 (21)	3.96 (20)
Finland	190.2 (4)	103.9 (22)	2.45 (27)	1.29 (13)	10.04 (26)	10.17 (22)	66.71 (3)	3.95 (28)	14.22 (24)	88.56 (1)	2.48 (7)	1.83 (6)	33.83 (9)	17.17 (10)	11.82 (21)	6.50 (13)	5.83 (2)
France	180.4 (9)	99.9 (26)	11.08 (3)	0.93 (26)	19.48 (13)	13.97 (15)	29.27 (24)	3.41 (35)	16.99 (22)	10.55 (22)	1.70 (17)	1.30 (18)	19.32 (27)	9.17 (31)	15.45 (5)	6.80 (11)	4.46 (13)
Germany F.R.	177.2 (10)	125.4 (6)	1.96 (31)	0.61 (37)	21.24 (10)	16.85 (10)	43.15 (11)	4.55 (24)	18.79 (18)	12.21 (14)	1.91 (15)	1.41 (15)	33.14 (10)	17.87 (8)	13.52 (13)	6.04 (19)	4.43 (14)
Greece	125.4 (29)	76.3 (34)	1.30 (39)	0.48 (39)	5.30 (36)	5.20 (36)	33.10 (21)	5.81 (16)	9.83 (31)	6.19 (37)	0.94 (31)	0.72 (34)	14.90 (36)	8.71 (33)	5.79 (32)	7.46 (2)	4.78 (8)
Hong Kong	182.7 (8)	101.7 (24)	20.70 (1)	7.71 (1)	15.52 (18)	8.43 (26)	40.65 (12)	19.04 (1)	8.61 (34)	9.07 (31)	0.78 (34)	0.33 (37)	20.56 (26)	10.08 (27)	3.97 (34)	3.48 (35)	2.75 (33)
Iceland	127.8 (27)	130.9 (3)	3.37 (17)	1.19 (17)	13.92 (21)	10.76 (21)	13.87 (33)	8.80 (7)	23.57 (8)	16.51 (7)	0.75 (36)	– (39)	36.95 (5)	13.63 (14)	12.83 (16)	4.01 (31)	6.50 (1)
Ireland	147.8 (21)	121.5 (7)	4.72 (8)	2.06 (8)	21.49 (9)	18.71 (6)	36.36 (18)	9.08 (5)	23.73 (7)	8.07 (34)	2.64 (3)	2.27 (3)	22.42 (22)	15.87 (12)	11.87 (20)	6.13 (18)	3.80 (22)
Israel	121.5 (31)	117.8 (13)	1.71 (36)	0.94 (25)	11.92 (23)	10.11 (23)	20.68 (27)	6.41 (12)	25.06 (4)	5.85 (38)	1.67 (19)	1.23 (22)	16.13 (30)	9.82 (28)	7.18 (29)	7.29 (4)	5.45 (3)
Italy	159.0 (15)	101.0 (25)	5.71 (5)	0.96 (23)	14.99 (20)	11.46 (19)	34.17 (20)	4.55 (23)	16.79 (23)	12.20 (15)	1.63 (22)	1.12 (24)	30.69 (13)	15.79 (13)	9.92 (25)	6.91 (9)	4.81 (7)
Japan	142.1 (23)	93.1 (29)	1.48 (37)	0.66 (35)	8.94 (28)	7.46 (28)	15.10 (31)	5.04 (19)	4.01 (38)	11.85 (17)	0.81 (33)	0.53 (36)	65.84 (1)	34.39 (2)	2.05 (38)	3.81 (33)	2.98 (31)
Luxembourg	204.6 (2)	118.1 (9)	3.33 (18)	1.39 (11)	25.54 (1)	16.28 (12)	59.57 (5)	3.57 (33)	20.93 (15)	14.21 (11)	1.48 (28)	0.57 (35)	22.02 (23)	12.16 (20)	14.66 (9)	6.89 (10)	3.95 (21)
Malta & Gozo	114.0 (32)	86.5 (30)	4.53 (9)	2.67 (5)	8.99 (27)	8.26 (27)	36.62 (17)	3.73 (29)	21.78 (14)	10.76 (21)	0.71 (37)	0.90 (30)	15.01 (35)	9.23 (30)	9.22 (26)	4.71 (26)	3.64 (24)
Mauritius	77.3 (37)	62.0 (38)	1.81 (34)	1.01 (22)	5.53 (35)	4.16 (37)	11.96 (34)	1.41 (40)	4.87 (36)	18.92 (4)	0.20 (40)	– (40)	16.11 (31)	5.92 (37)	2.19 (37)	1.54 (39)	0.91 (40)
Mexico	51.1 (38)	68.4 (37)	1.17 (40)	0.57 (38)	2.57 (40)	3.28 (38)	6.98 (38)	3.68 (30)	4.15 (37)	18.04 (6)	0.65 (38)	0.73 (33)	9.89 (37)	8.88 (32)	4.43 (33)	2.13 (38)	1.98 (37)
Netherlands	184.7 (7)	121.1 (8)	1.80 (35)	0.62 (36)	18.50 (16)	16.83 (11)	60.76 (4)	3.58 (32)	26.51 (1)	10.13 (23)	1.66 (20)	1.28 (19)	25.55 (15)	12.92 (17)	15.38 (6)	7.18 (6)	4.99 (5)
New Zealand	157.1 (16)	109.7 (16)	2.60 (25)	1.18 (18)	22.30 (4)	20.25 (3)	43.88 (10)	6.69 (11)	23.35 (10)	8.29 (32)	4.44 (2)	2.49 (1)	15.74 (32)	7.03 (35)	14.12 (11)	6.73 (12)	4.93 (6)
Northern Ireland	163.7 (13)	118.1 (10)	3.28 (19)	2.29 (7)	22.26 (5)	21.09 (1)	48.62 (8)	8.90 (6)	24.54 (5)	9.44 (29)	2.59 (5)	1.74 (8)	21.40 (25)	11.67 (23)	12.66 (17)	6.37 (14)	3.65 (30)
Norway	133.9 (24)	105.0 (20)	2.94 (23)	1.09 (21)	15.16 (19)	12.79 (17)	17.88 (29)	3.61 (31)	19.17 (17)	9.12 (30)	2.14 (11)	1.75 (7)	24.58 (16)	13.12 (16)	16.50 (3)	7.49 (1)	5.00 (4)
Philippines	45.4 (39)	40.4 (39)	4.01 (12)	2.78 (3)	2.85 (39)	2.30 (40)	4.40 (39)	2.24 (38)	5.28 (35)	5.31 (39)	0.77 (35)	0.75 (32)	5.84 (39)	4.32 (38)	1.05 (39)	2.43 (37)	2.12 (36)
Poland	147.1 (22)	103.2 (23)	3.50 (15)	0.87 (29)	8.50 (29)	6.82 (31)	33.08 (22)	4.96 (22)	11.23 (27)	1.59 (40)	1.99 (13)	1.57 (12)	40.44 (3)	18.81 (6)	8.07 (27)	5.01 (24)	3.61 (25)
Portugal	112.4 (33)	82.9 (33)	4.11 (11)	1.11 (20)	11.74 (24)	10.97 (20)	11.55 (35)	2.51 (37)	12.03 (25)	12.51 (13)	1.52 (25)	1.32 (17)	31.47 (12)	18.78 (7)	11.88 (19)	5.01 (23)	4.16 (17)
Romania	123.3 (30)	86.0 (31)	2.78 (24)	0.90 (28)	6.33 (34)	5.58 (35)	26.42 (25)	5.27 (18)	9.19 (32)	18.73 (5)	1.11 (30)	1.00 (26)	32.43 (11)	15.89 (11)	8.00 (28)	4.61 (28)	3.40 (28)
Scotland	205.1 (1)	130.5 (4)	3.39 (16)	1.66 (9)	25.18 (2)	21.06 (2)	80.02 (1)	12.89 (2)	26.36 (2)	9.81 (25)	1.68 (18)	1.67 (10)	22.88 (19)	11.99 (21)	11.45 (23)	5.35 (22)	3.55 (26)
Singapore	168.8 (11)	98.2 (28)	15.17 (2)	5.49 (2)	13.01 (22)	8.77 (24)	31.37 (23)	11.75 (3)	11.15 (28)	12.07 (16)	2.35 (9)	0.94 (29)	35.11 (6)	17.20 (9)	3.13 (36)	3.93 (32)	2.46 (34)
Sweden	129.8 (26)	106.4 (19)	2.27 (28)	1.12 (19)	16.46 (17)	12.94 (16)	18.69 (28)	4.49 (25)	18.62 (19)	10.02 (24)	2.11 (12)	1.41 (14)	18.40 (28)	10.09 (26)	17.98 (1)	7.05 (7)	4.75 (9)
Switzerland	168.0 (12)	107.9 (17)	5.55 (6)	0.95 (24)	20.03 (12)	12.28 (18)	38.90 (15)	3.01 (36)	23.04 (11)	11.11 (18)	2.48 (6)	1.59 (11)	22.94 (18)	12.33 (19)	16.85 (2)	6.13 (17)	4.00 (19)
Venezuela	111.6 (34)	112.7 (14)	3.69 (13)	2.71 (4)	5.06 (37)	6.54 (32)	13.95 (32)	6.79 (10)	9.87 (30)	26.87 (3)	2.20 (10)	1.99 (4)	34.29 (8)	21.12 (4)	11.52 (22)	3.68 (34)	2.84 (32)
Yugoslavia	107.6 (35)	73.9 (35)	2.52 (26)	0.66 (33)	6.80 (32)	5.62 (34)	24.44 (26)	4.31 (27)	9.08 (33)	10.95 (20)	1.33 (29)	1.12 (23)	22.80 (20)	11.71 (22)	6.85 (30)	4.46 (29)	3.52 (27)

NOTE: Figures in parentheses are order of rank within site and sex group.

Source: World Health Statistics Annual 1968-1969.

Mortality for the Five Leading Cancer Sites by Age, Sex and Site, U.S. — 1971

TOTAL		UNDER 15		15-34		35-54		55-74		75+	
MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Lung 54,931	Breast 29,969	Leukemia 923	Leukemia 707	Breast 495	Breast 9,364	Lung 8,509	Breast 35,258	Lung 14,487	Breast 10,098	Lung 9,880	Colon & Rectum 722
Colon & Rectum 22,410	Colon & Rectum 23,924	Brain, etc. 489	Brain, etc. 364	Leukemia 495	Colon & Rectum 2,403	Lung 3,503	Colon & Rectum 12,049	Colon & Rectum 11,251	Prostate 9,807	Breast 6,473	Hodgkin's Disease 484
Prostate 17,772	Lung 13,686	Lympho-sarcoma, etc. 113	Bone 74	Uterus 344	Pancreas 1,417	Uterus 3,104	Prostate 7,625	Lung 7,388	Colon & Rectum 7,737	Pancreas 2,940	Testis, etc. 235
Pancreas 9,967	Uterus 12,216	Bone 81	Kidney 67	Brain, etc. 321	Brain, etc. 1,242	Colon & Rectum 2,628	Pancreas 5,773	Uterus 5,999	Stomach 3,295	Uterus 2,766	Brain, etc. 429
Stomach 9,421	Ovary 9,978	Soft Tissue 62	Lympho-sarcoma, etc. 51	Hodgkin's Disease 296	Stomach 1,147	Ovary 2,477	Stomach 4,918	Ovary 5,333	Pancreas 2,714	Stomach 2,730	Lympho-sarcoma, etc. 254

Source: Vital Statistics of the United States, 1971

Mortality for Leading Causes of Death: United States, 1971

Rank	Cause of Death	Number of Deaths	Death Rate Per 100,000 Population	Percent of Total Deaths
All Causes		**1,927,542**	**932.2**	**100.0**
1	Diseases of Heart	743,138	359.5	38.6
2	Cancer	337,398	163.2	17.5
3	Stroke	209,092	101.1	10.8
4	Accidents	113,439	54.9	5.9
5	Influenza & Pneumonia	57,194	27.7	3.0
6	Certain Diseases of Infancy	38,494	18.6	2.0
7	Diabetes Mellitus	38,256	18.5	2.0
8	Cirrhosis of Liver	31,808	15.4	1.7
9	Arteriosclerosis	31,521	15.2	1.6
10	Suicide	24,092	11.7	1.2
11	Emphysema	22,539	10.9	1.2
12	Homicide	18,787	9.1	1.0
13	Congenital Anomalies	15,957	7.7	0.8
14	Nephritis and Nephrosis	8,443	4.1	0.4
15	Hypertension	7,837	3.8	0.4
	Other & Ill-Defined	229,547	110.8	11.9

Source: Vital Statistics of the United States, 1971
Prepared by: Research Department, American Cancer Society, July, 1974

Applying Cancer Statistics Locally

Community Population	Estimated No. Who are Alive, Cured of Cancer	Estimated No. Cancer Cases Under Medical Care in 1975	Estimated No. Who Will Die of Cancer if Present Rates Continue
1,000	7	4	150
2,000	15	9	300
3,000	22	13	450
4,000	30	18	600
5,000	37	21	750
10,000	74	43	1,500
25,000	185	107	3,750
50,000	370	215	7,500
100,000	740	430	15,000
200,000	1,480	860	30,000
500,000	3,700	2,150	75,000

Estimated No. Who Will Die of Cancer in 1975	Estimated No. of New Cases in 1975	Estimated No. Who Will be Saved from Cancer in 1975	Estimated No. Who Will Eventually Develop Cancer
1	3	1	250
3	6	2	500
4	8	3	750
6	11	4	1,000
7	14	5	1,250
15	28	9	2,500
37	70	23	6,250
75	140	47	12,500
150	280	93	25,000
300	560	186	50,000
750	1,400	465	125,000

NOTE: The figures can only be the roughest approximation of actual data for your community. It is suggested that every effort be made to obtain actual data from a Registry source.

BREAST CANCER

Breast Cancer Detection Demonstration Projects

The American Cancer Society and the National Cancer Institute have funded 27 detection projects across the nation in a joint effort to demonstrate the value of better diagnostic technology in achieving earlier case-finding to reduce the shocking mortality from breast cancer, the foremost cancer killer of American women.

At each center a comprehensive breast examination will be available to women 35 and over who have no present or past indications of breast disease. The restriction was imposed because this is a test program designed to develop techniques which eventually will make it feasible for community medical facilities to offer early detection to women everywhere. All project centers were operational by late 1974, with fair geographic distribution and adequate service potential as prime considerations in site selection.

The examination has been standardized as a four-part procedure which can detect breast cancer in its earliest stages when it is most curable: 1) Interview (general and personal health questions related to the breast); 2) Palpation (each breast felt by examiner for lumps or other abnormalities); 3) Mammography (painless, low-radiation X-ray examination to expose the inner structure of each breast, and pinpoint small abnormalities); 4) Thermography (a camera picture of the heat patterns in the breast).

To get these tests, qualified women in the areas served by the 27 projects need only contact their local ACS Unit where a Society volunteer will set up an appointment. Women with symptoms will be referred to their own physicians or to a radiologist, hospital or clinic.

