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

President's FY 1988 Budget Request For NCI: $1.87 Billion, But It Really Isn't What It Seems To Be

A quick look at President Reagan's FY 1988 budget request for NCI, included in the trillion dollar budget for the entire federal government that went to Congress Monday, focusses on an eye popping figure: $1.875 billion. The first reaction, which lasts about a half second, is that those nice folks at the Office of Management & Budget have finally

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In Brief

Beahrs Headed Team For President's Surgery; Chiles Chairs HHS Appropriations Subcommittee

OLIVER BEAHRS, retired Mayo Clinic surgeon, headed the team from Mayo which performed prostate surgery on President Reagan and examined his colon for recurrence of cancer. Beahrs specialized in surgery of the colon and head and neck, primarily in the treatment of cancer, and has been a member of various NCI advisory groups. Beahrs was a close friend of the late Loyal Davis, Nancy Reagan's physician stepfather . . . . **LAWTON CHILES**, Florida Democrat, will chair the Senate Labor-HHS Appropriations Subcommittee, the group that writes that body's NIH and NCI appropriations bills. William Proxmire and Ernest Hollings had seniority over Chiles on that subcommittee but chose to head others. The subcommittee was chaired most recently by Lowell Weicker, now its ranking minority member. Chiles also heads the Senate Budget Committee. . . . **PETER NOWELL**, associate director of the Univ. of Pennsylvania Cancer Center, will receive the Leukemia Society of America's highest award, the de Villier medal and a cash prize, at the society's national symposium in San Diego March 18-21. . . . **NIH EMPHASIZED** in a recent announcement the importance of timely submission of noncompeting continuation grant applications. They should be submitted to the awarding unit eight weeks before the starting date of the budget period. Late and incomplete applications place unnecessary burdens on NIH staff and sometimes result in late awards. . . . **REGIONAL WORKSHOPS** on implementation of revised PHS policies on the humane care and use of laboratory animals are scheduled March 12-13 in Portland, OR (contact Nancy Praskell, Dept. of Animal Care, Oregon Health Sciences Univ., 3181 SW Sam Jackson Park Rd., Portland 97201); and March 30 in Miami (contact Cynthia Stingone or Margaret Moncure, Mannheimer Primatological Foundation, 20255 SW 360 St., Homestead, FL 33034).

President's Budget Obscures Cut Of $100 Million For NCI In FY 1988

(Continued from page 1)
gotten the message that Congress, the American people and the cancer research community have been trying to get across to them for 16 years.

Then reality sets in, and it is obvious that not only have the budget makers in the White House **not** found wisdom and agreed to fund the cancer program at an optimal level, but they have become more devious than ever.

The $1,875,229,000 figure in NCI's column becomes a cut of $100 million from NCI's 1987 appropriations, via a bit of cutesy manipulation by OMB. Here's how they did it:

*The White House has proposed taking $64 million from NCI's 1987 appropriation of $1.402 billion ($1 billion, 402 million) which has been allocated for research project grants--ROIs and POIs--and move it to the 1988 fiscal year.

*In a bizzare revival of OMB's 1985 flop, the Forward Funding Follies, the White House is proposing that competing grants in FY 1988 be funded to completion, although the money for the outlying years would not be awarded until those years. That money would come from the 1988 appropriation. The amount estimated needed for those future years of 1988 grants is $508.3 million.

By leaving the $64 million where it belongs, in 1987, and deducting that amount from the OMB 1988 figure; and by forgetting the trick mirror $508.3 million, the real OMB request for NCI in FY 1988 is $1.302 billion --exactly $100 million less than Congress voted for NCI in the current fiscal year.

When OMB came up with the forward funding fiasco two years ago, it proposed that the money for outlying years be taken out of the existing fiscal year budget, which represented an irresponsible and devastating cut. The White House claimed it had the authority to do that without Congressional approval. Threats of court action and corrective legislation finally prevailed, but it caused considerable turmoil at NIH and havoc among grantees while the issue was being fought out.

This time, at least, the White House is asking Congress to do it legally.

