THE CANCER LETTER

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NCI'S SHARE OF GRAMM-RUDMAN CUTS FOR FY 1986 IS $54 MILLION; STAFF PONDERS HOW TO ABSORB IT

NCI's share of the reduction in the 1986 fiscal year budget required to meet the Gramm-Rudman-Hollings cuts will total $54 million, **The Cancer Letter** learned this week. That amounts to a cut of 4.3 percent, the across the board reduction imposed on all non-

(Continued to page 2)

In Brief

NCI PLANNING 50TH ANNIVERSARY IN 1987, SEEKS INFORMATION ON ALUMNI FOR OBSERVANCE IN MAY

NCI PLANS to observe its 50th anniversary in 1987, with one of the major celebrations to be an alumni reunion, tentatively scheduled for May. NCI is in the process of gathering names and addresses of former employees of the Institute so that invitations may be sent to them. Those interested may contact Dr. B.H. (Bud) Morrison, Bldg 31 Rm 10A52, NCI, Bethesda, Md. 20892, phone 301-496-6445. Legislation creating NCI as the first NIH institute was signed by President Franklin Roosevelt in 1937; one of the principal backers of the bill was a young Washington Congressman, Warren Magnuson, who later as a senator became a champion of increased funding for cancer and all biomedical research. The NIH clinical center is named for him. .... **JOHN KIRKWOOD,** associate professor of medicine at Yale, has been named associate director for medical oncology at the new Pittsburgh Cancer Institute by Director Ronald Herberman. Kirkwood also will be chief of the Div. of Medical Oncology in the Univ. of Pittsburgh School of Medicine. He is presently on sabbatical from Yale at the Tumor Institute of Milan and will assume his new position July 1. "That is a key clinical position," said Herberman, who left NCI last September as acting director of the Biological Response Modifiers Program and chief of the Biological Therapeutics Branch to develop the Pittsburgh center.... **DONALD HILL,** associate director of the Biochemistry Research Dept. at Southern Research Institute, has been named director of the department by SRI President Sabert Oglesby. He succeeds Lee Bennett, who has retired from administrative duties .... **CERTIFICATION EXAMINATION** for tumor registrars will be held March 15. Those interested should contact the National Tumor Registrars Assn., Testing Office, Professional Testing Corp., 1211 Ave. of the Americas, 15th Floor, New York 10036.... **WILLIAM ROPER,** a physician who is special assistant to President Reagan for health policy, is reportedly the Administration's choice to head the Health Care Financing Administration. McClain Haddow, HHS chief of staff, has been acting head of HCFA since Carolyne Davis resigned last year. New HHS Secretary Otis Bowen has other top health jobs to fill, including his assistant secretary for health.

NCI'S 1986 BUDGET CUT 4.3 PERCENT TO MEET GRAMM-RUDMAN DEFICIT GOAL

(Continued from page 1)
protected agencies to achieve the $11.7 billion cut in the deficit the legislation requires.

NCI executives now know the size of the cut they will have to deal with; they have not yet (or had not by press time) determined how they would absorb it. Earlier plans for the cut that would have it come entirely out of indirect costs apparently have been abandoned, or at least modified.

Indirect costs still seem to be the most vulnerable target for cost cutting. Trimming the average indirect payments from 26 percent to 20 percent would save about $30 million (from NCI's grants pool). That would leave $24 million in cuts to be spread among centers, cooperative groups, the contract supported programs and intramural research.

It would appear that the traditional (RO1) and program project (PO1) pools are safe in this round of cuts, but that may not be the case. In the 1986 appropriations bill, Congress mandated that 6,100 competing NIH grants be funded. That, coupled with congressional directives to fund grants at their peer review recommended levels, in the past would have assured no cuts in that area.

Gramm-Rudman changed the rules of the game, however. Previous congressional directives have been superceded by the provisions of the legislation which is supposed to bring about a balanced budget by 1991. Congressional intent on full funding of grants never was written into law; it was expressed in committee reports on appropriations bills. NIH has tried to comply, but that is not mandatory.

Congress was more adamant about the 6,100 grants, but the mood on Capitol Hill now, with the heavy hand of Gramm-Rudman worrying everyone, may well be to let NIH fund a few less grants if executives of the institutes feel they need to spread the cuts among all their constituents. NCI's share of the 6,100 grants was expected to be 931.

