THE CANCER LETTER

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NCI Programs To Average Eight Percent Increase Over '87 Under House Total, But Some Would Vary

NCI has submitted to NIH its analysis of how the FY 1988 budget approved for it by the House last week would impact the Institute's programs. By press time this week, NIH had not yet completed its own analysis, and the estimates were not yet available. The total approved by the House for NCI,

(Continued to page 2)

In Brief

Robert Bast Succeeds Singleton As Director Of Duke Cancer Center; Robert Bell Deputy

DUKE UNIV. has named the successor to **William Shingleton** as director of its Comprehensive Cancer Center. He is **Robert Bast**, who had been codirector of the Div. of Hematology and Medical Oncology at the Duke Medical Center and director of clinical research for the cancer center. Bast, 43, joined the Duke faculty in 1984 from Harvard, where he was associate professor of medicine. He received his MD from Harvard. **William Anlyan**, Duke chancellor for health affairs, also announced that **Robert Bell** had been named deputy director of the cancer center. Bell, also 43, is professor of biochemistry at Duke. He has been at the university since 1972, after receiving his PhD in biochemistry from the Univ. of California (Berkeley). Shingleton, the founding director of the cancer center, has spent his entire career at Duke after receiving his MD there, except for his wartime service. He will retire later this year. . . . **UNIV. OF ARIZONA** Cancer Center is seeking someone to fill a newly created senior level position as head of its biostatistical unit. The job involves overseeing and coordinating biostatistical resources related to cancer clinical trials and laboratory programs. A junior faculty level position is also open which involves extensive professional collaborations and interactions with epidemiology and prevention and control programs. Contact Frank Meyskens MD, Chairman of Biostatistical Recruitment, Arizona Cancer Center Rm 3945, Univ. of Arizona, Tucson 85724. . . . **JOHN GUNN**, senior vice president and chief fiscal officer at Memorial Sloan-Kettering Cancer Center, has been appointed executive vice president and chief operating officer. . . . **SAMUEL HELLMAN**, physician in chief at MSK, has been elected to the Institute of Medicine of the National Academy of Sciences. His boss, MSK President **Paul Marks**, has received an honorary doctor of philosophy degree from Hebrew Univ. in Jerusalem.

Construction Program In Jeopardy, With Senate As Final Hope For '88

(Continued from page 1)
$1.448 billion without the $94 million in AIDS money that would be allocated out of the HHS Secretary's office, represents an increase of eight percent over the 1987 appropriation.

While overall spending would have to average an eight percent increase (barring AIDS expenditures) the increases allocated to individual programs could vary considerably. For instance, without any money for construction, the average goes up a little elsewhere. NCI received $5 million for construction in FY 1987. Other variations will be made for programmatic reasons.

Using the eight percent figure for some of the major programs would give these approximate totals: centers, $100 million; cancer control, $72 million; intramural, $250 million; research project grants (RO1s, PO1s), $700 million.

What that would do to paylines, percentage of approved that are funded, and how much reduction from recommended levels would have to be taken, all have yet to be determined. The House Appropriations Committee recognized that some reductions from peer review approved levels would have to be taken.

The program in greatest jeopardy is construction. For the first time since the construction program received the major boost in funds after passage of the National Cancer Act, one body of Congress has gone along with the perennial Administration requests to abolish extramural construction grants. The committee indicated that leaving money out this year possibly would be only a temporary situation, pending a review of construction needs. The Senate more than likely will restore some funds.

Congress adjourned with the Senate Labor-HHS-Education Appropriations Subcommittee, which is chaired by Lawton Chiles (D-FL), still not having marked up its bill. That will be first on the agenda when Congress reconvenes Sept. 9.

Correction: The total for AIDS funding in the House bill for the National Heart, Lung & Blood Institute is $25.8 million, not $94 million as reported last week in **The Cancer Letter**. NHLBI is receiving $17.1 million in the current fiscal year. NCI's total in the House bill for AIDS is $94 million, up from $61.7 million this year.

Biomedical Science Leadership-- "America's Greatest Contribution"

The issue of whether money appropriated by Congress for NCI has been well spent comes up every year, usually about the time the House and Senate appropriations subcommittees are getting ready to write the bills (the "countless billions," one critic said, which prompted NCI Director Vincent DeVita to say that critic must not be able to count up to 15, that being the number of billions spent by NCI in its 50 year history).