Women tested at the centers will also be taught how to do breast self-examination (BSE), a simple procedure. The ACS recommends that every woman practice BSE monthly. Statistics show that 95% of all breast cancers are discovered by women themselves.

The demonstration project idea was initiated by the ACS in 1971 because complete breast screening had been obtainable at relatively few medical centers in the U.S. The Society allocated $2-million to launch the program.

In 1972, the NCI joined and helped expand the effort by providing additional financial backing. The two agencies allocated $5.4-million to support all 27 centers for the *first year*, with NCI contributing nearly $4-million and the ACS nearly $1.5-million.

Some of the institutions will use their funds (around $200,000 each) to expand ongoing programs. Most will use the money to set up new facilities. Each funded institution must screen at least 5,000 women during the first year and an additional 5,000 in the second year. Each of these 10,000 women will be reexamined through five years and then followed up for another five years. ACS volunteers will help motivate women – many of them from low-income families – to have the free examinations. The program will be evaluated through national tabulation of findings by the University City Science Center, Philadelphia.

BREAST CANCER DETECTION DEMONSTRATION PROJECTS–SCREENING CENTERS
(Listed alphabetically by states)

University of Arizona
Arizona Medical Center
Tucson, Ariz. 85724
602-882-7401 or 7402

Los Angeles County, University of Southern California/John Wesley Hospital
Los Angeles, Calif. 90033
213-748-5379

Samuel Merritt Hospital/Breast Screening Center
384 34th Street
Oakland, Calif. 94609
415-658-8525

Wilmington General Hospital
Chestnut & Broom Streets
Wilmington, Del. 19899
302-428-4815

Georgetown University Medical School
3800 Reservoir Road, N.W.
Washington, D.C. 20007
202-625-2183

St. Vincent's Medical Center
Barrs Street & St. Johns Avenue
Jacksonville, Fla. 32204
904-389-7751 ext. 8491 or 8492

Georgia Baptist Hospital
340 Boulevard N.E.
Atlanta, Georgia 30312
404-525-7861
and
Emory University
Atlanta, Georgia 30322
404-355-4940

Pacific Health Research Institute, Inc.
Alexander Young Building, Suite 545
Hotel & Bishop Streets
Honolulu, Hawaii 96813
808-524-4337

Mountain States Tumor Institute
215 Avenue B
Boise, Idaho 83702
208-345-3590

Iowa Lutheran Hospital
University at Penn
Des Moines, Iowa 50316
515-283-5678

University of Kansas Medical Center
Rainbow Boulevard at 39th Street
Kasnas City, Kan. 66103
913-342-1338

University of Louisville School of Medicine
601 S. Floyd Street
Louisville, Ky. 40402
502-583-2894

University of Michigan Medical Center
396 W. Washington Street
Ann Arbor, Mich. 48103
313-763-0056

Cancer Research Center
Business Loop 70th & Garth Avenue
Columbia, Mo. 65201
314-443-2216

College of Medicine and Dentistry of New Jersey
15 S. 9th Street
Newark, N.J. 07107
201-484-9221

Guttman Institute
200 Madison Avenue (at 35th Street)
New York, N.Y. 10016
212-689-9797

Duke University Medical Center
3040 Erwin Road
Durham, N.C. 27705
919-286-7943 or 383-1060

University of Cincinnati Medical Center
Eden & Bethesda Avenues
Cincinnati, Ohio 45229
513-872-5331

Oklahoma Medical Research Foundation
800 N.E. 8th Street
Oklahoma City, Okla. 73190
405-235-8331 ext. 241

Breast Cancer Screening Project
2222 N.W. Lovejoy
Portland, Ore. 97210
503-229-7292

Temple University
3401 No. Broad Street
Philadelphia, Pa. 19140
215-221-3832
and
Albert Einstein Medical Center
York & Tabor Roads
Philadelphia, Pa. 19141
215-567-0559

University of Pittsburgh School of Medicine/The Falk Clinic
3601 Fifth Avenue
Pittsburgh, Pa. 15213
412-624-3336

Rhode Island Hospital
Rhode Island Department of Health
Eddy Street
Providence, R.I. 02908
401-831-6970

Vanderbilt University School of Medicine
Nashville, Tenn. 37322
615-322-2501

St. Joseph's Hospital
1919 La Branch
Houston, Texas 77002
713-225-3131 ext. 301

Virginia Mason Medical Center
911 Seneca Street
Seattle, Wash. 98101
206-624-1144

Medical College of Wisconsin
8700 W. Wisconsin Avenue
Milwaukee, Wis. 53236
414-257-5200

The ACS Approach

With about 89,000 new cases and 33,600 deaths expected in 1975, breast cancer remains the foremost site of cancer incidence and death in American women.

Although this disease is found most often among women of middle age and over – who are the main educational target – the ACS has in recent years been encouraging girls of high school age to learn breast self-examination as a future health habit. At present rates, one of every 15 American women will develop breast cancer at some time. Early detection through self-examination and periodic health checkups are of primary importance in control of breast cancer.

The current methods of therapy are highly effective (85% survivals at five years) when diagnosis and treatment are achieved at an early stage. At the present time, about 95% of patients discover their cancers themselves through breast self-examination but, by that time, 60% of them have cancers that have spread to the axillary lymph nodes, a stage when the five-year survival rate is only 40–45%. However, the percentage of those with localized cancers has increased since the 1940s, as a result of wider public education, and a more alert medical profession. Most lumps in the breast are not malignant – 65–80% of breast biopsies are benign.

Studies on the various techniques of treatment of primary operable breast cancer are now underway in a number of U.S. institutions.

The American Cancer Society recommends that any woman suspecting that she may have breast cancer should consult a physician who is knowledgeable in this field, seek and rely on the physician's advice and judgment in the selection of treatment for her individual medical situation. All American women should be well informed so that they may intelligently discuss important considerations with their physicians.*

Women's Attitudes, Beliefs, Habits

Cancer is the number one disease concern of American women and breast cancer figures prominently in this concern, according to the Gallup survey conducted for the ACS in late 1973 on "Women's Attitudes Regarding Breast Cancer."

Despite the high degree of concern, few women have their breasts examined regularly by their physician or engage in monthly breast self-examination, though they are aware that early discovery improves chances of cure. In fact, results of interviews with more than 1,000 women 18 and over showed that wider and better education is needed on this subject because too many women hold too many mistaken beliefs about the disease.

For example, there is widespread belief that most breast lumps are cancerous – only about 20–35% are.

A majority (62%) of women mistakenly believe that a blow or injury to the breast can cause breast

*For a copy of the American Cancer Society Policy Statement on the Surgical Treatment of Breast Cancer, contact your local ACS Unit or Division.

ORAL CANCER

Cancers of the mouth area afflict some 23,000 Americans annually and kill about 8,000. So many deaths arising from a site so easily observable underline the need for a more intensive program of education. To achieve this, the Society has accelerated its efforts to make dentists, physicians, nurses and the general public more aware of the potentials for closer control at this site. It is accomplished through professional and public education programs and materials, together with community-wide screening projects.

SKIN CANCER

More than 9,000 new cases of skin cancer are reported in the U.S. each year (excluding superficial cases). Superficial skin cancer, which ranges in incidence from 300,000 to 600,000 cases a year, is a form of cancer that is preventable through avoidance of overexposure to the sun. Early detection is achievable through the annual physical examination and knowledge of the Warning Signals. The ACS estimates that about 95% of skin cancer could be cured if sores which do not heal were reported promptly to a physician. Deaths run about 5,000 a year and are caused mainly by melanoma.

LUNG CANCER

Today over 100,000 American men and women are suffering from lung cancer. In 1975, another 91,000 will be stricken with this disease. During the same year, 81,000 will die of lung cancer–or approximately 225 a day.

This is largely a preventable disease, since most lung cancer is caused by cigarette smoking. Unfortunately, it is difficult to diagnose in time for cure. Only about 10% of all cases are being saved.

Though the general trend of smoking has been upward in the past 25 years, there were a number of years during which there was a sharp decline – 1965-71 – due to the impact of educational anti-smoking campaigns. In 1965, nearly 43% of the total adult population was smoking; by 1971, this had dropped to 36%, or about 1 in every 3 adult Americans was a smoker, with 29-million ex-smokers.

While no national survey has been taken since 1971, there are indications that the total percentage of smokers in the adult population is beginning to increase again.

In 1971, the anti-smoking educational campaign was weakened when the number of anti-smoking spots on television was markedly reduced. This occurred when Congress outlawed cigarette advertising on broadcasting and the stations applied public service standards for usage to the anti-smoking messages. Prior to this, stations were acting on a ruling from the Federal Communications Commission to give the spots significant air time. As a result, during the past 4 years, there has been an upturn in the per capita rate of smoking, although it is still below the peak of 10 years ago.

During the past 20 years, as a result of pressure brought by the ACS and other anti-smoking forces, the cigarette companies have reduced the tar content of cigarettes. It is important because the ingredients of tobacco tars are regarded as the factors which cause lung cancer as well as other cancers. The tar content of the average cigarette today is 50% lower than it was 20 years ago and 30% lower than it was 10 years ago. An important factor in the reduction of tar content is the addition of filters which strain out a good deal of the tar. Today, 85% of all cigarettes smoked have filters. A generation ago, only 3.5% of all cigarettes were filter-tipped. The tar content of cigarettes is also reduced by adding to the tobacco synthetic products which have very little tar; also by "puffing up" the tobacco, resulting in greater bulk, and therefore less actual tobacco per cigarette.

Women and Smoking

Though women used to feel safe from lung cancer because the death rate was low for women compared with that for men, this picture is beginning to change alarmingly. The female lung cancer death rate has doubled in the past ten years. While female death rates from lung cancer were once as low as 1/6 the death rate for men, they are now only 1/4 the death rate for men and are threatening to catch up.

The recent upsurge in the lung cancer death rate for women can be attributed to the fact that women began to smoke in much greater numbers about 30 years ago and the trend has been increasing steadily since then, partly as a result of advertising and promotion.

Smoking habits are established in the teens, and in the great majority of cases, teen-age girl smokers will become adult women smokers. Teen-age girls, who never smoked to the extent teen-age boys did, have now caught up. In 1968, only about half as many teen-age girls smoked as boys – 8.4% of girls between 12 and 18 were smokers compared to 14.7% of the boys. But, by January 1974, 15.3% of the girls between 12 and 18 were smoking, only a fraction of a point below the boys' 15.8%. This means that in about another 10 years or less, there should be as many adult female smokers as there are adult male smokers, with a commensurate increase in lung cancer deaths for women.

Recently, some vital information has been disclosed concerning women and smoking. There is evidence of a link between smoking by pregnant women and (1) stillbirths, (2) increased mortality among newborns, and (3) low birth weight of babies. Lower-than-normal birth weight is associated with a child's poor physical and emotional development.

Smoking mothers set the example for children. Statistics show that youngsters whose parents smoke are more likely to adopt the habit than the children of non-smoking parents.

ACS Policies and Programs

The major thrust of the ACS effort is to educate Americans – particularly young people – regarding the personal health hazards of cigarette smoking. To help disseminate the facts to the broadest possible public audience the Society makes available a wide variety of materials and activities. Basic to the Society's policy is the conviction that adult individuals must make up their own minds about smoking, but this requires that individuals know the facts.

The ACS believes there have been a number of developments which are cause for concern, vigilance and action: per capita consumption on the rise again; gross consumption (584.7-billion cigarettes in '73) up over '72, some 52-million smokers still numbered among the population, no genuine abatement of advertising on the part of manufacturers.

The ACS, therefore, has reaffirmed its decision to expand and intensify the fight against smoking along the following general lines: 1) Support Federal action to reduce tars and nicotine in cigarettes, to require disclosure of these figures on packages and in advertising, and to require a stronger warning label; 2) Seek elimination of cigarette advertising in all media, hopefully by voluntary self-regulation; 3) Oppose cigarette company sponsorship of indirect advertising via televised sports events, which has become a new promotional device since explicit TV advertising became illegal in 1971; 4) Urge TV personalities and entertainers to refrain from smoking during their broadcasts because of their influence on the young; 5) Support restrictions on smoking in places of public assembly, such as theaters, restaurants, offices, hospitals, and in trains, planes, buses, elevators and other places of common transport; 6) Involve physicians, dentists and nurses more deeply in local programs and educational efforts; 7) Expand educational programs for primary and secondary school students with new emphasis on teacher involvement and teachers as exemplars, while maintaining the position that smoking areas should not be provided on school grounds or in school buildings; 8) Extend anti-smoking information through films, television, radio, magazine and newspaper articles, posters, brochures.

The Society also reiterates its strong support of research into the health hazards of smoking, the carcinogenic components of cigarette smoke, the development of less dangerous cigarettes, the nature of addiction and the motivations for smoking, the effects of smoke on the non-smoker, the most effective methods for persuading and helping people quit the habit.

One way is through "helping smokers quit" clinics. Approximately 200 ACS antismoking clinics were in operation in 1974. The National ACS goal for 1975 is to conduct 1,000 clinics at the community level. The average percentage of people quitting cigarettes through clinics is 35–40%. ACS cessation programs are run in industry, hospitals, health centers, schools and colleges. Company incentive programs are encouraged and aided. Hoped-for goal is at least one clinic in each community.

Help for Nonsmokers

Ex-smokers in the U.S. number some 30 million. Increasingly, these nonsmokers are making their own feelings about smoking felt in various ways. They are being aided by Federal and state and local

Clinical Fellowships

The ACS National Clinical Fellowship program has, since 1948, invested approximately $18-million for the training of more than 3700 physicians and dentists in the diagnosis and treatment of cancer. Training is provided on two levels at approved teaching centers and hospitals. The regular Clinical Fellowship program, for hospital residents, is designed to provide specialized training in scope and depth beyond that which would ordinarily be received in residency training programs. The Junior Faculty Clinical Fellowship program, for postresident physicians and dentists, is intended to strengthen cancer teaching programs by supporting outstanding young clinicians in academic careers upon completion of their specialty training. Fellows put their special skills and knowledge to work through their professional societies, teaching activities, participation in hospital cancer programs and in their private practices. Many new departments and divisions of oncology in hospitals and medical schools in the nation are now headed by ACS former Fellows. During 1973-74, 190 Clinical Fellows and 45 Junior Faculty Clinical Fellows received training in 117 institutions in 39 states, Puerto Rico and Washington, D.C.

Clinical Professorships

In 1971, the Society established a new program and category of support: American Cancer Society Professors of Clinical Oncology. The purpose of the Professorships, awarded to medical schools, is to improve cancer teaching at the undergraduate, postgraduate and continuing education levels, to stimulate clinical investigation of cancer and to coordinate all cancer-related activities – educational, service and research – in the medical school. Nine Clinical Professors have been appointed and at least five others are being proposed.

SERVICE AND REHABILITATION

The prime objectives of the Society's service and rehabilitation program are to support physicians' efforts in early detection, to bring greater comfort to cancer patients, to ease the burden on their families, and to improve the quality of survival by assisting patients in their physiological and psychological rehabilitation.

Service

The Society expects all of its organized Units to conduct a minimum service program which: 1) includes information and counseling regarding existing facilities and services related to cancer within the community; 2) provides assistance to the cancer patient and family with the help of community resources (medical and social), with loan of sick room equipment and with transportation service to and from treatment facilities.

