DRS 12/16/86

THE CANCER LETTER

Vol. 12 No. 48

Dec. 12, 1986

Subscription $160 year North America
$175 year elsewhere

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

SEER Data Show Under Age 55 Death Rates Are Decreasing, Mixed Results In Various Categories

NCI's annual update of cancer incidence, survival and death rates were presented to the National Cancer Advisory Board and the public this week, and they generated a mixed

(Continued to page 2)

In Brief

Fischinger Hints Of "New Players" at FCRF; Gigliotti Named Cancer Control Science Director

CURRENT RECOMPETITION of the five contracts NCI has for operations and research at the Frederick Cancer Research Facility could mean that in a few months "we may be dealing with an entirely new group of players," NCI Deputy Director Peter Fischinger told the National Cancer Advisory Board Monday. Fischinger, whose duties include primary NCI staff responsibility for FCRF, was not necessarily hinting that some or all of the incumbent contractors have lost out. Review of the proposals is still in progress. More likely, he was merely telling the NCAB that the possibility of new contractors still exists. Later, Fischinger declined to tell **The Cancer Letter** whether competing proposals had come in for each of the five contracts, indicating the government would like to negotiate with a single proposer without that organization knowing it was the only one in the game (if that were the case). Fischinger emphasized to the NCAB that key employees would remain in their present positions, for the most part, whoever wins the contracts. . . . **FISCHINGER ALSO** said that NIH had wrapped up its investigation of allegations of misdeeds which surfaced last summer, when Program Resources Inc. and two of its top employees at FCRF had a temporary falling out (**The Cancer Letter**, Aug. 8 and Aug. 22). The probe found absolutely no evidence of wrong doing, Fischinger said. PRI holds the $40 million plus operations and support contract. . . . **LILLIAN (LEE) GIGLIOTTI** has been appointed associate director of NCI's Div. of Cancer Prevention & Control and director of the Cancer Control Science Program. The position has been vacant since Donald Iverson left earlier this year for the Univ. of Colorado. Gigliotti, who holds a PhD in Social Systems Sciences and is a former oncology nurse, has been chief of the Health Promotions Science Branch . . . . **SHEILA TAUBE** has been named chief of the Cancer Diagnosis Branch in the Div. of Cancer Biology & Diagnosis' Extramural Research Program. She has been chief of the Biochemical Diagnosis Section.

Breast Cancer Death Rate Under Age 50 Goes Back Up; Blacks Still Lag

(Continued from page 1)
bag of results and reactions. Some examples:

*The cancer death rate for those under age 55 decreased 7 percent, from 38.2 per 100,000 population in 1975 to 35.7 in 1984, the latest year for which NCI's Surveillance, Epidemiology and End Results (SEER) Program has complete figures.

"This decline in the death rate comes in the face of a slow increase in the cancer incidence rate in this age group, and is one of the most encouraging cancer statistics we see this year," NCI Director Vincent DeVita said in the statement sent out with the report.

The decline is evident for every age group under age 55. It is seen even if lung cancer death rates, which are decreasing among the young and middle aged, are excluded.

DeVita attributed much of the decline to advances in cancer treatment. He said that another measure of treatment success, survival statistics, shows gains among those in that age group.

"People under 55 have a higher overall five year relative survival rate for cancer than older patients, indicating that we're being particularly successful in treating these patients," DeVita said.

The five year relative survival rate for patients under age 55 for all cancer sites combined is 59 percent. This includes patients of all races, both sexes, diagnosed with cancer between 1974 and 1983. The five year relative survival rate for all races and ages of both sexes, also diagnosed between 1974 and 1983, is 49 percent.

*The less encouraging aspect of this year's report is the 49 percent overall survival figure. That has remained level for the last two-three years. Last year, DeVita blamed the lack of improvement in overall survival on the reluctance of many physicians to use full dose chemotherapy for appropriate indications.

*One of the most discouraging aspect of the new figures was that, for the first time in the past decade, the death rate from breast cancer for white women under age 50 increased from 5.9 to 6.3 per 100,000. That rate had been decreasing an average of 1 percent yearly for the last 10 years. "The reason for the increase is not certain, but it is for only one point in time and may simply reflect a random fluctuation in the data," the NCI statement said.

Others were not so sure. Critics, from John Bailar to Rose Kushner, attributed those results to failure of chemotherapy.