Just how well that money has been spent which has been appropriated for NCI since the National Cancer Act of 1971 was put into place is of particular interest to Benno Schmidt--he headed the Citizens' Panel which drafted the recommendations that led to the Act. Schmidt was the first chairman of the President's Cancer Panel, a creation of the National Cancer Act, and as such he played a major role in helping to determine how much of the increased money was spent.

Schmidt particularly enjoys responding to that issue, and his address at the Academic Convocation at Memorial Sloan-Kettering Cancer Center, where he is chairman of the Boards of Managers and Overseers, was one of his best efforts.

"This money has been well spent--the bulk of it on good basic biomedical research--with the result that the research of the past 15 years is beginning for the first time to give us enough knowledge at the cellular level to commence a fundamental attack on many of the diseases that make up today's health agenda, including, of course, cancer," Schmidt said.

"Let us be thankful that we as a nation have had the wisdom to pursue basic biomedical knowledge with greater determination and zeal. This nation's leadership in biomedical science will one day be recognized as America's greatest contribution to civilization in this era."

Schmidt took on the critics head first. "Fifteen years have passed since Congress enacted the National Cancer Act of 1971 calling for an enhanced and accelerated National Cancer Program. During that 15 years enormous scientific progress has been made. And yet, in the past few days we have seen once more the General Accounting Office questioning the performance of the National Cancer Program, and the "New York Times" editorial page questioning the 'battle plan' of the National Cancer Institute and

suggesting that the Cancer Program is in 'stalemate.' The same suggestions received much publicity one year ago when they were made by Dr. John Bailar of the Harvard School of Public Health. These and similar criticisms seem to raise two questions: (1) Have we really made during the past 15 years scientific progress that is unmatched in the history of biomedical research? And, (2) if so, what is the explanation of these negative views?

"As to the first of these questions, it is clear to me that we have made even greater scientific progress than any of us could have anticipated at the time the National Cancer Act was passed. As a result of the Act, the budget of the National Cancer Institute moved in successive steps from $180 million in 1971 to over $1.2 billion in 1986, and equally importantly, the budgets of the National Institutes of Health went from $1 billion in 1971 to $5.3 billion in 1986, thus belying the fears so widely expressed in 1970 and 1971 that any increase in the cancer budget would be at the expense of the other institutes of NIH."

Schmidt referred to "this new biological revolution" made possible by the increased federal support, including progress against a host of diseases in addition to cancer.

"These developments illustrate once more that no one can predict in advance the clinical areas to which good basic research will lead. Although much of the research that led to the recombinant DNA technology was funded as a result of the Cancer Act, we see from these examples that, as we promised Congress in 1971, there will be a very significant impact on diseases other than cancer.

"But there are also a number of other substances that will, in all likelihood, be very significant in cancer medicine: the factors that stimulate the growth of various types of white cells (GM-CSF, G-CSF, M-CSF, interleukin-3), and also tumor necrosis factor, interleukin-2, and the interferons.

"It is too early to know with certainty how important any of these products will be; but the probability is high that this list and many other products to come will produce a significant impact on today's disease agenda. Equally important are the monumental discoveries relating to a great variety of monoclonal antibodies and oncogenes.

"While I cannot hope to begin to do justice in these few minutes to even a summary of this vast new body of basic biomedical science, or to the excitement which it engenders, I hope I have been able to convey the idea that our basic science is racing ahead at a pace that is totally unprecedented; that reaches almost beyond the imagination; and that seems certain to produce important consequences for today's health agenda.

"I should mention one final development that would never have occurred if we had not materially increased the pace of our government funded academic research. In the past 15 years, hundreds of millions of dollars have gone into the establishment and operation of biotechnology companies and genetic engineering divisions of existing pharmaceutical companies committed solely to biomedical technology transfer. There can be no doubt today that the caliber of science being performed in the best of these companies is, for the first time, on a par with the best biomedical science being conducted in our academic centers. This means that today we will get our basic science discoveries to the patient at a rate never before approached and largely with private rather than government funds.

"These private sector dollars would not be going into our biomedical research effort but for the science foundation built by the government supported academic research of the past 15 years, and the flow of these entrepreneurial dollars is the strongest possible evidence of the promise that this science holds.