Depending on local needs and financial resources available, the program may be expanded by Units from a minimum program to a total program which includes: medication, nursing service, homemaker services and rehabilitation. Community projects having the endorsement of state and local medical societies may be supported to include cancer detection in physicians' and dentists' offices, diagnostic services, and community programs including support of cancer registries and hospital cancer clinics for limited periods.

In 1973, 270,759 cancer patients received all types of ACS services. (A tabulation of services provided to these patients shows: 35,439 equipment loans, 38,188 gift items, 31,827 transportation services, 50,876 rehabilitation services, 166,764 information and referral activities.)

Rehabilitation

The American Cancer Society conducts rehabilitation programs for mastectomy, ostomy and laryngectomy patients:

1) The Reach to Recovery program, first step of an organized and comprehensive plan for the rehabilitation of the mastectomy patient, is now in operation in most parts of the country with additional Units of the ACS adopting it almost daily. Carefully selected and trained volunteers assist the physician and surgeon in providing specialized assistance without interfering in any way with the doctor–patient relationship. The high quality of this effort is assured by uniform training practices under the direction of a qualified medical advisor at the Division and Unit level. The patient sees and talks to another woman who had the same surgery – intimate proof that it will be possible for her to look normal and return to normal activities. She receives practical help on how to go about it and medical personnel are relieved of time-consuming activities not primarily medical in nature. There were 32,000 such visits during 1973. A film, *Recovery After Mastectomy*, can be shown at the patient's bedside.

2) Volunteers of the ACS, in many instances working with volunteers of the various ostomy groups throughout the country, are mobilizing to provide psychological reassurance for patients with ostomies. The volunteer in the ostomy visitor program, himself an ostomate, can provide the assurances that a patient can gain in no other way. Again, careful selection of volunteers and high standards of training under medical supervision will provide valuable assistance to the surgeons and enterostomal therapists in the medical team who face the problem of rehabilitation of the ostomy patient. Enterostomal therapists are being sponsored for training by ACS Divisions and training facilities are receiving ACS support. Bedside film is *People With Colostomies*.

3) The International Association of Laryngectomees, which assists those who have lost their voices to cancer, is sponsored by the American Cancer Society. It is composed of 213 member clubs in 45 states of the United States, in Canada, England, Israel, Australia, Japan, New Zealand, Belgium, India, South Africa, Jamaica and Venezuela. Stated purpose is to promote and support the total rehabilitation of laryngectomized persons by the exchange and dissemination of ideas and information to the clubs and to the public; to facilitate the formation of new clubs; to foster improvement in the teaching of postlaryngectomy speech. Programs of the IAL include: 1) seminars and institutes for prospective teachers; 2) public and professional education in first aid and artificial respiration required for laryngectomees; 3) registry of postlaryngectomy speech instructors; 4) international annual meetings; 5) encouragement of the new patient with helpful literature; 6) Film: *To Speak Again*.

UNPROVEN METHODS OF CANCER MANAGEMENT

The ACS provides information to physicians and the public on unfounded claims concerning unproven methods of cancer management, and aids in the creation or strengthening of state laws to control the use of worthless cancer remedies and tests. An active file of information on such unproven methods is maintained.

RESEARCH

The ACS entered the field of cancer research in 1946, putting close to a million dollars into grants. Since then, the Society has been a major independent source of research support along with the National Cancer Institute, the National Science Foundation, and other agencies. The Society's research program has grown because the demand has grown. In 1950, the average project grant was $6,600 per year. In 1973, the average allocation was $35,500.

The year the Society got into the research business, the NCI program was just getting off the ground. Together, they opened up the field. Millions of dollars were plowed into universities, medical schools, hospitals and institutes to set up research programs where none existed. Hundreds of scientists were attracted to this new area. Once established, many moved on to other centers, setting up new programs, and attracting additional hundreds (later, thousands) of scientists. Each new wave of expansion created a new demand for support. Both the ACS and NCI responded with increased research budgets. Some scientists applied to the ACS, others to the NCI, some to both.

In fiscal year 1974 (Sept. 1, 1973 through Aug. 31, 1974), the ACS made 498 grants to 127 major institutions in this country and to scientists working both here and abroad. The total amount, subject to audit, was $27,316,950 which includes some $3,000,000 granted directly by ACS divisions. Refund of unexpended balance of some $900,000 from prior year awards, left a net total of $26,416,950.

SUMMARY OF RESEARCH GRANTS & FELLOWSHIPS AWARDED BY ACS (NATIONAL SOCIETY & DIVISIONS) DURING FISCAL YEAR ENDED AUGUST 31, 1974

Alabama, University of, Tuscaloosa, Ala. (4)	$ 190,704.00
Albany Medical College of Union University, Albany, N. Y. (1)	32,170.00
American Health Foundation, New York, N. Y. (2)	125,000.00
Arizona University, Tucson, Ariz. (3)	70,475.00
Basel, University of, Switzerland (1)	9,915.00
Baylor College of Medicine, Houston, Tex. (8)	401,817.00
Beth Israel Hospital, Boston, Mass. (2)	114,687.00
Boston University, Boston, Mass. (1)	1,457.00
Brandeis University, Waltham, Mass. (5)	165,957.00
Brown University, Providence, R. I. (3)	116,764.00
California Institute of Technology, Pasadena, Calif. (3)	42,795.00
California, University of, California (state system) (44)	2,133,307.00
Carnegie-Mellon University, Pittsburgh, Pa. (1)	35,096.00
Case Western Reserve University, Cleveland, Ohio (6)	248,484.00
Cedars of Lebanon Hospital, Los Angeles, Calif. (1)	9,705.00
Chicago, University of, Chicago, Ill. (10)	531,062.00
Children's Cancer Research Foundation, Boston, Mass. (3)	207,922.00
Children's Hospital of Los Angeles, Calif. (1)	55,000.00
Children's Hospital Research Foundation, Cincinnati, Ohio (1)	30,720.00
Cincinnati, University of, Cincinnati, Ohio (1)	22,188.00
Cold Spring Harbor Laboratory of Quantitative Biology, N. Y. (1)	8,500.00
Colorado, University of, Boulder, Colo. (15)	591,129.00
Columbia University, New York, N. Y. (6)	176,767.00
Community Blood Council of Greater New York, N. Y. (1)	30,976.00
Connecticut, University of, Storrs, Conn. (3)	132,531.00
Cornell University, Ithaca, N. Y. (4)	256,012.00
Cornell University, New York, N. Y. (2)	99,365.00
Dartmouth College, Hanover, N. H. (1)	134,750.00
Duke University, Durham, N. C. (4)	316,065.00
Emory University, Atlanta, Ga. (1)	50,000.00
Florida, University of, Gainesville, Fla. (3)	182,083.00
George Washington University, Washington, D. C. (2)	137,500.00
Georgetown University, Washington, D.C. (1)	65,685.00
German Cancer Research Center, Heidelberg, Germany (1)	19,585.00
Grumman Aerospace Corporation, Bethpage, N. Y. (1)	204,937.00
Harvard University, Boston, Mass. (15)	477,308.00
Illinois, University of, Urbana, Ill. (5)	180,168.00
Indiana, University of, Bloomington, Ind. (2)	65,288.00
Institute for Cancer Research, Philadelphia, Pa. (3)	207,250.00
Institute for Medical Research, N. J. (1)	17,501.00
Iowa, State University of, Iowa City, Iowa (2)	74,097.00
Jackson Laboratory, Bar Harbor, Me. (2)	$ 69,975.00
Jewish Hospital of St. Louis, Mo. (2)	84,653.00
Johns Hopkins University, Baltimore, Md. (7)	408,078.00
Kansas, University of, Lawrence, Kan. (1)	100,000.00
Karolinska Institutet, Stockholm, Sweden (1)	17,536.00
Los Alamos Scientific Laboratory, Albuquerque, N. M. (1)	51,350.00
Louisiana State University, Baton Rouge, La. (1)	62,590.00
Louisville, University of, Louisville, Ky. (1)	30,000.00
Southern California, University of, Los Angeles, Calif. (4)	181,376.00
Southern Research Institute, Birmingham, Ala. (2)	88,835.00
St. Jude Childrens Research Hospital, Memphis, Tenn. (2)	78,797.00
Stanford University, Stanford, Calif. (14)	642,668.00
State University of New York at Albany, N.Y. (1)	65,229.00
State University of New York, Brooklyn, N.Y. (2)	107,838.00
State University of New York, Buffalo, N.Y. (2)	146,508.00
State University of New York at Stony Brook, Stony Brook, N.Y. (4)	206,737.00
Switzerland, University of, Geneva, Switzerland (2)	$ 28,015.00
Temple University, Philadelphia, Pa. (5)	193,113.00
Tennessee, University of, Memphis, Tenn. (3)	98,441.00
Texas, University of, Houston, Tex. (11)	452,533.00
Thomas Jefferson University, Philadelphia, Pa. (1)	55,000.00
Trudeau Institute Inc., Saranac Lake, N. Y. (1)	61,025.00
Tufts University, Medford, Mass. (5)	222,538.00
Universities Assoc. for Res. & Educ. in Pathology, Inc., Bethesda, Md. (1)	57,334.00
Utah, University of, Salt Lake City, Utah (6)	284,062.00
Utrecht, University of, Utrecht, Netherlands (1)	8,751.00
Vanderbilt University, Nashville, Tenn. (2)	42,200.00
Vermont, University of, State Agricultural College, Burlington, Vt. (2)	75,899.00
Veterans Administration Hospital, Minneapolis, Minn. (1)	37,852.00
Virginia, University of, Charlottesville, Va. (3)	57,905.00
Walter and Eliza Hall Inst. of Medical Research, Melbourne, Australia (2)	20,702.00
Washington, University of, Seattle, Wash. (7)	324,582.00
Washington University, St. Louis, Mo. (10)	590,376.00
Wayne State University, Detroit, Mich. (1)	8,335.00
Wesleyan University, Middletown, Conn. (1)	135,000.00
Wisconsin, University of, Madison, Wis. (17)	701,857.00
Wistar Institute of Anatomy and Biology, Philadelphia, Pa. (2)	75,490.00
Yale University, New Haven, Conn. (21)	814,171.00
Yeshiva University, Bronx, N. Y. (18)	769,443.00
To Support Journal "Cancer Research" (1)	70,000.00
Eleanor Roosevelt–ACS International Cancer Fellowships (1)	375,000.00
Tobacco Habituation (1)	8,645.00
Professional Programs of the UICC (2)	37,500.00
Nutrition and Cancer (1)	30,000.00
Committee and Operating Expenses in Evaluating and Processing Research Applications (1)	1,170,010.00
National Epidemiological Studies (1)	787,156.00
Division Research Grants (1)	3,000,000.00
Total Awarded (496)	$27,316,950.00
Refund of Unexpended Balances of Prior Year Awards	(900,000.00)
Total	$26,416,950.00

Note: Numbers in parentheses indicate number of grants per institution for the year ending August 31, 1974; **totals are subject to audit.**

The number of ACS grants applied for and approved by its expert research committees, but which were not supported because of insufficient funds, has increased at a phenomenal pace in recent years – from 60 grants of about $1.5-million unfunded in 1964, to 903 grants totaling over $50-million in 1974. These figures apply to National Office grants only and are illustrated in the following table:

	Requested		Funded		Approved But Not Funded	
Fiscal Year	No. of Requests	Amount	No. of Grants	Amount	No. of Grants	Amount
1965	756	$23,829,008	482	$13,088,622	157	$ 4,046,015
1966	611	25,042,749	384	11,013,667	106	4,955,328
1967	932	40,338,782	528	16,884,962	103	4,393,132
1968	986	43,498,174	489	17,174,670	200	7,603,796
1969	1,254	63,995,580	534	19,652,785	375	15,713,333
1970	1,252	67,607,098	507	19,125,420	460	21,318,199
1971	1,126	58,378,944	642	22,692,927	325	14,183,963
1972	1,361	82,416,461	516	21,676,069	650	34,914,342
1973	1,260	75,849,496	525	23,052,737	527	27,092,335
1974	1,613	105,095,040	498	27,316,950	903	50,643,280

A summary of all project and personnel grant applications reviewed in fiscal '73 by anatomical sites shows this breakdown:

Head and Neck – 12 applications (1% of all applications reviewed), 4 funded (33%) for $227,000 with 4 unfunded (33%) for $151,400 and 4 unapproved (33%); Digestive Organs – 113 applications reviewed (10% of all), 33 funded (29%) for $1,469,000 with 61 unfunded (54%) for $3,798,500 and 19 unapproved (17%); Respiratory Organs – 39 applications reviewed (3% of all), 14 funded (36%) for $742,200 with 19 unfunded (49%) for $1,187,000 and 6 unapproved (15%); Female Genital Organs – 96 applications reviewed (8% of all), 38 funded (40%) for $1,876,300 with 43 not funded (45%) for $2,764,600 and 15 unapproved (15%); Urinary Organs – 21 applications reviewed (2% of all), 10 funded (48%) for $536,300 with 7 not funded (33%) for $421,200 and 4 unapproved (19%); Lymphomas and Leukemia – 165 applications reviewed (14% of all), 69 funded (42%) for $3,306,000 with 82 not funded (50%) for $6,129,900 and 14 unapproved (8%); Other Sites, including eye, skin, central nervous system, thyroid, bone – 202 applications reviewed (17% of all), 62 funded (31%) for $3,259,400 with 100 not funded (50%) for $6,483,900 and 40 unapproved (20%).

Of a total 1,260 applications reviewed by the ACS in 1973, 40% were funded for $23,052,737 with 46% not funded for $33,835,600 and 14% unapproved. These represent sum totals and not just those involving anatomical sites. Applications for these grants are carefully screened by scientific review committees. A small percentage are approved and funded. Another group consists of approved grants for which no funds are available. The third is made up of applications which were not approved or funded.

The Society makes three types of grants to support research: 1) "Research Project Grants" to finance individual work; 2) "Institutional Research Grants" to universities, institutes and hospitals for support of pilot studies and of young investigators in the cancer field; 3) "Research Personnel Grants" to outstanding scientists and students specializing, or planning to specialize, in cancer research; these cover many levels of academic and professional training, starting with fellowships and scholarships for recent M.D. and Ph.D. graduates and ranging to research professorships.

Studies of Occupational Groups

With the cooperation of industry and labor unions, a number of studies of union workers exposed to various agents have been started. For example, it has been found that asbestos workers have a high risk of lung cancer, gastrointestinal cancer and other conditions; thus studies of a number of groups of asbestos workers are underway. Analysis of death rates from lung cancer and other diseases in these groups was published in 1974. Printing pressmen are exposed to carbon black, various dyes, talc containing asbestos and various other substances; thus, in cooperation with the Printers Union and the Printers Guild, a study of death rates of long-time members of this trade is being conducted.

Cancer death rates among typographers, cotton mill workers, vinyl chloride workers and other occupational groups are under study. A survey of roofers was recently completed and is being prepared for publication.

