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ORGAN SITE GRANTS FARE BADLY IN NIH STUDY SECTION REVIEW; RPMI, UT GALVESTON, RUSH COMPETE FOR HQ

The chairmen of the four national organ site programs, in defending those programs and the system in which review of grants was carried out by working cadre independent of NIH study sections, invariably contended that the quality of their grants was at least equal to that of RO1s reviewed at NIH and that working cadre review was as stringent as that at NIH. At the same time, however, they would express concern that return of their

(Continued to page 2)

In Brief

LANDERS NEEDLES PAULING ON VITAMIN C STUDY RESULTS; DAVID GOLDENBERG HEADS N.J. CENTER

ANN LANDERS, referring to a report on the Mayo Clinic finding that vitamin C does not improve cancer treatment, said at the recent National Cancer Advisory Board meeting, "This is a self serving, vengeful comment. We had a knock down, drag out discussion on funding Linus Pauling. I opposed it because I didn't think there was any validity to the claims for vitamin C. Now I see that it didn't make any difference in treatment." NCI Director Vincent DeVita said that Pauling had proposed several vitamin C studies, treatment being one of them. "I went along with him, but that study did in fact see no value in treatment. He doesn't agree but does acknowledge that the study was done. In prevention, however, we are very excited about vitamin C's possibilities". . . . DAVID GOLDENBERG, director of pathology at the Univ. of Kentucky and founder and former executive director of the Ephraim McDowell Community Cancer Network, has been named president of the Center for Molecular Medicine & Immunology at the Univ. of Medicine & Dentistry of New Jersey . . . . MURRAY SHEAR, whose work as a biochemist helped advance chemotherapy as a treatment for cancer, died last month in Bethesda at age 83. Shear retired in 1969 after 30 years with NCI. . . . EDWIN MIRAND, associate director of Roswell Park Memorial Institute, speaking at the dedication of a conference room and establishment of an annual visiting professorship at M.D. Anderson in memory of the late Murray Copeland, said Copeland "was an exemplar of the teacher-investigator-clinician so important in the present period of explosive scientific growth."

ONLY 10 PERCENT OF APPROVED ORGAN SITE GRANTS WITHIN FUNDING RANGE

(Continued from page 1)
grants to NIH for review would result in rank discrimination by study sections without the expertise to fairly judge their proposals, or (as most of the organ site people felt) without the inclination to go along with targeted programs attempting to fill in specific scientific gaps.

Now that review has been returned to NIH for nearly a year, it appears that either the chairmen were wrong about the quality of their grants, or their worst fears about the fallibility of NIH study sections have been realized.

The cycle completed with review of grants by the National Cancer Advisory Board earlier this month could be considered a disaster for the organ site grantees, now competing with other RO1s under the rules of the new Organ Systems Program. Here's how each of the four old national programs fared:

* Bladder. Four applications were submitted, all were approved, none with a score of 175 or better and thus none was in the funding range.
* Bowel. Nine applications were submitted, eight were approved, only one with 175 or better.
* Pancreas. Ten applications were submitted, seven were approved, none was in the funding range.
* Prostate. The only good showing of the cycle, although not to the extent to which the old organ site program grantees had become accustomed. Seven applications were submitted, six were approved, and two were in the funding range. That funding rate of 33 percent of approved applications probably is a little better than NCI's overall funding rate will be this year.

Breast cancer was not a part of the old off campus organ site program but has been included in the new Organ Systems Program. Breast cancer grants have always been reviewed within NIH. That fact might lead one to assume that those grantees would do better in competing for the favor of study sections.

One would be only partly correct in that assumption. Forty six breast cancer applications were submitted, 43 were approved, and nine were funded. That works out to about 21 percent of approved which were funded. That's better than the 10 percent for the four other sites, not as good as prostate by itself.

One of the first tasks of the new Organ Systems Coordinating Center, when that competition has been completed, probably will be to assess the impact of the move to NIH review. If the unfunded grants are leaving too many gaps, the center could ask Director Vincent DeVita to make some funding exceptions, going beyond the payline where necessary, or to establish some protective review with RFAs and ad hoc study sections.

