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PRESIDENT'S FY 1987 BUDGET TRIMS NCI $73 MILLION FROM 1986 APPROPRIATION; BASIC RESEARCH HIT HARD

President Reagan's 1987 fiscal year budget request for NCI totals $1.158 billion, a cut of $73 million from the appropriation voted by Congress for the 1986 fiscal year. If Congress goes along, research projects (RO1s and PO1s) would be hit hard, centers and cancer control would suffer serious reductions, and construction grants would be

(Continued to page 4)

In Brief

JOHN KOVACH SUCCEEDS MOERTEL AS MAYO CC HEAD; DEA DEPUTY APPOINTED; NEW NCAB MEMBER NAMED

JOHN KOVACH has been named director of the Mayo Clinic Comprehensive Cancer Center, succeeding Charles Moertel, who requested replacement after holding that position for more than 13 years. Kovach went to Mayo in 1976 to establish a new Div. of Developmental Oncology Research, after serving as deputy director of clinical oncology at the Columbia Univ. Cancer Research Center. Moertel will continue his work in GI cancer research at Mayo as chairman of the North Central Cancer Treatment Group which he organized as one of the first regional cooperative groups. He is a former president of the American Society of Clinical Oncology and has served on the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control and on the FDA Oncologic Drugs Advisory Committee.... **PAUL RAMBAUT,** manager of biomedical research for NASA, haa been appointed deputy director of NCI's Div. of Extramural Activities, Div. Director Barbara Bynum announced. Rambaut is an expert in nutrition. The DEA deputy job has been vacant since William Walters retired more than two years ago... **BARBARA SHOOK** of Birmingham has been appointed by President Reagan to the National Cancer Advisory Board seat left vacant by the death of Angel Bradley. Shook is a member of the board of Southern Research Institute.... **ROBERT BROWNING,** who has been health scientist administrator in NCI's Div. of Cancer Prevention & Control, is the new chief of the Grants Review Branch in the Div. of Extramural Activities. He succeeds Dennis Cain, who moved over to the Div. of Cancer Treatment (**The Cancer Letter**, Dec. 6).... **ELI GLATSTEIN,** chief of the Radiation Oncology Branch in the Div. of Cancer Treatment, was one of three NIH executives to receive presidential awards for meritorious service, which include bonuses of $10,000. The others were Norman Mansfield, director of the NIH Div. of Financial Management, and Franklin Neva, chief of the Laboratory of Parasitic Diseases in the National Institute of Allergy & Infectious Diseases. Ruth Kirschstein, director of the National Institute of General Medical Sciences, won the top presidental award for distinguished service and a $20,000 bonus.

NCAB COMMITTEE SEEKS OSP UPGRADE TO CENTERS, CLINICAL TRIALS STATUS

Members of the National Cancer Advisory Board's Committee on Organ Systems Programs, unhappy with what they perceive as NCI's de-emphasis of the program, recommended to the full Board last week steps be taken to upgrade OSP "to the same (status) level of the cancer centers, clinical trials and training programs."

That would involve reserving a certain amount of money, not specified by the committee, which would be allocated to the program every year to support grants generated by the Organ Systems Coordinating Center's various working groups.

The recommendation met immediate opposition from NCI staff and was certain to be opposed by NCI Director Vincent DeVita. The proposal was scheduled to go to the full NCAB later this week.

The committee's action reflected frustrations expressed by working group chairmen in presentations to the Board in December (**The Cancer Letter**, Dec. 6). They were unhappy because the first round of concepts for research aimed at "filling the gaps" in existing organ related research consisted entirely of program announcements, which carry no assurances of funding. Respondees to program announcements compete for RO1 (or sometimes PO1) grants. On the other hand, if the concept is presented as a request for applications (RFA), a definite sum of money must be reserved for it and proposals are reviewed by ad hoc study sections. Funding is guaranteed, provided proposals are considered of scientific merit and the overall NCI budget is adequate enough to provide that money.

NCI's four Boards of Scientific Counselors each approved a program announcement concept at their fall meetings. They had been cleared by the NCI Executive Committee. Neither the Executive Committee nor the BSCs blocked any concept presented by the working groups, and only one was significantly modified—the Div. of Cancer Treatment Board broadened the concept on colon cancer to include all solid tumors.