The only reason for the new version of forward funding offered to **The Cancer Letter** by press time this week was that it would "present the total costs of research project grants" incurred in the fiscal year. Inferred is the theory that if we know the total cost of three, four and five year grants, maybe we'll be a little more cautious about awarding so many.

One guess as to the real reason: by getting the ostensible figure for FY 1988 up so high (this policy also applies to the rest of NIH), the scientific community and biomedical research advocates will be confused and won't put so much pressure on Congress, making it easier to slip through a massive cut in research spending.

The proposed moving of $64 million from 1987 to 1988 would create substantial distress on its own. The major effect would be that the number of NCI competing awards in FY 1987 would be reduced by about 120, down from the 1,060 decreed by Congress and supported in the appropriations bill. About 3,100 grants would be funded, including the noncompeting continuing grants.

Negotiations downward would be required for both competing and noncompeting grants in FY 1987. Since the proposal was submitted after the first round of grants for this fiscal year had been processed, the reductions would have to be applied to those funded in later rounds. In other words, those later grants would suffer most of the cuts.

Reductions in the remaining competing grants would average about 18 percent, while remaining noncompeting grants would have to take a cut averaging 4.7 percent.

No More Construction

As it usually does, the President's budget proposal would completely eliminate NCI support of construction. The White House asked zero dollars for construction in FY 1987; Congress voted $5 million, split evenly among intramural (NIH campus and Frederick Cancer Research Facility) and extramural construction grants. The 1988 request starts out the same: no money for construction of any kind.

Other than that, and the mirror trick with research project grants, the 1988 Presidential request would fund other budget mechanisms at about their 1987 levels, except for AIDS research contracts, which increases.

NCI is spending $61.7 million on AIDS research this year; the White House is asking for an increase to $84.9 million, with the entire increase going into the contracts column. Contracts would go up from $183.6 million to $202.9 million.

Cancer centers would remain exactly the

same--$93.2 million. National Research Service Awards would stay at $31.7 million.

Cancer prevention and control would go up slightly, from $67 million to $67.4 million.

The intramural program would go up a little, from $234.8 million to $245.1 million.

When the $508.3 million allocated for outlying years of 1988 grants and the $64 million earmarked for transfer from 1987 to 1988 are removed from the 1.092 billion shown in the President's budget for research grants, the amount left is slightly under $530 million. The amount appropriated by Congress for research project grants in FY 1987 was $647 million.

That means that OMB would place the entire burden of the $100 million total cut in NCI's budget on basic research, for the most part. Also, $17 million of the additional AIDS money would come from basic research, with the rest from construction.

NCI Director Vincent DeVita and NIH Director James Wyngaarden always tell the congressional appropriations committees that basic research is their top priority, and it will be protected above all else. As officers of the Administration, they will have to defend this budget request, which decimates basic research. How they do it will be interesting to see.

In recent years, as funding of centers, clinical trials, and drug development have been held level or cut back, DeVita has been expressing concern that further cuts could destroy those programs. It appears that this year, he will have to tell Congress that priorities have to be changed.

Peter Greenwald, director of NCI's Div. of Cancer Prevention & Control, has lost round one in his campaign to get a significant increase in cancer control funding. Greenwald has argued that as advances are made in new therapeutic techniques, pressures will increase for widespread availability of new technology. He has pointed out that DCPC's budget has been static for about five years. Earlier this year, Greenwald scolded those in the Administration and Congress who have opposed increases for cancer control. The next round will be fought out in Congress, although Greenwald can't openly demand more money, now that the budget is public.

In every year since the National Cancer Act was adopted in 1971, Congress has saved the Cancer Program from the OMB penny pinchers. There is no reason to believe this year will be any different. Cancer research, and biomedical research in general, have a stronger base of support in both the House and Senate, than any other federal program, with the possible exception of Social Security. That support did not change with the election.

Four Cancer Center Grants In Danger; Shingleton To Retire, Owens Promoted

Cancer centers at the moment are more worried about the 1987 budget than 1988's. Unless NCI is successful in an effort to reprogram $4 million into center core grants, as many as four of the existing grants recompeted this year will be left unfunded.