Here's what the situation looks like at NCI with each of the major funding mechanisms:

*RO1s, PO1s—Even at the full appropriations of $1.25 billion, the priority score payline was estimated to be no higher than 165, with the percentage of approved grants that would be funded estimated at 30 to 33. Those funded would receive close to their recommended levels, however. NCI would much prefer to keep the payline up, and maybe even raise it into the 170s, by reducing the amounts each grantee receives rather than by leaving many of them completely unfunded. Whether that is an option that is available remains to be seen.

*Clinical cooperative groups and cancer centers —Again, at the full $1.258 billion level, there still would not have been enough money to pay all those in the fundable range at full recommended levels. The range would have been from about 70 to 90 percent. The Gramm-Rudman cut could drop those figures from five to 10 percent, and possibly result in leaving one or two centers completely unfunded. NCI's plans already including cutting out one cooperative group.

*Contracts—These have been cut back so much in recent years that there may not be much room left. Heavy cuts in drug development have reached the point where any further reduction may be impossible without placing the entire program in jeopardy. Other major contracts, in cancer control, epidemiology and intramural research support, possibly will have to take some of the impact.

*Intramural research—Reductions in staff positions already are causing hardships and inefficiencies. If any further substantial reduction is to be made, NCI may have to consider closing some labs.

The 4.3 percent across the board cuts, which sliced the total NIH budget by $236 million, were presented last week by the White House to the Congressional Budget Office. CBO and the General Accounting Office (GAO is also an arm of Congress) were to present their changes, if any, to the White House this week. That version must be enacted by the President, with his orders to the affected agencies due to go out no later than Feb. 1.

Those who don't like what Gramm-Rudman has done to the budget this year haven't seen anything yet. The President's FY 1987 budget will be presented to Congress Feb. 3 or soon after. The reductions it will propose, to meet the Gramm-Rudman target of a deficit of $144 billion, will be three to four times the cuts being imposed for FY 1986.

Congress will have more time to deal with those proposals, which will go through the regular appropriations process and budget hearings. Congress will have the opportunity to allocate the reductions as it sees fit, with the Gramm-Rudman across the board cuts coming into play only if the Office of Management & Budget (White House) and CBO determine by Aug. 15 that the budget goal will not be met. If the anticipated deficit exceeds the goal by more than $10 billion, GAO will draft a plan for across the board cuts. The President will issue the order imposing the cuts Sept. 1, but Congress will have until Oct. 15 to enact its own cuts and/or raise taxes, before the Presidential order goes into effect.

The National Cancer Advisory Board Committee on Planning & Budget will hear details of the 1987 budget in a closed meeting Feb. 3, starting at 7:30 p.m. The full Board meeting is scheduled for Feb. 3-5, with Feb. 4 closed for grants review.

PUBLIC SHOULD BE WARNED ABOUT RISKS OF SMOKELESS TOBACCO, PANEL SAYS

The public should be warned that the use of smokeless tobacco, particularly snuff when started in childhood, increases the risk of oral cancer, a draft consensus statement developed by a panel of experts concluded at the end of a three day consensus conference on the health implications of smokeless tobacco use. The conference was sponsored by NCI, the National Institute of Dental Research and NIH's Office of Medical Applications of Research.

NCI is going to issue a program announcement seeking applications for smokeless tobacco prevention and cessation studies. The program announcement is to be modeled after an RFA issued last year that generated only one fundable application (See related story, p. 6).

While smokeless tobacco was widely used in the United States in the past, its use has declined sharply during this century, the panel noted. There is evidence, however, that the trend has reversed and smokeless tobacco is gaining popularity. "Market data show marked increases in manufacturing and sales, especially in the category of moist snuff, and total annual sales of smokeless tobacco are close to $1 billion. Reports from schools in different regions of the country indicate that smokeless tobacco—principally moist snuff— is being used by very young people, especially adolescent males."

The panel estimated that at least 10 million Americans have used smokeless tobacco within the past year, with three million of these users being less than 21 years old.

Studies indicate that significant proportions of teenage boys are current users, and the number of users in this age group is steadily increasing, it added. While detailed national data on trends in the use of smokeless tobacco products are not currently available, "there are indications of recent significant changes." Production of smokeless tobacco in the U.S. declined steadily from 1930 until the late 1960s. A resurgence in production, however, has led to a steady increase in the manufacture of smokeless tobacco totaling about one third since 1970. In the last five years alone, from 1981 to 1985, the production of moist snuff has increased by one third. Moist snuff is the form of smokeless tobacco often used by youths.