"Now, if the results of our biomedical research of the past 15 years are so compelling, why the controversy over whether the money has been and is being well spent? That is a very complex question. For one thing, cancer research has always been controversial. Don't ask me why, but it has. Fifteen years ago I was recruited to go to Washington and head a Senate Panel to make recommendations on the subject. I must say that I went in the innocent belief that no one would be opposed to better and more extensive cancer research. How wrong I was. Who opposed the idea of an enhanced and accelerated cancer research program 15 years ago? It seemed at the time that almost everyone did, including, among others, many of our most distinguished biomedical scientists. Among other things, they told us that we didn't know enough to spend more money. Some of us thought that was

precisely why we needed to spend more. Fortunately, Congress and the President supported us, and the National Cancer Act became law.

"After 15 years, the scientist have long since been won over. They have seen the money spent for first class basic research; they have seen the budgets of the other institutes grow proportionately with that of the Cancer Institute; they have seen the rapid explosion of scientific knowledge; in fact, many of the early doubters have significantly contributed to that explosion, and it is their peer review that has largely guided it. I know of no first class scientist today who doubts the wisdom or desirability of the program that has put us where we are. Such esteemed leaders of the scientific community as Dr. David Baltimore and Dr. Lewis Thomas have publicly asserted that they were wrong 15 years ago and have expressed themselves as most thankful that their views did not prevail. But though the scientists have been won over, it is clear that some of the other doubters have not.

"Since the progress in building the fundamental science base is essentially irrefutable, such critics as the General Accounting Office, the "New York Times," and a few others such as Dr. Bailar are now looking at the cancer statistics and they are critical because we failed to go, in 15 years, from a position in which the best of our scientists were saying that we didn't know even enough to spend more money on research to a position of having eliminated enough human cancer to make a major impact on the cancer survival statistics. This is a patently untenable position. In the first place, they are looking at the 1982 statistics, which means they are looking at patients treated in the mid-70s before the Cancer Act could possibly have had an impact; more importantly, no one could have expected substantial inroads on human cancer without first having a major expansion of our knowledge.

"All of us agree that all of what we do is aimed ultimately at the cancer patient. We want to prevent his cancer and, failing that, to diagnose it early and cure it. And the final test of our success will be reflected in the cancer statistics. But not today. Most of the substances I have mentioned as examples of our progress were discovered or first produced within the last five years or so, and we all know the time it takes to purify these products, obtain the expression essential to large scale production, determine the safety and efficacy, do clinical trials, get regulatory approval, move into commercial production; and only then into patient use--first gradually and then, if our hopes are realized, more generally. This is necessarily a long cycle but we are beginning to see results, and it is ironic that those who are now most vocal in their impatience were among those who 15 years ago opposed the expansion of our research.

"We have in fact made notable progress in the clinic in the past 15 years in many types of cancer. I wish I had time to summarize the clinical advances that have been made because, to the tens of thousands of patients who are leaving our hospitals cured today who would have been lost 15 years ago, those advances are important. Of course, these advances are partially offset in the statistics by other statistically negative forces beyond our control--some good, such as the increasing age of the population, and some bad, such as our inability to make much progress in reducing smoking.

"But there is no need to quibble about the statistics, and we should not be misled by them. Starting as we did 15 years ago with almost no knowledge of how cancer or even we as human beings worked at the cellular level, it is clear that there has not been time for a major statistical impact, and no one need apologize for that (particularly with a five year time lag in the statistics).

"The important thing is that we have not been standing still. We are building at an incredible pace an enormous base of knowledge at the cellular level, and knowledge has always been the condition precedent to major steps in clinical progress. Only after we knew about germs could we make antibiotics; only after we knew that three viruses and no others caused polio could we develop a vaccine. I wish there were a faster way, that we could cure disease without going through the laborious process of learning to understand it. Unfortunately there are no shortcuts. In the most literal sense of the words, life is not that simple. But there is no doubt in my mind that clinical results in the next few years will begin to reflect the progress of our recombinant DNA research and the developments in monoclonal antibodies, oncogenes and other related areas. . . With a little luck, we will see major clinical advances emerge."