Since the working groups batted 1.000 and had submitted the concepts as program announcements, what was their beef?

It turns out that they really wanted them to be RFAs but were advised that they would have had a much rougher time in the BSCs. That would have involved commitment of division funds, and the Boards so far have not indicated that much interest in the Organ Systems Program. The Div. of Cancer Etiology Board, in fact, was inclined to disapprove the OSP concept presented to it, until DCE Director Richard Adamson pointed out the money would come from the RO1 pool rather than division funds.

All this is seen by the working group members as quite a fall from the old Organ Site Program, when the working groups had as much as $17 million a year to fund the grants they both solicited and reviewed. They have not been impressed by NCI staff pointing out that many organ related grants now are being funded through the RO1 process, and that they are holding their own in competiton with other grant applications.

OSP Committee Chairman Robert Hickey presented a report summarizing the history of the Organ Sites-Organ Systems Programs and the needs described by working group chairmen in December. He also offered recommendations.

Hickey's report said that major needs of the program are to interest new and young investigators; assurance of research support; appropriate review mechanism for the unique programs "because of the multidisciplinary and programmatic nature of the grants;" shortening the time lag from concept to issuance of the RFA, PA, or RFP.

Hickey's report recommended that "OSP should be continued, and the thread and recommendations from prior reviews be recognized; the Organ Systems Coordinating Center as a single headquarters be continued with periodic reviews and recompetition; and the grant review process... be structured as recommended (in a 1970s report, so that it is) relevant to the program and not cancer in general."

Hickey added, "In other wards, targeted."

Committee member William Powers offered the amendment recommending that OSP be recognized and operated by NCI similar to the way the cancer centers, clinical trials and training programs are operated, with discrete funds allocated to it and with grants review by a chartered committee. The amendment also asked that a separate Board of Scientific Counselors be established for OSP to review concepts presented by the working groups, or that such review be accomplished by a group consisting of representatives of each of the existing BSCs.

The committee accepted the Powers amendment. "There is some superb organ systems research in RO1s and PO1s," Victor Braren said. "The crux of the problem is to fill in the holes. The NCAB and NCI owe it to the American people to integrate research into more targeted research to deal with these tumors."

"People go where the money is," Rose Kushner said in arguing for specific sums to be allocated to OSP.

Geza Jako argued that the major organ systems tumors "don't have the type of moral support that some minor cancers get from NCI, because leading staff of the institute is interested in other areas."

Hickey's report also called for establishing two

new working groups, one for "neuro-oncology" (tumors of the brain and central nervous system), the other for tumors of the upper aerodigestive systems. Those had previously been approved by the committee.

NCAB REMOVES ITS RESTRICTIONS ON ACCESS TO PDQ; STAFF NOW DECIDES

The National Cancer Advisory Board voted Monday to remove restrictions it had previously placed on the access of NCI's computerized Physician Data Query (PDQ) system by non-physicians. The vote was unanimous, with one abstention by Ed Calhoon.

The action lifts earlier restrictions imposed by the Board that limited access to PDQ to physicians and other health professionals and allows NCI staff to make whatever operational changes they feel are necessary to aid in the promotion and dissemination of the computerized cancer information system.

The restrictions have led to difficulties in both promoting PDQ and in obtaining vendors for the system, Susan Hubbard, director of NCI's International Cancer Information Center, told the Board. A major stumbling block, she said, was the need for the development of software to be able to determine a user's occupation in order to allow access. In addition, potential vendors were reluctant to promote the system to only a subset of their on line medical information users, she said.

Hubbard emphasized that NCI has no intention of promoting PDQ to non-physicians, but is concerned that the restrictions have hindered the institute's ability to publicize the system.

For example, officials of the National Library of Medicine planned to use PDQ as "a centerpiece" in their 150 year anniversary this week, she said. If the access restrictions were not lifted, science writers from an estimated 150 medical and scientific journals would be denied the opportunity to see how PDQ works, subsequently prohibiting them from efforts that would help publicize the system.

National Library of Medicine Director Donald Lindberg has expressed concern about the restrictions that do not allow non-physician code holders to NLM's MEDLARS on line database to access PDQ. In addition, there are a number of "legitimate health care organizations interested in using PDQ" in order to help cancer patients and their families find the best cancer care, Hubbard said.