A national representative study conducted in 1985 found that 16 percent of males between the ages of 12 and 17 had used some form of smokeless tobacco within the past year. About one third of this group used it one or more times a week.

Elbert Glover, an associate professor of community health at East Carolina Univ., told the conference that a national collegiate survey found that 22 percent of collegiate males reported that they used smokeless tobacco. Only two percent of collegiate females used smokeless tobacco products. Overall, approximately 12 percent of students in U.S. colleges and universities were users. About eight percent of nonusers reported that they intended to use smokeless tobacco products in the future. The majority of those who used the products used less than one can or pouch of smokeless tobacco per week.

More than half (54 percent) of the 5,894 students surveyed believed that dipping and chewing tobacco were less harmful to their health than smoking, he said.

A statewide survey of 2,094 Oklahoma students found that 13 percent of third grade males and approximately 22 percent of fifth grade males used smokeless tobacco. The survey found a linear relationship with age and grade level, increasing to approximately 22 percent, 33 percent and 39 percent among males in grades seven, nine and 11, respectively.

The study also examined the students' intention to use smokeless tobacco and cigarettes. Males plan to use smokeless tobacco two to four times more than they plan to smoke cigarettes. Females, however, are much more likely to smoke cigarettes in the future, two to 16 times more likely, depending on grade level. The study found that school age smokeless tobacco users initiate smokeless tobacco use at an earlier age than they initiate smoking.

A survey conducted by Glover of adults in a North Carolina county that produces more flue cured tobacco than any other county in the U.S., found a crude prevalence of 24 percent, which was noted at 15 percent after an age adjustment. Adult males were found to be 4.5 times more likely to use smokeless tobacco than adult females.

Another study by Glover conducted at a North Carolina university found a 9 percent prevalence for the university, with males reporting a 19 percent prevalence. The study found that there were three times more exsmokers taking up smokeless tobacco than former smokeless users taking up cigarettes. "The major self reported reason for the switch from cigarettes to smokeless was that smokeless tobacco was perceived as 'less harmful' and served as a method of quitting cigarettes," he said.

The panel noted that smokeless tobacco use is subject to wide variations among subgroups. "Currently, males over 21 years of age use somewhat less, with use decreasing for the older groups," it said. "Only 2 percent of females use smokeless tobacco, whereas blacks and Hispanic youth are

intermediate users. Patterns of use appear to be similar in most of the country, with the lowest use in the Northeast."

Significant use even by kindergarten children has been reported in some areas in one state. In one longitudional study from 1976 to 1982, tobacco chewing doubled and snuff dipping tripled, with peak use among boys age 12 to 14.

The risk of oral cancer in the U.S. is small among those who do not smoke, drink alcoholic beverages or use smokeless tobacco.

Human data presented at the conference, however, "provide convincing evidence for an increased risk of oral cancer as the result of smokeless tobacco use," it said. For example, one North Carolina study of women "provides the most compelling data to support a role for snuff dipping in the causation of oral cancers," it said. "In this study, among nonsmokers, the risk of oral cancer was 4.2 times greater for those who used snuff than for those who did not, and for users over several decades the risk was much higher.

"These data are particularly striking in that 1) the oral cancer risks were greatest for cancers located in the buccal mucosa and gingiva where the snuff was placed; 2) the risk increased with increasing duration of snuff use; 3) factors such as diet, dental hygiene, alcohol intake, and cigarette smoking were found not to be responsible for the association between snuff and oral cancers; and 4) the risks were so large that it would be difficult to postulate alternative explanations for the association between oral cancer and snuff other than a causal one."

The North Carolina study was inspired by U.S. cancer maps for 1950-1969 that showed unusually high death rates for oral cancer among white women in the southern U.S., about 30 percent over national rates in urban areas and 90 percent in rural areas. White women who used snuff were found to have more than a fourfold statistically significant increased risk of oral and pharynx cancer than those who never used tobacco, according to a paper presented at the conference by Deborah Winn, an epidemiologist at the National Center for Health Statistics.

Smoking was the other major risk factor in this population, accounting for a threefold increased risk. Alcohol enhanced the risk associated with smoking.