Competition for the coordinating center is limited to three, which DeVita has called "excellent applications." The Cancer Letter has learned that the three are from Roswell Park Memorial Institute, with Gerald Murphy as the principal investigator; Univ. of Texas Medical Branch, Galveston, with Palmer Saunders the PI; and Rush Presbyterian St. Luke's Medical Center, Chicago, in collaboration with Gilbert Friedell of the Univ. of Kentucky as the PI.

Another program with headache causing potential for NCI and NIH is that created by the Small Business Innovative Research Act. That was Congress' mandate to involve the private sector more in federally supported research, and NIH was assigned a share of the Dept. of Health & Human Service's allotted dollars for the program.

Ninety eight applications were channeled to NCI. Forty seven of those were approved, and 31 were funded. Compare that 66 percent of funded to approved to the average for all other NCI programs! Priority scores averaged 264, and the payline was 248, with NIH bending considerably to get the new program off the ground. Total awarded was $1.5 million, including negotiated indirect costs.

That was the first round. Applications deadline for the second round was Oct. 2.

Some unsuccessful applicants in the new program complained about inconsistencies they perceived in the review and in instructions they were given while developing their proposals. They were urged to resubmit for the new round.

NEW INTERNATIONAL POLICY ON CLINICAL TRIALS IS NEEDED, VERONESI CONTENDS

A new international policy on clinical trials is needed to ensure that cancer patients receive the best possible treatment, Umberto Veronesi said in Venice this week.

Veronesi, director of the Italian National Cancer Institute in Milan, and Gianni Bonadonna, director of medical oncology there,

organized the program for the sixth annual Bristol-Myers Symposium on Cancer Research, held in Venice this year. Veronesi is past president of the International Union Against Cancer.

"About 1,500 clinical trials of cancer treatment are now in progress around the world," Veronesi said. "Only a minority have a true impact in modifying therapeutic practices. Some trials are never completed because of poor planning. Others give unclear results. About 55 percent of trials produce meaningful results, but all too often these results have not led to changes in the methods doctors use to treat their patients."

Veronesi continued, "Trials that suggest new types of treatment or additional treatments are usually easily accepted. But trials showing that certain treatments are not useful are not easily accepted." He pointed to his own experience with trials in malignant melanoma.

"We did a trial showing that in malignant melanoma, after removal of the primary tumor, there is no need to remove the regional lymph nodes if they are not palpably involved. We followed up 600 patients for 12 years, and our results are very clear. These findings were published five years ago. But the reaction of general surgeons has been strong and hostile—the majority of surgeons still remove the regional lymph nodes."

To help overcome such problems, Veronesi recommended "more exchange of information about clinical trials worldwide and a centralized data bank where information on all trials in progress would be supplied." He said this would allow better comparison and evaluation and would help avoid duplication in clinical trials.

Veronesi perhaps was overlooking the fact that NCI for 10 years has had in operation the International Cancer Research Data Bank, which maintains records on cancer research throughout the world. One part of the program, CLINPROT, has 4,000 records on all clinical trials in cancer treatment being carried on everywhere in the world.

Veronesi's point that information from trials "in progress" should be available involves a more difficult problem than merely presenting descriptions of protocols and regimens, or published reports on completed studies. Preliminary results from ongoing trials frequently are reported at meetings or in the literature, and ICRDB is working on making those available as soon as possible. ICRDB staff also is working with the European Organization for Research on Treatment of Cancer to provide methods for easier access to CLINPROT and other ICRDB services. It could be that overseas access to PDQ-2 would fill the need Veronesi sees.

Veronesi also said in Venice that he advocates formation of an international group to plan clinical trials and to give them "a rational, coherent, logical step by step policy." Stephen Carter, vice president for cancer research at Bristol-Myers and former director of the Northern California Cancer Program, agreed.

Carter, speaking at the Venice meeting, emphasized the need for a standardized approach to data reporting. To avoid problems in interpreting data from clinical trials, he said "it would be much easier to understand and compare experiments if those who reported on clinical trials supplied data in the same way."

Carter argued for randomized trials. "Most cancer researchers and clinicians agree that the most reliable clinical trial is one in which patients are prospectively randomized to different kinds of treatment." Prospectively randomized trials take a long time and require a large number of patients, but they are still "the gold standard" for deciding whether new therapies should be introduced into standard practice, Carter said.

