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Breast Cancer Low Fat Investigators To Seek RO1 Funds For New Compliance, Biochemical Studies

Investigators involved in the terminated Stage 2 Breast Cancer Low Fat trial will submit an application to NIH for an RO1 grant June 1 in an effort to conduct a two year trial

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In Brief

Moertel To Deliver Karnofsky Lecture; Hopkins, Cold Spring Harbor Receive Bristol-Myers Awards

CHARLES MOERTEL, chairman of the North Central Cancer Treatment Group and former director of the Mayo Comprehensive Cancer Center, will deliver the 17th annual David A. Karonofsky Memorial Lecture May 5 at the 22nd annual meeting of the American Society of Clinical Oncology in Los Angeles. The lecture is titled, "Therapeutic Odyssey in the Land of Small Tumors." It will follow the presidential address by ASCO President John Durant. . . . **BRISTOL-MYERS** has announced two more $500,000 awards in its program of unrestricted grants for cancer research: Cold Spring Harbor Laboratory and, for the second time, Johns Hopkins Univ. Oncology Center. Each will receive $100,000 a year for five years. Albert Owens, Hopkins Oncology Center director who will administer the grant, said it would be used to develop a more comprehensive program in breast cancer biology and treatment. Cold Spring Harbor Director James Watson will administer that grant, which will help support the basic research there. . . . **CORRECTION**: The phone number listed in the April 4 issue of **The Cancer Letter** for Gayle Boyd, program director for prevention and cessation of use of smokeless tobacco grants, was incorrect. The correct number is 301-427-8620. . . . **RICHARD O'REILLY**, chief of the Bone Marrow Transplantation Service and head of the Laboratory of Bone Marrow Transplantation Research at Memorial Sloan-Kettering Cancer Center, has been named chairman of the Dept. of Pediatrics there. . . . **JOHN GRIFFITH**, chairman of pediatrics and professor of neurology at the Univ. of Tennessee (Memphis) Health Science Center, has been appointed executive vice president for health sciences and director of the Georgetown Univ. Medical Center. He replaces Matthew McNulty, who retired earlier this year. . . . **JAMES MORRE**, director of the Purdue Cancer Center, has been named the first Dow Distinguished Professor of Medicinal Chemistry there.

Delays And Insufficient Accrual Led To Termination Of Feasibility Study

(Continued from page 1)
that will study compliance and the effects of a low fat diet on biochemical parameters such as hormones and lipids, Ernst Wynder, the principal investigator of the terminated trial, told **The Cancer Letter.** The American Health Foundation, which Wynder heads, the original trial's statistical and nutrition center, and six of the eight clinical centers involved in the original trial, will compete for RO1 funds for the trial.

The original trial was terminated at the end of February due to insufficient accrual of patients. That trial was to test the hypothesis that cutting fat intake in half would reduce the recurrence of breast cancer in 250 women with Stage 2 breast cancer. The feasibility study was delayed several months because of controversy over whether patients should be given chemotherapy until after NIH's consensus conference on adjuvant therapy for breast cancer last fall (**The Cancer Letter,** Feb. 14). The National Cancer Advisory Board voted in February to "keep alive" the concept behind the institute's low fat adjuvant trial for Stage 2 breast cancer even if the study were terminated. The unanimously approved recommendation states that "the concept that reducing fat calories in an attempt to reduce recurrence rates in breast cancer is a valid one, disregarding the problems the trial has encountered."

Asked about the possibility of expanding the proposed two year trial in the future, Wynder said, "As we see how diet works in both instances, we hope to extend it. We have to go through the first phase" of assessing diet effects on biochemical parameters.

If the study is approved for funding, Wynder and his colleagues plan to accrue 300 women into the trial. Accrual will be possible for both women on chemotherapy and those receiving tamoxifen, he said.

NCI's related breast cancer low fat prevention trial entitled the Women's Health Trial has not had a problem in patient accrual. After completion of its feasibility study, a report calling for implementation of a greatly expanded trial that could cost more than $100 million over 10 years was endorsed by the NCAB, NCI's Executive Committee and the Div. of Cancer Prevention & Control's Board of Scientific Counselors.