NCRP Announces Recommendations For Radiation Protection Standards

Revised recommendations on radiation protection standards for workers and the public were announced this week by the National Council on Radiation Protection & Measurements (NCRP), a congressionally chartered, nongovernmental scientific body. The revised recommendations are published in NCRP Report No. 91, "Recommendations On Limits For Exposure To Ionizing Radiation."

"The report contains substantial changes from our 1971 report on this subject," Warren Sinclair, NCRP president, said.

The report introduces a new concept of a risk level so low as to be negligible and to require no attention or action. That level, called a Negligible Individual Risk Level, corresponds to a radiation exposure of 0.01 millisievert or 0.001 rem per year.

Another change is the recommendation that occupational exposures of pregnant workers be managed so that the unborn child receives no more than a tenth of the recommended population exposure limit in any month during the pregnancy. The earlier recommendation had urged that the unborn child receive no more than the recommended annual population exposure limit for infrequent exposure but did not recommend the monthly limit which could be important relative to organ formation at certain stages. Such levels can be achieved with pregnant workers by changing work assignments or by providing added shielding.

In this report, NCRP urges that exposures from internal and external sources be explicitly added to obtain a person's total exposure. Total exposure has always been considered but heretofore NCRP had not recommended a method that allowed specific addition of internal and external exposures and the addition of exposures to different parts of the body.

The exposure limits recommended by NCRP are intended to apply to all man made radiation sources except medical procedures and cover exposure of members of the public and workers. As a lifetime guide, NCRP recommends that employers control radiation levels in the work place such that the cumulative occupational exposure of employees does not exceed 10 millisieverts (1 rem) for each year of life, though the worker maximum for a single year is 50 millisieverts (5 rem). NCRP is dropping a more complex formula for lifetime exposure based upon the difference between the worker's age and age 18.

This report also recognizes that on rare occasions it may be necessary to permit a few workers to exceed the annual limit of 50 mSv (5 rem) in order that certain essential tasks be performed. The lifetime limit for these planned special exposures is 100 mSv (10 rem) which may be received at one time or over the working life of the employee and are to be separately recorded from other radiation exposures.

The report recognizes that neutron radiation, potentially received by a relatively small number of workers, is biologically more potent than previously thought. So NCRP urges the assignment of a 20 fold factor in comparing neutron exposures to exposures from x-rays or gamma rays, rather than the 10 fold used previously.

For exposures to members of the public, NCRP reaffirms the annual limits it adopted three years ago of 1 millisievert (0.1 rem) for continuous exposures not including exposures from natural background radiation, as well as a level five times that great for infrequent or episodic exposures. Also reaffirmed are the remedial action levels for radiation exposures of individuals of 5 millisierverts (0.5) rem) per year for continuous external exposures including natural background radiation and two working level months per year (0.007 joule hours per cubic meter) for continuous lung exposures from radon and its progeny.

Report 91 is available for $11 from NCRP, 7910 Woodmont Ave., Suite 1016, Bethesda, MD 20814.

DCPC Planning To Make Up To 10 More Prevention Fellowship Awards

NCI's Div. of Cancer Prevention & Control has reissued its call for applications for the Cancer Prevention Fellowship Program. This program is aimed at attracting individuals from a multiplicity of health science disciplines into the field of cancer prevention and control research.

Here's what the program provides:

*Participation in the DCPC Cancer Control Academic Program, a formal four month course in cancer prevention and control

*Twenty months at NCI working directly with individual preceptors on ongoing cancer prevention and control projects and the NCI Year 2000 goals.

*One year at a DCPC approved cancer control program or state health department (this may be optional).

Funding permitting, up to 10 fellows will be accepted for up to three years of training, beginning Aug. 28, 1988. Benefits include selected relocation and travel expenses, paid federal holidays, and participatory health insurance.

Applicants must possess an MD or DO from a U.S., Puerto Rico or Canada medical school or have a current ECFMG/FMGEMS certification and have completed approved PG1 Council on Medical Education internship. Alternatively, candidates may possess other accredited U.S., Puerto Rican or Canadian doctoral degrees in a discipline related to cancer prevention and control research (biomedical, medical, nutritional, public health or behavioral sciences) or provide documented evidence that doctoral foreign education is comparable to that received in accredited U.S. institutions.

Applicants must possess U.S. citizenship or be a resident alien eligible for citizenship within four years.