*Perhaps most discouraging of all is the continued poor survival among black patients for almost all cancer sites compared to that of white Americans. Some examples:

--Oral cavity and pharynx, the five year relative survival, 1977-83, for whites, was 53 percent; for blacks, 31 percent.

--Colon, 53 percent vs. 47 percent; rectum, 50 percent vs. 37 percent; melanoma, 80 percent vs. 38 percent; female breast, 75 percent vs. 62 percent; prostate, 71 percent vs. 62 percent; bladder, 76 percent vs. 53 percent.

Only in stomach cancer (16%), ovarian cancer (38%), Hodgkin's disease (74%) and non-Hodgkin's lymphoma (49%-48%) were white and black survival rates virtually equal. Survival rates among blacks were better in kidney cancer (53% vs. 50%) and brain cancer (27% vs. 23%).

NCAB member Phillip Frost suggested that if lack of accessibility to treatment were the reason why blacks do worse in most cases, "you would expect it to be the same across the board."

NCAB member Louis Sullivan asked if any studies have shown whether socioeconomic differences have anything to do with the variances in black-white rates.

Edward Sondik, chief of NCI's Surveillance & Operations Branch who presented the report to the NCAB, said there has been but on analysis, "the differences go away. I don't think the bottom line is in on that yet. If there is one message from this, it is that we have to look at the differences site by site, on a detailed basis, before we try to draw any conclusions."

Other items gleaned from the report:

Incidence and death rate trends--The cancer incidence rate, all sites combined, for the under 55 population, all races, increased an average of 0.2 percent yearly (since 1973) and was 99.8 per 100,000 in 1984. In spite of this, the death rate decreased 6.7 percent between 1975 and 1984.

For the total U.S. population, all races and ages and both sexes, the cancer incidence rate has been increasing an average of 0.7 percent yearly and was 351.8 in 1984. The death rate has been increasing an average of 0.5 percent yearly and was 170.7 in 1984.

Colon cancer--The incidence rate for colon cancer, all races combined, has been increasing an average of 0.5 percent yearly and was 50.3 in 1984. However, the death rate has been decreasing an average of 0.6 percent yearly and was 21.0 in 1984.

The decreasing death rate in the face of an increase in incidence reflects "in part advances in cancer treatment and in part earlier detection," DeVita said. The five year survival rate for colon cancer increased from 49.5 percent for patients diagnosed between 1974 and 1976 to 52.6 percent for those diagnosed between 1977 and 1983.

Lung cancer--The incidence rate was 81.4 for white men in 1984, only slightly higher than the rate of 80.9 in 1983. Rates for both 1983 and 1984, however, were consistently lower than those for 1980 through 1982.

For black men, the incidence of lung cancer is leveling off, but the rate is more than 60 percent higher than for white men.

For women, the overall death rate for lung cancer increased between 1983 and 1984 only 2.9 percent, from a rate of 24.3 to 25.0. The rate had been increasing an average of 5.5 percent yearly since 1975.

These changes are consistent with the changes that have occurred in the smoking patterns of Americans over the past 20 years. "Again we're seeing evidence that individuals can take positive steps to reduce their risk for certain cancers by not smoking," DeVita said.

Incidence of lung cancer among white women, all ages, remained about the same between 1983 and 1984 and were 33.8 and 33.7, respectively. This is in contrast to a pattern of average yearly increases of five percent in previous years. For white women under age 45, the incidence rate has been falling an average of one percent yearly over the past decade.

More on breast cancer--The report comments that the "continued absence of a decrease in mortality in the face of successful major clinical studies of breast cancer screening would indicate, very strongly, that minimal screening for breast cancer took place during the 1970s."

Testicular cancer--The decrease in mortality, 27.7 percent since 1975, "is all the greater when the increase in incidence is taken into account. The decrease is directly attributable to improved treatment." Five year survival for whites is now 89 percent, for blacks 78 percent.

NCI To Keep Preclinical AIDS Drug Development, Gets More Resources

In a complete about face, NCI and the National Institute of Allergy & Infectious Diseases have agreed now that preclinical AIDS drug development will remain with NCI's Developmental Therapeutics Program.

Div. of Cancer Treatment Director Bruce Chabner had reported to his Board of Scientific Counselors that NCI was happy to relinquish its role in AIDS drug development and that NIAID was happy to take it on (**AIDS update**, November). It was reported then that the Developmental Therapeutics Program, which has responsibility within NCI for preclinical drug development, would train personnel for transfer to NIAID by FY 1988.