THE COSTS OF CANCER

After the cardiovascular diseases, cancer is the most devastating in terms of lives lost but may be more costly in over-all implication because it can continue for years and become as chronic in its financial as in the medical aspects. Economic specifics are limited as they relate to cancer but they can be measured somewhat in the light of total health cost.

In 1971, the nation's spending for all medical care reached $75-billion and accounted for 7.4% of the gross national product; in 1950, the figure was $12.1-billion. Of the $75-billion total, $65-billion, or 87%, was for personal health care – meaning for health services of direct benefit to individuals.

Of this $65-billion, 27% was spent by or on behalf of the aged. This group comprises only 10% of the population but their higher costs reflect these facts: 1) average over-65s have more and costlier illnesses than younger age groups; 2) they are twice as likely to have chronic conditions (such as cancer); 3) they enter hospitals more often and stay longer; 4) they use physician services to a far greater extent.

In 1971, the personal health care bill for the average American was $311, but for the average aged person (over 65) it was $861. Per capita hospital-care expenditures for the aged was $410 and for physicians' services $144. In 1971, 37% of every personal health care dollar was a direct patient outlay with the remaining 63 cents paid by government (Federal, state, local), private health insurance, philanthropy and industry.

Direct Cost Estimate

The nearest approximation of the direct costs of cancer was arrived at some years ago by the President's Commission on Heart Disease, Cancer and Stroke. Personal services, such as hospital and nursing home care, physicians' and nurses' services and drugs, were put at a $920.7-million total, with non-personal services, such as research, training, construction, insurance, health services, etc., adding another $326.8-million. That comes to nearly $1.25-billion, and the year was 1962. At the ACS National Conference on Human Values and Cancer, at Atlanta in June '72, an American Hospital Association director put that figure at $3-billion, an increase of 150% in 10 years.

The 1962 report cited cancer illness among those under 65 as costing 72,000 man-years of productivity among the labor force; 44,000 man-years among those keeping house, and 52,000 man-years among those unable to work.

Among women, cancer far exceeds any other disease as a cause of "working years lost"; among men, it is third after accidents and heart disease. Cancer also costs American business and industry the loss of valuable executives at the peak of their efficiency and of trained workers at the height of their productivity. Lung cancer, the greatest cancer killer among men and continuing to rise at an alarming rate, becomes a major cause of disability among the country's work force. Lung cancer and emphysema, another chronic lung disease caused mainly by cigarette smoking, may be the prime disablers of workmen between 40 and 65. Emphysema now ranks second to heart disease in that respect, and as a killer it increased its U.S. death toll 700% between 1950 and 1965.

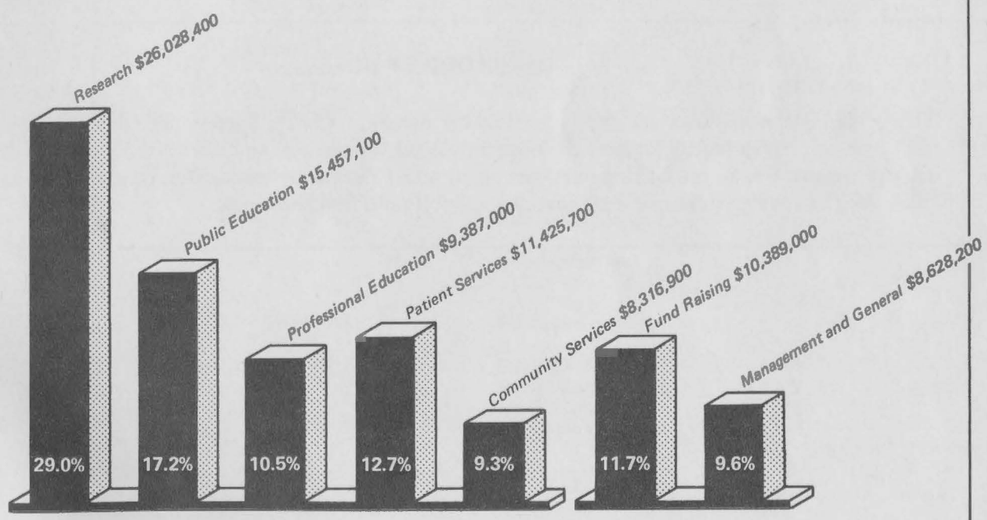
SOURCES OF INCOME

Financial support of the American Cancer Society in fiscal 1974 reached about $97 million from public sources. The Cancer Crusade raised approximately $73 million. National Headquarters and chartered Divisions received $24 million from bequests and legacies. The public has given generous and growing support to the Crusade. In 1944, the Society raised $800,000; in 1956, the figure was $27,234,906; in 1973, more than $93 million.

Legacies – in which the Society becomes beneficiary of willed funds – are an increasingly important source of ACS income. Income from legacies indicates confidence in the leadership of the Society and a determination by many to continue the fight against cancer even after their lifetime. Legacy income in relation to Crusade receipts is shown below.

Year	Crusade	Legacies	Year	Crusade	Legacies
1958	29,796,676	2,894,239	1966	38,590,502	11,673,973
1959	30,372,944	4,237,179	1967	41,070,771	9,996,188
1960	28,356,626	5,372,115	1968	43,410,932	11,810,927
1961	30,791,708	6,151,247	1969	46,605,435	14,407,712
1962	33,313,773	5,758,100	1970	50,147,609	15,099,088
1963	33,151,138	7,608,928	1971	56,427,471	13,636,651
1964	34,093,865	9,681,476	1972	62,044,243	16,774,295
1965	36,920,999	8,887,755	1973	67,784,862	25,228,782

HOW ACS FUNDS ARE ALLOCATED
(BASED ON TOTAL 1973-74 BUDGET $89,633,000)



THE AMERICAN CANCER SOCIETY

WHAT THE ACS IS: The American Cancer Society, Inc., is a voluntary organization of about 2.3-million Americans united to conquer cancer. It is a national organization fighting cancer through balanced programs of research, education and patient service and rehabilitation.

HOW ORGANIZED: The American Cancer Society, Inc., is composed of a National Society, with 58 chartered Divisions, and 2,758 local Units.

THE NATIONAL SOCIETY: A 190-member "House of Delegates" provides a basic representation from the 58 Divisions and additional representation on the basis of population. It elects and is governed by a Board of Directors of 114 voting members – approximately half members of the medical or scientific professions and half laymen. The National Society is responsible for over-all planning and coordination, and provides technical help and materials to Divisions and Units. The National Society administers programs of research, medical grants and clinical fellowships, and is charged with carrying out public and professional education on the national level.

THE 58 DIVISIONS: These are governed by 4,794 members of Divisional Boards of Directors, again medical men and laymen, in all the states plus six metropolitan areas, the District of Columbia, Puerto Rico. Physicians and dentists also serve as regular volunteers.

THE UNITS: These are organized to cover the 3,130 counties in the U.S. There are over 66,850 community leaders who direct the Society's programs at this level. The basic strength of the Society lies in the loyal ranks of volunteers fighting cancer in their communities.

THE BRANCHES: An organizational development of growing importance whereby the ACS reaches more people at the "grass roots" action level by involving more people in its programs. A Branch is the organizational element next below the Unit, and is established on the basis of geographic subdivision of Unit areas. These are permanent (year-round) organizations that are involved with program activities as well as Crusade.

THE SWORD OF HOPE:

This is the registered trademark and insignia of the American Cancer Society. The double-edged blade with twin serpent caduceus forming the hilt emphasizes the medical and scientific aspects of the Society's programs. The Sword of Hope appears on all ACS Crusade materials, literature, posters, ads, films, etc., and is shown at meetings, lectures, exhibits and film showings.

CELEBRITIES AND CANCER

Cancer has struck many personalities of world and national fame. Such greats of stage and screen as John Wayne, William Powell, Glynis Johns and Van Johnson have all had cancer but are alive today – cured of the disease. Other famous names on the cured list include: Senator Maureen Neuberger, the NAACP's Roy Wilkins, theatre's Richard Rodgers and William Gargan, television's Virginia Graham and Arthur Godfrey, pro-football's Jack Pardee.

Most people in public life are reluctant to talk about, or perhaps ever think about, their personal involvement with this or any disease, so the actual records are sparse. Even among those lost to cancer, the death cause is not always accurately specific, but the toll of world figures with each passing year is a dramatic reminder of the full dimensions of cancer's human devastation.

In 1973-74, these well-known people died of cancer: Stewart Alsop, Bud Abbott, Bernt Balchen, Sidney Blackmer, Catherine Drinker Bowen, Betty Bruce, Norman Chandler, Eddie Condon, Martha Deane, Duke Ellington, John Ford, Laurence Harvey, Chet Huntley, Allen Jenkins, Gene Krupa, Charles A. Lindbergh, Anna Magnani, Frank McGee, Nancy Mitford, Marcel Pagnol, Georges Pompidou, Arthur W. Radford, Diana Sands, David Siqueiros, Lewis L. Strauss, Del E. Webb, William L. White.

In 1972-73, these: Leo G. Carroll, Robert Casadesus, Dave Chasen, Sir Francis Chichester, Walter Van Tilburg Clark, Richard Crooks, Edward-Duke of Windsor, Harvey Firestone Jr., Jack Hawkins, Fay Holden, Tim Holt, Elena Krushchev, Elmer Layden, Frank Leahy, Jose Limon, Matthew McCloskey, Neil McElroy, Katina Paxinou, Lester Pearson, Edward G. Robinson, Winthrop A. Rockefeller, Aline Saarinen, Ellen B. Stevenson, Admiral Felix Stump, Margaret Webster, Marie Wilson.

Among other past victims in various fields:

Entertainment
Tallulah Bankhead
Richard Barthelmess
Mimi Benzell
Humphrey Bogart
Spring Byington
Jack Carson
George M. Cohan
Gary Cooper
Brian Donlevy
Dan Duryea
Fernandel
Cedric Hardwicke
Sonja Henie
Jean Hersholt
Judy Holliday
Edward Everett Horton
Charles Laughton
Gertrude Lawrence
Gypsy Rose Lee
Harold Lloyd
Paul Lukas
Dennis O'Keefe
Zasu Pitts
Dick Powell
Charles Ruggles
Ann Sheridan
Zachary Scott
Ed Sullivan
Lee Tracy
Sophie Tucker
Ed Wynn

Science
Marie Curie
Tom Dooley
Enrico Fermi
J.B.S. Haldane
Irene Joliot-Curie
William Menninger
John von Neumann
Peyton Rous
Richard E. Shope

Literature
Charlotte Armstrong
Hamilton Basso
Ludwig Bemelmans
Van Wyck Brooks
Thornton W. Burgess
Henry Seidel Canby
Rachel Carson
T.S. Eliot
Edna Ferber
Lewis S. Gannett
Erle Stanley Gardner
John Gunther
Lorraine Hansberry
Mark Hellinger
James Hilton
Aldous Huxley
Oliver LaFarge
Harold Lamb
Howard Lindsay
Gavin Maxwell
Clifford Odets
Edward Arlington Robinson
Damon Runyon
Lillian Smith
Gertrude Stein
Jacqueline Susann
James Ramsey Ullman

Government
William C. Bullitt
Harry F. Byrd
Grenville Clark
John Foster Dulles
Herbert Hoover, Jr.
Adam Clayton Powell, Jr.
Sam Rayburn
Lurleen Wallace

Music
Sidney Bechet
Eddy Duchin
Amelita Galli-Curci
Percy Grainger
Glen Gray
Oscar Hammerstein II
Spike Jones
Franz Lehar
Frank Loesser
Malcolm Sargent
Alec Templeton
John Charles Thomas

Sports
Tommy Armour
Ty Cobb
Ernie Davis
Hank Gowdy
Willie Hoppe
Walter Hagen
Fred Hutchinson
Red Rolfe
Barney Ross
Babe Ruth
Horton Smith
Dick Tiger
Paul "Dizzy" Trout
"Pop" Warner
Babe Didrikson Zaharias
Robert Carl Zuppke

Communications
Arthur "Bugs" Baer
John Chapman
Bill Cunningham
Rube Goldberg
Dan Parker
Quentin Reynolds
Joe Williams
Walter Winchell

DIED OF LUNG CANCER

Creighton W. Abrams
Michael Arlen
Gene Austin
William Baziotes
Joseph Drexel Biddle
Elizabeth Bowen
Frank Buck
Bruce Cabot
Clair L. Chennault
Nat "King" Cole
Bill Corum
Bebe Daniels
Walt Disney
Glenda Farrell
King George VI of England
Betty Grable
Buster Keaton
Josef Krips
Sean Lemass, P.M., Eire
Hal March
Edward R. Murrow
Boris Pasternak
Hubbell Robinson
Robert Ryan
Robert A. Taft
William Talman
Robert Taylor
Jennie Tourel
Franchot Tone
Martin Whitaker

2,300,000 volunteers want to wipe out cancer in your lifetime.

2,300,000 American Cancer Society volunteers are giving their time, talent, and energy for all of us to live in a world free of cancer.
These people are the lifeforce behind 58 ACS Divisions, including the newest, Puerto Rico, and 3,200 local Units. They deserve to go down in history because they are: helping the cancer patient today; teaching the public how to be on guard against cancer; supporting research that will find the answers.
It is to these caring people that this 1973 Annual Report is dedicated.

"I'm Beverly Fawcett, a Connecticut wife and mother of four boys, and I make time in my schedule when a cancer patient like David Campbell has a medical appointment in his schedule and needs a ride. I want a world free of cancer for my loved ones, and I want a stranger like Mr. Campbell to know that someone cares. I think that's the wish of most ACS volunteers."

"My name is Bill Youman and I coach the University of Houston 'Cougars.' I've seen what cancer can do to a man like Vince Lombardi, who played to win but lost to cancer. That's why I'm an ACS volunteer determined to beat cancer for good. I work on fund raising and speak to people about the importance of checkups."

CONTENTS

"Our greatest asset is the volunteer... dedicated and compassionate..."

Our single aim—to wipe out cancer—requires a many-sided effort and confronts us with myriad tasks. Of all the attributes of the ACS needed to accomplish this formidable objective, our greatest asset is the volunteer. Dedicated and compassionate volunteers, working in harmony with trained staff, multiply many times over the impact of every dollar expended for the fight against cancer.

How valuable this volunteer effort is will be illustrated by just one aspect of the cancer problem. Whatever the percentage actually is, practically all cancer experts are in agreement that a large number of cancers, probably most, are a consequence of environmental causes or conditions. Thus, in Japan the incidence of colon and rectum cancer is low. But when Japanese come to our country and live here the incidence of that type of cancer tends to approach that of other Americans. Similarly with the peoples of Africa: in that continent, the incidence of bowel cancer is low; for Afro-Americans, it rises to approximately the same level as for other Americans.

We are becoming increasingly aware of the results of the pollution of our environment. But, perhaps many in the medical profession and among lay people have been slow to recognize the potential injury from external causes and from our way of life. These include repeated insults to the respiratory tract and other organ systems by the inhalation of cigarette smoke, combustion products or asbestos fibers.