Application packets may be obtained by sending a postcard with name and address to CPFP Coordinator, NIH/NCI/DCPC/CCAB, Blair Bldg Rm 4A05, Bethesda, MD 20892, or by phoning 301/427-8788.

Tobacco Council Awards $10 Million In '86, Bringing Total To $110 Million

The Council for Tobacco Research said in its recently released annual report that it awarded more than $10 million in grants for research on smoking and health in 1986, bringing the total awarded since 1954, when the Council was formed, to more than $110 million.

The funds have supported 592 independent scientists for 969 original research projects in 296 medical schools, hospitals and research institutions, the report said.

Grant applications are evaluated by the Council's Scientific Advisory Board. Two scientists joined the Board last year--Jeffrey Idle, senior lecturer in pharmacology at St. Mary's Hospital Medical School, London; and Alfred Knudson, recently retired director of the Institute for Cancer Research, Fox Chase Cancer Center.

Also during the year, Peter Howley, a Board member since 1982, resigned and was replaced by Roswell Boutwell, who rejoined the Board after spending two years in Hiroshima as chief of Research of the Radiation Effects Research Foundation. Boutwell, with McArdle Laboratory at the Univ. of Wisconsin, is a member of the National Cancer Advisory Board.

U.S., Japan Establish Joint Biomedical Panel On AIDS

The United States and Japan have announced the establishment of a new biomedical panel to foster collaborative research on acquired immune deficiency syndrome.

The joint panel will be composed of five scientists from each country, and will encourage bilateral collaboration and convene annual scientific meetings to promote sharing of information, materials and techniques in AIDS research.

Although selection of panel members is not yet complete, officials of the National Institute of Allergy & Infectious Diseases, which will administer the U.S. program, have chosen Martin Padarathsingh as program officer for the U.S. panel. Padarathsingh is chief of NIAID's AIDS Program Pathogenesis Branch. Japanese officials have named M. Ito, director of the Office of Infectious Disease Control in Japan's Ministry of Health & Welfare, as program officer for the Japanese panel.

High Priority Areas

Guidelines for the panel will assign high priority to specific research areas: drug and vaccine development, including the establishment of in vivo and in vitro model evaluation systems; clinical and epidemiological studies to determine risk factors for infections caused by AIDS and other retroviruses; and basic research into the causes of AIDS.

Other areas include followup studies to determine how frequently immunodeficiency or neurological disorders occur as a consequence of chronic HIV infection; and the identification and long term study of populations at high risk for developing HIV infection. The panel will also exchange information and share techniques and materials pertinent to studying human retrovirus infections.

AIDS is the tenth area of study established by the U.S.-Japan Cooperative Medical Science Program since its inception in 1965. Other panels address a variety of areas, including viral diseases, environmental mutagenesis and carcinogenesis, and immunology.

RFA Available

RFA 87-DK-09

Title: Pathogenesis of intestinal dysfunction in AIDS
Application receipt date: Nov. 23

The National Institute of Diabetes & Digestive & Kidney Diseases wants to stimulate support of multi-disciplinary basic and clinical research aimed at examining the causes and consequences of intestinal dysfunction and their response to treatment of AIDS.

NIDDK is inviting applications for regular research project grants relating but not limited to:

A. Studies of the severity and course of mal-nutrition and its relationship to the timing of death and to the observed immune deficiency.

B. The characterization of the intestinal injury that occurs in patients with AIDS, the examination of its development from infectious and noninfectious factors, and the determination of the relationships between intestinal injury and dysfunction.

C. The determination of the mechanisms of intestinal maldigestion and malabsorption in AIDS and their response to treatment of selected aspects of the syndrome.

D. Investigation of intestinal mucosal immune function in AIDS.

E. The determination of the intestinal epithelial portals of entry (including mechanisms of adherence and penetration) in AIDS of the viral causative agent and opportunistic pathogens.

F. The development of strategies for treating patients with AIDS using a combination of treatments effective against both the viral causative agent and opportunistic pathogens, correction of nutritional deficiencies, and immunomodulatory agents.

The abnormalities of gastrointestinal function in AIDS are certainly complex, and although not the primary cause, they could play a major role in the course and clinical outcome of the disease. The proposed studies should provide information that might be important in devising strategies to treat this disease effectively.