BSC Chairman Paul Calabresi told the National Cancer Advisory Board this week that members of his board were not pleased by that development. After their meeting had ended, several board members and Calabresi met with Chabner to express their concerns and ultimately convinced him and NCI Director Vincent DeVita that it would make more sense for the AIDS preclinical drug work to stay where it was. Why spend the time and effort to create a counterpart to NCI's DTP? they argued. NCI has been in the drug development business for more than 20 years.

Chabner agreed, provided the necessary resources could be made available. NIH went along and allocated 18 additional positions to DCT for AIDS research. About 11 of those will be assigned to DTP Director Michael Boyd for the screening effort. DCT also will get an additional $5 million from the NIH AIDS pool.

Robert Gallo, whose laboratory is housed in DTP, will be better able to lend his expertise to the effort, Chabner pointed out.

NIAID will retain most of the responsibility for clinical research in AIDS, except for the work being done by Samuel Broder in DCT's Clinical Oncology Program.

Final Issue of 1986; Next, Jan. 2

This issue of **The Cancer Letter** is the 48th and final one of the year and of volume 12. The next issue will be Volume 13, No. 1, dated Jan. 2, 1987.

The Cancer Letter office will be open most of the business days during the holidays. The tape machine will be on to record calls when the office is closed.

Best wishes for the holidays and New Year.

EORTC Randomized 4,738 Patients To Phase 2 and 3 Trials Last Year

A total of 4,738 patients were randomized to phase 2 or 3 trials coordinated by the European Organization for the Research and Treatment of Cancer last year. That number is comparable to the total number of cancer patients enrolled in phase 2 and 3 clinical trials in the U.S. last year.

More than 275 European institutions participated in EORTC trials last year. The monitoring of as many as 200 clinical protocols per year is conducted by EORTC's Data Center in Brussels. Headed by Maurice Staquet, the data center currently monitors about 150 trials underway by approximately 25 different cooperative groups within EORTC.

Most of the trials (between 50 and 60 percent) coordinated by the center involve the use of chemotherapy alone. A similar proportion of trials are phase 2 studies, with the remainder being phase 3 trials or studies of combined modalities. The center does not coordinate phase 1 trials.

Since the first patient's data was entered into the center's computer in 1974, more than 32,000 patients have been entered into the system.

EORTC describes the center as "the mainstay of clinical research in Europe."

The basis of the structure for the center's creation was laid in 1972 by Henri Tagnon, EORTC president from 1975 to 1978, and William Levine, chairman of NCI's Committee of Clinical Investigation.

When the center was first established, NCI funds represented about 90 percent of financial support for the data center.

In recent years, however, the proportion of support provided by NCI has steadily declined to the point where NCI funds currently represent only 10 to 15 percent of the data center's overall budget.

Today, the European Economic Community and the EORTC Foundation represent the major sources of funding for the data center. Each provides between 40 and 50 percent of the center's funding.

"NCI played a catalytic role" in the development of the data center until "Europe took over," NCI Liaison Office representative Omar Yoder said. While noting that NCI's contribution to the data center is less important now, he said it is still important for the data center to receive NCI funds.

"The fact it is associated with NCI helped to get it funded" by other groups, he said. "One of the major points of justification for NCI to continue support [in Europe] is that this is what happens," Yoder said.

EORTC Foundation Secretary Ann Money-Coutts agreed. "We have such a debt to the NCI for the first years" of the center's existence, she said. "They really kept us going."

The EORTC Data Center recently received $2 million from the national lottery in order to buy a new computer system and to buy or build a new building for the center.

The European Economic Community is also providing funds for the center to coordinate activities of more than 275 centers. In the form of a grant, the EEC support is expected to be renewed every year.

The center currently has an electronic mail system in place for the cancer centers, which can also access electronic mail at NCI in Bethesda. The center plans to eventually be able to exchange data between participating centers.

Under a recent grant by the EEC, the center is beginning to study treatment for opportunistic infections associated with AIDS. The first EORTC multicenter trials began this fall, with several more slated for the coming year (See related story in this issue's **AIDS Update**). Cancer, however, remains the organization's main concern.

The data center has a staff of 22 people.

Among its many other projects, EORTC is currently conducting three joint studies with NCI: one in lung cancer, one in melanoma; and a third antimicrobial study.