With cancer-causing factors in the environment, cancer prevention becomes a major task, and that is the name of an historic study, the ACS Cancer Prevention Study conducted for six years, and now in operation again. It is unique for its size and significance as an epidemiological study. It is made possible because more than 60 thousand volunteers painstakingly followed up a million subjects. They were questioned about diet, smoking, contact with possible

carcinogenic substances, life style and even psychological factors, to find whatever it is in the environment that may contribute to causing cancer.

This is now being supplemented by the Society's occupational studies, to find substances in the work environment that may cause cancer and other diseases. In cooperation with the Mount Sinai School of Medicine in New York, this project has already conducted studies of asbestos exposure as a hazard in various industries. These studies are made possible in large part because of the volunteer cooperation of thousands of labor union members around the country.

A vital concern is to discover which individuals constitute the high risk groups for the common types of cancer. If the individuals who are in such high risk groups can be identified, then it should be possible to develop screening measures in order to detect their cancers while in a localized stage, enabling prompt treatment to be instituted, thereby saving many lives.

Saving lives through preventing cancer, promoting the widest use of detection methods we have in hand now, and searching for causes and new cures of cancer, along with programs to rehabilitate those who have had cancer, are the Society's priorities. However, we can never lose sight of the fact that the problem of cancer is still an individual one. Each patient needs to be helped as an individual and not as a statistic. Every effort should be made to know what the patients' reactions are, the fears, the hopes, desires, how they will react to stress, and how they can best be helped. That is the common concern of all our volunteers.

W. Armin Willig

W. ARMIN WILLIG,
Chairman

Justin J. Stein M.D.

JUSTIN J. STEIN, M.D.
President

"...the ACS is an organization of people helping people...the people next door..."

In 1973 the public gave the Society a record vote of confidence through its financial support of the Crusade.

At least two basic aspects of our program are surely in the public mind. Last year's combined total of $93 million in Crusade and legacies is a mandate for us to push against the frontiers of the unknown in the biological sciences, for both clinical and basic research to help conquer cancer. It is also a rewarding recognition of our programs of service and rehabilitation and of public and professional education.

The American Cancer Society is an organization of people helping people. Approximately 2,300,000 volunteers are involved in its activities and their efforts are what make the Society so distinctive and so successful. It is this special feature of the organization which is the theme of the 1973 Annual Report.

Two years have gone by since the National Cancer Act became the law of the land. It was a major turning point in the fight against cancer and we can be justly proud of the Society's pioneering efforts to make the conquest of cancer a national goal.

As the Society anticipated, enactment of this legislation did not lessen the demands upon the ACS.

One of the most promising features of the developing cancer program is the closer cooperation of the voluntary sector—ACS—and the government sector—the National Cancer Institute. Twenty breast cancer demonstration projects, jointly sponsored by ACS and NCI, are now operating around the country in a determined effort to bring about a nationwide system to detect breast cancer early—when it is more highly curable.

An example of how the voluntary agency can bring about life-saving changes is in the work of the Task Force on Uterine Cancer Control. In hundreds of communities this Task Force has secured coordinated programs for delivering the Pap test to all income groups through hospitals, physicians' offices, clinics and special projects.

The dramatic story of the volunteers who make ACS what it is unfolds in the following pages. The report also describes recent cancer research and gives a full accounting of how the funds contributed by the public were spent. Here we will just mention a few of the year's highlights in the unrelenting fight against cancer:

—All 58 ACS Divisions have made strides toward the goal of the Uterine Cancer Task Force Program—a Pap test for every adult woman by 1976.

—A record $25 million was spent by ACS for research and clinical investigation grants.

—The National Conference on Virology and Immunology in Human Cancer, co-sponsored by the Society and the NCI, was one of the most successful professional meetings held during the year, attended by an unprecedented total of 3,000 medical scientists.

—The 15th Annual Science Writers' Seminar involved 55 scientists, including four Nobel laureates, and 65 of the top medical science reporters and editors, media representatives who gave wide coverage to the research reports.

—The Society stepped up its educational activities in the schools on the health hazards of cigarette smoking and sought greater national impact through the use of spots on TV and radio.

—The Society's 30 professional education films were made available by Divisions to physicians and other professional personnel on a wider scale than ever before.

—A record number of 31,000 women were visited by Reach to Recovery volunteers after breast surgery and both the ostomy and laryngectomy rehabilitation programs were expanded.

We look back with a sense of gratification for what has been accomplished through remarkable volunteer leadership and look forward to the challenges of the year ahead with a determination to continue to do our utmost in the fight against cancer.

Lane W. Adams

LANE W. ADAMS
Executive Vice President

ACS volunteers are achieving community involvement and understanding for a crucial program to find breast cancer early, when it is most curable—a very real way to serve the cancer patient.

In its first year, in each of 20 facilities across the country, 5,000 women over the age of 35 are receiving the latest and best combined testing in a $4 million ACS-National Cancer Institute demonstration program.

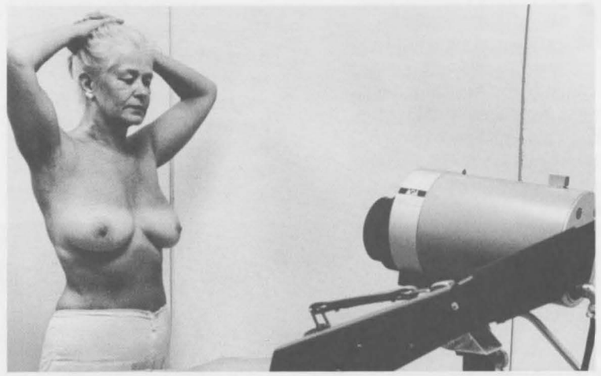
Hopefully, as the ACS-NCI program develops over the next few years, we will discover how the benefits of careful clinical examination plus a medical history and diagnostic tests, including thermography (heat pattern image) and X-ray (mammography or xeroradiography), can most practically and economically be brought to every woman at risk. The importance of monthly breast self-examination is also being continually emphasized.

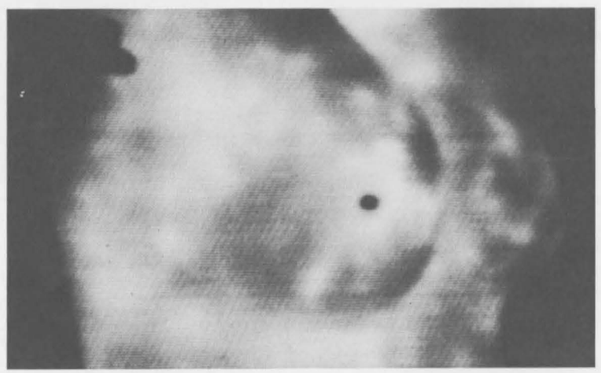
Volunteers inform women about the need for this painless, quick testing, offered free of charge. Thus far the public response has been overwhelming.

The entire Service and Rehabilitation program of the ACS is mobilized by volunteers doing invaluable jobs as different as driving a cancer patient to a treatment center or teaching firemen how to give emergency artificial respiration to a person who has lost the voice box due to surgery.

The amount of volunteer work is immense—and is very personal. For example, in 1973, volunteers chauffeured 31,827 patients. During the year, carefully-trained volunteers aided 50,876 patients recovering from breast, bowel or larynx cancer by saying, first of all—"I've had the same thing myself. I'm back enjoying life. If I can do it, you can too."

Meet three of these unique volunteers on the next page.

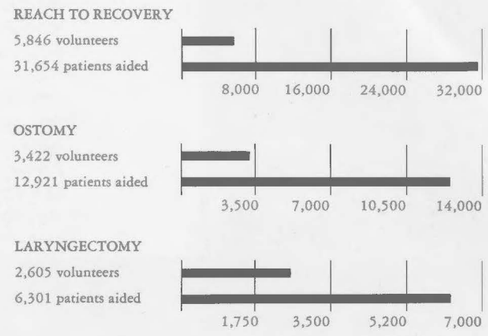




Thousands of women across the nation are receiving advance combined tests in a multi-million dollar ACS-NCI demonstration program that might make the dream of mass screening for the early detection of breast cancer a reality. ACS volunteers are deeply involved in this pioneering effort to stop the greatest cancer killer of American women.

"Look at me, listen to me. I've had cancer and I enjoy life to the full. You can too!" That's the message of unique volunteers who encourage and aid new patients on their way to recovery.

Rehabilitation Volunteers and Patients They Helped in 1973



First, Jan Holmes hurdled mastectomy, breast removal for cancer, then she learned how to take horses over hurdles. Now, as a carefully-trained ACS Reach to Recovery volunteer, she visits new patients in the hospital and helps them to hurdle an often difficult time by answering personal questions and teaching rehabilitative arm exercises.

"Cancer didn't make me quit my job or anything else," Jack Mumma, an ACS Ostomy Rehabilitation volunteer, tells patients recovering from bowel cancer surgery. A busy vice president of a metal fabricating firm, he offers living proof that a return to an active life is possible.

Barbara Smith teaches firemen how to give artificial respiration to laryngectomees like herself, people whose voice boxes have been removed for cancer. She also teaches new patients how to speak again, the esophageal way that she learned years ago after her own surgery.

The latest and best information about cancer must get to the professionals on the frontline of treatment fast. Through major conferences, timely publications, films and special clinical fellowship programs, the ACS helps make sure that it does.

Five major ACS conferences with record audiences of professionals had a big impact in 1973—equally important is the continuous ripple effect of wide distribution of conference material published by the Society.

The five meetings are part of a determined ongoing effort to bring the latest knowledge in cancer diagnosis and management to the many kinds of professionals who deal with the disease daily. 1973 included a "first," a national ACS cancer nursing conference that brought together 2,500 nurses from all parts of the country.

Meetings deal with specific forms of cancer as well. For example, a conference on urological cancer was held in Washington, D.C. and the ACS Second National Conference on Cancer of the Colon and Rectum was held in Florida. Indicative of the close cooperation between the ACS and the government's National Cancer Institute, the Seventh National Cancer Conference in Los Angeles and a National Conference on Virology and Immunology in Human Cancer in New York City were under joint ACS-NCI sponsorship.

There are many ways of communicating to professionals. For example, the ACS has 30 films available through its Divisions, and a pilot project using videocassettes prepared from these films is under way.

Special exhibits are prepared regularly. A new one on uterine cancer control was shown at the 1973 American Medical Association annual meeting.

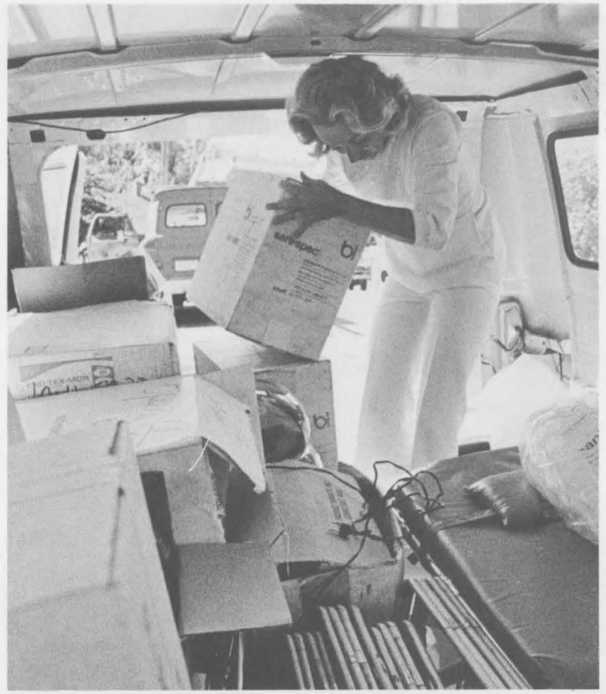
The Society's *Ca-A Cancer Journal for Clinicians* reached over 345,000 in circulation in 1972-73. Voluminous ACS files on unproven methods of cancer diagnosis and treatment were widely used.

Number of Professionals Receiving ACS Information

Professional Audience 1973		Special ACS Professional Education Programs
150,472 physicians		
	>	9,242
70,518 students		
26,916 dentists		
	>	1,230
17,656 students		
326,207 nurses		
	>	29,594
509,768 students		

Last year the ACS provided 233 clinical fellowships for young physicians and dentists, enabling them to obtain specialized clinical training in cancer. At the same time, five outstanding cancer clinicians throughout the country were added to the list of ACS Professors of Clinical Oncology.

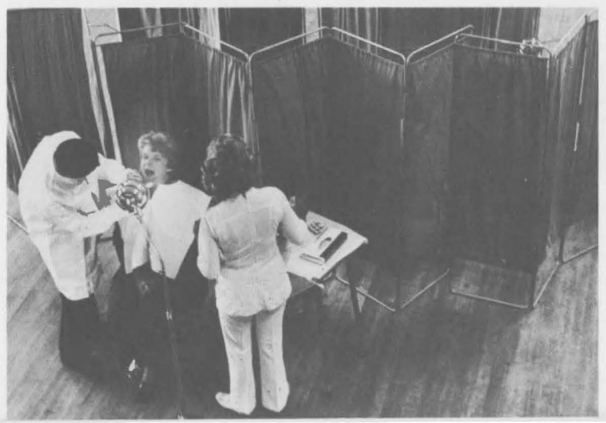
Physicians, dentists, nurses, who see advanced cancer too often, volunteer to find it early.



The nurse preparing equipment in an ACS mobile unit for a volunteer-run detection clinic indicates the detailed work volunteers are willing to do.

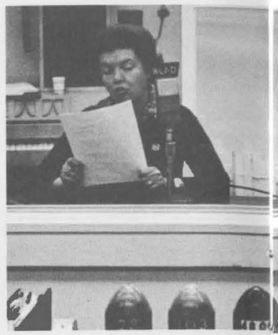
A surgeon, Dr. Joseph Gathe, uses the time between operations to speak to women in a family planning clinic about the Pap test, shows what energy it takes to be an ACS volunteer.

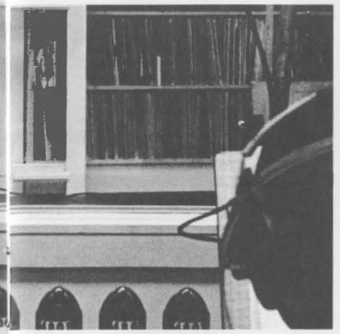
Professionals who want to save more lives from cancer with what we know today, take the lesson of early detection into their home communities in a direct way.
The physician (left) is performing a Pap test on a volunteer basis, giving a woman the best diagnostic test for uterine cancer, while also educating her about the need for this protection regularly.

