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WHITE HOUSE BACKS DOWN ON FY 86 CUTS, SAYS NOW THEY WILL BE LIMITED TO TRIMMING INDIRECT COSTS

The White House has backed away from making drastic cuts in the budgets for NIH and NCI during the current fiscal year and now intends only to go ahead with reducing indirect costs of grants from 26 to 20 per cent. That would cut about \$30 million from NCI's FY 1986
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In Brief

PANEL TO MEET JAN. 30 IN LOS ANGELES; FATE OF PROPOSED UROLOGIC GROUP DEPENDS ON BUDGET

PRESIDENT'S CANCER Panel will have its next meeting Jan. 30 in Los Angeles. It will be held in the Beverly Wilshire Hotel, starting at 2:30 p.m., following the Armand Hammer Cancer Prize award luncheon. Hammer, chairman of the Panel, has invited a group of scientists to lead a discussion on innovations in cancer therapy. The 1985 Hammer prize of \$100,000 will be shared by NCI's Steven Rosenberg and Tadatsuga Taniguchi of Japan. The Panel meeting is open to the public; the luncheon is by invitation. . . . **FATE OF THE** proposed new urologic cooperative group has to await better determination of available funding, NCI's Robert Wittes told **The Cancer Letter**. The new group would attempt to fill the gap left by the demise of the bladder and prostate cancer clinical trials groups, which didn't make it through peer review last year. Those groups had been moved into the cooperative groups from the old Organ Site Program. Wittes, who heads the Cancer Therapy Evaluation Program, said the decision on whether to seek applications for a new group might be made "in a couple of months". . . . **RENEWAL APPLICATION** of the Gastrointestinal Tumor Study Group will go to the National Cancer Advisory Board at its February meeting. . . . **GEORGE HILL**, director of surgical oncology at the New Jersey Medical School in Newark, is the new president of the American Assn. for Cancer Education. Sidney Saltzstein, head of surgical pathology at the Univ. of California (San Diego) School of Medicine, was elected president elect at the association's recent annual meeting. Stephen Stowe, New Jersey Medical School, was reelected secretary; Beverly Raney, Univ. of Virginia Medical School, was reelected treasurer; and Daniel Hays, Univ. of Southern California School of Medicine, assumed chairmanship of the advisory counsel. Victor Newfeld delivered AACE's annual Samuel C. Harvey lectureship. . . . **DENMAN HAMMOND** has been appointed associate vice president for health affairs at the Univ. of Southern California; he had been associate dean of the School of Medicine. His new job involves planning the new USC Health Sciences Center, which will include a university hospital, medical office building and clinic, a hotel and conference center, and a diagnostic center.

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MAJOR CUTS STILL SEEN FOR FY 87; COALITION WINS ON GME FUNDING

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appropriations of \$1.258 billion, a much easier blow to absorb than the \$100-125 million slash originally proposed by the Office of Management & Budget (**The Cancer Letter**, Jan. 3).

OMB is in the process of making cuts in both the 1986 and 1987 budgets to comply with the Gramm-Rudman-Hollings balanced budget act. The plan OMB floated in late December would have cut NIH by 10 per cent both years while maintaining competing grant awards at the 6,100 level. That would have meant that cooperative groups, cancer centers and NIH intramural programs would have borne the brunt of the devastating reductions. That could still be the case in FY 1987, when the full impact of the legislation will be felt.

The law requires OMB and the Congressional Budget Office to submit a plan for the FY 1986 budget cuts to the General Accounting Office by Jan. 15. GAO is required to review it, make any changes it feels are necessary and present it to the President by Jan. 20. The President must issue the order imposing the cuts on Feb. 1.

Meanwhile, the President will present his 1987 fiscal year budget to Congress late this month or early February. The target required by Gramm-Rudman is for a deficit of \$144 billion in that year, which starts next Oct. 1, down from \$171.9 billion which is the 1986 target. The deficit in the 1985 fiscal year was over \$200 billion, so the magnitude of the cuts required is impressive. If there are no new taxes nor appreciable additional revenue generated by economic growth, and with the defense cuts limited to no more than half of those required, virtually every domestic program faces severe reductions next year. Congressional support, which has saved the cancer program in the past, may not prevail this time.

"Our only hope may be that Gramm-Rudman is declared unconstitutional," one cancer program advocate said. Several court challenges are in various stages of development.