Protocols are reviewed and approved by EORTC's Protocol Review Committee, which meets every three months. A representative of NCI's Clinical Therapy Evaluation Program sits on the review committee.

The data center also provides assistance with protocol development. The center helps in writing the section regarding randomization, and with forms and procedures and statistical considerations, Richard Sylvester, assistant director for biostatistics, told **The Cancer Letter.**

All participating institutions have to phone or telex the data center when they want to enter a patient on a trial. All patients entered into phase 2 or 3 trials are entered through the central data system.

Patient information and clinical data is stored on a diskette, then mailed and transferred to a mainframe computer at the center.

The center expects to have its new computer installed by the end of the year. When the new computer system is fully operational, centers will be able to send the data directly to the main computer over the phone.

Each center needs a PC and a data manager. The data center will provide software to the centers. Currently, 14 institutions use a "CODE" (Computerized Oncologic Data Entry) program developed by the center.

Interim analyses are conducted on trials underway at about six months to ensure that there are no ethical problems for continuing the trial, such as toxicities, or major differences in survival. The cooperative groups meet every six months. The center also utilizes a central pathology review.

When a study is closed, a first statistical analysis is prepared and presented by the center. In phase 3 trials, the center tries to do a second paper dealing with prognostic factors.

The data center is part of the EORTC's Clinical Research Branch, one of four branches in the organization. The Clinical Research Branch also includes EORTC's New Drug Development Committee, which is itself composed of four groups: screening & pharmacology, pharmacokinetics and metabolism, early clinical trials, and clinical screening. EORTC's New Drug Development Office is directed by Herbert Pinedo of the Free Univ. of Amsterdam.

The other three branches are prevention & epidemiology; basic research; clinical research; and education.

EORTC has initiated six major efforts in the field of cancer treatment. The first, a screening program of potential anticancer agents, screens an average of 3,000 new compounds annually, the majority of which (about 80 percent) are tested through the NCI contractor screening lab in Brussels. Only compounds that have not been tested previously in the American program are screened. After preclinical pharmacology, pharmacokinetics and toxicology testing, drugs are tested clinically by the Clinical Screening Group, the Early Clinical Trials Group, the Pharmacokinetics and Metabolism Project Group and other disease oriented groups.

Industry is encouraged to submit samples to the screening program. The producer retains patent or priority rights on substances submitted for screening.

The second effort is the organization of clinical and preclinical cooperative groups to carry out controlled clinical trials. The studies are carried out in collaboration between radiotherapists, and medical and surgical oncologists.

A third area is the organization of collaborative research programs. EORTC's Research Project Group brings together scientists to analyze a problem in detail. A Project Group is then formed, and a systematic research program developed. Results are analyzed at regular intervals and serve as the essential basis for the design of subsequent lines of research. Working Parties are national or regional organizations affiliated with EORTC. Central coordination for the activities of the EORTC groups is provided by the data center in Brussels.

EORTC also conducts several symposia, and workshops on cancer research and treatment each year. Work is often reported in the European Journal of Cancer and Clinical Oncology, the organization's official organ. It also produces two book series, the EORTC Monograph Series, edited by Staquet of the data center, and the EORTC Cancer Chemotherapy Annual Series, edited by Pinedo.

In addition, EORTC cosponsors the European School of Oncology, a nonprofit, nongovernmental organization to improve the general level of oncologists and to disseminate in Europe the results of clinical research carried out by EORTC Cooperative Groups. The school organizes and conducts theoretical and practical courses in different fields of oncology, produces and disseminates teaching materials and organizes workshops.

EORTC also offers two fellowship programs. The first provides fellowships to European doctors to facilitate study and exchange within Europe. The second program, conducted in collaboration with NCI, provides reciprocal exchange and information for young clinicians and research workers.

EORTC was founded in 1963 in order to promote cancer research in Europe and in order to catch up with progress in the U.S. in the search for new and better treatments.

The current president of EORTC is Umberto Veronesi, director general of the National Cancer Institute of Milan.

The next issue of **The Cancer Letter** *will include a more detailed discussion of new drug development activities underway by the EORTC, as well as activities of the EORTC Foundation and England's Cancer Research Campaign.*

NCI Advisory Group, Other Cancer Meetings For Jan., Feb., Future

International Symposium on Breast Cancer--Jan. 1-4, New Delhi. Contact Dr. I. Mittra, Organizing Secretary, Tata Memorial Hospital, Dr. Ernest Borges Marg, Parel, Bombay 400 012, India.