Transrectal Ultrasound Can Be Used As Prostate Cancer Screening Tool

Transrectal ultrasound can provide an accurate measure of tumor presence and size, and could be used in screening asymptomatic patients for prostate cancer, Fred Lee, an instructor of radiology at the Univ. of Michigan in Ann Arbor, told a press conference at the annual meeting of the American Roentgen Ray Society in Washington.

While the technology has been around since the early 1970s, Lee said that past work with the procedure demonstrated a high sensitivity but low specificity. Physicians previously thought that prostate cancer produced a white image upon ultrasound, but Lee and his colleagues have discovered that small sized "curable cancer is in fact black, the total opposite of what it was" believed to be before.

In a series of 360 patients examined by transrectal ultrasound, eight cancers and two precancers were found. The cost per cancer found is approximately $6,000, comparable to the cost of digital examination, he said.

"We found our detection rate is so much higher, actually double, than the finger" exam, he said. "I think by using ultrasound, we can detect a curable cancer."

Lee, who has been diagnosed with incurable prostate cancer himself, hopes that the technique "will become so prevalent that many patients throughout the country will be urging" their physicians to perform the test.

There is currently a waiting list of more than 300 men from the Detroit and Ann Arbor area who have requested the examination, he said. The procedure is done on a strictly outpatient basis, and up to four exams can be performed an hour. If an abnormality is detected, a needle biopsy can be performed at the same sitting, he said, emphasizing the cost effectiveness of the biopsy procedure. Currently about 90% of traditional prostate biopsies are done in the operating room at a cost of between $2,000 and $2,500, he said. The outpatient ultrasound needle biopsy technique costs approximately $500 and is not very uncomfortable.

In addition to its higher detection rate than the finger exam, ultrasound is able to detect tumors under 1 cm in size, meaning a more favorable prognosis for and greater chance for cure in those patients, he said. The smallest cancer found by the exam so far was 3 mm. "We would like to find it before it

reaches 10 mm. We've got to find it somewhere between 10 and 15 mm of size in order to offer men a potential cure."

Past studies have indicated that 85% of patients who present with prostate cancer have already metastasized. "Now a urologist can say "your cancer is so small I don't know what to do with it."

He noted that the technique is not widely used in the U.S. Transrectal ultrasound machines are in place at 15 centers in Michigan, and about 50 in the U.S. as a whole.

Lee predicts that the technique will become a standard screening procedure such as mammography for breast cancer.

"We need a multicenter national study," Lee said. He plans to submit a paper for publication on the first 400 men examined by the procedure, and if similar results are found with a study currently underway of 1,200 men, he will apply for NCI funding.

Lee thinks that eventually the technique could be used in order to perform a sort of "lumpectomy" by the use of a needle and laser or cryosurgery in an effort to spare prostatic nerves and sexual function. A method for the implantation of radioactive seeds with ultrasound has been devised by Danish physician Dr. Holm. Another area being explored is the cytological examination of cells obtained by needle biopsy with ultrasound.

A two day international symposium on prostate cancer and transrectal ultrasound will be held Sept. 11-12 at the Renaissance Center in Detroit. For more information, contact Dr. Fred Lee, St. Joseph Mercy Hospital, Ann Arbor 48106.

In the paper presented at the conference, Lee discussed 565 transrectal ultrasounds, of which 64 were proven cancers. Of the 64 cancers, 13 were less than 1.5 cm in diameter, with three being less than 1 cm. "Since 1 cm. is the critical size for carcinoma of the prostate before extra-capsular spread, these 13 cancers diagnosed by transrectal ultrasound are potentially curable," he reported. "Since cancer can now be reliably recognized, accurate staging can be performed."

In 19 whole prostates obtained following autopsy or surgery that were also studied by ultrasound, six of eight cancers were detected by ultrasound.

Discussing the use of CT in staging carcinoma of the prostate, Joel Platt of Detroit's William Beaumont Hospital System told the meeting that transrectal ultrasound or magnetic resonance imaging may prove useful screening tools in the future for prostate cancer. Platt said that CT scanning for prostate cancer should not play a major role in staging nor should it be used to influence decisions on surgical therapy for prostate cancer.

An evaluation by CT of 32 patients with biopsy proven cancer of the prostate found that CT had a sensitivity for prediction of stages C or D of 50%, a specificity for predicting stages A and B of 70%, and an overall accuracy of 66%. Interpretation errors were due to the inability to detect lymph node metastases, errors in evaluating the seminal vesicles, and errors in interpreting densities surrounding the prostate gland.