NCI Director Vincent DeVita, deploring what he called "chronic underfunding" of the centers program, told the National Cancer Advisory Board last month that the 1987 budget of $93.2 million for centers would fall $3.6 million short of funding all of the existing grants approved this year in peer review. Priority scores in that review "were astonishingly good," DeVita said.

That shortfall will occur even with the recompeted grants being funded only at 85 percent of the recommended levels, or at last year's level, whichever is higher. The program would need $7 million more to fund all of the approved grants at close to recommended levels, as requested by Congress in reports accompanying the appropriations bill.

DeVita noted that the increase for centers, from $88.4 million in FY 1986, was the lowest percentage increase of any NCI program.

Most of the core grant money supports research, DeVita said, with about one third supporting basic research.

DeVita intends to submit a reprogramming request to repair the shortfall, but unless Congress forces the Office of Management & Budget to change its policies on reprogramming, that will not be easy. That policy requires approval by NIH, which has resisted reprogramming for the benefit of centers in the past.

Six of the 14 recompeting center core grants have already been approved for funding by the NCAB. They are the Univ. of Wisconsin's McArdle Laboratory; Wistar Institute; Columbia Univ. Cancer Center; Univ. of Chicago Cancer Center; St. Jude Children's Research Hospital; Univ. of California (San

ICF Clement FCRF Proposal A Joint Venture With Dynalectron Corp.

A few more details involving recompetition of the Frederick Cancer Research Facility contracts have surfaced:

--ICF Clement's bid for the massive operations and support contract (**The Cancer Letter**, Jan. 2) is a joint venture with Dynalectron Corp., a services organization headquartered in McLean, VA.

ICF Clement is a subsidiary of ICF Inc., a privately held company established about 15 years ago. The parent company has more than 500 employees and grosses about $50 million a year, with major government management contracts at the Environmental Protection Agency, Dept. of Defense and Dept. of Energy. ICF Clement, with offices in Washington DC, has 75 employees, more than 40 of them PhDs.

Elizabeth Anderson is president of ICF Clement. An organic chemist, she left EPA a year ago after 14 years there, during which time she became the first director of the agency's Cancer Assessment Committee. At one time she represented the EPA director as an ex officio member of the National Cancer Advisory Board.

Anderson is not related to NCI's Elizabeth Anderson, who is program director for the Breast Cancer Working Group of the Organ Systems Program, in the Div. of Cancer Prevention & Control.

Dynalectron, publicly traded on the New York Stock Exchange, is primarily a services business,in operations and maintenance of aircraft and air cargo, electrical contracting and security systems. The 41 year old company has 14,000 employees and grosses about $750 million a year.

--NCI Deputy Director Peter Fischinger, whose responsibilities include overseeing the FCRF contracts, recently revealed anticipated costs at the facility for each of the five contracts in FY 1987.

The operations and support contract will increase from $45.2 million in 1986 to $66.3 million. Most of the increase can be attributed to AIDS research and development. The basic research contract will go up from $8 million to $9.9 million; the animal holding contract, from $1.4 million to $2.4 million; the computer services contract from $700,000 to $900,000; and the scientific library contract from $600,000 to $700,000.

Total expenditures, which also include a payment to the Army for utility and other

Diego) Cancer Center; and Case Western Reserve Univ. Cancer Center.

The NCAB has not yet acted on eight more core grants being recompeted, nor on two new applicants. The priority score payline at the moment is 179, which places four of those in jeopardy. NCI would like to fund all of them.

Some significant changes in cancer center leadership are impending.

Albert Owens, founding director of the Johns Hopkins Univ. Comprehensive Cancer Center, left that position Jan. 1 to become president of Johns Hopkins Hospital. Donald Coffey, who has been deputy director of the cancer center, is acting director while a search committee starts the process of finding a permanent director.

William Shingleton, whose entire academic career has been spent at Duke Univ. and who has been the only director of the Comprehensive Cancer Center there, intends to step down later this year, probably November or December. A search committee has been formed to find his successor.

Michael Brennan let it be known about two years ago that he was ready to give up his role as director of the Comprehensive Cancer Center of Metropolitan Detroit, although he would remain as director of the Michigan Cancer Foundation, one of the center's principal components. However, one of the other components, Detroit Medical Center, has been in the throes of reorganization and it was determined that selection of a new cancer center director should await completion of that process.