Marvin Zelen, Harvard biostatistician, cautioned about the dangers of misinterpreting clinical trials. "The problem of choosing the best treatment for cancer is difficult and, for many cancer sites, unresolved," Zelen said. "Different cancers tend to progress in different ways, and their outcomes depend on such factors as the type of cancer, the aggressiveness of the cells, the stage of the disease when it was first diagnosed and treated, and the patient's physical status.

"Poorly conducted trials may ignore the influence of these characteristics and report a positive effect of therapy that may not have resulted from treatment," Zelen said.

"Authors of papers on clinical trials and editors of journals in which they are published must be especially careful in reporting on clinical trials because whatever is published could do positive harm if it's wrong," Zelen emphasized.

The symposium, "Clinical Trials in Cancer Medicine: Past Achievements and Future Prospects," was scheduled to end today.

PENNSYLVANIA CANCER CONTROL RFPS FOR BREAST, CERVICAL PROGRAMS ISSUED

The Pennsylvania Dept. of Health's Cancer Control Program is planning programs in breast and cervical cancer and is in the process of soliciting proposals from organizations to carry out those programs.

The contracts which will be awarded will be limited to Pennsylvania organizations.

The RFPs are available from Katherine Marconi, PhD, Director, Cancer Control Program, Pennsylvania Dept. of Health, P.O. Box 90, Harrisburg 17108, phone 717-787-5251. Deadline for submission of proposals is Nov. 21.

The breast cancer screening and detection program will require contractors to develop a series of innovative interventions which will increase breast cancer detection among high risk women and will provide screening and detection models for possible application statewide. The contracts will be for a three year period beginning Jan. 1, 1984. Plans are to award a minimum of one contract in each of four areas of Pennsylvania.

Contractors must demonstrate experience and capacity to deliver services and have access to a data base for identifying high risk women. They must also have written letters of cooperation from local American Cancer Society units and the local medical society for carrying out planned interventions.

Contractors will be required to:

1. Identify high risk women to be contacted from their data base (100 to 500 women with breast cancer diagnosed after 1980 together with adult sisters and daughters of these patients).

2. Determine current breast cancer detection practices among these patients via interviews.

3. Design and implement intervention systems that will promote increased prevalence of early detection practices among these women.

4. Institute a method of followup to assess the knowledge levels, and the percentage of women who practice monthly breast self exams, and if appropriate, mammographies and related physicals. This would include a notification system of when mammographies and related exams are due.

5. Provide: a) monthly project progress, status, and plan reports; b) one methodology report prior to the interventions on the data base to be used and the methodology for contacting and gaining cooperation of the high risk women; c) one report describing the interventions; and d) a final report containing the project evaluation.

The RFP for cervical cancer detection and education interventions includes most of the same requirements as for the breast cancer program. Contractors will be required to develop a series of interventions which will increase cervical cancer detection and education among high risk women. Contractors will be required to complete the following tasks:

1. Identification and justification of a target population of women at high risk for cervical cancer. A minimum of 100 women must be screened from this population each project year.

2. Determination of current cervical cancer detection practices by interview among high risk women.

3. Development and institution of cervical cancer screening, detection, referral, and followup services for high risk women into existing programs.

4. Evaluation of the screening, detection, referral, and followup services for cervical cancer.

The Pennsylvania Cancer Control Program is one of several being developed by states in the realization that the emphasis at NCI in cancer control now is on research rather than demonstration, and that implementation of cancer control efforts (including the funding) is the responsibility of state and local entities.

CONFEREES SPLIT DIFFERENCE, NCI TO RECEIVE $1.075 BILLION IN 1984

House and Senate conferees agreed Tuesday to split the difference on NCI's FY 1984 appropriations between their respective bills, giving NCI approximately $1.075 billion, with the final figure depending on the amount to be appropriated later for National Research Service Awards.

NRSA money was left out of the regular appropriations bill because the program requires special reauthorization. NCI had asked for $22.8 million, and the final amount probably will be at least that. If that is the final NRSA figure, NCI's total would be very close to one billion, 75 million dollars.