Two View Mammography Less Costly Than One In Screening

Baseline screening mammography done with two views per breast is actually less expensive than initial screening with one view, Edward Sickles told the annual meeting of the American Roentgen Ray Society in Washington. The two view method is more cost effective because it results in a fewer number of call backs for abnormalities detected.

Although the one view per breast method is reported to miss 5% to 10% of small cancers that would be found in a two view screening, proponents of the one view per breast screening have maintained that the procedure is more cost efficient and could enable the screening of a greater number of women than the two view procedure.

A study of 2,500 asymptomatic women conducted by Sickles at the Univ. of California (San Francisco), however, demonstrated that that is not the case, he reported.

In the study, all patients had two views taken per breast in craniocaudal and mediolateral oblique projections. Sickles made two separate interpretations of each case, one using both views, the other using only the oblique image. The examinations were randomly evaluated by Sickles, with a minimum of two months between one and two view interpretations.

The screening for all patients used an interpretive strategy of simply detecting

unsuspected lesions rather than fully characterizing them. All abnormalities required additional mammographic images.

The number of abnormal interpretations with one view was more than three times greater than in the two view examinations. Of the 2,500 women screened, 26% (642) of the one view exams were abnormal as compared to only 7% (179) of the two view exams. The number of biopsies generated in the two view group was higher (83 versus 76) than in the one view group because the two view exam was able to detect lesions not found on the oblique view alone.

The number of detected cancers was also higher (27 versus 25) with the two view exam than with one view. Sickles advised that the recommendation for two view mammography is for initial baseline screening and that when baseline exams are available for comparison, the approach may not be required.

Radiology Adovacted As First Diagnostic Test After Hemoccult

Double contrast colon examination should be the initial diagnostic test performed on hemoccult positive patients, to be supplemented in select patients by flexible sigmoidoscopy or colonoscopy, Robert Halpert told the American Roentgen Society.

Discussing the results of 98 patients evaluated at the Henry Ford Hospital in Detroit as part of a regional screening program, Halpert said DCBE had a high degree of accuracy comparable to endoscopic studies. The exam detected all carcinomas and 92% of polyps in the patients, who also had proctosigmoidoscopies performed. The technique, however, does have "some limitations in patients with severe diverticulosis," he reported. Overall, DCBE found 37 polyps in 21 patients. The exam missed three polyps, two that were 1.5 cm in size, and the third 8 mm. All of the missed polyps were in an area of diverticular disease. "It is clear that fiber optic endoscopy is recommended " in patients with large severe diverticular disease, he said. Six carcinomas were identified, 6% of patients examined.

"Analysis of our study does show that double contrast colon examination has a high degree of accuracy, most comparable to endoscopic studies."

Halper also reported that DCBE was the most cost effective procedure for screening the hemoccult positive patients. The cost per cancer detected was $3,920, and $692 per polyp detected. The cost of each cancer detected by colonoscopy was $12,250, and $1,986 per polyp. Colonoscopy "dramatically increased screening costs, and there was no evidence to support its use in all hemoccult positive patients.

"To examine all of these patients by colonoscopy, it would have cost almost $10,000 more per cancer discovered by colonoscopy as compared to cancer discovered by double contrast colon exam."

While proctoscopy had a cost per cancer detected that was the same as the DCBE, $3,920, the cost per polyp detected was nearly three times higher, $1,960 per polyp. "Rigid proctoscopy was extremely limited," he said, advising that flexible sigmoidoscopy is recommended instead. Upper gastrointestinal tract evaluation "had a very small yield and is not routinely warranted," he said.

"It would seem practical that the initial study for quantifying hemmocult positive patients should be the double contrast colon exam. This would give an overall survey of colon disease and would be most cost effective. A good proportion of our patients, particularly the younger ones, had no further evaluation necessary. The double contrast colon exam would identify a substantial amount of pathology and direct the initiation of what further procedures need to be done. This would streamline the diagnostic pathway, and thus [reduce] costs."