Other major cancer center directorships which remain open include Ohio State Univ., still looking for a director of its new cancer research hospital; the Univ. of South Florida, still seeking a director of its new Moffitt Cancer Research Hospital; the new John Graham Brown Cancer Center at Louisville Univ.; and the Univ. of Hawaii Cancer Research Center.

With Owens' promotion and Shingleton's impending retirement, only six founding directors of the NCI designated comprehensive cancer centers remain in those roles: Gordon Zubrod, Papanicolaou Comprehensive Cancer Center at the Univ. of Miami; Emil Frei, Dana-Farber Cancer Institute at Harvard Univ.; John Potter, Vincent Lombardi Cancer Research Center at Georgetown Univ.; Richard Steckel, Jonsson Comprehensive Cancer Center at UCLA; David Yohn, Ohio State Univ. Comprehensive Cancer Center; and Brennan.

services (the Army still operates the Ft. Detrick base) of $5.9 million and $3.2 million for other NIH institutes, will total $81.6 million in FY 1987, Fischinger said.

Budget Cuts To Force Early End Of P388 Screening, DTP's Boyd Says

NCI's Developmental Therapeutics Program is being forced by budget constraints to speed up termination of its P388 based, in vivo drug screening program, DTP Director Michael Boyd revealed at the recent meeting of the Frederick Cancer Research Facility Advisory Committee.

In vivo screening had been targeted for phase out by the end of 1988, provided DTP, Div. of Cancer Treatment Director Bruce Chabner and the division's Board of Scientific Counselors all concurred that the new in vitro screening system proved to be satisfactory. Boyd and Chabner are convinced now that it is, and the issue will be presented to the BSC at its February meeting. But meanwhile, decreases in DTP's contract funds require immediate termination of some contracts, and the P388 screening, which has been going on in parallel with the new in vitro screening, was the prime target.

Boyd outlined goals, strategies and program implementation of DTP for the FCRF committee:

"The (NCI) director has articulated the overall goal of NCI for the remainder of this century as the attainment of an overall reduction of 50 percent in cancer mortality by the year 2000. This goal is to be achieved by a balanced, concerted and coordinated Institute effort emphasizing further progress both in prevention and treatment. As a component of the Div. of Cancer Treatment, the Developmental Therapeutics Program identifies as its central mission the discovery of promising new anticancer drug candidates with maximum potential impact upon the achievement of the Institute's year 2000 goals. DTP also continues to bear major responsibility for preclinical drug development, as well as for the continuing support of clinical trials (e.g. through bulk drug synthesis, formulation, distribution, and quality control). However, the major contribution potentially to be made by DTP in the achievement of NCI's year 2000 goals clearly is in new drug discovery, particularly with a focus upon the major forms of cancer for which little or no effective therapy currently exists.

"It is only through innovation at the discovery stage that DTP can have a substantial impact on the introduction of promising new chemical entities into the clinical trials arena," Boyd continued. "Moreover, the introduction of such important new anticancer drug candidates must take place by the early 1990s to achieve the goal of major clinical impact by the year 2000. Continuing erosion of controllable base resources for new programs in drug discovery currently requires that any new DTP program must come at the expense of existing drug discovery program elements; at the same time, a minimum critical level of preclinical drug development capability must continue to be maintained to provide the follow through necessary for new drug innovation. Thus, it is particularly important that DTP's portfolio of new drug discovery initiatives represent a sensible balance between relatively short term, lower risk efforts and the longer term, higher risk ventures.

"The overall DTP strategy therefore is to emphasize the development and implementation, within existing resources, of a 10 year program aimed at the maximization of discovery, through exploitation of forefront science and technology, of novel drug candidates for treatment of the currently most common and/or least treatable human cancers.

"Adoption of the above strategy and the requirements for its implementation will necessarily impact all critical areas of management and administration of DTP including (a) organizational structure, (b) personnel, (c) budget, (d) space, and (e) specific projects/programs:

A. Organizational structure

Goals--"Simplify the DTP organizational structure, eliminating unnecessary, redundant or vestigial components; implement new organizational profile to most efficiently meet DTP central mission, while also maintaining other necessary DCT support responsibilities."