"Most striking were the risks associated with cancers arising in the cheek and gum, the tissues in direct contact with the tobacco product," she reported. "The risk was about 13 fold for those women who had used snuff for one to 14 years and it rose to about 50 fold for those who had used snuff for 50 or more years. Elevated risks were also evident for cancers arising in other parts of the mouth and pharynx, but to a lesser extent." No other patient characteristics such as education altered the risks associated with snuff use.

Noting that the findings are supported by other epidemiological studies and by clinical case series, the panel advised that the results can and should be extrapolated to include all forms of smokeless tobacco and all populations of users.

"Most of these studies did not specify the type of smokeless tobacco product, i.e., snuff or chewing tobacco. Thus, it seems prudent to recognize the carcinogenic potential of all smokeless tobacco products, acknowledging that the adverse effect of snuff has been more fully documented.

"Although this relationship has been most clearly demonstrated for elderly, rural women residing in the Southeastern United States, there is reason to believe that snuff would also be carcinogenic in women and men in all geographic locations. In fact, men using smokeless tobacco experienced a 3.9 fold increased risk for oral cancer in a study based on the Third National Cancer Survey.

"Youngsters, starting the use of snuff in grade school and continuing its use through adult life, are likely to experience a similar risk."

The panel's conclusion that oral cancer is associated with the use of smokeless tobacco "is supported by multiple studies showing a relationship between oral cancer and chewing of betel quid containing tobacco in India and Southeast Asia," it said. "Furthermore, this view is consistent with the judgment of a recent working group of the International Agency for Research on Cancer, which reported that the evidence associating snuff with oral cancer is 'sufficient' to indicate a causal relationship."

The panel concluded that data "are insufficient to determine whether cancers at sites other than the mouth and throat are related to smokeless tobacco use."

The statement also noted that smokeless tobacco contains carcinogenic nitrosamines in levels far higher than those allowed for foods and beverages in the U.S.

The chemical analysis of various types of smokeless tobacco reveals the presence of polonium-210, a radioactive alpha emitter and known radiation carcinogen, as well as "representatives of two classes of powerful chemical carcinogens, the polycyclic aromatic hydrocarcons and the nitrosamines." Of 19 nitrosamines identified in smokeless tobacco, the carcinogeic nitrosamines presenting the highest concentrations are NNN and

NNK, both of which are chemically related to nicotine. Snuff contains 1.6 to 135 mg per kilogram of NNN and 0.1 to 14 mg/kg of NNK. Food and beverages in the U.S. may not contain more than 0.01 mg/kg of nitrosamines. Looseleaf and plug tobacco contain 0.2 to 8.2 mg/kg of NNN and 0 to 1.0 mg/kg of NNK. Both nitrosamines "readily produce cancer in rats and hamsters in organs such as the nose, trachea, esophagus, and liver."

The conference also found evidence of an association of smokeless tobacco use with gingival recession and oral leukoplakia. It found insufficient evidence of an association with periodontitis or tooth decay.

"Leukoplakia is a frequent concomitant of smokeless tobacco use," it concluded. "Although multiple studies describe the transformation of leukoplakia to malignancy within the range of one to 18 percent over observation periods ranging from several months to 11 years, there are few data on whether snuff associated leukoplakia per se undergoes similar frequencies of malignant transformation." Studies from India and Southeast Asia involving different smokeless tobacco products and use patterns "suggest that the long term risk for malignant change of smokeless tobacco associated leukoplakia may be significant."

Other health risks include ones associated with blood levels of nicotine similar to those achieved by cigarette smokers, such as elevations of blood pressure, heart rate, certain blood lipids, and catecholamines. No direct epidemiological data are available on cardiovascular moribidity and mortality in association with smokeless tobacco use, however.

In addition to nicotine, heavy metals such as lead and cadmium have been found in smokeless tobacco products at levels that present potential health risks to the user and the offspring of pregnant women, the panel said. "The presence of lead in smokeless tobacco may pose a special risk for the developing fetus."

Plasma levels achieved by smokeless tobacco use are similar to those achieved by cigarette smoking. Studies of teenagers who have tried to stop using smokeless tobacco have found that only a small percentage were able to do so, "suggesting that tobacco by the oral route has substantial addicting properties. The continued use of smokeless tobacco even by those who experience serious adverse health consequences attests to its addicting powers," the panel said.