Original concerns about the potential for misuse of PDQ have declined since the system was established, she said.

In fact, one of the early opponents of allowing non-physician access to the system heartily endorsed the lifting of the restrictions. ""I've come, if not full circle, maybe 270 degrees on this," Board member Victor Braren told the meeting. "I think it's time to open it up and see how it goes...I heartily endorse the motion."

Board member Rose Kushner noted that the move to grant NCI the flexibility to loosen the restrictions mirrors the reality of the current use of the system. "Secretaries and technicians are doing the computer work for doctors" with access codes to PDQ, anyway, she said.

NCI has already proposed expanding the system's use to at least one other group — medical students. A proposed pilot study to be conducted at 20 medical schools will familiarize medical students with the computerized cancer information system through the introduction of PDQ into the medical school curriculum, Hubbard said.

While NCI does not plan to allow patient access to the information system, its PDQ editorial board will consider a suggestion by Board member William Powers to make the system more useful to lay people by putting cancer information in a lay person's language. "We would be able to honor that request by expanding the capsule summaries" in the system, Hubbard told Powers, adding that she would bring the suggestion to the editorial board's attention.

NIH STARTS "MERIT," "FIRST" AWARDS FOR TOP SCIENTISTS, NEW GRANTEES

NIH has established a new Merit award similar to NCI's Outstanding Investigator award. Under the new mechanism, NCI staff may extend an investigator's three or five year RO1 grant if they believe the investigator is doing outstanding work. After consulting with the National Cancer Advisory Board, NCI can extend the investigator's grant for three to five years without further review or the need for the investigator to apply for additional funding.

In addition to NCI staff, NCAB members may make recommendations for the Merit awards. NCI is accepting recommendations for the awards, Director Vincent DeVita told the NCAB Monday.

DeVita also announced the approval of NIH's new FIRST (first independent research support and transition) award for new investigators. The award replaces its new investigator research awards (R-23).

NIH plans to activate the new award as soon as possible, and hopes that the first application due date for the new award will be June 1. An article describing the new award in the Nov. 8 Cancer Letter gave the incorrect impression that the award mechanism had already reached final approval in the NIH and HHS structure.

The five year award is intended for researchers who have never previously had an NIH grant.

NCI Faces Massive Budget Cuts
(Continued from page 1)

wiped out. While Congress has saved the Cancer Program from the budget cutters in the past, it's a different ball game this year.

The budget, which went to Congress Wednesday, represents the third in a series of reductions which have hit NCI, NIH and many other agencies since GRH implementation. So far, the Administration (White House and its Office of Management & Budget) has pretty much had its own way in determining which cuts would be made. With the release of the President's FY 1987 budget, the distribution of the GRH 1986 cuts was revealed, along with still another cut in the form of a rescision which, for NCI, is limited to ROIs and PO1s. That rescision will have to be approved by Congress before it can be imposed, but the GRH mandated cuts in the 1986 budget are now a fact.

The budget as it was released (see tables) does not include about $35 million originally listed as part of NCI's $1.258 billion as appropriated by Congress for FY 1986. Those items include more than $28 million for AIDS research, some administrative costs and the $4.5 million earmarked for the Mary Babb Randolph Cancer Center construction at West Virginia Univ. Since the West Virginia money was ordered by Congress to be awarded regardless of peer review, HHS determined it would come directly from the Secretary's office, and NCI's peer review process will not be compromised. In the Senate committee report on the appropriations bill, it was clearly stated that further awards to the center would have to go through normal peer review.

The $1.58 billion in the President's FY 1987 budget may be compared with $1.231 billion as appropriated by Congress for 1986, a real reduction of $73 million. The cut may not seem quite so steep when the 1987 request is compared with the GRH-revised budget, although it hurts just as much. The GRH cut of $54 million, the previously reported 4.3% reduction, leaves NCI with $1.177 billion, just $19 million more than the FY 1987 request. Take off another $6.8 million in the rescision request for 1986, and the difference seems negligible in a billion dollar budget.

Overall, of course, the cuts are massive and will be severely disruptive in progress against cancer, if Congress lets the White House get away with it.