New Publications

"Dianon Systems tumor-marker bibliography," free. Update of a bibliography of recent research papers on 11 major circulating tumor markers. Markers included are alpha-fetoprotein (AFP), beta-human chorionic gonadotropin (bHCG), the double monoclonal antibody (115D8/DF3) system CA 15-3, cancer antigen 125 (CA 125), carbohydrate antigen 19-9 (CA 19-9), carcinoembryonic antigen (CEA), neutron-specific enolase (NSE), lipid-associated sialic acid (LSA, assayed with the firm's LASA-p test), prostate-specific antigen (PSA), and prostatic acid phosphatase (PAP), and the squamous cell carcinoma (SCC) TA-4 antigen. The 210 citation bibliography is organized by primary tumor site. Dianon Systems, Inc., 555 Lordship Blvd., Stratford, Conn. 06497, phone (800)328-2666.

"How to Raise Money for Your Hospice," Health Resources Publishing, P.O. Box 1442,

Wall Township. N.J. 07719, phone 201-681-1133. Price $19, and $2 shipping.

"Opiod Analgesics In The Management of Clinical Pain," edited by Kathleen Foley and Charles Inturrisi, $85. Raven Press, 1140 Avenue of The Americas, New York, N.Y. 10036, phone 212-575-0335.

The following publications are available from Thieme-Stratton, 381 Park Ave. South, New York, N.Y. 10016, phone 212-683-9757:

"Principles and Management of Testicular Cancer," by Nasser Javadpour, director of urologic oncology at the Univ. of Maryland (Baltimore). U.S. price $75. Outside the U.S. $90.

"Surgery of the Breast, Diagnosis and Treatment of Breast Diseases," by Jan Olaf Strombeck and Francis Rosata. U.S. price $98. Outside the U.S. $118.

Advantages, Disadvantages Listed For Proposed Clinical Trials Options

The Cancer Therapy Evaluation Program of NCI's Div. of Cancer Treatment presented five options for changes in the makeup of the clinical cooperative groups, ranging from keeping the present structure intact with some modifications to a complete reorganization by function, disease groups or regional groups (**The Cancer Letter**, April 11 and 18). Included in the options were the "radical" (as felt by many) suggestions that institutional grants be replaced by subcontracts from groups to members and that groups be permitted to recruit individuals for specific studies.

Not surprisingly, cooperative group representatives and others involved in NCI supported extramural clinical trials were extremely reluctant to accept major changes in the group structure. A large majority attending the meeting at which the proposals were presented preferred retention of the present system, although acknowledging that some "fine tuning" would have to be done. A few favored reorganization by disease or disease group.

Here's how CTEP described the advantages and disadvantages of each option:

Option 1--Conservation of the present structure with modifications. Groups approved by peer review with fundable priority scores would continue. Research focus and agenda could be expanded or contracted as needed.

Advantages--It would be the least revolutionary change; it clearly maintains the identity of groups that are proud of their long history of accomplishment and with which many productive investigators identify very closely; it would maintain an element of competition.

Disadvantages--The present collection of groups is a result of evolution over the past three decades and not necessarily of the need at any given time; it is not clear that the needed reforms will be as easy with present system as with a modified one; new needs may well require the creation of new groups; groups of national scope maximize certain kinds of costs (e.g., travel).

Option 2--One enormous group that can do everything.

CTEP thought so little of this idea that it did not prepare any list of advantages or disadvantages.

Option 3--Reorganize by function. This was split into two suboptions, 3 (a) and 3 (b).

3 (a)--One group for each broad class of clinical problems--pediatrics, adult surgical and surgical adjuvant, adult solid tumor advanced disease, adult hematology, adult radiotherapy.

Advantages--Considerable economies of scale for NCI; little overlap.

Disadvantages--Each group would be monopoly, which CTEP Director Robert Wittes said would be "an overwhelming disadvantage;" the whole national effort in a particular area would depend on the activities of one group; it would accommodate the fewest people in positions of authority ("There are too many good people to squeeze into five groups," Wittes said); the large size of the individual groups would make them difficult to manage.

3 (b)--Two groups for most classes of clinical problems (same groups as listed above, but two of each).

Advantages--Groups would be of manageable size; competition would exist; more positions for intellectual leadership would be available; there would be better possibilities for the surgical subspecialties to develop greater identification with and participation in multicenter trials; they would be more nearly homologous to what the structure of the present group system will likely be after the current review cycle.