The House bill had added $81 million to NCI's total over the amount requested in the President's budget. The Senate bill added

$17.2 million over the House figure. Thus, splitting the difference was a matter of $8.6 million.

The conferees handled their differences over all other NIH institutes in a similar manner, splitting the differences between the higher Senate and lower House figures.

Conferees made no changes in the language of either House or Senate committee reports which "advised" NCI on how the additional money should be spent. Both committees insisted that grants be paid at or near their full recommended levels, and that full indirect costs be paid. They also restored enough money to the Cancer Centers Program to fund all 20 of the core grants up for renewal in FY 1984 (the Administration's budget would have allowed only enough money to fund four of the 16). Whether all 20 are funded, of course, depends on how they fare in review and whether any new core grant applications are in the competition.

NCI Director Vincent DeVita and the National Cancer Advisory Board have complained that the direction to fund grants at full recommended levels takes away the flexibility to stretch the available money over more grants, which NCI has been doing the last two years. Since committee report language does not have quite the same requirement for compliance as language in the bill itself, there may be some room for negotiation with the committees. The reports clearly stated, however, that the committees did not believe the number of grants should be increased by inadequately funding all grants.

NCI will have some discretion on how it will spend part of the additional money. The House bill left about $7 million unallocated, along with about $7 million more added for research and development contracts with no directions on how that should be spent. The Senate's additional money had no earmarks at all (the amounts needed for full funding of grants and indirect costs being covered in the amount approved by the House). Adding the $8.6 million over the House total as agreed upon by conferees to the $14 million unallocated House money would seem to give DeVita and his staff about $22 million to spread around. That should be enough to fund a few more grants, put some back into drug development, pump some new life in the construction grant program, or whatever else NCI staff and the NCAB agree merits additional support this year.

It is now clear that the FY 1984 bypass budget request of $1.075 billion was woefully inadequate. Obviously, it did not have enough money to fund the desired number of grants at recommended levels. The final appropriation bill of almost the identical amount requested in the bypass would have enough to meet the bypass request for $20 million for construction grants if NCI chooses to spend all the unallocated money for that purpose. But that would leave very little for other high priority areas. That's not how a supposedly optimal budget should end up.

NCI CONTRACT AWARDS

TITLE: Assay development and preclinical pharmacology studies with bisbenzimidazole--Task #2
CONTRACTORS: Ohio State Univ., $79,181; and Mayo Foundation, $27,295.

TITLE: Preclinical pharmacology studies with 5-Azacytidine—Task #4
CONTRACTOR: Univ. of Southern California, $95,357.

TITLE: Assay development and preclinical pharmacology studies with phyllanthoside—Task #5
CONTRACTOR: Mayo Foundation, $38,530.

TITLE: Assay development and preclinical pharmacology studies with caracemide--Task #3
CONTRACTOR: Midwest Research Institute, $128,423.

TITLE: Screening of radiosensitizers and radioprotectors
CONTRACTOR: Northern California Cancer Program, $790,648.

TITLE: Dose calculations for cancer therapy using radioactively labeled antibodies directed to tumor associated and/or tumor specific antigens
CONTRACTOR: Sloan-Kettering Institute for Cancer Research, $1,071,711.

RFA NIH-NCI-DRCCA-CCAB-83-17
Cancer Control Science Programs

Deadlines: Dec. 1 for letters of intent, Jan. 15, 1984 for applications

The Div. of Resources, Centers & Community Activities of NCI invites program project (P01) grant applications from interested investigators for the support of Cancer Control Science Programs which will plan and implement focused research studies aimed at major cancer control problems. The research shall included innovative interventions with potential for reducing cancer incidence, morbidity and/or mortality, and for generalizability to larger populations.

The proposed research program should have a clearly identified theme or program and consist of an integrated group of projects from cancer control research phases II through V.

The general areas of DRCCA's cancer control research interest are described in cancer control program guidelines which have recently been released.

Applicants are strongly encouraged to submit letters of intent and consult with NCI program staff before submitting an application because of the need for a clear understanding of cancer control research issues and the PO1 guidelines, and to facilitate planning for the review of applications.