Nonbiochemical factors that are correlated and readily manipulated for smokeless tobacco include advertisements, influence from peers, parental acceptance of smokeless tobacco use, and the perception that smokeless tobacco is less harmful than smoking tobacco. "Behaviors can become interchangeable based on their function to the individual," the panel said. "For example, current opinion is that some smokers are switching to smokeless tobacco because the latter is considered a safe alternative for maintaining their nicotine dependence. Others suggest that young people using smokeless tobacco often switch to cigarettes. Use of smokeless tobacco in children is sometimes associated with the use of hard liquor, beer, wine, cigarettes and marijuana."

The panel identified a number of areas in which further research is needed on smokeless tobacco use. "There is a pressing need for well designed studies of:"

a. Prevalence of smokeless tobacco use based on continuing national probability sample data, including type of product, age , sex, region, and concomitant cigarette smoker. In addition, longitudional studies should be conducted.

b. Users and nonusers of smokeless tobacco products, to characterize better the prevalence and incidence of periodontal diseases, caries, leukoplakia, and cancer. These studies should identify, as far as possible, the nature and contents of products used, patterns and durations of their use, concomitant use of other substances such as alcohol and smoking tobacco, and occurrence of viral infections. Where appropriate, they should use tissue biopsy as wel as critical clinical and laboratory measurements.

c. Cancers of sites other than the mouth carried out in geographic areas with high rates of smokeless tobacco use.

d. Potential role of smokeless tobacco in cardiovascular disease and adverse outcomes of pregnancy.

e. Potential of users of smokeless tobacco to produce nitrosamines in vivo.

f. Research on the relationship between amounts of smokeless tobacco used and plasma levels of lead, cadmium, and other potential toxins.

g. Strategies for the development and evaluation of prevention programs, including school-based programs, taking into consideration regional, ethnic, age, socioeconomic and other variables.

h. Development and evaluation of early intervention and treatment programs to reduce smokeless tobacco dependence with special consideration of specific populations, including:

1. School and college age.

2. Persons with specific risk or disease conditions, including malignancies, cardiovascular disease, women at risk for pregnancy.

3. Workplace and industry specific populations where elevated smokeless tobacco use is common.

Such programs should include a range of approaches based on pharmacological and behavioral treatments.

The panel did not make any recommendations on the labeling of smokeless tobacco products. "Those whose function it is to warn people of health dangers should take note of" the panel's conclusions, Panel Chairman Brian MacMahon told a press conference at the end of the conference. MacMahon is a Henry Pickering Walcott professor of epidemiology at the Harvard School of Public Health.

PROPOSED SMOKELESS TOBACCO WARNING LEGISLATION MAY GO TO HOUSE FLOOR

A measure that would require smokeless tobacco products to carry rotating health warnings similar to those required for cigarettes may go to the House floor as the 99th Congress begins its second session. Under the proposed legislation, the warnings would rotate between three messages that would say, in capital letters, "This product may cause mouth cancer," "This product may cause gum disease and tooth loss," and "This product is not a safe alternative to cigarettes."

The bill would also establish a ban on broadcast advertisements for smokeless tobacco products.

The Senate passed its version of the labeling act S 1574 by voice vote in December. That version does not ban broadcast ads for smokeless tobacco products, but opts for having one of the three warnings read once during the broadcast.

Rep. Henry Waxman (D-Calif.) brought an amended version of the Senate bill to the House floor under unanimous consent procedures before its December recess, but the measure failed due to an objection by Rep. Thomas Bliley (R-Va.). Under unanimous consent procedures, a measure can pass only if there are no objections.

Bliley objected to a House amendment that would require manufacturers to place a circle pierced with an arrow around the word "warning." "The compromise is fine except for the circles and arrows on the warning labels," Ron Hamm, a legislative assistant for the Virginia legislator said, adding that Bliley would vote for the measure if that portion of the bill were removed. The congressman is concerned that the law would establish a precedent for the new labeling that would then be applied to cigarettes. He also questioned the effectiveness of arrows and circles on warning labels.

"The only way the bill is going to get consideration is to come before the full Energy & Commerce Committee," Hamm said. The House version of the legislation is currently in the committee, but no markup has been scheduled.

Waxman, however, reportedly plans to bring the amended Senate bill back to the House floor under suspension of the rules. Under suspension of the rules, a two-thirds vote is required for passage. Debate is limited to 40 minutes and no amendments may be made from the floor under the procedure, which is intended for noncontroversial measures.