Disadvantages--Some economies of scale are lost compared with 3 (a); some of the separations implicit in this arrangement are arbitrary and perhaps not entirely healthy (e.g., solid tumor from hematology, surgical

adjuvant from solid tumor advanced disease); it would require a single individual with multiple interests to affiliate with several organizations, which could be more of a problem for members of group committees than for those whose principal role is accrual of cases.

Option 4--Reorganize by disease or disease group. The result would look like an expanded version of the disease oriented segment of the present cooperative group system, e.g., thoracic, head and neck, GI, GU, breast, hematology, melanoma/sarcoma, neuro-oncology, gynecology, pediatrics.

Advantages--Covers the entire spectrum of diseases; provides coherence of research agenda within groups; assures multimodal representation and required expertise; assures access to relevant patient populations, including many high risk ones.

Disadvantages--It is not clear that scientific priorities require all possible groups to exist at all times, or at least need to operate at a uniform level of intensity; there would be little competition, with the entire national effort in a particular area in the hands of one organization; it would be an inefficient organization for modality oriented developments, such as biologicals, with the need to recreate the same research structure in all groups simultaneously; each of these groups would probably be national in scope, which maximizes certain costs; individuals would have to join several groups at once; it is likely that certain individuals would be overextended by being involved in committees of multiple groups.

Option 5--Reorganize by geographical region. Targeted regions could be either a few mega ones (e.g., SW, SE, NW, NE, NC, SC) or a larger number that has some geographical identity. Pediatrics and developmental radiotherapy would remain national.

Advantages--Geographical cohesion might make intragroup interactions more effective; travel costs would be minimized; community physicians might be more likely to identify with regional organizations than with national ones (Wittes said that is "pretty speculative").

Disadvantages--Scientific critical mass is not always available within a region; it is unlikely (and perhaps undesirable) that each group would be able to cover the spectrum of diseases by itself; considerable intergroup coordination and intergroup studies would have to exist; effective previously established liaisons between institutions do not always respect geographic boundaries; the entire spectrum of disease and modality coverage would have to be recreated in each group.

Adamant opposition from participants at the meeting to the suggestion that institutional grants be abolished appears to have cooled CTEP's enthusiasm for that move.

Wittes acknowledged as much in his summary of the discussion, although he did manage to extract a somewhat grudging agreement, if not a consensus, that per case reimbursement is a viable possibility if used along with institutional grants. They insisted that each group should have flexibility in deciding on how the per case system should work for it.

"The next move is to think about the implications of what was said at the meeting," Wittes said. "It was a wonderful meeting, with a lot of interaction. We got a lot of very useful input. We knew our proposals would have to be heavily modified."

The issue will be discussed with the Div. of Cancer Treatment Board of Scientific Counselors in May, and again with cooperative group chairmen at their next meeting, tentively set for June 30.

No timetable for a final decision on what, if any, changes will be made has been set, but "there is a sense of urgency on our part," Wittes said. Changes will be submitted to the DCT board as well as to the National Cancer Advisory Board.

NCI Advisory Group, Other Cancer Meetings For May, June, Future

5th Annual Endocurietherapy/Hyperthermia Workshop for Physicians--April 29-May 2, Memorial Medical Center, Long Beach, CA. Contact Dr. Khalid Sheikh, Dept. of Radiation Therapy, Memorial Medical Center of Long Beach, 2801 Atlantic Ave., Long Beach 90801, phone 213-595-2929.

Workshop on Cancer Screening and Detection--April 29, Los Angeles. Precongress workshop of the Oncology Nursing Society sponsored by Stuart Pharmaceuticals.

Oncology Nursing Center Stage--April 30-May 3, Los Angeles. 11th annual congress of the Oncology Nursing Society. Contact Nancy Berkowitz, ONS, 3111 Banksville Rd., Suite 200, Pittsburgh, PA 15216, phone 412-344-3899.

American Society of Clinical Oncology--May 4-6, Los Angeles Convention Center. 22nd annual meeting.

American Assn. for Cancer Research--May 7-10, Los Angeles Convention Center. 77th annual meeting.

Current Concepts in Breast Cancer--May 7, New York. Contact Beverly Baptiste, Medical Education, Beth Israel Medical Center, First Ave. at 16th St., New York 10003, phone 212-429-2000.

Div. of Cancer Prevention & Control Board of Scientific Counselors Budget & Evaluation Committee--

May 7, NIH Bldg 31 Rm 2, 7:30 p.m., open.