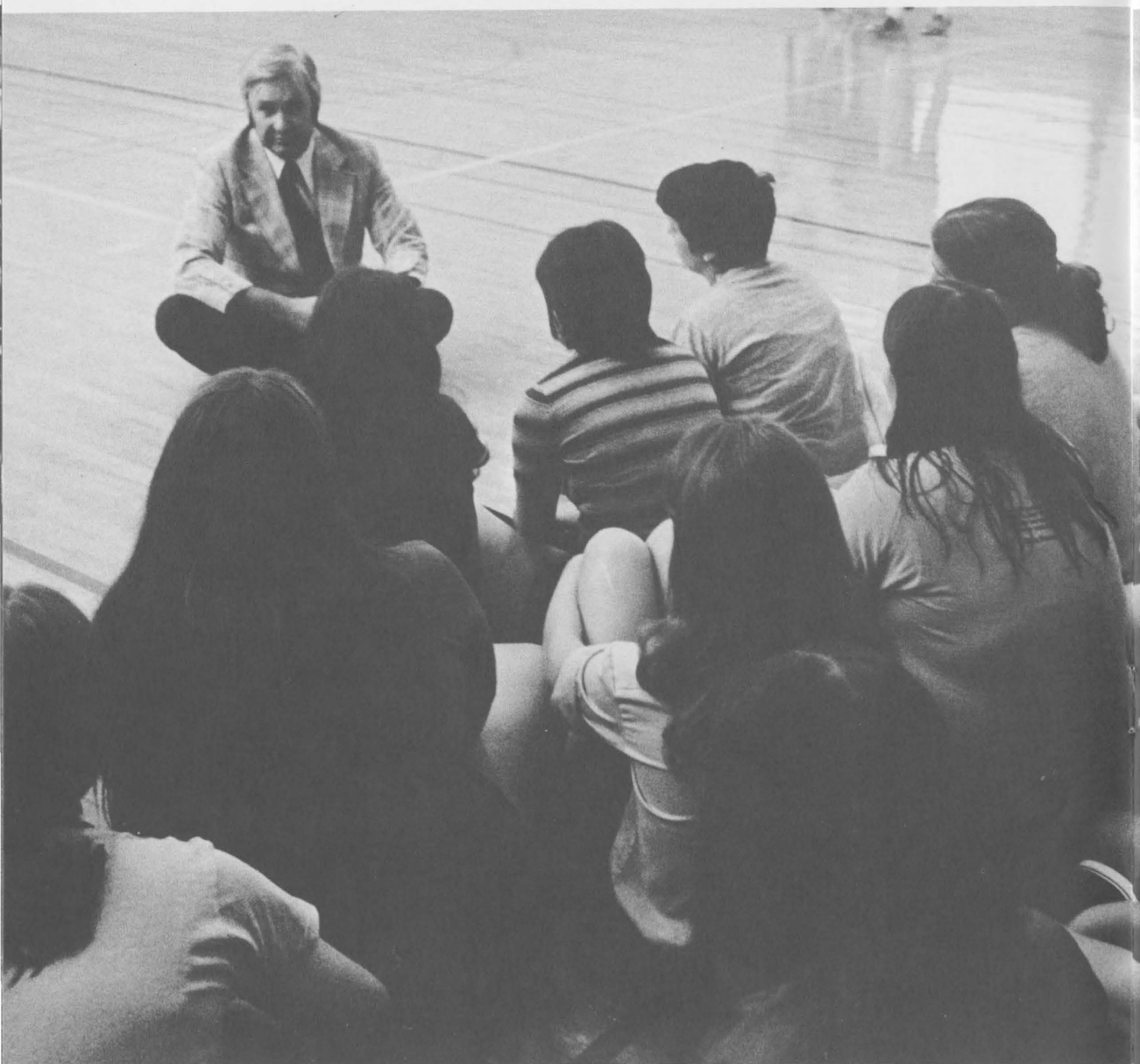


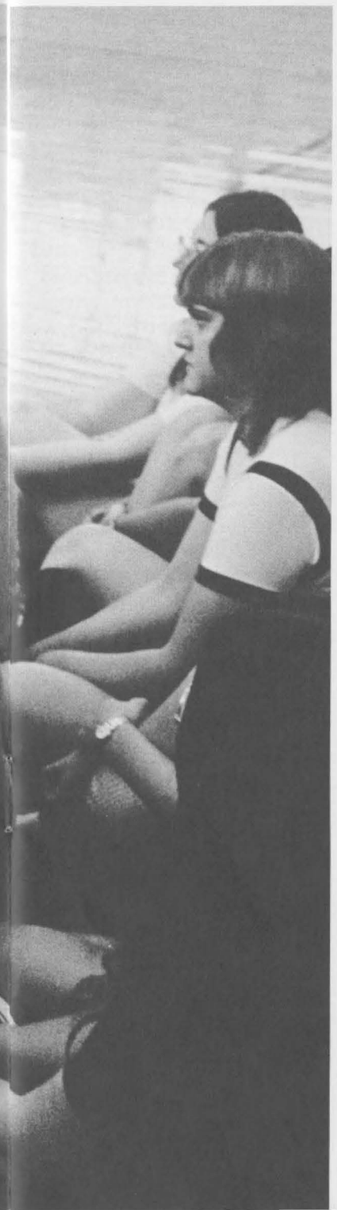
The dentist performing free exams for oral cancer in his free time illustrates the volunteers' zeal.

Ignorance can cost lives. Public Education volunteers go into schools, homes and businesses to teach young and old, men and women, how to safeguard themselves against cancer.









Thousands of women die needlessly each year of uterine cancer, but a woman like Mrs. Josephine Riedl (left) who has been cured of this form of cancer, and a physician like Dr. Henry Blansfield (below) know that regular Pap tests can save lives. That's why Mrs. Riedl volunteered to tape a personal radio message for the ACS, and why Dr. Blansfield volunteered to lead an ACS question and answer session with college girls in their gym. Sometimes there is a fear or simply a language barrier to understanding the need for a Pap test, but an at-home visit by a volunteer (above, left), who understands both the language and the fear, can make all the difference in the world.

1973

ACS VOLUNTEERS' PUBLIC EDUCATION AUDIENCE

7,052,408	adults
11,413,032	students
1,463,483	employees at work
1,484,635	organized groups
296,280	film showings
93,321,480	literature recipients

In every state there's real progress towards the ACS Uterine Cancer Task Force's goal—to have every woman who hasn't had a Pap test to take one.

Since the nationwide effort began in 1972, ACS volunteers have conducted more than 45,000 programs in their home communities. Public education about the importance of the test, and its local availability, is the heart of the program. Here's just a fraction of the action:

—HAWAII: volunteer physicians sail to a settlement on the tiny island of Niihau to give Pap tests. Eighty women are tested, 14 are referred for further examinations.

—MARYLAND: ACS volunteers distribute "bank checks" for free Pap tests at a local facility —more than a thousand women "cash them in."

—FLORIDA: Mrs. George Papanicolaou, widow of the renowned creator of the Pap test, is honorary chairman of a task force working with every influential state organization to reach the largest groups of women possible.

—LOUISIANA: When a survey showed that the statewide percentage of women who had never had a Pap test was unusually high, and that uterine cancer deaths among black women in Louisiana were increasing, ACS volunteers set up free clinics and health fairs to reach these women.

—PHILADELPHIA: The number of uterine cancer programs doubled in a single year: Pap Test Week served the Inner City where many women had never had a Pap test.

The fight against cigarettes is stronger than ever.

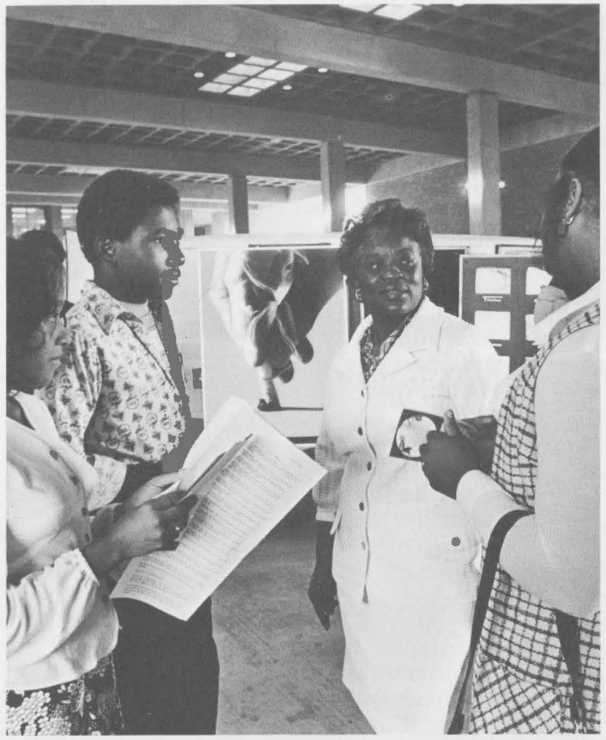
In 1973 the mask was stripped off those little cigars pretending not to be cigarettes, and the year was busy with efforts to establish nonsmoking areas in public places.

Also, volunteers continued their vigorous efforts to teach the hazards of smoking to schoolchildren and to help the established smoker quit. Star volunteers, Eva Gabor and Tony Randall are the co-chairmen of the ACS (IQ) I Quit Smoking Campaign.

On the 10th anniversary of the famous 1964 Surgeon General's report on the dangers of cigarette smoking, the ACS notes that, while there is no such thing as a "safe" cigarette, tar and nicotine content of cigarettes has been dramatically cut in the 10 years since the report was issued.

During the same time, there was a substantial decline in the per capita rate of cigarette consumption. However, in the last two years, there has been evidence of a slight reversal of this trend. Nonetheless, today's per capita consumption rate is still lower than when the report was issued.

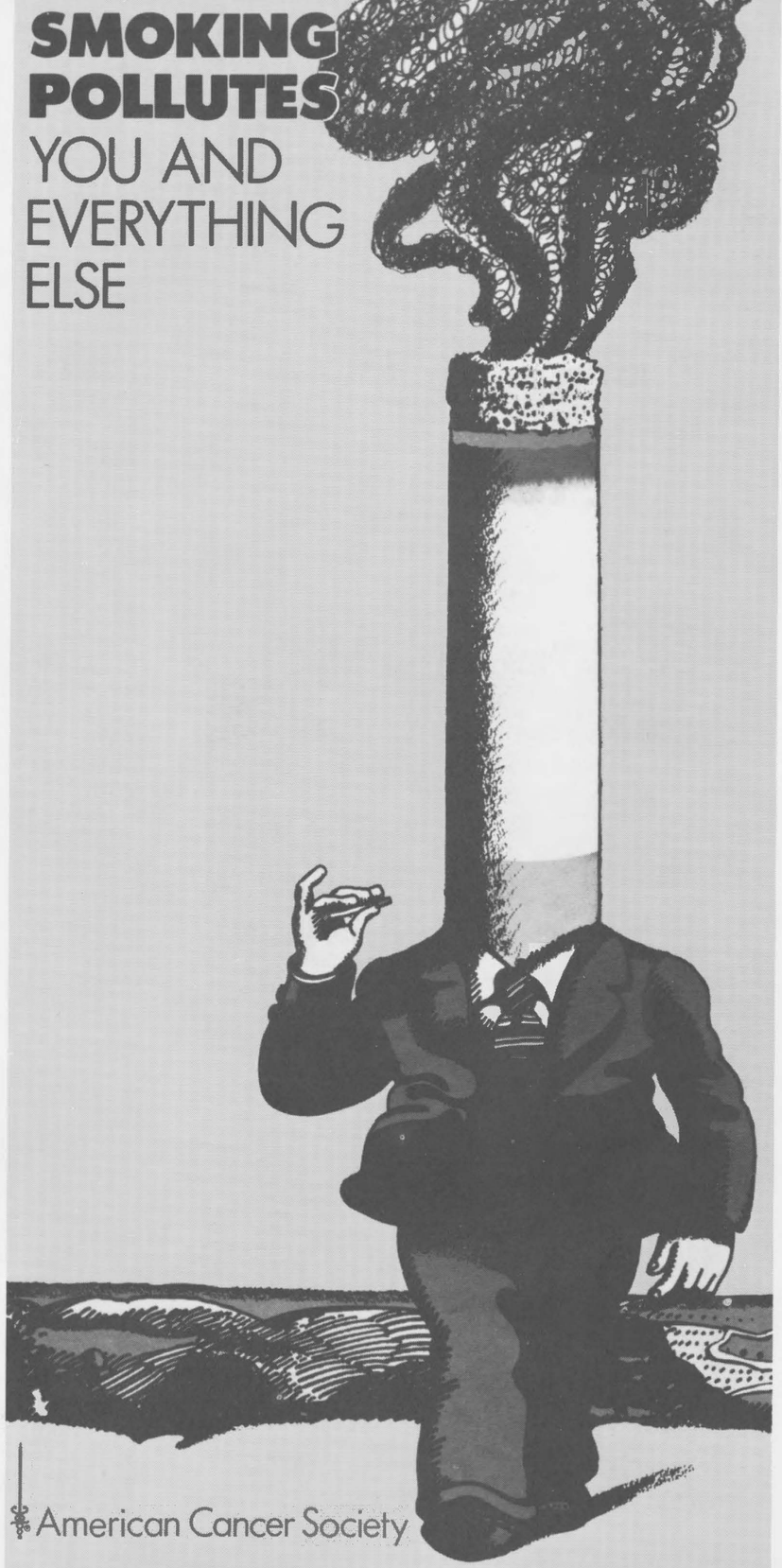
It should be remembered that, during the years of the decline in per capita consumption, the imaginative and energetic ACS radio and TV anti-smoking campaign was at its height. Since the 1971 ban on cigarette advertising in the broadcast media, the equal-time provision for anti-smoking messages has no longer been in effect. But many stations continue to use anti-smoking messages, often



The ACS is against designated smoking areas in the schools, and volunteers believe that their first priority is a determined effort to personally convince the young not to begin the habit. Mrs. Lillian Bastine (left) is assistant principal of a school with 2,000 teenagers and she knows how they feel—she was a two-pack a day smoker herself. But, she quit, and became an ACS volunteer who parks an ACS anti-smoking unit in the school's yard regularly.

And, for the established smoker, volunteers conduct "I Quit" clinics that lead to the magic moment when people toss away their last pack of cigarettes and take a step towards a healthier life.

To combat the lure of advertising, the ACS calls on people in that industry like Milton Glaser to design a poster (right) for use in the schools.



motivated by the ACS.

While cigarette advertising was banned from the broadcast media, "little cigars", packed twenty to the box like cigarettes and almost identical to cigarettes in look, were being energetically promoted through radio and TV. In 1973 Congress took the action that forced "little cigar" advertising off the air.

In an effort to clear the air of cigarette smoke for health reasons, the Arizona Legislature passed a law prohibiting cigarette smoking in many public places, including theaters, libraries, concert halls and museums, except in designated places.

The state followed such communities as Miami, Fla., where smoking was banned in government offices, elevators and department stores. The sale of cigarettes in hospitals and nursing homes also was banned. This nonsmoking movement is strongly endorsed by the ACS and is being promoted by volunteers in their home territories.

Another form of endorsement came from the Civil Aeronautics Board when, in July, no-smoking sections on airplanes became mandatory. The ACS had long worked for just such a result.

An additional indication of the growing no-smoking movement is the two motel chains that have set aside no-smoking rooms for guests.

A subtle plug for cigarette smoking occurs when tobacco companies sponsor athletic events—linking a health event with a dangerous habit. In Colorado, for example, some citizens are beginning to fight back, asking ski enthusiasts not to permit such a contradictory exploitation of the sport.

Immunology... virology...the computerized study of huge population groups...cell biology—the avenues of cancer research are many, the promises great.

The research attack on cancer is being fought on many fronts and one of the most promising is immunology—enlisting the body's natural defenses against disease.

