Abstract

Dr. William DeWys of the National Cancer Institute (NCI) examines the first AIDS related conference held by NCI on 15 September 1981. He addresses the planning of and the reason behind the conference, the various people involved, the general attitude of the scientists at the meeting, and the subjects discussed. He briefly discusses post-conference NCI involvement and also his work before the detection of AIDS.

This is an interview with Dr. William DeWys of the National Cancer Institute (NCI), at the National Institutes of Health (NIH), Bethesda, Maryland, on 21 November 1989. The interviewer is Dennis Rodrigues, program analyst, NIH Historical Office. The interview was conducted at the Kaiser-Permanente clinic in Springfield, Virginia.

Rodrigues: As you may recall, one of the first actions that NIH took to respond to AIDS was to put together a workshop on the occurrence of Kaposi's sarcoma in homosexual men. According to a memorandum by [Dr.] Bruce Chabner, you were the organizer of this meeting [held on 15 September 1981]. Before we discuss the meeting in detail, could you provide some background information on your training and research experience, how that brought you to NIH, and where you were situated when you first became involved with AIDS?

DeWys: I am trained as a physician and certified in internal medicine and medical oncology. Prior to working at the NIH, I was on the faculty at Northwestern University Medical School in Chicago. In 1979, I joined NCI as a member of the Clinical Investigations Branch. Subsequently, I became the chief of that branch.

It was in my role as branch chief that I was the coordinator for this September conference. The initiative for it, as I recall, came from Dr. Chabner's office, although there had been some general discussion within the division about this topic. It was Dr. Chabner's office that made the idea concrete of having a conference or workshop to gather the information available on AIDS and Kaposi's sarcoma and to think of what we might plan in terms of research directions. There were a number of reasons for having a conference. We were concerned at the appearance of Kaposi's sarcoma in younger men, instead of its usual presentation in aging men. Kaposi's sarcoma had also been seen in a few other situations, such as in patients with kidney transplants. That provided a hint that the immune system had something to do with the appearance of this tumor. We thought it worthwhile to organize the conference to bring together people who were knowledgeable about Kaposi's sarcoma and people who were knowledgeable about the epidemiology of this tumor as it was appearing in younger men.

We were interested in the tumor per se, because it was a tumor that was responsive to treatment, and we wanted to maximize the therapeutic advantage for the patients who had this tumor. We were also interested because of the connection, that I just noted, with the immune system. This made the tumor interesting in terms of trying to identify its pathogenesis. Was there, for example, a virus etiology or something along those lines? We also knew that the tumor was developing in a population that was also developing Pneumocystis [carinii]

pneumonia [PCP]. The Cancer Institute had a long interest in Pneumocystis pneumonia because of its appearance in cancer patients undergoing vigorous anti-cancer therapy, particularly patients with acute leukemia. Those were some of the background factors that underlay our interest in this tumor. I am not sure why I was selected to be the coordinator of this conference other than because I had had previous experience bringing conferences together in a number of areas and because I knew a number of the people who were active in the field.

Rodrigues: How did you identify conference participants? Did you meet with other people at the NIH?

DeWys: I do not remember the exact composition of the group that did the planning, but most likely it involved a number of other people from the Division of Cancer Treatment. My immediate supervisor, who was the director of the Cancer Therapy Evaluation Program, Jack [Dr. John] MacDonald, was involved. There was representation from the Biologic Response Modifiers Program and from the Division of Cancer Cause and Prevention. I cannot remember who was involved from that division, except for Jim [Dr. James] Goedert. He was involved because he had an interest in the epidemiology. Jim [Dr. James] Curran from the CDC [Centers for Disease Control] was also involved. I had known him from the time when I was a resident and he was a medical student. We had several preliminary meetings at which we drafted lists of topics and the names of people who would speak on each of these particular topics. It was a committee effort in which you begin with a draft, and then you add things to it, both topics and names. In

addition to the people who were authoritative in the field and could make a presentation, we invited a number of people who were working in the field and could attend as discussants. Then we had the meeting.