NCI and NIH executives have always said, when faced with budget cuts in the past and under the anti-budget busting orders from OMB, that come what may, "we'll always protect basic research."

This time, if they say it at all, no one will believe them. Here's the picture for funds allocated for RO1s and PO1s, this year and in the 1987 budget:

In the congressional appropriation for 1986,

BUDGET MECHA

Dollars in

	1985 Comp Actual Obligations	
Research Projects	$507,463	$
Cancer Centers	84,957	
Other Research:		
Resrch career programs	6,799	
Organ Sites	935	
Clin. Education Program	3,963	
Coop. Clinical Research	50,822	
Minority Biomed. Support	3,373	
Other Research Related	3,679	
Subtotal, Other Research	69,571	
Total, Research Grants	661,991	
National Research Service Awards	30,797	
Research & Dev Contracts	143,142	
Intramural Research	200,959	
Res Mngmnt & Support	56,518	
Cancer Prev & Control	63,794	
Construction	6,535	
Total, NCI	**1,163,736**	1,

ISM SUMMARY

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1986 Approp-riation	86 Avail. After Se-questra-tion (GRH)	1986 Revised (After Rescision	1987 Pres Budget
31,438	$556,581	549,781	537,134
35,823	82,132	82,132	82,282
6,907	6,610	6,610	6,907
1,000	957	957	800
4,700	4,498	4,498	2,400
50,204	48,045	48,045	49,884
3,400	3,254	3,254	3,400
3,[illegible]0	3,292	3,292	3,161
59,651	66,656	66,656	66,552
36,912	705,369	698,569	685,968
30,838	29,512	29,512	28,610
41,506	135,532	135,532	133,960
94,847	185,361	185,361	190,291
59,829	57,256	57,256	58,129
53,878	61,131	61,131	61,131
3,200	3,114	3,114	0
81,010	**1,177,275**	**1,170,475**	**1,158,089**

NCI research projects were to get $581.4 million. The GRH reduction sliced that by $15 million, the biggest dollar cut for any NCI mechanism, to $556.6 million. Then, the proposed rescision chopped off another $6.8 million, leaving research projects with $549.8 million. And finally, the 1987 proposal would cut still another $12.7 million from the mechanisms which support most of NCI's investigator initiated basic research.

That is a reduction of $44.3 million. When the fact that the original appropriation, before the cuts, would fund only about one third or less of approved competing grants, and that the priority score payline would be in the low 170s, the seriousness of the threat to basic research becomes apparent.

The situation is still too unsettled to make an accurate determination of paylines, but here is what it looks like at the moment:

If the rescision is not allowed, the payline would be between 160 and 170. However, since NIH must fund the 6,100 grants as decreed by Congress, the GRH reduction is forcing all NIH institutes to negotiate budget reductions from the peer review approved levels.

If the rescision is approved by Congress, NCI will effect the $6.8 million reduction by cutting about 70 grants from the number of new and competing renewals it had expected to fund. The payline would be driven down into the 150s.

If the 1987 budget request stands as submitted, the payline then would be between 150 and 160.

OMB included 1985 fiscal year spending in the budget documents, and it shows a 5.8% increase for research projects in 1987 over 1985. That probably will be held out to the scientific community as evidence that basic research really is being adequately supported.

Cancer centers go down about $3.5 million, and cooperative clinical research drops $2 million in 1986 from the appropriated levels, but clinical research goes back up $1.8 million in the 1987 budget. Cancer control loses $2.7 million all the way across.

Intramural research absorbed the second biggest dollar loss due to GRH, $9.5 million, more than $15 million under the 1985 level. It would go back up $5 million in the President's 1987 budget.

Contracts continue the long downward trend, from $143 million in 1985 to $134 million in 1987.

Construction, long the favorite whipping boy of the White House, would cease to exist under the President's budget. It is the first time since the program started in 1972 that no money has been requested. The $3 million shown in the 1986 columns includes about $2 million earmarked for the St. George, Utah, screening center.