The proposed legislation represents a compromise between the Smokeless Tobacco Council and the Coalition on Smoking and Health, whose members include the American Cancer Society, the American Heart Assn. and the American Lung Assn.

NCI TO RECOMPETE SMOKELESS TOBACCO RFA AS PROGRAM ANNOUNCEMENT

NCI plans to issue a program announcement on prevention and cessation of smokeless tobacco use in February. If issued next month as planned, applications will be due the first of June. The announcement is expected to be modeled after a request for applications issued by the institute last year.

While NCI received 22 applications for smokeless tobacco prevention and cessation projects under the RFA, only one was able to be funded. More than half of the applications received were recommended for disapproval, with the remainder receiving very poor priority scores.

NCI officials have contacted institutions and agencies that applied under the RFA to notify them of the upcoming program announcement. The unsuccessful applicants are being advised to pay special attention to criticisms contained in the summary statements. A variety of institutions and agencies applied for awards under the RFA, including some state agencies that lacked expertise in grantsmanship.

The only award to be made by NCI for smokeless tobacco prevention and cessation was made to Carol D'Onofrio at the Univ. of California (Berkley). D'Onofrio's project is entitled "Curtailing the Use of Smokeless Tobacco Through 4-H." First year funding for the project, which began Sept. 30, will total approximately $330,000. The project involves youth in Northern California.

Under the proposed program announcement, NCI hopes to support studies designed to develop and evaluate the effectiveness of interventions to prevent the onset and reduce the prevalence of smokeless tobacco use in the U.S.

According to the original RFA issued last year, the studies should seek to (a) identify patterns of smokeless tobacco use and the primary factors influencing such use; (b) develop and evaluate

intervention strategies to reduce the incidence and prevalence of smokeless tobacco use; and (c) develop and evaluate assessment procedures to determine the long term effectiveness of these intervention strategies.

Last year's RFA noted the fast growth in sales of smokeless tobacco in recent years. Fine cut tobacco used in snuff increased 188 percent between 1970 and 1979, it said.

"Very little is known about the patterns of use and factors influencing use of smokeless tobacco products within these new populations of users," it said. "Specificially, the realtionship of use to cigarette smoking is unclear. Users often absorb as much or more nicotine than do smokers. Nicotine dependence may therefore be established, and among the young, use of smokeless tobacco could serve as an introduction to cigarette smoking, which poses even greater health risks. Use of smokeless tobacco by populations that have previously not used it is a very recent phenomenon. We are, therfore, in a unique position to monitor this new trend in health risk behavior and to intervene at an early stage, thereby minimizing the potential health consequences for the nation."

NCI previously stressed that the focus of the studies should be on the long term effectiveness of interventions, with funded studies to be phase 3 and 4. It did acknowledge, however, that "there are substantial gaps in our knowledge concerning use of smokeless tobacco which may be essential to the development of an effective and durable intervention program. In particular, little is known about the demographics of users and those at risk for use, patterns of use, factors influencing use, and the relationship to use of other forms of tobacco, particularly cigarettes." The RFA also suggested that proposals use a phased in approach in which, during the first year, data describing the target population, prevalence and patterns of use are obtained, unless such data are already available and proposed interventions are pilot tested.

Standardization of data collection techniques and instruments were encouraged in the original RFA in order to allow for comparisons of patterns of smokeless tobacco use in different geographic and demographic populations.

The RFA also advised prospective investigators to note that (1) the outcome measure of these studies should be smokeless tobacco use, not cancer incidence/mortality, and (2) that the desired overall outcome of studies are interventions that are a) cost beneficial; b) cost effective; c) durable in their effects; and d) readily adoptable by others with only those modifications that are necessary for a broad community/population impact.

Research questions cited in the RFA include whether the study population chosen is sufficiently stable to permit long term followup; means of monitoring use of other forms of tobacco so that shifts in product use can be detected; the role of the family or other suppport groups in smokeless tobacco intervention programs; environmental factors; consideration of multiple domains of individual health and social behavior in the interventions; differences among subgroups of tobacco users; the need for developing new intervention approaches for smokeless tobacco or whether already existing programs for cigarette smoking be modified for such use; and the role advertising does or can play either in the initiation or the prevention/cessation of smokeless tobacco use.

ACOS SURVEY TO ASSESS TUMOR BOARDS' IMPACT ON CARE OF CANCER PATIENTS

The impact of tumor boards on the care of cancer patients is the subject of a survey being undertaken by the Cancer Department of the American College of Surgeons. The project was initiated by NCI.