One program important to oncology subspecialties was apparently rescued late in the last session of Congress by the American Society of Clinical Oncology working with the Assn. of American Cancer Institutes and a coalition of internal medicine subspecialty organizations.

The Senate, in a deficit reduction bill not part of Gramm-Rudman, had agreed to include a proposal by David Durenberger (R.-Minn.) which would have limited Medicare reimbursement for direct medical education costs to hospitals to five years or the

number of years required for first board eligibility, whichever came earlier. It would have provided funding for internal medicine residencies only through the first boards, and no funding for subspecialty graduate medical education would have been provided.

ASCO and its allies objected, formed a coalition headed by Jane Desforges, president of the American Society of Hematology, and convinced Sen. Lloyd Bentsen (D.-Tex.) of the validity of their case. In the conference with the House to resolve differences in the bill, Bentsen prevailed on the conferees to adopt a compromise which would preserve Medicare reimbursement for the subspecialties. The compromise is somewhat complex:

"Starting after July 1, 1986, a hospital will receive 100 per cent of its approved FTE resident amount for each year of a resident's training that is within the minimum number of years of formal training necessary to satisfy specialty requirements for initial board eligibility, plus one year, to a maximum of five years. For training years exceeding these limits, Medicare payment for residency years/cost reporting years beginning on or after July 1, 1986, will be made at 75 per cent of the rate that would otherwise be recognized; and for residency years beginning on or after July 1, 1987, at 50 per cent of the rate that would otherwise be recognized."

The conferees completed their work, but the final bill was not passed by Congress before it adjourned, with the bill bogged down on an issue not related to Medicare, the superfund for toxic waste cleanup and its level of funding. When Congress returns Jan. 20, the bill is scheduled for immediate consideration by both houses.

"It was an excellent win for a coalition that no one would have given a chance to succeed," said Randy Fenninger, of the firm of Grupenhoff, Endicott, Maldonado & Fenninger, which helped develop and staff the coalition. "A lot of people from the groups that made up the coalition contacted the conferees and did a first rate job of educating those members of Congress on the importance of internal medicine subspecialty graduate education."

"We gained a reprieve after considerable work," said John Durant, ASCO president. "This compromise, if finally agreed to by Congress, will allow us to look at manpower policies for the future, without simultaneously having to face a crisis in our training programs."

Other members of the coalition were the American Gastroenterological Assn., American College of Cardiology, American College of Chest Physicians, American Society of Gastrointestinal Endoscopy, American Lung Assn., National Hemophilia Foundation, Cooley's Anemia Foundation, American

Society for Internal Medicine, Assn. of Program Directors in Internal Medicine, Assn. of Professors of Medicine, and the American College of Physicians.

NIXON TO RECEIVE ACCC ANNUAL AWARD; WILL SPEAK AT LUNCHEON ON APRIL 5

The Assn. of Community Cancer Centers will present its annual award for outstanding contributions to community cancer care to former President Richard Nixon at the association's annual meeting in April.

Nixon signed the National Cancer Act of 1971 just before Christmas that year and declared that the legislation signaled the start of the "war on cancer."

Nixon has agreed to accept the award and to be the featured speaker at the luncheon meeting April 5. The meeting will be held in Washington D.C., at the Hyatt Regency Capitol Hill Hotel, April 2-6.

ACCC President Edward Moorhead and David King, program chairman, pointed to the signing of the National Cancer Act as a major turning point in the nation's commitment to cancer research, education and treatment.

"President Nixon's advocacy of a war on cancer was crucial to the increased funding and commitment to the National Cancer Program," Moorhead said. "That major leap in funding and the continuing commitment of successive administrations and congressional support enabled the entire National Cancer Program to expand and develop. A crucial part of the 1971 bill, however, was the commitment to cancer control, to a mechanism that would assure that NIH and NCI were to disseminate the latest technology to communities. It was this commitment and the significant educational thrust provided by the Act that led to the widespread availability of high quality community cancer care that exists today.

"The National Cancer Act was the product of the energy and imagination of many members of Congress and the national cancer community," Moorhead continued. "Former Congressman Paul Rogers, Sen. Edward Kennedy, former Sen. Ralph Yarborough, Dr. R. Lee Clark, Mrs. Mary Lasker, Mr. Benno Schmidt and many others played key roles in its formulation and passage. Yet without a doubt, it was President Nixon's declaration of a war on cancer that caught the imagination of the public and focused national attention on our ability to begin to address the problem."