Support for the initiative will be through grant in aid and applications may be submitted for traditional research project grants (RO1s) only. NIDDK plans to make 10 to 14 awards for up to five years under the program, with total FY 1988 funding for the entire initiative expected to be $2.8 million.

Support is contingent on the actual availability of funds and receipt of applications deemed worthy of support by the accepted NIH peer review procedure.

The RFA label available in the 9/86 revision of application form 398 must be affixed to the bottom of the face page. Failure to use this label could result in delayed processing of the application such that it may not reach the review committee in time for review.

For more information, and copies of the complete RFA, contact, G.G. Roussos, PhD, Director, Pancreas Program, and Gastrointestinal Digestion & Immunology Programs, DDDN/NIDDK, NIH, Westwood Building, Room 3A-18A, Bethesda, MD 30892, phone 301/496-7121.

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-CN-75432-20

Title: Master agreements to conduct efficacy studies of chemopreventive agents in animal models
Deadline: Approximately Oct. 3

Master agreements will be awarded to all offerors who are found to be technically acceptable. This pool of offerors will be eligible to compete for master agreement orders (MAOs) for a five year period of performance. It is estimated that 10 MAOs will be awarded per year.

The objective of this study is the evaluation of efficacy of various designated chemopreventive agents at several dose levels in animal models and the refinement and improvement of animal test models for chemopreventive studies. The emphasis of the activity will be to take initial leads on designated agents and expand the data base as to the spectrum of carcinogens, spectrum of target sites and range of species.

These agents have previously been evaluated for chemopreventive activity in various in vitro tests and in a limited number of in vivo studies. However, before a decision can be made as to their suitability for phase 1 clinical trials, their efficacy and bio-availability must be evaluated in various animal models. Agents to be tested are potentially hazardous. The animal model systems also involve the use of carcinogens. Laboratory practices shall be employed which will keep any element of risk to personnel at an absolute minimum. Where indicated, tissue and compound handling must be performed in (at least) class 1 laminar flow cabinets which must meet NIH specs for work with carcinogen agents. It shall be required that the animal facilities be maintained in accordance with PHS policy on humane care and use of laboratory animals.

Incoming animals are to be held in quarantine to monitor health and condition prior to entrance into the experimental animal facility. All laboratory and animal studies are to be conducted in facilities that are in full compliance with the FDA good laboratory practice regulations.

The contractor must have all the equipment necessary to accomplish the studies including but not limited to animal racks and caging, hazardous chemical storage cabinets and refrigerators, pathology equipment such as microscopes and microtomes and miscellaneous laboratory equipment. The laboratory shall have or have access to appropriate terminal and computer facilities and equipment for data collection and storage.

Contracting Officer: Charles Lerner
RCB Blair Bldg Rm 2A07
301/427-8745

AIDS Prevention Projects

FY 1987 supplemental funds available for cooperative agreements from the Centers for Disease Control

CDC announces the availability of supplemental funds in the amount of $27 million for AIDS prevention project cooperative agreements. This is in addition to $24.4 million already awarded for such projects.

These cooperative agreements are limited to official public health agencies of the states, District of Columbia, Puerto Rico, Virgin islands, Guam, Micronesia, Marshall Islands, Palau, Northern Mariana Islands, and American Samoa, plus local governments which have reported at least 2,000 cases of AIDS.

Purpose of these awards is to assist state and local health departments in (1) establishing or maintaining AIDS health education/risk reduction programs for the general public and high risk groups (2) maintaining counseling and testing services that confidentially and effectively target individuals at

high risk for AIDS and educate them about ways to prevent transmission od HIV infection through sexual activity, parenteral drug use and donating blood, semen or other body fluids; and (3) evaluating the effectiveness of those programs and services in reducing transmission of HIV.

Of the total funds available in the supplemental appropriations, $20 million is available for AIDS prevention activities, primarily counseling, testing and partner notification efforts. The remaining $7 million is intended for competing awards to support initiatives targeted to minority populations. Priority consideration will be given to areas with comparatively large numbers of diagnosed AIDS cases, or other evidence of increased risk among minorities.

Prevention of HIV perinatal infections

CDC has available $1.484 million in FY 1987 money to fund one to three new cooperative agreements ranging from $350,000 to $1.484 million with an average award of $495,000. It is expected that new cooperative agreements will begin on or about Sept. 1, 1987 and will be funded for 12 months in a one to five year project.