NCI TO SUPPORT ROSENBERG PROTOCOL AT SIX INSTITUTIONS; UPDATE GIVEN

NCI has awarded cooperative agreements to six institutions for the support of clinical trials using the lymphokine activated killer cells-interleukin-2 protocol developed by Steven Rosenberg. Awards are for one year, with each group expected to enter at least 50 patients into the study.

Cetus Corp. will provide at no charge the recombinant IL-2 required for the trials, which are expected to start within two months.

The six institutions, PI and award total for each:

New England Medical Center, David Parkinson, $556,160; Montefiore Medical Center/Albert Einstein College of Medicine, Peter Wiernik, $442,506; Loyola Univ. Medical Center, Richard Fisher, $420,682; Univ. of Texas Health Science Center (San Antonio)/Audie Murphy VA Hospital, Charles Coltman, $407,096; Univ. of California (San Francisco) Cancer Research Institute, Anthony Rayner, $495,378; and City of Hope National Medical Center, James Doroshow, $550,727.

The study will be limited to patients with advanced melanoma, colon and kidney cancers. NCI Director Vincent DeVita told the National Cancer Advisory Board Monday that results from 41 additional patients receiving the therapy at NCI indicates that "not every kind of cancer responds." Of the 41 (which are in addition to the 25 reported by Rosenberg in his "New England Journal" article published in December), there were six responses from all six patients with renal cell cancer; five responses from 10 melanoma patients; three responses out of 14 with colorectal cancer. There were no responses from five patients with sarcomas nor from one patient each with esophageal cancer, stomach cancer and large cell lymphoma.

RFA 86-CA-03
Title: Prevention clinical trials utilizing intermediate endpoints and their modulation by chemopreventive agents
Application receipt date: April 11

The Div. of Cancer Prevention & Control invites applications for cooperative agreements to support clinical trials which are directed toward examining the role of various chemopreventive trials which utilize biochemical and biological markers to identify populations at risk and/or to provide intermediate endpoints that may predict later reduction in cancer incidence rates.

These studies should be developed in phases, including a pilot phase, which could later proceed to a full scale intervention. The main emphasis should be on small, efficient studies aimed at improving future research designs of chemoprevention trials, providing biologic understanding of what is happening in the trials, or providing better, more quantitative and more efficient endpoints for these trials. After successful completion of the pilot phase (i.e., demonstrated modulation of marker endpoints by the intervention), subsequent studies will include monitoring test system and a cancer incidence or mortality endpoint may be implemented.

Investigators may apply at this time for the pilot phase, or submit an application for both phases. However, if the application is for the pilot phase only, the proposed study must be relevant to a clinical application and utilize a chemopreventive agent, marker test system, and study population which could later be the subject of a full scale, double blind, randomized, risk reduction clinical trial.

Applicants funded under this RFA will be supported through the cooperative agreement mechanism. An assistance relationship will exist between NCI and the awardees to accomplish the purpose of the activity. The recipients will have primary responsibility for the development and conduct of the research. Programmatic involvement by the government will be in the form of (1) NCI assistance with FDA in securing investigational new drug applicatons, if required; (2) safety toxicity review; (3) safety monitoring in cases when NCI is the IND sponsor; and (5) review of clinical laboratory quality assurance activities in the assay of collected sera if necessary.

The concept from which this RFA was derived was approved by the DCPC Board of Scientific Counselors last fall and reported in The Cancer Letter, Sept. 27, page 1.

Copies of the complete RFA and additional information may be obtained from Mary Ann Sestili PhD, Chemoprevention Branch, Blair Bldg Rm 616, NCI, Bethesda, MD. 20892, phone 301-427-8680.

PROGRAM ANNOUNCEMENT
Title: Interactions among micronutrients in the prevention of experimental mammary cancer
Application receipt dates: June 1, Oct. 1, Feb. 1

The Div. of Cancer Prevention & Control through the Organ Systems Program (breast cancer) seeks applications for studies to evaluate the interactions of micronutrients that have been observed to inhibit mammary tumorigenesis. The aim would be to define a unique set or multiple sets of micronutrients that inhibit mammary carcinogenesis to a greater extent than do the individual nutrients alone. The hypothesis to be tested is that "the preventive effect of low doses of two or more micronutrients in combination is greater than the effect of high doses of the same nutrients given singly."