The National Cancer Act was born when Clark, encouraged by Lasker, Schmidt and the late Solomon Garb prevailed on Texas Senator Yarborough, who was chairman of the Senate Health Subcommittee, to appoint a Panel of Consultants to develop recom-

mendations for legislative consideration on needs of cancer research and control. Schmidt was cochairman along with the late Sydney Farber. Before the Panel completed its work, Yarborough was defeated for reelection and Kennedy became chairman of the subcommittee. The Massachusetts Democrat enthusiastically supported the Panel's recommendations and succeeded in getting near-unanimous approval in the Senate of the resulting bill.

Rogers, who was chairman of the House Health Subcommittee, was less enthusiastic and his bill presented a much less aggressive, but perhaps more realistic approach (Kennedy's bill would have taken NCI out of NIH and the Dept. of Health, Education & Welfare and established it as a separate agency).

The legislation was bogged down and headed for a stalemate when Nixon stepped in, declared his support and encouraged Kennedy and Rogers to work out a compromise. That was promptly done, and after columnist Ann Landers asked her readers to join in with their backing (which resulted in the greatest mail deluge ever seen in Washington), the compromise sailed through both houses.

Nixon, in the years after his presidency ended in the bitterness of Watergate, has said that he considers the National Cancer Program to be the outstanding domestic accomplishment of his Administration, ranked with the best of his international successes—detente with the Soviet Union, opening relations with China, initiating the Middle East negotiations which led (in the Carter Administration) to the Camp David Accords.

In the first year after the National Cancer Act, Nixon requested from Congress and received an immediate boost of \$100 million for NCI. That kind of support, the kind that really counts, diminished somewhat in his remaining years in the White House as he attempted to cope with growing budget deficits by cutting domestic spending. Nothing ever seems to change in that respect; every President since Nixon has done the same, paying lip service to cancer research while annually submitting inadequate budget requests for NCI.

Previous recipients of the award include Sen. Robert Dole (R.-Kan.) for his recognition of the potential negative impact of prospective reimbursement for Medicare and Medicaid on clinical research; former Sen. Birch Bayh, for his support of community cancer programs and their involvement in clinical research; B.J. Kennedy for his involvement in developing medical oncology as a specialty; Harold Amos, for his leadership in science and as a member of the National Cancer Advisory Board and President's Cancer Panel; and Garb, for his relentless and effective lobbying for the National Cancer Act and adequate appropriations to support it.

NURSING CENTER IMPLEMENTATION TO BE HEADED BY DORIS MERRITT

The implementation of NIH's new National Center for Nursing Research will be headed by Doris Merritt, research training and research resources officer in the NIH Office of Extramural Research & Training. Merritt, who also serves as special assistant to NIH Director James Wyngaarden, was named project leader for the center's implementation this week.

The search continues for an acting executive officer for the new center, which was mandated by Congress in the NIH reauthorization bill. The acting executive officer will probably also be chosen from existing NIH staff in order to ensure the necessary expertise in matters such as personnel and budget.

Although plans for the new center remain up in the air, NIH's Div. of Management Policy is in the process of drawing up an implementation plan for the new center. Officials from the division met with NIH institute directors, their staff and others interested in the new center in December. The division is also consulting with NIH personnel involved in the establishment of the newer institutes such as the National Eye Institute and National Institute on Aging.

Some NIH and NCI officials have predicted that the center will have many of the functions normally associated with a full fledged institute. For example, the center will probably have certain granting authority and will have the potential for intramural research training.

Others speculate that the center could eventually evolve into a full scale institute. The National Institute for Dental Research operated as a center before its designation as an institute.

While opportunities for nursing research have varied among institutes within NIH, nurses are eligible for a number of training grants and programs offered by NCI in the areas of both research and clinical practice.

For example, nurses are eligible for five National Research Service Awards offered by the Div. of Cancer Prevention & Control's Cancer Training Branch. Very few nurses apply for the variety of training awards for which they are eligible, however, Branch Chief Barney Leopvestsky told **The Cancer Letter**.

"NCI has been foremost" in training opportunities for nurses, he said. For example, NCI is the only NIH institute that offers an award specifically designed for nurses who want to earn a PhD in one of the sciences relevant to cancer, he said. NCI currently awards three individual predoctoral fellowships for oncology nurses (F31 awards) per

year. The award is intended for nurses who want to earn a PhD in a basic or applied cancer science. Registered nurses who are U.S. citizens, nationals or permanent residents and who have earned at least a bachelor's degree are eligible for the award, which provides a stipend of \$6,552 and an institutional allowance of \$4,000 per year.