To date, no data have been available regarding how cancer conferences and boards impact on cancer patient care, ACOS notes in a letter to field liaison physicians, hospital cancer committee chairmen and tumor registrars. "Many hospitals sponsor such activities but little is known about their organization, operation or effectiveness in terms of time and professional resources expended," it explains.

Information received will be reviewed externally, summarized and shared with all participants. The assessment can be important in the cost benefit analysis and justification of the components of a institution's cancer program, and in identifying the accomplishments of the board and areas that may require modification or expansion, ACOS says.

Information to be collected includes general hospital characteristics such as the number of total beds, number of cancer cases accessioned in the tumor registry in the last calendar year, and information on the cancer program, cancer committee, tumor registry, physician statistics, and institutional affiliations.

Cancer conference and board information to be collected includes the composition of the committee, the frequency of its meetings, attendance figures, and data such as what medical disciplines and non physicians attend the meetings. ACS is also seeking information on the content of the meetings, such as the proportion that include case presentations, didactic presentations or a combination, and the types of cases presented.

HOSPICE ASSN. OF AMERICA'S ANNUAL MEETING TO BE HELD IN D.C. IN APRIL

The Hospice Assn. of America will host its spring seminar in Washington D.C. on April 5. The meeting will focus on issues of particular concern to medical directors and administrators and will be held in conjunction with the annual meeting of the Assn. of Community Cancer Centers. The meeting will be held at the Hyatt Regency Washington from 1:30 to 5:30 p.m. Registration is $25.

Bob Enck of Lourdes Hospital in Binghampton, N.Y., will present welcoming remarks. Irving Fleming of the Mid-South Oncology Group will discuss "Surgery for the terminally ill -- is it necessary?" Legal, ethical, and malpractice issues of hospice care will be the subject of a panel discussion by Robert Veatch, professor of ethics at the Kennedy Institute of Ethics at Georgetown Univ.; William Dugan, Methodist Hospital of Indiana in Indianapolis; Chris Copeland, an attorney at Wood, Lucksinger & Epstein; and a hospice administrator or medical director.

HAA is jointly sponsoring with the Joint Commission for Accreditation of Hospitals a "JCAH Hospice Standards" seminar on May 6. The one day seminar will be held from 8:30 a.m. to 4:30 p.m. at the Holiday Inn in Bellingham, Washington. Registration is $90. For more information on either or both meetings, contact HAA at 214 Massachusetts Ave. N.E., Suite 240, Washington, D.C. 20002, phone 202-547-5263.

Children's Hospice International will host its second national conference at the Sheraton Washington, D.C. on May 9-19. For more information, contact Leslie Whitman at (202) 745-3393.

The National Assn. for Home Care will hold its legislative conference at the J.W. Marriott in Washington, D.C. on March 16-19. For more information, contact Ron Kolanowski at 202-547-7424.

A four day workshop entitled "Hospice Care in Terminal Illness: An Update" will be held by the International Hospice Institute July 8-11 in Airlie, Va. For more information, contact Gail Good at 313-559-9209.

HAA is encouraging all interested parties to submit proposals for its annual meeting to be held in New Orleans on Sept. 9. The deadline for submission of proposals is March 15. Proposal applications may be obtained from HAA's Washington office at the address given above.

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. 20892. 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-65016-34

Title: National occupational cancer control clinical research network

Deadline: Approximately April 19

The Div. of Cancer Prevention & Control is interested in increasing its pool of master agreement holders.

The objective of this study is to conduct a large volume of occupational population assessments to determine their potential for inclusion in intervention studies. The population to be assessed will have been identified as a result of epidemiological studies. The concern of this solicitation is to determine the opportunity to use these occupational high risk populations in the evaluation of newly developed cancer control applications (e.g., chemopreventive agents), in a repetitive manner based on standardized protocols.

Phase 1. The identification of potential occupational populations for interventions.

Master agreement orders (MAOs) involving this phase may include assessment of hazards by walk through type survey and assessment of the suitability of high risk occupational populations.

Phase 2. The development of intervention methods and study design.

MAOs involving this phase may include exerimental design of cancer control intervention study, baseline clinical examinations, and registration of potential study populations.

It is estimated that up to five MAOs per year will be issued pursuant to the awards of the master agreements.

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