Evidence from experimental carcinogenesis in animal models indicates that a diet supplemented with large doses of single micronutrients, such as specific vitamins, antioxidants, or trace elements, can inhibit both viral and chemical carcinogen induced mammary cancer. Most promising of those explored thus far appear to be selenium and retinoids, and others are open to exploration; in addition, certain phenolic antioxidants used as food

additives have been observed to have favorable chemopreventive effects. It is now timely to examine the concept that low doses of several such micronutrients used together may be more effective and desirable than high doses of single micronutrients. Experiments thus far on using two or more factors together have been relatively few, but results are strongly suggestive of synergistic effects. Vitamin E has been found to be synergistic with selenium at levels of vitamin E which, alone, are not inhibitory.

The project would have the ultimate aim of defining one or more sets of two to five micronutrients which, when given together, significantly reduce or block experimental mammary tumorigenesis in animal model systems over an extended period of time (>1 year). Good animal models exist for both viral and chemical mammary tumorigenesis, and any of these are feasible and appropriate test systems for this study. Particular program interest in this area addresses such questions as:

*Which micronutrients are most promising, what range of levels for each achieves maximum preventive effects in combinations with others, and, from comparison with the preventive effects of these nutrients administered singly at comparable levels, whether interactions are additive, synergistic, or possibly antagonistic.

*For each nutrient, how levels that give maximum preventive effect compare with the minimum toxic level, and whether there are any toxicity potentiations among the nutrients.

*What regimen of micronutrient administration (route, timings, duration, etc.) in relation to exposure to the carcinogenic agent, is needed to maximize preventive effects, and whether any particular regimen nullifies such effects; further, whether the optimal regimen is the same for all nutrients in the combination.

*Whether there are further interactions of micronutrients with hormonal factors in mammary tumorigenesis and any prevention synergisms with the hormones or antihormones to which mammary tissue and tumors respond.

*Whether the micronutrients tested exert preventive effects by similar or by quite different mechanisms of action (effects on carcinogen metabolism, DNA repair or other specific enzymatic processes, hormonal intracellular action, immune response, to name some that have been postulated, or others). Understanding of the mechanisms of action of many micronutrients is at present minimal, and studies that go beyond the necessary, systematic data collection to probe the mechanism of action and of interaction are particularly invited.

*Interactions with level or type of dietary fat could also be explored; in any case, level and type of fat should be controlled as an important and potentially confounding variable.

Support for this program will be through the traditional research grant. Policies that govern research grant programs of NIH will prevail.

Applications in response to this announcement will be reviewed in accordance with the usual PHS peer review procedures for research grants. Review criteria include the significance and originality of the research goals and approaches; feasibility of the research and adequacy of the experimental design; training, experience, research competence, and dedication of the investigators; adequacy of available facilities; provision for the humane care of animals; and appropriateness of the requested budget relative to the work proposed. Following study section review, the application will be evaluated for program relevance by the Organ Systems Program of DCPC. Funding decisions will be based on the initial review group and National Cancer Advisory Board recommendations, program relevance, and availability of appropriate funds.

To alert the Organ Systems Program to submission of applications, copies of the face and summary pages should be sent to Dr. Elizabeth Anderson, Breast Cancer, Organ Systems Section, DCPC, Blair Bldg Rm 717, NCI, Bethesda, MD. 20892, phone 301-427-8818. The original and six copies of the application should be sent to Grant Application Receipt Office, Div. of Research Grants, NIH, Westwood Bldg Rm 240, Bethesda, MD, 20892.

The concept from which this program announcement was derived was approved by the DCPC Board of Scientific Counselors last September and reported in The Cancer Letter, Sept. 27, page 4.

Title: Surgical oncology research training grants
Application receipt dates: Sept. 10, Jan. 10, May 10

The surgeon's role in cancer research and treatment necessitates familiarity with the principles of clinical trials methodology, medical oncology, radiation oncology and preventive oncology. Furthermore, the nature of the surgeon's task and the increasing sophistication in cancer research and treatment has created the need for flexibility in the preparation of those seeking careers in academic surgery.