Cancer Biology-Immunology Contract Review Committee--Jan. 9, NIH Bldg 31 Rm 2, open 9-9:30 a.m.

Colorado Cancers: Medical and Legal Implications--Jan. 14-16, Marriott Mark Hotel, Vail. 21st annual Mindwinter Cancer Seminar. Contact Jiri Tvrdik, BSN, Professional Education Director, American Cancer Society Colorado Div., 2255 S. Oneida, Denver 80224, phone 303-758-2030.

UCLA Symposia--Jan. 17-23, Park City, Utah. Growth regulation of cancer and steroid hormone action. Contact Molecular Biology Institute, UCLA, Los Angeles 90024, phone 213-206-6292.

Chromosomes in Solid Tumors--Jan. 18-20, Arizona Cancer Center, Tucson. Second international workshop. Contact Mary Humphrey, Conference Coordinator, Arizona Cancer Center, Univ. of Arizona College of Medicine, Tucson 85724, phone 602-626-2276.

Div. of Cancer Prevention & Control Board of Scientific Counselors--Jan. 22-23, NIH Bldg 31 Rm 10, 8:30 a.m., open.

Second Dresden Hyperthermia Conference--Jan. 22-24, Dresden, G.D.R. Contact Dr. Winfried Krueger, c/o Research Inst., Manfred von Ardenne, Zeppelinstrasse 7, 8051, Dresden.

Advances in Urologic Oncology--Jan. 22-24, Sanremo, Italy. 1st international symposium. Contact Div. of Oncologia Clinica, Istituto Nazionale per la Ricerca sul Cancro, Viale Benedetto VX 10, 16132 Genova, Italy.

Gastroenterology Update: 1987--Jan. 24-31, Lion Square Lodge and Conference Center, Vail, CO. Contact Jeanne Ryan, Office of Continuing Education, Johns Hopkins Medical Institutions, 720 Rutland Ave., Turner 22, Baltimore 21205, phone 301-955-6046.

30 Tutorial on Clinical Cytology--Jan. 24-31, Universal City, CA. Contact 30th Tutorial on Clinical Cytology, 5841 S. Maryland, HM 449, Chicago 60637.

Recent Advances in Leukemia and Lymphoma--Jan. 25-31, Keystone, CO. Contact Molecular Biology Institute, UCLA, Los Angeles 90024, phone 213-206-6292.

International Radiation Collaborators--Jan. 28-29, Lyon. Final meeting to evaluate results in study of cervical cancer patients. Contact International Agency for Research on Cancer, 150 cours Albert-Thomas, 69372 Lyon, Cedex 08, France.

Second Alpbach Seminar in Radio-Oncology--Jan. 28-31, Alpbach, Tirol, Austria. Contact Prof. Hermann Frommhold, Universitatsklinik fur Strahlentherapie, Anichstr. 35, 6020 Innsbruck, Austria.

Focus on Melanoma--Jan. 31, Cleveland. Contact Barbara Guy, Ireland Cancer Center, Lowman Bldg 211, University Hospitals of Cleveland, 2074 Abington Rd., Cleveland 44106, phone 216-844-7856,

Oncology Practice 1987: A Perspective--Feb. 1-7, Snowmass, CO. Contact Stephen Jones MD, Sammons Cancer Center #4800, Baylor Univ. Medical Center, 3500 Gaston Ave., Dallas 75246.

Artificial Intelligence Systems as Diagnostic Consultants for the Cytologic and Histologic Diagnosis of Cancer--Feb. 1-3, North Hollywood, CA. Contact International Academy of Cytology, 5841 S. Maryland Ave., HM 449, Chicago 60637.

National Cancer Advisory Board--Feb. 2-4, NIH Bldg 31 Rm 6, 8:30 a.m. Closed Feb. 3.

Telemark Cancer Conference--Feb. 4-6, Cable, WI. Contact Marshfield Clinic Medical Education Office, 1000 N. Oak Ave., Marshfield, WI 54449, phone 715-387-5207.

U.A.E. Cancer Conference--Feb. 13-18, Abu Dhabi. Contact 2nd U.A.E. Cancer Conference, Secretariat, c/o Mafraq Hospital, PO Box 2951, Abu Dhabi, U.A.E.