"In order for cancer to occur and persist there must be a failure of the immunologic process. We've never found a cancer patient in whom something wasn't screwed up immunologically," says Dr. Robert A. Good, Director of Sloan-Kettering Institute for Cancer Research.

In the case of infectious disease, vaccination has long been used successfully to stimulate disease-fighting blood cells. Now, some investigators have achieved promising results against skin cancer, with BCG, the tuberculosis vaccine, and the experimental agent DNCB, both of which stimulate immunity.

The goal of immunologists, many backed by the ACS, is to find out how the complicated system of immunity can be manipulated to strengthen the natural body defenses against cancer. The question is not *if* anymore, but *how* and *when?*

Another hopeful area of the research effort is virology. The work of the late Dr. Wendell M. Stanley, a Nobel laureate, who isolated and identified the baffling microscopic virus particles in 1935, opened up a new front against cancer.

Soon investigators were using electron microscopy to discover cancer-causing viruses in fowl and small mammals. In humans there is growing experimental evidence linking viruses to cervical cancer, and suspicions centered on virus-like particles in human breast milk.

Conclusive proof of cancer viruses in humans is still the goal of investigators such as ACS-supported researcher, Dr. Andre J. Nahmias of Emory University or Dr. Sol Spiegelman of Columbia.

Volunteers collected data on one million people for the ACS Cancer Prevention Study. Scientists use computers to sift this information for clues to high-risk groups.

This investigator is working with human cells and tumor viruses. Viruses can cause cancer in animals but their influence on human cancer is unclear.

Much cancer research involves probing into the innermost secrets of life itself—taking the cell apart and studying it with highly sophisticated equipment for leads into the nature of normal and abnormal growth. The study of enzymes, those substances which are the key to the chemical processes of life, is another area of basic research being backed by the ACS.

Cancer chemotherapy has made notable strides since it was pioneered in the 1940s by the late Dr. Sidney Farber, a past president of ACS. Several types of cancer have yielded in varying degrees to more than 40 new research products, drugs or combinations of drugs, used separately or in combination with surgery or radiation.

More than 63,000 ACS volunteers in 23 states are now carrying out the renewed massive Environmental Cancer Research Project of the ACS. Under the direction of ACS Vice President Dr. E. Cuyler Hammond and Dr. Irving J. Selikoff, of the Mount Sinai School of Medicine in New York, the volunteers are following up the nearly 1,000,000 original subjects in the ACS Cancer Prevention Study of 1959-65. This historic study produced significant data on such health and cancer hazards as cigarette smoking and air pollution. The new information will provide insights into some of the other sites of cancer; also data on whether or not reduced tar and nicotine content in cigarettes is reflected in lowered cancer death rates; and the cancer death rates of persons exposed to occupational agents suspected of causing cancer.

Key to the new project is the cooperation of labor

unions and industries such as the Printers' Union and Printers' Guild where the cancer death rates of workers exposed to various dyes and other industrial agents are being studied. Cancer death rates among cotton mill workers, typographers and roofers are under study, and arrangements are being made to evaluate similar data among workers in various other industries.

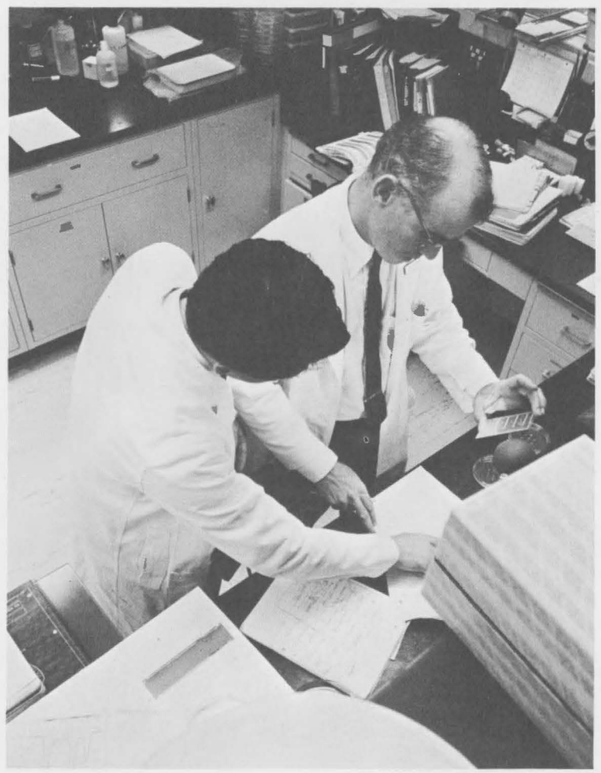
During the year, 1,200 applications for National ACS basic research and clinical investigation grants, support grants for research personnel, and institutional research grants were received and evaluated by leading scientists. Funds were awarded totalling $22,582,657 to support 525 grants. The critical need for increased research funds was shown when ACS-approved requests for research totalled $50.1 million, leaving about $27.5 million in unfunded but approved grant applications.

As in past years several ACS Divisions supported local research programs. This year they supplied an additional $5.4 million.

In 1973, several ACS scientific conferences were held. The subjects included cervical cancer and herpes viruses; urologic cancer, colon and rectum cancer; and virology and immunology, cosponsored by ACS-NCI. They brought together leading U.S. and international researchers to assess the current state of cancer control in these special areas and to consider new developments in both basic and applied research.

In all of these research activities, the roles of both scientists and laymen have helped advance the struggle to control cancer. They are committed to victory.

Basic research is trying to understand life processes in order to understand the abnormal process called cancer. The senior scientist is using the powerful electron microscope to monitor chemical changes within the cells of a chick embryo.



In addition to basic research there is clinical research, concerned with the diagnosis, prevention and management of cancer in man. The medical scientists (left) are seeking a relationship between a protein abnormality and the cancer patient they are treating.

One world fighting cancer: International cooperation in research; mutual belief in the value of volunteers.

In both research and volunteer activity, the ACS was busy at home and abroad.

In 1973, for the first time, a cancer society staffer from abroad was brought to this country for intensive training by ACS volunteers and staff. And for the fourth time, ACS volunteers went to a Latin American country to present a special course on cancer.

Our visitor was Mrs. Jenny Shabudin of Malaysia who visited ACS Divisions in southeastern states. Mrs. Shabudin said, "We realize that there is very much that we can learn from the ACS, its organization, and set-up of various programs." Her visit was part of a pilot program based on cost-sharing with other nations.

The Society's fourth postgraduate course in cancer was given in 1973 in collaboration with the National University Pedro Henriquez in Santo Domingo. At the same time, a special program on the organization of a cancer society was held with the Dominican League Against Cancer. Also, foreign professionals came to the U.S. last year to attend ACS medical conferences in greater numbers than ever before.

In 1973, as in prior years, the international approach to the cancer fight was exemplified by the ACS-Eleanor Roosevelt International Cancer Fellowship Grant Program, administered by the International Union Against Cancer in Geneva. Sixteen awards totalling $233,975 were made in 1973 to allow American researchers to work abroad, and foreign investigators to come to the U.S. and other countries. Since its inception in 1961, some 243 awards have been made.

Mrs. Shabudin of Malaysia comes here to meet the ACS.

The ACS goes to Santo Domingo for a special conference...

The financial statements which follow, prepared in conformity with the "Standards of Accounting and Financial Reporting" developed by the National Health Council (NHC) and the National Assembly for Social Policy and Development, reflect the combined financial position of the American Cancer Society (National and all Divisions) as of 8/31/73 and the combined results of its operations for the fiscal year then ended. It should be noted that our independent auditors have given their unqualified opinion on these statements. The Society is the first nation-wide voluntary health agency, reporting in accordance with the "Standards," to attain this unqualified report as a result of developing uniformity of reporting and control over funds entrusted to it by the contributing public.

The NHC, an organization of more than 70 national voluntary professional and governmental agencies, together with other groups, works for health protection and improvement through the cooperative efforts of its members among themselves and with others.

In addition to the accounting criteria, the ACS met organizational and operational membership standards established by the NHC in the category of "Active Members-Voluntary Health Agencies."

Acceptance by the NHC is assurance to the public that the ACS is democratically organized and controlled by a volunteer Board of Directors comprising both lay and professional people from throughout the country; has no restrictions on participation based on race, religion, age, or sex; is primarily and predominately supported by voluntary contributions; follows ethical methods of fund raising, promotion, and reporting of fund raising costs; and meets other stringent criteria for ethical and democratic operation.

Total support and revenue during the fiscal year covered by this report reached an all-time high of $99,468,515. Of this amount $67,784,862 was received from the contributing public in the 1973 Crusade; $25,228,782 came from legacies and bequests, and the balance of $6,454,871 represents the Society's income from investments and revenues from other sources. Funds available are temporarily invested at short-term interest rates during the period between receipt of contributions and the time funds are actually needed for program purposes.

Our practice of budgeting funds based on previous year's income enables us to conduct the Society's affairs in a manner to assure advance planning and provide for continuity of program and support for ongoing research projects. Substantially all of the unrestricted funds on hand at August 31, 1973 were budgeted for fiscal 1974 programs.

Except for gifts restricted by donors for specific purposes, contributions received in the annual Cancer Crusade are divided so that 60% is retained by the Divisions for their programs of Public and Professional Education, Research, Service to the cancer patient, and for supporting services of Fund Raising and Management and General; a minimum of 25%* is for the Society's nationally-administered research program; 3% is for a national program of medical grants and fellowships; 12% is for National Office programs including technical and advisory help to Divisions in program planning and support service activities.

Funds bequeathed to the Society which are not restricted by the testators for specific program purposes are also divided so that 60% is retained by Divisions for their programs with 40% going to the National Headquarters for use principally in support of the research program.

The ACS, Inc. invites inquiry and will be pleased to respond to requests for information on its program activities or finances. The financial statements of the Society's National Office for the year ended August 31, 1973 together with the report of our auditors, are also available on request.

Joseph S. Silber
Treasurer, 1972-1973

*Actually 30.7% of 1973 expenditures by National and Divisions was for research.

COMBINED BUDGET 1973-1974

Program Services	
Research	
$26,028,400	29.0%
Public Education	
$15,457,100	17.2%
Professional Education	
$ 9,387,000	10.5%
Patient Service	
$11,425,700	12.7%
Community Service	
$ 8,316,900	9.3%
Sub total	
$70,615,800	**78.7%**
Supporting Services	
Management and General	
$ 8,628,200	9.6%
Fund Raising	
$10,389,000	11.7%
Sub total	
$19,017,200	**21.3%**
Grand Total	
$89,633,000	**100%**

To the Board of Directors of
American Cancer Society, Inc.:

We have examined the combined balance sheet of American Cancer Society, Inc., National Headquarters and Chartered Divisions, as of August 31, 1973, the related combined summary of financial activities and the combined statements of awards and expenditures by functions and changes in fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We have previously examined and reported on the combined financial statements for the preceding year.

In our opinion, the accompanying combined financial statements present fairly the assets, liabilities and fund balances of American Cancer Society, Inc., National Headquarters and Chartered Divisions, as of August 31, 1973, and its revenues, expenditures and changes in fund balances for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Arthur Andersen & Co.

New York, N.Y.
January 11, 1974

	1973 Current Funds General	1973 Current Funds Donor Restricted	1973 Donor Endowments	1973 Total	1973 Percent	1972 Total	1972 Percent
Support from the public:							
Contributions—These gifts include bequests of $25,228,782 and special events of $4,967,103 (net of direct expenses of $835,428). The cost of raising this money was $10,164,482 or 11% (Note 1 and Exhibit 1)	$86,851,505	$4,579,230	$1,582,909	$93,013,644		$78,818,538	
Other support and revenue:							
Investment income—Pending actual disbursement for budgeted program expenditures, funds are invested in bank savings accounts, certificates of deposit, U.S. Government short-term securities, etc.	5,905,577	175,994	—	6,081,571		4,770,678	
Other income, including $148,910 from U.S. Government agencies	216,873	156,427	—	373,300		533,229	
Total support and revenue	92,973,955	4,911,651	1,582,909	99,468,515		84,122,445	
Awards and expenditures:							
Program services—							
Research—To support basic scientific studies, clinical investigations and conduct programs seeking new knowledge for the cure of cancer	21,711,897	3,342,513	—	25,054,410	30.7%	23,611,718	31.5%
Public education—Programs designed to inform the public about cancer prevention and symptoms and to encourage periodic physical examination	13,229,256	156,347	—	13,385,603	16.4	12,347,465	16.5
Professional education—Programs designed to improve the knowledge, skills and techniques of the medical and allied health professions in the detection and treatment of cancer	8,452,498	394,072	—	8,846,570	10.8	7,792,401	10.4
Patient services—To provide for information, counseling, nursing and homemaking services, transportation, dressings and loan closet items	10,191,898	291,386	—	10,483,284	12.8	9,284,236	12.4
Community services—To provide for programs in cancer detection, mass screening, rehabilitation and development of cancer registries	5,667,454	105,173	—	5,772,627	7.1	5,201,185	7.0
Total program services	59,253,003	4,289,491	—	63,542,494	77.8	58,237,005	77.8
Supporting services—							
Management and general—To direct the overall affairs of the Society, accounting, personnel and office service activities	7,977,041	16,380	—	7,993,421	9.8	7,582,768	10.1
Fund raising—Activities to secure increased support from the public for the needs of research, education, service and overall direction	10,129,167	35,315	—	10,164,482	12.4	9,032,313	12.1
Total supporting services	18,106,208	51,695	—	18,157,903	22.2	16,615,081	22.2
Total awards and expenditures	77,359,211	4,341,186	—	81,700,397	100.0%	74,852,086	100.0%
Support and revenue in excess of awards and expenditures	$15,614,744	$ 570,465	$1,582,909	$17,768,118		$ 9,270,359	

The accompanying notes to combined financial statements and Exhibit 1 are an integral part of this statement.