Recognizing this need, an adaptable National Research Service Award surgical oncology research training grant opportunity has been developed cooperatively with the Div. of Cancer Treatment and the Div. of Cancer Prevention & Control. These grants will be awarded and administered by the Cancer Training Branch of DCPC. They will fund programs for long term research training in either basic or applied research. Also, they can provide didactic opportunities for the research trainees in the general principles of clinical research, medical oncology, radiation oncology, and preventive oncology. It is important that attention be given to recruiting individuals from minority groups that are underrepresented in the biomedical sciences. Grants will be made to successfully competing institutions for a renewable project period of up to five years. The review criteria are the usual ones for any NRSA T32 (institutional) research training grant. The initial review of this applications will be performed by the Cancer Research Manpower Review Committee which reviews all T32 applications assigned to NCI. Secondary review will be by the National Cancer Advisory Board.

An applicant institution should propose a program

in accordance with one of these possible training plans:

1. Two years of research training, which should entail two full years of research by trainees and which may include patient care activities required to maintain the trainee's surgical proficiency. In no case may this activity require more than 20% of the trainee's time.

2. Three years of research training shaped in accordance with the guidelines in Plan 1, or two years of research coupled with one year of instruction in medical oncology, radiation oncology, preventive oncology, clinical trials methodology, epidemiology and biostatistics.

3. Four or five years of research training for each trainee divided into two parts. Part 1 would be one to two years long and would be offered between the first and second, or the second and third years of the regular surgical residency program. This one or two year period would provide full time research training at the bench. Part 2 should be scheduled after specialty training is complete. It would be three years long, with two years devoted to bench research training. This should be constructed so that the trainee will have an integrated training experience over the four years devoted to bench research training. That is, the research training undertaken in Part 2 of this plan should be an extension of that experienced in Part 1, or should at least be clearly related to it. A trainee could elect to take Part 1, Part 2, or both parts of this training plan.

The three year limit placed on an individual's postdoctoral research training by NRSA is waivable on sufficient justification. NIH policy favors approval of such requests from physicians who require more than three years to prepare for academic careers.

Where the terms "full year of research" or "full time research" are used, this does not prohibit the trainee from performing a nominal amount of surgery to maintain surgical proficiency.

Other requirements of the program include:

--In depth research training in a cancer related investigation. Any science relevant to cancer is acceptable.

--One hundred percent of the trainee's time will be devoted to research training.

--While it is not the primary purpose of this program to enable a trainee to earn a master's or doctor's degree, she/he may matriculate in a degree granting program incidental to the training.

--Research preceptors must be qualified to train researchers. This means they must have significant publication records and hold peer reviewed research grants, preferably from NIH.

--Up to one year of educational activities is suggested. These activities should consist of training and education in medical oncology, radiation oncology, preventive oncology, clinical trials methodology, epidemiology and biostatistics.

--Two years of bench research training under a qualified preceptor.

--Trainees may participate in a reasonable amount of teaching and related activities provided they spend at least 40 hours per week on the research training grant, and provided further that such other activities do not detract from the quality of the training.

Applications should be sent to the Referral Office, Grants Review Branch, Div. of Extramural Activities, NCI, Westwood Bldg Rm 826, Bethesda, MD. 20892. Questions may be directed to Program Director, Cancer Training Branch, DCPC, NCI, Blair Bldg Rm 424, Bethesda 20892, phone 301-427-8898.

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-CP-61011-13
Title: Continuation of followup on participants in the Breast Cancer Detection Demonstration Project
Deadline: Approximately March 10

The Div. of Cancer Etiology and the Div. of Cancer Prevention & Control are jointly soliciting proposals from qualified organizations to provide the necessary resources to conduct biyearly followup activities among a cohort of approximately 61,000 former participants in the Breast Cancer Detection Demonstration Project. These activities were previously conducted by 28 screening centers. The proposed contract will coordinate activites from one central location. Data previously collected will be provided to the successful offeror.

The contractor shall perform the following tasks:

1. Tracing vital status of study subjects. 2. Information collection. 3. Obtaining copies of pathology reports and death certificates. 4. Preparation of data for keypunching. 5. Producing computer files. 6. Developing a ready access system for clinical information.

Contract Specialist: Sharon Miller
RCB Blair Bldg Rm 114
301-427-8888

The Cancer Letter _Editor Jerry D. Boyd Associate Editor Patricia Williams
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