Nonprofit and for profit institutions within the United States are eligible to apply for project periods of up to five years. It is anticipated that a maximum of five awards will be made as a result of this RFA. This RFA is the successor to the Cancer Control Science Program announcements previously published last year.

Copies of the complete RFA, the Cancer Control Program guidelines, and the 1983 Program Project guidelines may be obtained from Carlos Caban, PhD, Program Director, Cancer Control Applications Branch, DRCCA, NCI, Blair Bldg. Rm 1A01, Bethesda, Md. 20205, phone 301-427-8735.

RFA NIH-NCI-DRCCA-CCAB-83-18
Cancer Control Research Units

Deadlines: Dec. 1 for letters of intent,
Jan. 15 for applications

DRCCA invites grant applications for the support of Cancer Control Research Units which will plan and implement focused research studies aimed at major cancer control problems. The research will address cancer control interventions with potential for reducing cancer incidence, morbidity and/or mortality, and for generalizability to larger populations. The CCRU will be a long term resource for research and training for the Cancer Control Program of NCI.

The proposed CCRU should have one or more clearly identified themes or programs, each consisting of an integrated group of projects from cancer control research phases II and V. The general areas of DRCCA's cancer control research interest are described in Cancer Control Program guidelines which have recently been released.

The required components of a CCRU will include:

--A rationale for the CCRU in terms of the cancer control themes and problems which will be investigated.

--A CCRU director with research and administrative experience.

--A multidisciplinary cancer control research team of qualified investigators.

--At least three high quality research projects which are approved with the CCRU application, of which two must be defined population studies.

--Organizational, administrative and institutional procedures, commitments and support.

Optional components of a CCRU are:

--Limited developmental or research projects, including applied epidemiology studies.

--Shared research cores which are integral to two or more projects.

The CCRU will be encouraged to establish cancer control research training programs, including field involvement and applications. At this time, however, there will be no funds specifically earmarked for training within the CCRU grant, and potential applicants are encouraged to seek peer reviewed support through the NCI training grant mechanisms. After the CCRU grants are awarded and under way, spinoffs such as training programs may develop.

Applicants are strongly encouraged to submit letters of intent and consult with NCI program staff before submitting an application because of the need for a clear understanding of cancer control research issues and the P50 guidelines, and to facilitate planning for the review of applications.

Nonprofit and for profit institutions within the United States are eligible to apply for project periods of up to five years. It is anticipated that a maximum of five awards will be made as a result of this RFA. This RFA is the successor to the RFA entitled Cancer Control Research Units for Defined Population Studies which was previously announced last year.

Copies of the complete RFA, the 1983 Cancer Control Program guidelines, and the 1983 program project guidelines may be obtained from Caban at the address listed in the announcement above.

RFA NIH-NCI-DCBD-DB-83-15
Application of recombinant DNA technology to diagnosis of cancer

Deadline: Feb. 15, 1984 for applications

The Div. of Cancer Biology & Diagnosis of NCI is inviting grant applications to search for new applications of recent advances in recombinant DNA technology for the diagnosis of patients with cancer. The development of molecular approaches to the identification of malignant and premalignant cells may improve the accuracy of cancer diagnosis, result in detection of the disease, and lead to improved methods for classification of tumors.

The techniques of molecular genetics, especially restriction endonuclease analyses of DNA, nucleic acid hybridization after electrophoretic separation of nucleic acid fragments, and in situ hybridization with DNA probes (e.g. oncogenes) are widely employed in basic cancer biology research.

Purpose of this RFA is to encourage the submission of research applications that use this technology as sensitive tools for diagnosing cancer and/or determining the predisposition to cancer. Recent basic scientific studies have shown that nonrandom chromosome mutations, translocations, deletions, and amplifications are associated with specific kinds of malignancies, often accompanied by the increased or altered expression of oncogenes. The possibility exists that specific genetic changes may be identified in malignant cells of cancer patients which are not present in cells from suitable control patients. Ideally, suitable collaborations can be developed between basic scientists who have experience with the technology and clinicians who have access to patients. In this way NCI hopes to stimulate proposals that rigorously test the value of state of art molecular genetic techniques and recombinant DNA technology to cancer detection and diagnosis.