NCI is also one of only a few institutes to have awarded a T32 research training grant to a school of nursing, Lepovetsky said. The grants are intended to provide long term basic or applied research training to predoctoral and postdoctoral trainees in any science relevant to cancer. NCI currently has 165 grants supporting 570 predoctoral and 700 postdoctoral trainees under the award, which is available to any domestic nonprofit research institution. Active T32 grants include one at the Univ. of Washington School of Nursing.

Nurses are also eligible for individual postdoctoral fellowships (F32s) that provide stipends of \$15,996 to \$30,000 per year and an institutional allowance of \$3,000 per year. NCI spends about \$4.6 million per year to support 180 of the F32 fellowships.

Nurses holding a PhD may also apply for senior individual postdoctoral fellowships (F33), which provide a negotiable stipend of up to \$30,000 per year, and an institutional allowance of \$3,000 per year. NCI makes four to six fellowship awards at a total cost of \$120,000 to \$180,000 per year.

Other grants for which nurses are eligible include the research career development award (K04). The award is designed to free investigators having high research potential from most teaching and administrative duties so they may spend fulltime in research, and to bring developing researchers to the status of fully independent investigators. Candidates must have at least three years beyond a doctorate, and be not already developed as an independent investigator, i.e., have from six to 30 publications and be of instructor or assistant professor rank, or have been recently appointed associate professor.

The award provides a salary of up to \$40,000 per year, fringe benefits and indirect costs up to eight per cent of total direct costs. NCI currently has 92 active K04 awards, for a total cost of \$3.6 million.

Nurses with a doctoral degree or equivalent may also apply for preventive oncology academic awards (K07). The award is intended to stimulate research and teaching career development in cancer prevention and control, and to strengthen the research and education programs of schools in which high quality research in preventive oncology already exists. Candidates must have at least two years postdoctoral

experience, possess an appropriate teaching and/or research appointment in the sponsoring institution, and commit full time to preventive oncology research and to the proposed program. The award provides a salary of up to \$40,000 per year, fringe benefits and indirect costs of up to eight per cent of total direct costs.

In addition, NCI's Cancer Education Program (R25) grants are available to schools of nursing that award doctoral degrees. NCI currently funds about 50 grants.

Other training activities for nurses offered by the Cancer Training Branch include a day long course for nurse researchers held the day preceding the annual meeting of the Oncology Nursing Society. The course supports the efforts of up to 12 predoctoral or postdoctoral nurse researchers who present research plans or research problems to a faculty of four nationally known nurse scholars or researchers, who critique the activities.

A second class offered by the branch is a two day course for black nurses drawn from various sections of the country. The course is intended to both update the nurses' oncology nursing knowledge, and to aid them in acting as public educators when they return to their home districts.

Other research and training opportunities for nurses exist on the NIH campus in Bethesda.

For example, the Cancer Nursing Service at the NIH Clinical Center offers a special nine month internship program for new bachelor of science in nursing graduates who are interested in cancer nursing.

Started last September with nine new graduates, the program has initial funding for two years, at which time it will be evaluated. NCI plans to enroll 12 BSN graduates in the program in September 1986. Although NIH hopes the program will aid in the recruitment and retention of oncology nurses at the Clinical Center, that is not its only purpose, Jean Jenkins, clinical coordinator of the Cancer Nurse Training Program, told **The Cancer Letter**. NIH believes that in the long run, the program will also "be very helpful to the community to have these nurses" who are trained in cancer nursing, she said.

In the first six months of the internship, participants spend three days in one of three cancer clinical units—medicine, surgery or pediatrics. The remaining two days are spent in the classroom. Classes are selected on the basis of requirements for certification by the Oncology Nursing Society, with speakers selected from within the clinical center.

The new graduates are assigned to a clinical preceptor, from whom they receive

biweekly evaluations. Learning labs are employed to help the nurses develop the technical expertise needed for oncology nursing in such areas as working with infusion pumps.

During the last three months of the internship, the nurses can choose to stay in the same clinical area, or work in a different nursing area within cancer. They may also choose to spend two days a week to work on a project of their choosing, such as a patient teaching project, or may spend all five days in a clinical setting, if they prefer.

To date, no other nursing service besides cancer offers a similar internship program.