This program also is limited to state, local and territorial health departments. Applicants are encouraged to have health care providers or research groups participate in the program. The proposed program must be located within or include a Standard Metropolitan Statistical Area, with a minimum of 10 cases of AIDS among adult women meeting the CDC case definition and reported to CDC during the 1986 calendar year.

Current state and local AIDS prevention projects are designed to prevent infections among women and children by expanding health education and risk reduction efforts among IV drug abusers; promoting less risky sex practices among nonmonogomous women of reproductive age; developing approaches to reach female sex partners of infected males; and expanding efforts to involve minority communities at increased risk of HIV infection. This program's objective is to meet an urgent need to develop additional programs to prevent pregnancies among HIV infected women, and women at high risk of HIV infection.

Since the program is a demonstration, it is intended that grantees will identify and develop a rationale for promising and different approaches, and conduct evaluation studies to demonstrate which of the approaches is most effective.

Grantees will be expected to obtain community participation, define the target population, develop methods to identify infected women, develop education and counseling methods, develop referral systems, evaluate the effectiveness of the program by developing and implementing (1) systems to monitor program activities and the outcomes of interest and (2) evaluation studies to determine the best education and counseling methods and referral systems; and participate in the transfer of perinatal prevention information and methods developed in this program to other states and communities.

CDC will provide consultation and technical assistance in planning, operating and evaluating activities for preventing the perinatal transmission of HIV infection and AIDS; will provide current scientific information relevant to program strategies for such prevention; participate in the analysis of data gathered from program activities and the reporting of results; and participate in transfer of perinatal prevention information and methods developed in this program to other states and communities.

Information on application procedures may be obtained from Grants Management Branch, Centers for Disease Control, 255 E. Paces Ferry Rd NE, Rm 321, Mailstop E14. Atlanta, GA 30305, or by phoning 404/262-6575.

Resource for Mapping of DNA Probes

The Metabolic Diseases Reserch Program of the National Institute of Diabetes & Digestive & Kidney Diseases, and the Div. of Life Sciences of the Los Alamos National Laboratory, have developed a resource for mapping of DNA probes by hybridizing 32-P labeled DNA probes to dot blots of separated and purified human chromosomes on nitro cellulose filters. Los Alamos staff will provide the laboratory services required to map a minimum of 20 probes during the first year of the service without charge to the applicant. Mapping of two DNA probes per month is anticipated.

Researchers who are principal investigators on at least one NIDDK supported grant at a domestic institution will have highest priority. Researchers supported by other NIH institutes and the Div. of Research Resources will also be given consideration. Researchers with no active NIH support will be considered only if resources are available.

Eligible applicants should have at least three years of research experience in genetics with a publication in a peer reviewed journal relevant to genetics.

In order to qualify for mapping, a human genomic cloned DNA probe, or a synthesized DNA probe, or a mouse DNA probe must meet the following requirements: be a single copy, be free of repetitive sequences, have a documented clean Southern blot, and be ready for labeling with P-32 (150 million counts). Only one probe per application will be considered.

The application should include a description of the probe (including a reproduction of a recent Southern blot of the probe to be mapped); any additional useful data and expectations; documentation on elegibility (description of grant support and one peer reviewed scientific publication or preprint in related research areas; when the service will be needed.

Service will start Sept. 1, 1987. Applications must be received at least one month before the requested date of service. The applicant will ship the labeled probe to the Life Sciences Div., Los Alamos National Laboratory, where expert staff will map the probe. Probes that map to chromosomes 9-12 will require a second shipment in order to complete the mapping process.

Send applications to Robert Katz, PhD, Director, Metabolic Diseases Research Program, NIDDK, Westwood Bldg Rm 607, Bethesda, MD 20892, phone 301/496-7997.

NCI CONTRACT AWARDS

Title: Resource to support the chemical, economic and biological information needs of the Div. of Cancer Etiology and to provide chemical process, production and economic information as support to the International Agency for Research on Cancer
Contractor: Technical Resources Inc., $1,701,096

Title: Survey of compounds which haye been tested for carcinogenic activity 1987-88 and 1989-90
Contractor: Technical Resources Inc., $720,542

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