The support mechanism for this program will be the traditional NIH grant in aid. Appli-

cants will plan and execute their own programs. Approximately $600,000 will be set aside to fund applications which are submitted in response to this RFA. These applications will not compete for funding within the general pool of dollars available for other investigator initiated research proposals. However, all applications received will be evaluated by the rigorous standards of study section review. Only applications of sufficiently high scientific merit will be funded. The expected starting date is Dec. 1, 1984. Although this program is provided for in the financial plans of NCI, the award of grants pursuant to this RFA is contingent upon the availability of funds appropriated for fiscal year 1985.

Applications should be submitted on form PHS 398, available from the business office of most institutions or from the NIH Div. of Research Grants. The original and six copies of the application should be sent or delivered to DRG, NIH, Westwood Bldg. Rm. 240, 5333 Westbard Ave., Bethesda, Md. 20205.

A brief covering letter should accompany the application indicating it is in response to this RFA. A copy of the covering letter should be sent to Bill Bunnag, PhD, Chief, Pathology/Cytology Section, Diagnosis Branch, DCBD, NCI, Westwood Bldg. Rm 10A15, Bethesda, Md. 20205, phone 301-496-7147.

Program Announcement
Use of growth factors, maturation factors, and antigrowth factors in animal tumor models
Biological response modifiers research

Deadline: Nov. 1, March 1, July 1 for applications

NCI's Div. of Cancer Treatment is seeking applications for research grants concerned with the therapeutic effects of growth factors, maturation factors, and monoclonal antibody to growth factors on the growth and metastasis of cancer in animal tumor models. In making this program announcement it is not the intent of NCI to make or imply any delimitation related to biological response modifiers research, but rather to stimulate investigator initiated research in biological response modifiers.

Applications in response to this announcement (as to all program announcements) will be reviewed in accordance with the usual NIH peer review procedures. Applications should be submitted on PHS form 398. In space No. 2 on the first page, indicate the title of the program announcement.

A brief covering letter should accompany the application indicating it is being submitted in response to this program announcement. The original and six copies of the application should be sent to DRG, NIH, Westwood Bldg. Rm 240, Bethesda, Md. 20205.

A copy of the covering letter should be sent to, and further information may be obtained from, Dr. Cedric Long, Program Director for Preclinical Trials, BRB, BRMP, Bldg. 426 Rm. 1, Frederick Cancer Research Facility, Frederick, Md. 21701, phone 301-695-1098.

Program Announcement
Development of genetically engineered cell products
Biological response modifiers research

Deadline: Nov. 1, March 1, July 1

The Div. of Cancer Treatment is seeking applications for research grants concerned with the development of genetically engineered cell products for therapeutic application as biological response modifiers.

This announcement will support diverse approaches into the use of genetic engineering to transpose genes coding for biological response modifiers such as interferons, lymphokines, growth factors and other gene products into microbial organisms for a large scale production, isolation, purification and characterization of these factors for therapeutic application as biological response modifiers.

Follow procedures noted in the previous program announcement for applying and contacting Dr. Long.

Program Announcement
Use of tumor associated antigens as immunogens
Biological response modifiers research

Deadline: Nov. 1, March 1, July 1

The Div. of Cancer Treatment is seeking applications for research grants concerned with the development of methods of immunization that evoke effective in vivo antitumor immunity using purified tumor associated antigens as immunogens. Isolation of tumor associated antigens is now possible using monoclonal antibodies. There is considerable uncertainty, however, how best to administer purified antigens in vivo to evoke effective antitumor immunity. Certain antigens may facilitate and others may inhibit tumor growth and metastases. The proposed studies should investigate this issue in both normal and tumor bearing animals using purified antigens as therapeutic agents. Preference will be given to nonviral tumor associated antigens on recently derived spontaneous or chemically induced fully syngeneic tumors although consideration will be given to viral coded tumor antigens and even normal cell surface alloantigens as model antigens. The use of various immunization schedules and adjuvants in therapy models with detailed monitoring of the host cellular and immune responses will be required. These studies must be directed toward optimizing the therapeutic effects of these antigens in vivo as demonstrated by protection studies against subsequent tumor growth. Proposals to investigate monoclonal antibody purified tumor associated antigens as therapeutic reagents in man may also be submitted. As in the animal models, homogenous preparations of high purity are preferred for these investigations. End points may be assessed by in vivo assays or by in vivo therapeutic effects.