Div. of Cancer Prevention & Control Board of Scientific Counselors--May 8-9, NIH Bldg 1 Wilson Hall, 8:30 a.m. both days.

Society of Surgical Oncology--May 11-14, J.W. Marriott Hotel, Washington DC. 39th annual Cancer Symposium.

Society for Clinical Trials--May 11-14, Montreal. 7th annual meeting. Contact Genell Knatterud, 600 Wyndhurst Ave., Baltimore, 21210, phone 301-435-4200.

21st Congress of the International Society of Hematology and 19th Congress of the International Society of Blood Transfusion--May 11-16, Sydney, Australia. Contact Congress Secretariat, Box 2609, GPO Sydney, New South Wales, Australia 2001.

Frederick Cancer Research Facility Advisory Committee--May 12, Bdg 426, FCRF, open 8:30-10:15 a.m.

Managing Hospice--May 13-14, Marriott Twin Bridges Hotel, Washington DC. Seminar for hospice executives. Contact Managing Hospice, Brinley Plaza, PO Box 1442, Wall Township, NJ 07719, phone 201-681-1133.

Intraoperative Radiation Therapy--May 15-16, Dana Center for Continuing Education, Toledo. International symposium. Contact CME Office, Medical College of Ohio, C.S. 10008, Toledo, OH 43699.

National Cancer Advisory Board--May 19-21, NIH Bldg 31 Rm 6, 9 a.m. Closed May 20 for grant review. Committee meeting schedules to be announced later.

Integrated Approach to the Management of Pain--May 19-21, NIH Clinical Center. NIH consensus development conference. Contact Peter Murphy, Prospect Associates, 2115 E. Jefferson St., Suite 401, Rockville, MD 20852, phone 301-468-6555.

Hospice 1986: Pain and Symptom Management and Other Care Issues--May 19-23, Madison, CT. Contact Betsy Lewis, Connecticut Hospice Institute, 61 Burban Dr., Branford, CT 06405, phone 203-481-6261.

Gynecologic Oncology--May 20, Minneapolis. Third annual symposium. Contact Audrey Chan, Registrar, Univ. of Minnesota, Box 202 Mayo Bldg, 420 Delaware St. SE, Minneapolis 55455, phone 612-373-8012.

Current Concepts in Radiation Therapy--May 21-23, Minneapolis. Contact Seymour Levitt, MD, Office of Continuing Medical Education, Univ. of Minnesota, Box 202 Mayo Bldg, 420 Delaware St. SE, Minneapolis 55455.

Hormonal Therapy of Prostatic Diseases--May 21-24, Milan. Basic and clinical aspects. Contact M. Motta/M. Serio, Dept. of Endocrinology, Univ. of Milan, 21, Via Andrea del Sarto, 20129 Milan, Italy.

International Society for Experimental Hematology--May 21-23, Buffalo. Contact Michael McGarry PhD, Roswell Park Memorial Institute, Dept. of Health, 666 Elm St., Buffalo, NY 14263.

11th Annual Mental Health Conference--May 22-23, Medical Center Holiday Inn, Houston. M.D. Anderson Dept. of Pediatrics. Contact Office of Conference Services, Box 131, M.D.Anderson Hospital & Tumor Institute, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

American Industrial Health Council Washington Conference--May 22, Hyatt Regency Capitol Hill, Washington DC. Contact Suzanna Paulovkin, AIHC, 1300 Connecticut Ave. Suite 300, Washington DC 20036, phone 202-659-0060.

American Assn. for the Advancement of Science--May 25-30, Philadelphia. 152nd national meeting. Contact AAAS, 1333 H St. NW, Washington DC 20005.

Politics and AIDS--May 28-30, Hilton Hotel at Rockefeller Center, New York. Contact Sherry Chorost, phone 518-473-0641.

GI Tract Cancer: Update on Combined Modality Therapy--May 29-30, Heidelberg, West Germany. EORTC symposium. Contact Dr. P. Schlag, Chirurgische Klinik, Universitat Heidelberg, Im Neuenheimer Feld 110, 6900 Heidelberg, West Germany.

Div. of Cancer Treatment Board of Scientific Counselors--May 29-30, NIH Bldg 31 Rm 6, 8:30 a.m. Closed May 30 8:30-9:30 a.m.