Status--"Major reorganizations of both the intramural labs and extramural branches to accomplish the above goals are in final phase."

B. Personnel

Goals--"Maintain viable and effective intramural and extramural program staff pool to support the central mission of DTP. This must be accomplished in context of a severely restrictive full time equivalent ceiling and increasing support responsibilities to other

DCT and NCI programs."

Status--"Major reductions in personnel have been achieved in the course of the above reorganizations and through termination of selected programs and positions. Moreover, responsibility for the development and implementation of an AIDS preclinical drug development program has been additionally assumed and accomplished, also thus far solely with existing DTP staff."

C. Budget

Goals--"Implement a balanced new drug discovery program entirely through systematic, stepwise reprogramming of existing DTP base resources."

Status--"During 1986 the existing P388 primary in vivo screening program was reduced to approximately 40 percent of its 1985 level to permit funding for research and development on the new in vitro human tumor drug screening program, and the complementary in vivo human tumor screening program. Extensive restructuring and streamlining of the existing DTP animal production program is underway to meet the more highly specialized animal requirements of the new screening program, and to partially fund the operational requirements for the new in vitro and in vivo human tumor screens. A major across the board reduction of the DTP preclinical drug development capacity (approximately six drugs a year capacity to four drugs a year) provided necessary one shot monies for equipment and certain renovation costs for the new FCRF projects. For future years these base resources would provide the operational funds for the DTP biochemical prescreen program (starting in 1987). Under our original plan, i.e. assuming level contracts budget, complete phase out of the remainder of the existing screening program in late 1987 would have allowed full capacity operation of the new screening program and the initiation of the final phase of DTP's national drug discovery group effort. The goal for the ultimate configuration of DTP's new drug discovery program consists of an approximately $20 million total effort comprised of $15 million in contracts and $5 million in cooperative agreements. The achievement of this goal has become severely jeopardized, however, due to a consistently decreasing contracts budget."

D. Space

Goals--"Close physical proximity or colocation of DTP's intramural and extramural program staff and the new primary screening program is essential, especially during the critical early years of its development and implementation. FCRF is ideally suited to serve as the focus for DTP's new drug discovery initiatives."

Status--"Current limitations in specialized intramural animal research needs and in vivo human tumor model development, as well as uncertainties about the future status of Landow Building (in downtown Bethesda) space for the DTP extramural program, further complicate the implementation of DTP's new programs. A proposal has been developed and forwarded to the NCI director recommending a series of space transfers and reallocations needed to support the further development of DTP's new programs."

E. Specific new projects/programs

Goals--"Develop and implement a new drug discovery project portfolio to emphasize state of the art, innovative efforts both in rational drug design and in screening. Such projects should encompass specific disease oriented initiatives as well as general cancer mechanism directed efforts. There should be a prudent balance between relatively shorter term, lower risk projects and the longer term, higher risk projects. The screening programs should be designed and implemented in such a way that they are amenable to rapid modification, reorientation or other changes in prompt response to relevant new scientific advances."

Status--"The concepts for the major new DTP drug discovery projects have been developed and presented in detail and have received the appropriate approvals by the DCT Board of Scientific Counselors and the NCI Executive Committee. These projects include both the FCRF Disease Oriented Human Tumor Cell Drug Screening Project (the BSC initially approved an abbreviated version in June, 1984, as the Lung Cancer Drug Discovery Project; subsequent BSC approval of the fully expanded project concept came in February, 1985) and the Biochemical Prescreens project (BSC approval in February, 1986). The DTP National Cooperative Drug Discovery Group program (initially approved by the DCT BSC in 1983) was approved in 1986 by the BSC for expansion in late 1987 to a projected full funding level of $5 million to include two new specific disease oriented NCDDG concepts (groups for lung cancer and colon cancer). The biochemical prescreens program will be recommended to the BSC in 1987 for final expansion to its ultimate funding level of

approximately $2 million.