Nurses in the program do not have to stay at NIH once they have completed the program. Jenkins predicts, however, that those who wish to remain at the Clinical Center would have an advantage over other nurses because of their knowledge about how the center operates and what research is underway in cancer.

To be eligible for the internship, nurses must have a BSN, have passed their state boards, and have had a 3.0 grade point average. Nurses accepted into the program are not considered a part of government service, but receive a monthly stipend of \$1,300 from NCI.

Last year, NCI did not have much of a chance to advertise or promote the program due to its rapid initiation following the establishment of the program by Congress. This year, NCI plans to advertise in newspapers and by sending brochures about the program to baccalaureate nursing schools across the country. Nursing students who expect to receive their BSN in 1986 and who are interested in the program should contact Jenkins or coordinator Patricia Lake at the Cancer Nurse Training Program, NIH, Building 10, Room 7D37, 9000 Rockville Pike, Bethesda, Md. 20892, phone 301-496-3101.

NIH CLINICAL CENTER'S CANCER NURSING RECRUITMENT IMPROVED

Although the entire Clinical Center and the Cancer Nursing Service have been plagued in recent years by much publicized nursing shortages, recruitment for nurses in the cancer service has been on an upswing in the past year, Janice Feldman, director of nursing at the Clinical Center and associate director of the hospital, told **The Cancer Letter**.

Recruitment efforts "have been extremely successful" in the past year, resulting in the hiring of more than 60 nurses for the oncology units, she said. "The Cancer Nursing Service is the only nursing group to see that kind of major growth." As of late December, the Cancer Nursing

Service had approximately 20 vacant positions.

CNS currently employs approximately 210 employees, 185 of whom are registered nurses, and operates about 100 beds in seven units.

All nurses hired by the Cancer Nursing Service undergo a special orientation to oncology nursing in addition to the general orientation for the Clinical Center as a whole.

In addition to recruitment incentives for nurses to join the Clinical Center, NIH officials have been exploring ways to keep nurses once they go to work for NIH. One such retention tool is the initiation of a four step career ladder program for nurses in clinical practice.

The program is designed to promote and reward nurses who remain in clinical practice instead of pursuing administrative careers. The program recognizes clinical levels one through four for nurses. Most nurses are at the second and third level, with a limited number at level four, Feldman said. Level four nurses are "talented senior people" with very independent functions, she said. Such nurses are expert in their clinical area, orient other nurses, are involved in continuing education programs, and frequently serve as co-investigators. Feldman stressed that nurses at the Clinical Center often work as co-investigators, with some conducting phase 1 studies and independent nursing research studies.

Registered nurses employed by NIH are paid according to federal civil service guidelines. The lowest grade at which a clinical RN can be hired is the GS 7, which pays from \$18,000 to \$23,000 per year. RNs are also employed at GS 9, 10 and 11 grades. The maximum pay for a GS 11 employee at the highest step is currently \$34,500.

Sue Baird, who served as chief of cancer nursing at the Clinical Center until her resignation in January, 1984, said the federal pay scale made it difficult to recruit nurses to the Clinical Center. She contended that the pay scales looked competitive on the surface, but weren't adequate to bring a new graduate to the Washington D.C. area to live.

While Feldman acknowledges that pay scales for nurses are a little lower than those offered by private hospitals in the area, she pointed out the special opportunities for nurses that are available only in the research setting offered by NIH. For example, the center has a liberal continuing education and tuition reimbursement program.

Cancer nursing and critical care nursing seemed to have more recruitment problems than other nursing services during her time at the Clinical Center, Baird said. She cited the career ladder program as an important effort to improve retention.

"We always had unfilled positions in cancer," she said. Past problems with the service included

staffing ratios, which were usually fixed on patients who were less sick than cancer patients. The acuity level for cancer units was quite high due to the complexity of care required and the amount of data necessary for the research activities. The units didn't always have the number of nurses they were supposed to according to the acuity scale.

The size of the cancer nursing units varies according to the acuity of the patients admitted, Feldman said. For example, the complexity of care required for patients with acquired immune deficiency syndrome is so high that the number of beds for those patients had to be decreased. She also noted that the intensive chemotherapy received by medical oncology patients makes it necessary to increase staffing ratios.

Subspecialty units within the cancer service include pediatric oncology, surgical oncology, cancer immunology, the clinic, a unit that accepts all kinds of cancer patient, and two medical oncology units.