Assets	1973	1972	Liabilities and Fund Balances	1973	1972
Current Funds—General					
Cash:			**Research, Professional Education and Medical Project Awards Payable**	$ 22,339,043	$ 20,789,612
Checking accounts at National, 57 Divisions and their Units	$ 9,907,180	$ 11,256,811	**Accounts Payable and Accrued Expenses**	1,646,264	1,454,758
Savings accounts	8,355,249	16,881,722	Total liabilities	23,985,307	22,244,370
	18,262,429	28,138,533			
Temporary Investments, at cost, which approximates market:			**Fund Balances:**		
Certificates of deposit and time deposits	78,046,396	60,778,859	Appropriated for special projects	6,891,359	4,492,204
Commercial paper	7,737,444	4,674,687	Available for fiscal 1974 and 1973 programs ($88,631,000 budgeted for fiscal 1974 programs, including $6,845,000 to be financed from 1974 income)	90,119,737	78,008,380
U.S. Government and other securities	10,532,276	6,078,483		97,011,096	82,500,584
	96,316,116	71,532,029			
Accrued Interest, Other Receivables and Prepaid Expenses	4,654,745	3,397,452			
Inventories of Educational, Crusade and Service Materials, at lower of cost or realizable value	1,763,113	1,676,940			
	$120,996,403	$104,744,954		$120,996,403	$104,744,954
Current Funds—Donor Restricted					
Cash:			**Research Awards Payable**	$ 324,028	$ 23,984
Checking accounts	$ 1,804,543	$ 1,523,604	**Accounts Payable**	7,900	—
Savings accounts	1,266,132	1,302,313	Total liabilities	331,928	23,984
	3,070,675	2,825,917			
Temporary Investments, at cost which approximates market:			**Fund Balances**—Restricted by contributors for specific programs or use within specific geographic areas ($1,002,000 budgeted for fiscal 1974 programs) (Note 5)	7,788,608	7,218,143
Certificates of deposit and time deposits	3,897,507	3,011,876			
U.S. Government and other securities	1,017,368	1,335,547			
	4,914,875	4,347,423			
Accrued Interest and Other Receivables	134,986	68,787			
	$ 8,120,536	$ 7,242,127		$ 8,120,536	$ 7,242,127
Land, Building and Equipment Funds					
Land ($1,148,883 and $608,081) **and Buildings,** at cost, less accumulated depreciation of $342,186 and $352,612 (Note 1)	$ 3,455,626	$ 1,511,343	**5%-8% Mortgages Payable**	$ 797,384	$ 243,073
			Fund Balances (Note 1)	5,251,192	2,929,354
Electronic Data Processing Equipment, Office Furniture and Fixtures, at cost, less accumulated depreciation of $4,268,797 and $3,878,787	2,592,950	1,661,084			
	$ 6,048,576	$ 3,172,427		$ 6,048,576	$ 3,172,427
Endowment Funds and Funds Functioning as Endowments					
Cash:			**Fund Balances:**		
Checking accounts	$ —	$ 23,603	Donor endowments	$ 3,845,856	$ 2,359,504
Savings accounts	105,197	355,309	Funds functioning as endowments (by action of Boards of Directors)	4,894,775	4,451,702
	105,197	378,912			
Investments, at cost, which approximates market:					
Certificates of deposit and time deposits	4,101,778	3,310,456			
U.S. Government and other securities	1,212,908	1,281,231			
Commercial paper	1,691,703	205,976			
	7,006,389	4,797,663			
Notes Receivable	125,905	—			
Deposits with Trustee for Research Professorships (Note 6)	1,503,140	1,634,631			
	$ 8,740,631	$ 6,811,206		$ 8,740,631	$ 6,811,206

The accompanying notes to combined financial statements are an integral part of this balance sheet.

	Current Funds		Land, Building and Equipment Funds	Endowment Funds		1973 Total	1972 Total
	General	Donor Restricted		Donor Endowments	Funds Functioning as Endowments		
Balances, beginning of year	$82,500,584	$7,218,143	$2,929,354	$2,359,504	$4,451,702	$ 99,459,287	$90,275,533
Support and revenue in excess of awards and expenditures per combined summary of financial activities	15,614,744	570,465	—	1,582,909	—	17,768,118	9,270,359
Interfund transfers:							
Reservation of funds by action of Boards of Directors, net	(443,073)	—	—	—	443,073	—	—
Removal of prior donor restrictions	96,557	—	—	(96,557)	—	—	—
Property transactions:							
Acquisitions—							
Land and buildings (Note 8)	(84,081)	—	2,172,241	—	—	2,088,160	—
Electronic data processing equipment—primarily for use in statistical research	(673,635)	—	673,635	—	—	—	—
Office furniture and fixtures	—	—	905,528	—	—	905,528	638,263
Straight-line depreciation	—	—	(762,862)	—	—	(762,862)	(675,190)
Sales and retirements	—	—	(666,704)	—	—	(666,704)	(49,678)
Balances, end of year	$97,011,096	$7,788,608	$5,251,192	$3,845,856	$4,894,775	$118,791,527	$99,459,287

The accompanying notes to combined financial statements are an integral part of this statement.

AMERICAN CANCER SOCIETY, INC., NATIONAL HEADQUARTERS AND CHARTERED DIVISIONS
COMBINED STATEMENT OF AWARDS AND EXPENDITURES BY FUNCTIONS FOR THE YEARS ENDED AUGUST 31, 1973 AND 1972

	Program Services				Supporting Services			1973 Total	1972 Total
	Research	Public Education	Professional Education	Patient Services	Community Services	Management and General	Fund Raising		
Awards and grants	$22,608,951	$ 187,180	$3,361,983	$ 334,125	$1,462,424	$ —	$ —	$27,954,663	$25,308,110
Salaries	1,281,254	6,715,562	2,506,738	3,507,474	2,360,854	4,053,308	4,948,765	25,373,955	23,244,322
Employee health and retirement benefits (Note 1)	233,932	677,527	256,824	355,580	244,102	462,298	451,256	2,681,519	2,414,198
Payroll taxes	85,120	409,225	147,565	229,698	144,709	254,890	302,097	1,573,304	1,301,873
Professional fees and contract services	58,236	101,177	25,303	13,388	116,794	646,260	294,891	1,256,049	1,054,236
Office supplies	82,147	412,944	120,017	201,890	101,083	328,461	396,531	1,643,073	1,430,684
Telephone and telegraph	28,310	411,294	116,430	223,687	116,824	219,830	358,801	1,475,176	1,301,432
Postage and shipping	40,808	496,007	198,503	191,582	104,865	204,049	503,811	1,739,625	1,664,226
Occupancy (Note 7)	169,405	818,922	301,746	474,401	246,518	546,912	497,845	3,055,749	2,873,863
Printing, visual aids, etc.	32,211	1,612,783	927,438	162,553	103,496	205,768	963,687	4,007,936	4,148,728
Meetings, including related travel	226,687	402,559	473,046	164,601	206,179	504,547	538,103	2,515,722	2,511,646
Travel—other	127,760	687,023	237,261	300,698	262,825	276,315	415,239	2,307,121	2,095,120
Specific assistance to patients	—	—	—	4,144,064	107,064	—	—	4,251,128	3,952,249
Office furniture and fixtures (Note 1)	31,122	306,061	86,208	132,154	104,019	130,507	115,457	905,528	638,263
Other expenses	48,467	147,339	87,508	47,389	90,871	160,276	377,999	959,849	913,136
Totals	$25,054,410	$13,385,603	$8,846,570	$10,483,284	$5,772,627	$7,993,421	$10,164,482	$81,700,397	$74,852,086

The accompanying notes to combined financial statements are an integral part of this statement.

(1) Accounting policies:

Standards of accounting and reporting—
The Society follows the standards of accounting and financial reporting for voluntary health and welfare organizations developed by the National Health Council and the National Assembly for Social Policy and Development.

In accordance with these standards:

1. Purchases of office furniture and fixtures are reflected as Current General Fund expenditures in the year of acquisition. Major property additions are reported directly in the Statement of Changes in Fund Balances (Note 8). Fixed assets on hand are reflected in the Land, Building and Equipment Fund at cost, net of straight-line depreciation.
2. Donated land, buildings, equipment and other items are recorded at their fair market value at date of receipt.
3. Volunteers contribute their services to the Society in all aspects of its programs. Since no objective basis exists for assigning values to such services, they are not included in the accompanying financial statements. Similarly, the value of space and time contributed by various media for Society educational and fund raising advertisements is not subject to control or measurement and has not been reflected in the accompanying financial statements.

Principles of combination—
The accompanying combined financial statements include the accounts of the National Headquarters of the Society, which is a New York not-for-profit corporation, and its 57 Chartered Divisions which are separately incorporated under the laws of the various states. All significant intra-Society accounts and transactions have been eliminated in preparation of the combined financial statements.

Pension plan—
The Society has a contributory pension plan covering substantially all eligible employees. Annual payments are made to the plan trustee in accordance with the Society's policy of funding accrued pension costs. Prior service costs are amortized over the average future service lives of active covered employees. At August 31, 1973, pension fund assets were in excess of the actuarially computed value of vested benefits. The total pension expense for 1973 and 1972 was $1,751,000 and $1,620,000 respectively.

Outstanding legacies—
The Society is the beneficiary under various wills and trust agreements, the total realizable amounts of which are not presently determinable. The Society's share of such bequests is recorded when the Society has an irrevocable right to the bequest and the proceeds are measurable.

(2) Tax status:
The Society is a nonprofit voluntary health agency, exempt from income tax under Section 501(c)(3) of the U.S. Internal Revenue Code, and contributions to the Society qualify for the 50 per cent charitable contributions limitation. The Society has been classified as an organization that is not a private foundation and has been designated as a "publicly supported" organization.

(3) Allocation of public support:
Support from the public is received principally by the Chartered Divisions and is shared with the National Headquarters. In accordance with National policy, 40% of gross contributions, exclusive of approved special purpose gifts, is allocated to support the National research program and other program activities—for research (25%), medical grants and fellowships (3%) and other programs (12%). Unrestricted legacy income allocated to National (40%) is used principally in support of the research program.

(4) Available funds and budgets:
To provide continuity of programs and permit effective budgeting, substantially all activities are financed by the public support received during the previous fiscal year. Accordingly, substantially all of the available Current General Funds reflected in the accompanying balance sheet will be used for fiscal 1974 programs of education, service and related supporting activities covered by approved budgets.

Amounts appropriated for special projects by the Boards of Directors are not expendable in the ensuing budget year but are earmarked for program development or expansion over a period not to exceed three years.

(5) Current donor restricted funds:
Current donor restricted funds were restricted by contributors for the following purposes:

	1973	1972
Research	$3,852,197	$3,389,134
Other programs	1,497,391	1,246,549
For use within specific geographic locations	2,439,020	2,582,460
	$7,788,608	$7,218,143

(6) Research professorships:
Under the terms of agreements with 21 educational and medical institutions, the Society is obligated to pay the annual stipends of 23 career professorships in cancer research, each of which terminates upon the retirement of the approved investigator. The Society has appropriated and deposited with a Trustee $1,503,140 as performance bonds. The net income of each trust is paid to the Society.

As of August 31, 1973, the estimated amount required to fund the aggregate liability over the terms of the 23 active contracts, was approximately $5,821,000, exclusive of the liability for fiscal 1974 stipends which has been recorded in the accompanying financial statements.

(7) Lease agreements:
The Society is obligated to pay annual rentals of approximately $1,900,000 under the terms of agreements expiring at various dates, for lease of office and warehouse space throughout the United States.

(8) Acquisitions of land and buildings:
The principal property addition in 1973 resulted from the exchange by the New York City Division of its old headquarters land and building for a newly constructed facility and $500,000 in cash. Both the net book value of assets exchanged or retired in the amount of $560,437 and the contract value of the new building plus amounts expended for expansion, furniture and equipment amounting to $1,956,187 have been reflected in the Statement of Changes in Fund Balances.

Exhibit I

American Cancer Society, Inc.
1973 and 1972 Public Contributions by Divisions

	1973	1972
Alabama	$ 713,116	$ 600,189
Alaska	145,209	173,414
Arizona	792,330	618,004
Arkansas	469,127	483,680
California	10,159,764	9,287,737
Colorado	942,211	813,326
Connecticut	1,598,375	1,755,087
Delaware	352,751	289,260
District of Columbia	1,279,065	818,242
Florida	5,104,343	3,608,427
Georgia	2,428,911	1,981,103
Hawaii	1,019,104	807,044
Idaho	204,349	197,447
Illinois	5,164,587	4,782,870
Indiana	1,425,203	1,134,739
Iowa	1,266,899	1,187,149
Kansas	1,119,904	867,875
Kentucky	696,126	926,624
Louisiana	2,246,555	793,649
Maine	462,553	377,235
Maryland	1,861,926	1,934,283
Massachusetts	3 625,457	2,748,223
Michigan	2,942,193	2,562,902
Minnesota	1,434,903	1,202,624
Mississippi	424,203	408,170
Missouri	2,074,859	1,810,494
Montana	220,348	190,563
Nebraska	678,700	416,588
Nevada	171,972	200,289
New Hampshire	316,936	372,448
New Jersey	2,966,005	3,132,808
New Mexico	181,645	154,496
New York State:		
Long Island	1,185,617	1,010,548
New York City	5,291,382	3,772,584
New York State	3,843,109	3,589,972
Queens	478,396	446,391
Westchester	908,752	586,575
(Total)	11,707,256	9,406,070
North Carolina	1,233,996	979,872
North Dakota	250,682	200,060
Ohio	5,986,244	4,742,441
Oklahoma	589,857	575,951
Oregon	980,571	782,313
Pennsylvania:		
Pennsylvania	3,865,228	3,554,872
Philadelphia	1,114,778	979,982
(Total)	4,980,006	4,534,854
Rhode Island	587,596	380,736
South Carolina	771,174	619,014
South Dakota	196,569	172,848
Tennesseee	1,312,929	1,069,775
Texas	4,075,071	3,199,894
Utah	326,845	299,950
Vermont	427,584	238,214
Virginia	1,838,915	1,821,730
Washington	1,213,126	1,315,346
West Virginia	470,115	443,403
Wisconsin:		
Milwaukee	493,966	372,661
Wisconsin	940,381	898,148
(Total)	1,434,347	1,270,809
Wyoming	141,132	113,939
Canal Zone	—	14,330
Grand Total	$93,013,644	$78,818,538

National Officers

Mrs. Albert D. Lasker, *Honorary Chairman of the Board of Directors*

W. Armin Willig, *Chairman of the Board of Directors*

Thomas P. Ulmer, *Vice Chairman of the Board of Directors*

Justin J. Stein, M.D., *President*

George P. Rosemond, M.D., *Vice President and President-Elect*

Benjamin F. Byrd, Jr., M.D., *Chairman of the Medical and Scientific Executive Committee*

R. Lee Clark, M.D., *Chairman of the Medical and Scientific Committee*

Mrs. Robert W. Huff, *Vice President*

Joseph S. Silber, *Chairman of the Executive Committee*

John S. Lawson, *Treasurer*

Samuel M. Seegal, *Secretary*

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After having provided for loved ones, those drawing up wills may wish to consider the American Cancer Society deserving of support through their estates. What is bequeathed today can, in future years, be a gift of life to many.

Those wishing to name the Society as beneficiary under the terms of a will can do this in any of several ways. The simple and direct gift of money or property should state: "I give to (Division or National Society*) the sum of ..... dollars to be used for the general purposes of the Society." Accurate legal phrasing is important.**

*Persons wishing to name a Division of the Society should insert correct corporate title and address of the Division. To name the National Society, a donor inserts: "American Cancer Society, Inc., 219 E. 42nd Street, New York, N.Y. 10017."

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People who have lost relatives or friends to cancer often wish to make a contribution to the American Cancer Society as a living memorial. Such a gift greatly assists the Society's programs of Research, Education and Service to cancer patients. Each contribution is deductible for tax purposes. Each is acknowledged. An appropriate memorial card is sent to the family of the deceased, the amount of the gift not being indicated.

CANCER'S WARNING SIGNALS

- ☐ Change in bowel or bladder habits.
- ☐ A sore that does not heal.
- ☐ Unusual bleeding or discharge.
- ☐ Thickening or lump in breast or elsewhere.
- ☐ Indigestion or difficulty in swallowing.
- ☐ Obvious change in wart or mole.
- ☐ Nagging cough or hoarseness.

If you have a warning sign, see your doctor!

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