Clayton Foundation Conference on Photodynamic Therapy--Feb. 15-19, Los Angeles. Contact Charles Gomer PhD, Conference Chairman, Clayton Ocular Oncology, Childrens Hospital of LA, 4650 Sunset Blvd., Los Angeles 90027, phone 213-660-2450.

Supportive Care in Cancer Patients--Feb. 18-21, St. Gallen, Switzerland. Contact Secretariat "Supp-87", Prof. Dr. H.J. Senn, Med. Klinik C, Kantonsspital, 9007 St. Gallen, Switzerland.

Div. of Cancer Treatment Board of Scientific Counselors--Feb. 19-20, NIH Bldg 31 Rm 7, 8:30 a.m. Closed Feb. 20, 8:30-9:30 a.m.

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

American College of Medical Imaging Conference--Feb. 22-27, Lake Tahoe. Contact A.M. Mannheim, Executive Director, PO Box 27188, Los Angeles 90027, phone 213-275-1393.

Fudamental Tumor Registry Operations--Feb. 23-26, Orlando. Contact Florida Tumor Registrars Assn., Patricia Johnson, CTR, Local Coordinator, phone 305-646-4023 or 4024.

21st Annual Clinical Symposium--Feb. 27-28, St. Jude Children's Research Hospital, Memphis. Open to all physicians, no fees, but limited to about 200. Obtain registration forms from Dr. Joseph Simone, Director, St. Jude Children's Research Hospital, Box 318, Memphis, TN 38101.

Colorectal Carcinoma-1987--Feb. 28, Moseley-Salvatori Conference Center, Los Angeles. Contact Ilona Kapuy-Carlos, Manager, Cancer Center, Hospital of the Good Samaritan, 616 S. Witmer St., Los Angeles 90017, phone 213-977-2429.

FUTURE MEETINGS

Biennial International Breast Cancer Research Conference--March 1-5, James L. Knight Convention Center, Miami. Sponsored by the Papanicolaou Comprehensive Cancer Center and International Assn. for Breast Cancer Research. Deadline for abstracts is Jan. 15. Contact Dr. Diana Lopez, Conference Chairman, Dept. of Microbiology & Immunology D4-4, Univ. of Miami School of Medicine, PO Box 016960, Miami 33101, phone 305-547-6632.

Relationship of Time and Dose in the Radiation Therapy of Cancer: A Frontier Revisited--March 7-8, Sheraton Palace Hotel, San Francisco. 22nd annual San Francisco Cancer Symposium. Contact West Coast Cancer Foundation, 50 Francisco St., Suite 200, San Francisco 94133, phone 415-981-4590.

Growth Control and Cancer: Molecular Approaches and Clinical Implications--March 26-27, Univ. of North Carolina, Chapel Hill. Contact Lineberger Cancer Research Center, School of Medicine, UNC, Chapel Hill, NC 27514.

Nursing Management Strategies for Access/Delivery Devices--April 3, Cleveland Clinic. Contact Dept. of Continuing Education, Cleveland Clinical Educational Foundation, 9500 Euclid Ave., Rm TT3-3501, Cleveland 44106, phone (local) 444-5696; (Ohio) 800-762-8172; (elsewhere) 800-762-8173.

Multidisciplinary Approach to Control of Solid and Hematologic Neoplasias and Induced and Acquired Immune Dysfunctions--April 4-7, 1987 Nice. Contact the International Society for Preventive Oncology, 217 East 85th St., Suite 303, New York 10028, phone 800/874-4445. If calling from outside the U.S. or within New York, call 212/496-1900.

Genes and Cancer--April 10, Memphis. Dorothy Snider Foundation Forum on Cancer Research. Speakers include Howard Temin, William Haseltine, Robert Weinberg, Charles Sherr, John Minna, Garrett Brodeur, Janet Rowley, Ira Pastan and John Durant. Contact Dr. James

Hamner, Univ. of Tennessee (Memphis), 62 S. Dunlap, Suite 507, Memphis 38163, phone 901/528-6354.

National Tumor Registrars Assn.--May 27-30, Marriott City Center, Minneapolis. 13th annual meeting. Contact Mary Ellen Miller, Program Chairman 1987 NTRA Meeting, 37 N. Willowgreen Ct., Mason City, IA 50401, phone 515/357-5788.

RFAs Available

RFA 87-CA-07

Title: Cooperative agreements for Cooperative Group Outreach Program
Letter of intent receipt date: Dec. 15
Application receipt date: Feb. 20

NCI invites cooperative agreement applications from existing NCI supported clinical trials cooperative groups for the purpose of extending the ongoing clinical trials program to include community hospitals and physicians.