Follow procedures noted in the first program announcement above for applying and contacting Dr. Long.

Program Announcement
Development of cell lines producing lymphokines and cytokines
Biological response modifiers research

Deadline: Nov. 1, March 1, July 1

The Div. of Cancer Treatment is seeking

applications for research grants concerned with the development of cell lines producing lymphokines and cytokines with therapeutic effects as biological response modifiers. This announcement will encourage research in the development of such cell lines and the development of methods to isolate, purify and characterize the therapeutic potential of the various products of these cell ines in appropriate test systems. These products may have a potential long term usefulness in the treatment of cancer and/or in the alteration of biological responses in the course of cancer.

Follow procedures noted in the first program announcement above for applying and contacting Dr. Long.

Program Announcement
Determination of the therapeutic usefulness of purified cytokines and anticytokine monoclonal antibodies in cancer models
Biological response modifiers research

Deadline: Nov. 1, March 1, July 1

The Div. of Cancer Treatment desires to expand its support of research on cytokines (lymphokines, monokines, growth factors, etc.) and in determining the potential for using these factors in the treatment of cancer. The Biological Response Modifiers Program is seeking applications for research grants concerned with the modes of action of purified cytokines in ways that will be relevant to determination of therapeutic potential through the augmentation or regulation of certain components of the immune response or through direct effects on certain types of malignant cells or on supportive tissue of tumors. Methods of regulating or manipulating the specific cytokine levels through utilization of purified cytokines and/or utilization of anticytokine monoclonal antibodies are of interest. Work with in vivo animal models would be particularly relevant.

Follow procedures noted in the first program announcement above for submitting applications. Copies of the covering letter should be sent to and information obtained from Dr. Gary Thurman, Program Director for Molecular Immunology, BRB, BRMP, Bldg. 426 Rm. 1, NCI Frederick Cancer Research Facility, Frederick, Md. 21701, phone 301-695-1098.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CN-45167

TITLE: Phase I studies of new chemopreventive agents
DEADLINE: Dec. 19

The Div. of Resources, Centers & Community Activities, NCI, is seeking proposals for provision of all necessary personnel, labor, facilities, and equipment, not otherwise provided by the government, to provide necessary technical support to the Prevention, Detection & Diagnosis Program to establish clinical trials resources to perform phase I clinical trials of new cancer chemoprevention agents and to perform human pharmacokinetic studies during phase I studies. These will provide the phase I clinical evaluations of investigational agents which are developed through the Chemoprevention Linear Array and are sponsored by the Food & Drug Administration under an IND held by DRCCA.

The RFP will be available Nov. 3. This RFP was previously announced with a Dec. 12 deadline.

CONTRACT SPECIALIST: David Monk
RCB, Blair Bldg Rm 2A07
301-427-8745

RFP NCI-CN-45166-50

TITLE: Efficacy studies of chemopreventive agents in animal models including synthesis, bioavailability, and encapsulation studies.
DEADLINE: Dec. 15

(This is a correction of the RFP which originally appeared in the Oct. 7 issue of The Cancer Letter. Deadline has been extended, and additional objectives have been added.)

Additional objectives of this project will also involve synthesis, bioavailability and encapsulation studies for selected agents. This second task involves the synthesis and encapsulation of the chemopreventive agents for administration in laboratory diets having three goals: (1) the synthesis of specified quantities of designated compound having acceptable purity and potency in accordance with established standards; (2) the formulation used must provide good protection of the chemopreventive agent from oxidation, moisture, light and bacterial decomposition; and (3) the formulation used must allow good bioavailability of the chemopreventive agent in the gastrointestinal tract of rats, mice and hamsters.

The RFP will be available on or after Oct. 30.

CONTRACT SPECIALIST: David Monk
RCB, Blair Bldg Rm 2A07
301-427-8745

The Cancer Letter _Editor Jerry D. Boyd

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