Advances in Cancer Pain Control--May 30-31, Bunts Auditorium, Cleveland Clinic. Contact Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Rm TT3-301, Cleveland 44106, phone (local) 444-5696; (Ohio) 800-762-8172; (elsewhere) 800-762-8173.

National Tumor Registrars Assn.--June 3-6, Park Plaza Hotel, Boston. Annual meeting. Contact Shirley Foret, Eilliot Hospital, 955 Aurburn St., Manchester, NH 03103, phone 603-669-5300 ext. 2147.

Hormonal Manipulation of Cancer: Peptides, Growth Factors and New (Anti)Steroidal Agents--June 4-6, Rotterdam. Contact Trial and Data Dept., Dr. Daniel den Hoed Cancer Center, PO Box 5201, 3008 AE Rotterdam, The Netherlands.

Toxicology Update '86--June 9-11, Turner Bldg, Johns Hopkins Medical Institutions. Contact Program Coordinator, Office of Continuing Education, 720 Rutland Ave., Turner 22, Baltimore 21205.

Normal and Neoplastic Blood Cells: From Genes to Therapy--June 10-13, Rome. Sponsored by Fondazione Internationale Menarini; Istituto Superiore di Sanita; and World Health Organization.

Div. of Cancer Etiology Board of Scientific Counselors--June 12-13, NIH Bldg 31 Rm 10, open June 12 1 p.m.-adjournment and June 13, 9 a.m.-adjournment.

American Conference on Hospice Care--June 14-17, San Francisco. Contact 2nd Annual Conference, Stephen DiTullio, 470 Boston Post Rd., Weston, MA 02193, phone 617-899-2702.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--June 18, NIH Bldg 31 Rm 11A10, open 9-11 a.m.

Society for Oral Oncology and the ACS Cancer Conference for the Dental Profession--June 19-21, Seattle. Contact Ann Pomerinke, ACS Washington Div., PO Box Cl9140, Seattle, WA 98109, phone 206-283-1152.

Supportive Care of the Cancer Patient--June 20-21, Holiday Inn, Pensacola. Physicians seminar. Contact Dolly Partridge, Director of Education, Baptist Hospital, PO Box 17500, Pensacola, FL 32522, phone 904-434-4819.

Assn. of American Cancer Institutes--June 27-29, Hotel del Coronado, San Diego. Annual meeting. Contact La Jolla Cancer Research Foundation, Attn. AACI, 10901 N. Torrey Pines Rd., La Jolla, CA 92037, or phone Sondra Bernhardt, 619-455-6480.

FUTURE MEETINGS

Current and Future Contributions of Chemistry to Health: The New Frontiers--Sept. 22-26 Heidelberg. CHEMRAWN V world conference. Contact Gesellschaft Deutscher Chemiker, Abteilung Tagungen, PO Box 900440, D-6000 Frankfurt am Main, West Germany, or Bryant Rossiter, Research Laboratories, B-83, Eastman Kodak Co., Rochester, NY 14650, phone 716-722-2955.

Breast Issues 1986--Sept. 30-Oct. 3, Denver. Contact Joan Camp, 8200 E. Belleview, Suite 218, Englewood, CO 80111, phone 303-788-6966.

12th Annual Topics in Gastroenterology and Liver Disease--Oct. 9-11, Baltimore. Contact Jeanne Ryan, Office of Continuing Education, Johns Hopkins Univ. School of Medicine, 720 Rutland Ave., Baltimore, Md. 21205.

Oncology Nursing in Transition: Caring, Coping, Costs--Oct. 10-12, Waterville Valley, NH. Contact Lynn Westgate, ACS NH Div., 686 Mast Rd, Manchester, NH 03102, phone (in NH) 800-662-7100; elsewhere, 603-669-3270.

Early Treatment of Breast Cancer--Aug. 1, Denver Marriott West. 40th annual Rocky Mountain Cancer Conference. Contact Jiri Tvrdik, American Cancer Society, Colorado Div., 2255 S. Oneida, Denver 80224, phone 303-758-2030.

New Advances in Internal Medicine: Clinical Applications--Aug. 17-22, Hyatt Regency, Monterey, CA. Includes sessions on cancer chemotherapy, hematology/oncology, endocrinology and gastroenterology along with other fields of internal medicine. Contact Office of Continuing Education, Univ. of California (Davis), 2701 Stockton Blvd., Sacramento 95817.