The Cooperative Group Outreach Program (CGOP) was developed to extend the clinical trials program so that patients treated in their communities have access to the same quality care and technological advances available in major treatment centers. Clinical trials cooperative groups, with their widely distributed membership, afford a means of maintaining a network of community physicians interested in participating in clinical cancer research. This program has developed into a major source of patient accruals to cooperative clinical trials, thus providing more rapid and definitive answers to important clinical research questions which require large numbers of patients. NCI is therefore inviting applications from the headquarters or statistical office of NCI supported clinical trials cooperative groups to continue or extend CGOP.

A total of $4 million will be available for FY 1987 awards. It is anticipated that about seven awards will be made.

Complete copies of the RFA and further information may be obtained from, and letters of intent sent to, Richard Ungerleider MD, Cancer Therapy Evaluation Program, Div. of Cancer Treatment, NCI, Landow Bldg Rm 4A20, Bethesda, MD 20892, phone 301/496-2522.

RFA 87-CA-11

Title: Cooperative agreements for prevention clinical trials utilizing intermediate endpoints and their modulation by chemopreventive agents
Application receipt date: Jan. 30

NCI's Div. of Cancer Prevention & Control invites applications for clinical trials to examine the role of various chemopreventive agents and/or diet in preventing cancer. Objective is to encourage clinical 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. 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 phase 3 clinical trials involving the designated agent, the utilization of the 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.

Direct inquiries and requests for copies of the RFA to Winfred Malone PhD, Chemoprevention Branch, Blair Bldg 616, NCI, Bethesda, 20892, phone 301/427-8680.

RFA 87-CA-12

Title: Cooperative agreements for metabaolism and physiology of retinoids and carotenoids in humans.
Application receipt date: Feb. 23

The Div. of Cancer Prevention & Control invites applications for research on human metabolism and physiologic effects of retinoids and carotenoids. Studies of interest include metabolism in the intestinal mucosa, intestinal absorption, regulation of gastrointestinal uptake and tissue concentrations, and extra intestinal metabolism of these compounds.

The studies should span a range of dietary intakes. The proposed research requires innovative approaches to determine the dynamics of absorption and metabolism, target tissue levels, and specificities of the various vitamin A compounds and how these determinations would elucidate the roles of dietary retinoids and carotenoids in cellular integrity and resistance to tumor promotion. The long term objective of this research is to further the understanding of the physiological effects of retinoids and carotenoids in humans in order to help clarify the suspected relationship that these substances have with human cancer.

Copies of the RFA and further information may be obtained from Elaine Lanza PhD, Diet & Cancer Branch, DCPC, NCI, Blair Bldg Rm 623, Bethesda 20892, phone 301/427-8753.

RFA 87-CA-13

Title: Cooperative agreements for the physiochemical effects of dietary fiber in humans
Application receipt date: Jan. 30

The Div. of Cancer Prevention & Control invites applications for research on the physical, chemical and biologic effects of dietary fibers and their possible protective role in carcinogenesis. Studies of potential interest include but are not limited to the effects of fiber on (1) fecal mutagenic activity; (2) bile acids; (3) colon cell kinetics, morphology and physiology in order to further understand the relationship between dietary fiber and colon cancer. Studies funded under this RFA will be limited to those involving human subjects.

Contact Elaine Lanza, address and phone above, for copies of the RFA and further information.

RFA 87-CA-14

Title: Cancer prevention and control research, small grants program
Application receipt date: March 5

The Div. of Cancer Prevention & Control invites small grant research applications from investigators who meet the eligibility criteria. This RFA is a modified reissuance of RFA 86-CA-02. Three prior RFAs have resulted in 44 awards. Future plans are to issue this RFA at least annually for five years, with up to 30 awards per year if funds are available.

The Cancer Prevention and Control Small Grants Award is designed to encourage scientists from a variety of academic disciplines to apply their skills to scientific investigations in the field of human cancer control intervention research.

Cancer Control Program areas appropriate for research grants include human intervention research in the following:

*Prevention (chemoprevention; diet and nutrition;

early detection).

*Community oncology (improving the application of patient management and continuing care research advances into community settings).

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

*Smoking prevention and cessation.

*Cancer control operations research, evaluation.