Feldman also suggested that when clinical areas are fully staffed, the staffing ratios at the Clinical Center are probably better than at private hospitals.

Baird cited recruitment, retention and overall staffing levels as key problems during her time at NIH. "We never got to full staffing, never had the opportunity to see how it would be if we reached full staffing," she said.

For Feldman, the opportunity to see how the center operates at full staffing may become a reality. "Every month, we see a substantial number of positions filled," she said.

RFAs AVAILABLE

RFA 86-CA-02

Title: Cancer control small grants research program

NCI's Div. of Cancer Prevention & Control invites small grants research applications from interested investigators who meet the eligibility criteria noted below.

A cancer control small grants research award is designed to encourage scientists from a variety of academic disciplines to apply their skills to scientific investigations in the field of human cancer control intervention research. Cancer control research studies are classified into one of five phases: (1) hypothesis development; (2) methods development and testing; (3) controlled intervention trials to establish cause and effect relationships; (4) research in defined, human populations; and (5) demonstration and implementation studies. The division is primarily interested in research on cancer control interventions in phases 2 through 5.

Cancer control program areas appropriate for

research grants include human intervention research in the following areas:

--Prevention (chemoprevention, diet and nutrition, occupation and early detection).

--Community oncology (improving application of patient management and continuing care research advances in community settings).

--Health promotion sciences (modifying personal, social and lifestyle and health care system factors that contribute to cancer prevention and control).

--Smoking prevention and cessation.

--Cancer control operations research and evaluation.

--Control applications research (adaption of state and local health agency data bases for cancer control planning and evaluation; feasibility testing of interventions in community settings).

--Applied epidemiology (using epidemiologic methods to determine the association between exposure to an intervention and its impact on disease).

--Epidemiologic, planning and survey studies aimed at developing cancer control interventions.

Exclusions: Animal studies and studies to determine the efficacy of chemotherapy, surgery, radiotherapy and other primary treatment interventions are not considered cancer control research under this RFA.

Investigators are eligible to apply for a small grant to support research on a cancer control topic if they are interested in conducting exploratory studies in cancer control research. This includes established researchers from other disciplines, new investigators and investigators currently enrolled in an accredited doctoral degree program. The only exclusions are those individuals who have been a principal (or co-principal) investigator on an NCI funded cancer control grant or contract for more than two years. Dissertation research proposals are acceptable as specified in the RFA.

Awards will be made as research grants. Total costs (direct plus indirect costs) must not exceed \$35,000. The duration of support is one year but may be longer (up to two years) if the funding limits noted above are not exceeded. The direct costs for dissertation research should not exceed \$15,000. Prospective applicants are strongly encouraged to discuss their ideas with the program director to determine whether they fit within the definition and program guidelines of cancer control.

Copies of the complete RFA and additional information may be obtained from Carlos Caban, PhD, Program Director for Cancer Control Research, Cancer Control Science Program, DCPC, NCI, Blair Bldg Rm 4A01, Bethesda, Md. 20892, phone 301-427-8735; or David Postkanzer, MD, DCPC, same address, phone 301-427-8788.

RFA 86-CA-04

Title: Interventions to improve the quality of survival for recovered childhood cancer patients

Letter of intent receipt date: Jan. 15

Application receipt date: March 15

The Div. of Cancer Prevention & Control announces the availability of an RFA for research

projects to develop, implement, and evaluate interventions to address long term morbidity among survivors of childhood cancers, offer encouraging survival statistics, numerous deleterious physical and psychosocial sequelae have been documented. The RFA encourages research that focuses on approaches to preventing, reversing, or remediating negative outcomes in this population.

NCI plans to support up to two awards under this RFA. Up to a five year period of support is provided for, with costs for both projects totaling up to \$400,000 for the first year, depending on the availability of funds.

Direct all inquiries and requests for the full text of the RFA to Carolyn Cook Gotay, PhD, Community Oncology & Rehabilitation Branch, DCPC, NCI, Blair Bldg Rm 7A05, Bethesda, Md. 20892, phone 301-427-8708.

This RFA is based on a concept approved by the DCPC Board of Scientific Counselors last September (**The Cancer Letter**, Sept. 13).

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-CB-61014-55

Title: Human tumor cell bank for diagnostic studies

Deadline: Approximately March 10

NCI is seeking an organization with the technical capabilities and interest in continuing the maintenance of a human tumor cell line bank, which carries approximately 130 cell lines of various neoplasms and distributes samples useful for research in cancer diagnosis, to investigators throughout the United States and abroad.