Radiation Research Society--Feb. 22-26, 1987, Westin Peachtree Plaza, Atlanta. 35th annual meeting. Contact RRS, 925 Chestnut St., Philadelphia, PA 19107, phone 215-574-3153.

5th International Conference on the Adjuvant Therapy of Cancer--March 11-14, 1987, Tucson, Sydney Salmon, chairman. Deadline for abstracts is Dec. 1. For abstract forms and more information, contact Mary Humphrey, Conference Coordinator, Univ. of Arizona Cancer Center, Tucson 85724, phone 602-626-6044.

RFPs Available

Requests for proposals 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-CM-67876-16

Title: Computer based searches for chemical structures

Deadline: To be listed in the RFP

NCI is seeking small business firms, the size standard for which is $3.5 million in gross receipts per year, with the capability to perform high volume computerized full and substructure chemical searches. It is anticipated that the successful offeror shall be responsible for the following:

The Div. of Cancer Treatment database includes chemical and biological information on approximately 400,000 compounds. There is a continuing need to perform high volume computerized full and substructure chemical searches of the DCT database in support of various segments of our program: acquisition, compound screening and evaluation committees, national cooperative drug discovery groups, and grantee requests.

The main responsibility of the contractor will be to support the needs of the Drug Synthesis & Chemistry Branch for high volume substructure, full structure and data item searches. The contractor shall analyze each request, develop appropriate search strategy, making full use of the system's capabilities, phrase the search question, interactively process the query, check output via graphic terminal for accuracy, completeness, and relevancy, and generate the output report. The contractor will also generate systematic nomenclature on selected compounds.

The principal investigator should be trained in organic chemistry at the master's level, should have additional training in chemical documentation and retrieval, and should have at least four to five years experience in chemical information retrieval and substructure searching. There should be an additional chemist at the master's level, with chemical nomenclature knowledge and experience, available to the project for four to eight hours a week.

The contractor shall perform the tasks on site at the Developmental Therapeutics Program offices in Bethesda, as requested. The government will provide appropriate space and equipment for performance of the tasks.

Those who believe that they have the capability to undertake this project should submit complete documentation of their capabilities, including their eligibility for this small business size standard. Each of the above requirements should be addressed specifically. Ten copies of this document should be submitted to the contract specialist no later than 15 days after publication of this announcement.

Contract Specialist: Patricia Shifflett
RCB Blair Bldg Rm 216
301-4278737

PROGRAM ANNOUNCEMENT

Title: NIH program for developing treatments for acquired immunodeficiency syndrom

NCI and the National Institute of Allergy & Infectious Diseases have jointly organized an AIDS Drug Selection Committee to review and facilitate the developing (testing) of possible treatments for AIDS. This committee is constituted to review suggestions submitted for AIDS treatment and, in certain cases, to recommend appropriate preclinical and clinical research or further development. Interested parties who have synthetic or natural substances known to inhibit the growth of the retrovirus known to cause AIDS or which may preserve or augment the immune status of infected persons are encouraged to share this information. The committee will consider information of a proprietary nature in the strictest confidence. Detailed proposals should contain the following information:

1. The precise nature and composition of the substance or, if proprietary, a willingness to reveal that information to a closed session of the AIDS Drug Selection Committee.
2. Data regarding the substance's known biological, chemical, physical or physiological properties.
3. Data regarding the in vitro activity of the substance or substances such as to suggest that it might be active against the virus associated with AIDS, or to function as an immunomodulator.
4. Data from animal studies, if any, indicating its safety, tolerance, and efficacy in conditions possessing some similarities to AIDS.
5. Data from human studies, if any, indicating is safety and tolerance.
6. A statement of willingness by an organization to supply material or to cooperate in the preparation of adequate amounts of material for study purposes.

Proposals should be submitted in writing to Eddie Reed, MD, Executive Secretary, AIDS Drug Selection Committee, Bldg 31 Rm 3A49, NIH, Bethesda, MD 20892.

NCI CONTRACT AWARD

Title: Evaluation of periodic breast cancer screening using mammography, modification

Contractor: Health Insurance Plan of Greater New York, $116,604.

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

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