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

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

*Planning epidemiologic and survey studies aimed at developing cancer control interventions.

Excluded from this RFA are animal studies and studies to determine the efficacy of chemotherapy, surgery, radiotherapy and other primary treatment interventions.

Total costs (direct and indirect) must not exceed $35,000. The duration of support is one year but may be longer, up to two years, if the $35,000 total cost limit is not exceeded for the entire grant period.

Copies of the RFA and additional information may be obtained from either Carlos Caban PhD, Program Director for Cancer Control Research, Cancer Control Applications Branch, phone 301/427-8735; or David Poskanzer MD, Cancer Control Science Program, phone 301/427-8788; both at the Blair Bldg Rm 4A01, DCPC, NCI, Bethesda 20892.

RFA 87-CA-16

Title: Data based interventions for cancer control
Letter of intent receipt date: Jan. 8
Application receipt date: March 5

The Div. of Cancer Prevention & Control invites applications for grant support of projects that will serve as models of data use in the planning and evaluation of statewide cancer prevention and control programs.

This RFA is designed to stimulate development of cancer prevention and control intervention programs on the state and local level based on a thorough analysis and evaluation of the variety of data sources related to cancer control that exist in the state. The three phased project includes (1) identification and evaluation of existing population specific data sources related to cancer control and the development or modification of a cancer control plan; (2) initiation of new or modification of existing cancer prevention and control programs as specified in the plan; and (3) a period for evaluation of process and outcome.

Applications must be state or territorial health departments. Local health departments or agencies within the jurisdiction with primary responsibility for cancer control activities may apply through the state or territorial health departments. Health departments currently funded under the NCI grant for cancer control technical development in health agencies are not eligible for this grant.

Funding is limited to a maximum of five years. Approximately eight awards are anticipated for phase 1 with four continuing into phases 2 and 3, depending on the availabilty of funds and quality of applications.

Copies of the RFA and additional information may be obtained from, and letters of intent sent to, Dr. Leslie Boss, Program Director, Cancer Control Applications Branch, Cancer Control Science Program, DCPC, NCI, Blair Bldg Rm 4A01, Bethesda 20892, phone 301/427-8684.

Program Announcement

Title: International scientific exchange program in AIDS research
Response Deadline: Dec. 19

The Fogarty International Center of NIH proposes to establish a program to facilitate short and long term collaboration between scientists from the U.S. and other countries who are involved in AIDS research. The awards will be made to principal investigators in U.S. institutions who wish to invite to their laboratories foreign scientists at all career levels. Each award will include funds to support up to 60 months of fellowship activity, with periods for individual fellowships ranging from three to 24 months. The host institution will receive a small allowance to partially defray the fellow's research expenses in addition to support for the PI's efforts and indirect costs. Each fellow will receive a stipend and funds to cover the expenses of round trip travel and health insurance.

To be considered for participation, institutions must have ongoing clinical and multidisciplinary research programs in AIDS and must have planned or established research projects involving international collaboration. The proposed collaboration must have the potential for continuing after the foreign scientists return to their parent institutions.

Institutions that meet the criteria stated above and are interested in applying should submit the following information:

Name of PI; institution including department; mailing address and phone number; list of clinical and scientific disciplines; countries with which scientific collaborations are established or in development.

Send this information by Dec. 19 to Bettie Graham, PhD, International Research & Awards Branch, Fogarty International Center, Bldg 38A, Rm 615, NIH, Bethesda, MD 20892, phone 301-496-6688.

RFPs Available

RFP NIH-NIAID-AIDSP-87-21

Title: Development of small laboratory animal models for HTLV-3/LAV infections
Deadline: Jan. 29 (tentatively)

NIH has a requirement for the development of an in vivo, small animal system that will serve as a useful experimental model of natural HTLV-3/LAV infections in humans. The Prevention Branch of the AIDS Program in the National Institute of Allergy & Infectious Diseases is soliciting contract proposals from organizations having the facilities and demonstrated expertise to conduct studies on experimental viral infections in small laboratory animals.

This project will take approximately three years to complete. The work will require the availability of the proposed animals as well as the ability to detect viral replication. This will be a cost reimbursement contract. Multiple awards are anticipated.

For copies of the RFP, send two self addressed mailing labels to Larry Butler, Contract Specialist, Contract Management Branch, NIAID, NIH, Westwood Bldg Rm 707, Bethesda, MD 20892.

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

Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.