"Several major problems have arisen which seriously jeopardize the successful and timely launching of the new drug discovery program as conceived above. These problems have arisen primarily due to unanticipated and unpredictable constraints in budget and space. These constraints, unless adequately resolved, would have a drastic effect on the timetable for phase out of existing programs, and the development and phase in of the new programs, and indeed could make unlikely or even impossible the implementation of certain key elements, especially the longer term, higher risk components of DTP's balanced program matrix.

"The specific issues with regard to our current crises in budget and space are as follows:

"Budget--The planning and development of the new DTP as described herein was undertaken, beginning in 1984, under the assumption that DTP's resource base for development of new programs through internal reprogramming, would remain reasonably stable. Unfortunately, however, this has not been the case. DTP's controllable contract budget has shown a consistent, if not accelerating, decline. This is largely the result of the high vulnerability of DTP's contracts line as a potential source of funds for other rapidly developing high priority projects with DCT, such as Rosenberg's LAK cell project. With inadequate additional funding available to the division from elsewhere for such quickly breaking, and indeed exciting, new areas, the DCT director really has very few, if any, other reasonable options. However, the DTP contract base is now down to a crisis point, to the extent that we need to realistically reexamine our strategy and determine whether the 10 year plan, as originally conceived, can be accomplished at all.

"DTP's goal was to have in place by the end of 1988 its new drug discovery program, comprised of approximately $15 million contract activities (divided approximately equally between in vitro screening, in vivo screening and acquisitions programs) plus approximately $5 million total for the National Cooperative Drug Discovery Group Program. However, as the result of major decreases in DTP's contract base, both in 1985 and 1986 (total of approximately $4.5 million), this goal now no longer appears achievable; moreover, DTP must either immediately terminate more of its existing contract activities or excise other major DTP program elements, in order to meet its 1987 budget. The least disruptive option overall to the DTP new program development would be to terminate early the remaining P388 based screening program. Other possible options, which would have a major impact on either our intramural program or our remaining contract supported preclinical drug development capability, would not seem prudent.

"Space--As is clearly apparent in the timetable, there have been very long delays in the identification and development of permanent space for the operation of the new screening and natural products programs at FCRF. This has created an urgent need to have identified and assigned temporarily to DTP the necessary space for interim accomodation of these projects. Moreover, there is an immediate need to relocate an intramural research component of DTP from Bldg 37 (on the Bethesda campus) to FCRF. This would provide necessary on site basic research support for the new DTP programs under development at FCRF.

"DTP has forwarded to the NCI director a specific proposal for a space exhange and reallocation plan which addresses all the above issues," Boyd concluded.

New Publications

"Choices: Realistic Alternatives in Cancer Treatment," by Marion Morra and Eve Potts. Revised from the 1980 publication, it is designed to guide the patient in dealing with doctors, hospitals, diagnostic tests, treatments and side effects. Includes full chapters on the major cancers and an up to date nationwide listing of cancer treatment centers. Avon Books, 1790 Broadway, New York 10019, $10.95 U.S., $14.95 Canada. Avon said it will donate 50 cents for each copy it sells to the American Cancer Society and will match any amount buyers contribute to ACS along with their purchase.

"Genitourinary Cancer Management," edited by Jean deKernion and David Paulson. Lea & Febiger, 600 Washington Square, Philadelphia 19106, $50.

"An Ounce of Prevention," a new edition of the American Institute for Cancer Research cookbook. Includes recipes for reduced fat and calories, more fruits, vegetables and whole grains. A four volume series, one for each season, it is available for $6 per volume from AICR, Dept. CB, Washington DC 20069.

RFAs Available

RFA 87-AI-05

Title: Pathogenesis and immunology of animal lentivirus infections

Application receipt date: March 19

The National Institute of Allergy & Infectious Diseases invites applications for regular research grants to investigate the pathogenesis and immunology of animal lentivirus infections. These studies may explore any of the proprties of the virus or host that are responsible for or contribute to the pathologic processes encountered in the infections and/or the mechanisms of protective immunity.

AIDS is characterized by a severe and persistent breakdown in the immune system with a very high mortality rate. AIDS is caused by an infection with the retrovirus HTLV-3/LAV, which is considered by many to be closely related to lentiviruses. This project will support studies in comparative virology and immunology of this closely related group of viruses to provide additional basic information of potential importance to the study of AIDS.