Rodrigues: How about Dr. John Ziegler?

DeWys: John was involved. I cannot remember if by that time he was still at the Cancer Institute or had moved to San Francisco. My recollection is that he attended one of the planning meetings. He certainly was at the conference, and if he did not attend the planning meetings, we had his input via a phone discussion. I cannot recall what level of input he had specifically, but I know that we did have dialogue with him either through the committee structure or by phone.

Rodrigues: I cannot recall if he was listed as one of the attendees at the conference or not.

DeWys: He definitely was in attendance at the conference. He was also one of the speakers, discussing as I remember, his previous work with Kaposi's sarcoma. I am not sure whether he actually attended any of the planning meetings. He was at the conference itself. I think that Jim Goedert represented [Dr.] Joseph Fraumeni at the planning meetings.

Rodrigues: Some people believe that there were few physicians and other researchers at the NIH who were sensitive to what was going on in the field and who were keeping in touch with physicians seeing these patients with Kaposi's sarcoma. Some have suggested that the NIH was not very interested in the problem at all and was resistant to doing anything about it.

DeWys: Obviously I cannot speak for the NIH in general, but within the Cancer Institute,

there was a significant level of interest.

Rodrigues: The point you made about PCP as a troublesome infection in immunosuppressed cancer patients is very interesting. The question about the responsibilities of the different institutes in AIDS research has come up a number of times in the context of whether AIDS was viewed as an infectious disease or as cancer. Obviously, if you have a lot of opportunistic infections in cancer patients, you can see why it is a problem that concerns on the Cancer Institute, because it is not PCP caused by natural pathogenesis. It is related directly to cancer therapy.

DeWys: Yes. I am sure that if you did an analysis of which institute was supporting research on Pneumocystis carinii infection at that time, you would find that the Cancer Institute was supporting more research on PCP than any other institute.

Rodrigues: Would you say that the mood of the September 1981 conference was one of excitement or confusion? How were people reacting to the data coming in from New York? Did the attendees feel that these problems could be dealt with by conventional therapies for Kaposi's, or did they believe that this was something that went beyond that?

DeWys: There were several perspectives expressed at the conference. As the information evolved both prior to the meeting, and as it was summarized and crystallized during the meeting, there tended to be a general feeling that we were probably dealing with one or more viruses, both in the overall epidemic and specifically in relation to Kaposi's sarcoma. There was a general feeling that this might turn out to be a virus-related process. The concern that we had regarding treatment of

Kaposi's sarcoma was that this situation of the tumor in younger men was different from the Kaposi's sarcoma seen in the older men. These patients could not tolerate some of the more vigorous anti-cancer treatments because these treatments would tend to depress the immune system and make the patients more susceptible to the Pneumocystis infection and other infections. At that time, prophylaxis for Pneumocystis was not as available as it is today. So the concern was that we had to proceed very cautiously. We discussed establishing protocols on Kaposi's in the homosexual population. Such controlled clinical trials were the way we had approached other cancers. But we eventually decided not to take that course because we felt that more pilot studies were needed. Such studies would generate specific information about how well these patients could tolerate specific chemotherapy, which we needed before we could think about vigorous multi-agent chemotherapy. We did not mount any large scale clinical trials of treatment of the Kaposi's sarcoma because of the need for more information about the immune system aspects and the ability of patients to tolerate chemotherapy.

Rodrigues: After the meeting did you have any continuing involvement in this area?

DeWys: Yes, we had continuing involvement by the Division of Cancer Treatment, through its Clinical Trials Program and also through its Program Project Grants Program. These programs supported a number of treatment projects, both in the treatment of Kaposi's sarcoma and in the treatment of Pneumocystis. There also was interest in some of the other tumors that were seen with greater frequency than expected--lymphomas and squamous cell cancer of the anal region. Clinical

studies were reviewed, encouraged, and supported in each of those areas. After this conference, NCI involvement was not perhaps as visible, but there was continuing support for research in this area.

Rodrigues: Thank you, Dr. DeWys.

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