The organization must have the following: (1) experience and demonstrated proficiency in maintaining tumor cells in tissue culture, (2) the ability to freeze and retrieve viable tumor cells, (3) the expertise for characterization of established cell lines of human tumors and for sensitive detection of mycoplasma and other possible contaminants, (4) adequate space and equipment to maintain the proposed resource, and (5) the ability to maintain a computerized data base that contains clinical information related to each cell line. A five year contract is anticipated.

Contract Specialist: Mary McGarvey

RCB, Blair Bldg Rm 114
301-427-8888

RFP NCI-CN-65010-33**Title: Linkage of classical & DNA markers to the susceptibility gene for breast cancer in high risk families****Deadline: March 15**

NCI is seeking proposals to conduct a family study to test for the presence of chromosomal linkage of the disease gene for human breast cancer to any of a battery of protein and DNA polymorphisms in high risk breast cancer families.

Approximately 100 breast cancer cases, known to have positive and severe family histories for breast cancer, will be the initial target population. These cases participated in the Breast Cancer Detection Demonstration Project (BCDDP). NCI shall contact by phone each of the approximately 100 breast cancer patients (proband) who have participated in the BCDDP, and who have a record to a positive and severe family history of breast cancer.

This initial screening interview will serve to introduce and describe the objectives of the family study and the importance of obtaining adequate pedigree information, as well as epidemiological data on these families. NCI shall inform each proband that should her family meet eligibility requirements (based on adequate pedigree and disease frequency criteria), a home visit will be needed to obtain a blood specimen. The successful offeror shall arrange for this home visit and during this initial screening interview the vital status of the proband's relatives and current addresses and/or phone numbers of the next of kin will be assessed.

Through extensive review of interview, pedigree and questionnaire data according to defined criteria, approximately 15 to 20 families will be selected. All living members in these selected families will then be contacted and arrangements made for blood specimen collection. Data and samples on selected families will be obtained by a home visitation team and the specimens shipped express mail to the analysis laboratory under controlled conditions. Initial processing and analyses will be conducted on fresh blood using standard immunologic and electrophoretic techniques for red cell enzyme and protein polymorphism phenotyping. In addition, lymphocytes will be isolated and cell lines established for DNA marker studies.

Contract Specialist: Alan Kraft
RCB Blair Bldg Rm 2A07
301-427-8810

NCI CONTRACT AWARDS

Title: Information resource activities to identify, characterize and evaluate reports and scientific literature in the area of chemoprevention
Contractor: I.S. Grupe Inc., \$49,535
Title: Pilot test system of a distributed data

management system for NCI
Contractor: Information Transfer Systems Inc., \$49,963

Title: Feral mouse breeding colony
Contractor: Hazleton Laboratories America, Rockville, Md., \$358,304.

Title: Surveillance and selection of promising natural products

Contractor: Univ. of Illinois at Chicago, \$359,051.

Title: Support contract for the Smoking Tobacco and Cancer Program, five years

Contractor: Prospect Associates, \$2,299,565.

Title: Operation of a population based Surveillance, Epidemiology & End Results (SEER) cancer registry in a geographic area including at least 300,000 hispanics and 300,000 black residents, continuation for one year

Contractor: New Jersey State Dept. of Health, \$2,281,944.

Title: HTLV in migrant populations in Hawaii and Okinawa

Contractor: Kuakini Medical Center, Honolulu, \$655,676.

Title: Development of a computerized tracking system for pharmaceutical production and control (SBIR)

Contractor: General Software Corp, Landover Md., \$50,000.

Title: Development and refinement of technique for interstitial hyperthermia (SBIR)

Contractor: Thermal Technologies Inc., Cambridge, Mass., \$50,000.

Title: Refinement and evaluation of in vitro and in vivo screening systems to identify new chemopreventive agents

Contractor: Biological Research Faculty & Facility Inc., \$49,994.

Title: Case control study of cancer and drinking water contaminants

Contractor: Univ. of Iowa, \$625,000.

Title: Computer controlled multi-leaved collimators for radiation treatment accelerator (SBIR)

Contractor: Triangle Research & Development Corp., Research Triangle Park, N.C., \$50,000.

NEW PUBLICATIONS

"Ovarian Cancer," edited by Bleehen, from Springer-Verlag, PO Box 19386, Newark, N.J. 07195, \$55.

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