NIAID wishes to stimulate research on the pathogenesis and immunology of animal lentivirus infections, including those caused by HTLV-3 and other immunosuppressive retroviruses. Accordingly, NIAID wishes to solicit regular grant applications in these areas to determine if properties of the virus or of the host's response to infection can explain the pathologic processes that occur during or as a result of the infections. Proposed areas of investigation may focus on the properties of the virus that might explain pathogenic processes or characteristics of the host's humoral or cellular immune repsonse that might predispose to certain pathogenetic processes. Equally important are investigations on the mechanisms of protective immunity and vaccines.

Interested investigators may propose in vivo or in vitro laboratory studies or a combination of both. Finally, investigators may propose studies involving more than one investigator or institution.

For additional information and copies of the complete RFA contact John Nutter, PhD, Chief, Prevention Branch, AIDS Program, NIAID, Westwood Bldg Rm 753, NIH, Bethesda, MD 20892, phone 301/496-0545.

RFA 87-CA-03

Title: Prospective randomized studies correlating current treatment procedures with pain reduction in pancreatic cancer

Application receipt date: April 9

The Div. of Cancer Prevention & Control, through the Organ Systems Program, invites research grant applications from organizations capable and interested in participating in a network of collaborating research groups charged with carrying out studies in the reduction of pain in pancreatic cancer patients.

This RFA will be utilized to initiate prospective, randomized studies, which will be implemented through a collaboration among the successful applicant organizations. NCI proposes to encourage up to five existing pain research groups to assemble the expertise and patients needed to evaluate pancreatic cancer pain. The main goal is to determine which of the currently used, single or combined, procedures for treating pancreatic cancer patients are correlated with measurable and significant pain relief.

Since there are no treatments for pancreatic cancer which increase survival significantly, and there is no known way to prevent the disease, a special research emphasis to identify the best current methods to reduce pain and thus improve the quality of life deserves high priority.

NCI recognizes that research on pain in pancreatic cancer is technically difficult to conduct. The relatively low incidence of the disease combined with a brief survival results in few study subjects becoming available at an institution at any specific time. Furthermore, the complexity of the disease course elevates the numbers of patients which would be required for testing hypotheses adequately. An inter-organizational networking effort might overcome these difficulties and make possible the accrual of sufficient patients to answer definitive questions.

Organizations with established pain research facilities are encouraged to take the leadership in response to this RFA. Such organizations before applying are required to have the capacity for establishing liaison with investigators involved in clinical research in cancer, including specific expertise in the treatment of pancreatic cancer. The applicant organization or its affiliate should be involved in treating pancreatic cancer patients. At the time of submission, the required qualified investigators, technical expertise, patient populations and facilities should exist in the applicant organization and its proposed affiliates.

Potential applicant organizations are encouraged, but not required, to submit letters of intent and to consult with NCI staff before submitting. Letters of intent are requested by Jan. 16. The letter of intent will not enter into the review of an application submitted in response to this RFA.

The support mechanism for this program will be the NIH investigator initiated research grant (RO1). Applicants may apply for a period of support of up to three years. Funds will support research related to the protocols developed by the collaborative network. The awards also will support travel, planning, communications, and data management connected with the network effort. Contingent on the availability of funds and dependent on the receipt of a sufficient number of applications of high scientific merit, it is anticipated that five awards will be made at an annual total cost of approximately $400,000. Before the end of the three year period of funding, the Pancreatic Cancer Pain Network will be evaluated by NCI and a means for possible continued or expanded support determined.

Requests for copies of the RFA may be obtained from, and letters of intent directed to, William Straile, PhD, Cancer Centers Branch, DCPC, NCI, Blair Bldg Rm 727, NIH, Bethesda, MD 20892, phone 301/427-8818.

NCI CONTRACT AWARDS

Title: SEER Program modifications

Contractors: Connecticut Dept. of Health, $1,107,565; Fred Hutchinson Cancer Research Center, $893,182.

Title: Preparation of bulk chemicals and drugs by small business for phase 2 and 3 clinical trials

Contractors: Starks Associates Inc., $1,286,046; and Ash Stevens, $1,741,660

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

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