THE CANCER LETTER

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Centers, Groups, Others May Land In DeVita's Office; Hammer Offers Deal Congress Can't Refuse

A potential major reorganization involving several highly visible NCI programs, a possible $1 billion shot in the arm, and a definite decision to stop all funding of the Women's Health Trial at the end of next month were brought to the

(Continued to page 2)

In Brief

Kirsten To Join NCI As Head Of FCRF, AIDS Vaccine Development; Thaddeus Domanski Dies

WERNER KIRSTEN will leave the Univ. of Chicago to take over two of the jobs formerly held by NCI Deputy Director Peter Fischinger--director of the Frederick Cancer Research Facility and head of NCI AIDS vaccine development, relieving Div. of Cancer Etiology Director Richard Adamson of those tasks. Fischinger is now detailed for a year as the Public Health Service AIDS coordinator. Kirsten has been chairman of NCI's FCRF Advisory Committee.... **THADDEUS DOMANSKI**, who retired in 1983 as chief of the Chemical & Physical Carcinogenesis Branch in the Extramural Program of the Div. of Cancer Etiology, died of cancer Jan. 22 at Bethesda Naval Hospital. He was 76. He had been at NCI 16 years, after retiring from 23 years service in the Air Force. . . . **PRESIDENT'S CANCER** Panel will meet March 1 at the Columbia Univ. Cancer Center, 9 a.m.-1 p.m., to hear presentations on innovations in cancer therapy. . . **MAXINE SINGER**, chief of the Laboratory of Biochemistry in NCI's Div. of Cancer Biology & Diagnosis, became president Feb. 1 of the Carnegie Institution in Washington DC. She has been named scientist emeritus at DCBD and will continue with her own research. DCBD Director Alan Rabson named **Claude Klee**, chief of the Molecular Interactions Section, as acting chief of the lab . . . . **SEARCH FOR** an associate director of the Div. of Cancer Prevention & Control to head the Centers & Community Oncology Program will continue at least through March 14. The program, with a budget of about $114 million a year, includes a staff of 40. The salary range is $64,700 to $73,400 and physicians may be eligible for the comparability allowance up to $20,000 a year. Contact Dolores Guido, NCI, Personnel Management Branch, Bldg 31 Rm 3A19, Bethesda, MD 20892, phone 301/496-8182. . . . **CORRECTION**: The NCI-EORTC symposium on new drugs (Meetings, Jan. 29) will be held March 8-10, 1989, not this year.

Hammer Offers To Raise $500 Million If Congress Matches It; WHT Dropped

(Continued from page 1)
attention of the National Cancer Advisory Board at its meeting Monday. Details:

*Director Vincent DeVita revealed the direction he and senior staff members are leaning regarding the location within NCI of the Cancer Centers Program, now part of the Div. of Cancer Prevention & Control--in his office, along with a number of other programs, including the Clinical Cooperative Groups, the Community Clinical Oncology Program and the Organ Systems Program.

Cancer center directors have been agitating for about two years to get the centers program out of DCPC and into either DeVita's office or a new, separate division. DCPC Director Peter Greenwald has opposed such a change, arguing that centers should be located in the same division with cancer control. Centers people feel that they need an advocate on the NCI Executive Committe, which includes DeVita, his deputy and administrative officer and the division directors.

Location in the director's office office would not give them a seat on the Executive Committee, but it could in effect place DeVita himself in that role.

DeVita said that the new Office of Centers & Community Programs, or whatever it might be called, would be headed by an NCI associate director, somewhat higher on the ladder than division ADs.

Other elements from DCPC that probably would be included in the move would be the Research Facilities (construction) Branch, the Organ Systems Program (which is now a section in the Cancer Centers Branch), CCOP, and, probably, the Cancer Training Branch.

It had previously been mentioned that the Cooperative Groups, which are administratively located in the Clinical Investigtions Branch of the Cancer Therapy Evaluation Program in the Div. of Cancer Treatment, should be housed under the same roof as centers and CCOPs. The groups have close ties with centers and have become heavily dependent on CCOPs for patient accrual.

The cooperative groups, however, are a major part of CTEP. Would all of CTEP be involved in the move? If not, what would happen with the rest of it? Those questions were not brought up by DeVita Monday.

He did emphasize "the very early nature of these discussions" and indicated that a final decision might not be made before fall.

DCPC also would be shorn of a large portion of its current structure, but DeVita said that staff discussions (at the annual January retreat, when such mischief frequently surfaces) included talk about consolidating cause and prevention research back into one division.

Translated, that means moving some elements out of the Div. of Cancer Etiology into DCPC, namely the Epidemiology & Biostatstics Program. That won't happen without a fight, which DeVita acknowledged. "The Epidemiology Program is one of the jewels in our crown. They get nervous when we talk about moving them."

The Surveillance, Epidemiology & End Results Program, once part of Epidemiology & Biostatistics in DCE, was moved to DCPC about four years ago. At that time, consideration was given to moving the entire program. DCE Director Richard Adamson, E&B Director Joseph Fraumeni, and the DCE Board of Scientific Counselors resisted mightily and wound up losing only SEER (actually, the entire Biometry Branch).

One of the factors involved in staff resistance to the change will soon be eliminated. Fraumeni's staff works in the Landow Building, in downtown Bethesda. DCPC is housed entirely in the Blair Building, in Silver Spring--more remote from the NIH campus and generally considered less desirable.

All NCI offices are being moved from Landow and Blair into a new building in Rockville, just up the metro line from NIH. The moves will be completed later this year.

DeVita said he would present the reorganization plans to the NCAB at its fall meeting. In the meantime, he may convene a meeting of the chairmen of all NCI boards of scientific counselors and NCAB Chairman David Korn to discuss the proposals.

***Armand Hammer, chairman of the President's Cancer Panel, dropped a $1 billion bombshell on the NCAB.**

Hammer has insisted that he is not satisfied with the goal NCI has established for the Year 2000, of reducing cancer mortality by 50 percent. He wants the total elimination of cancer as a significant health hazard by then and firmly believes it is possible if enough effort and resources are devoted to that cause.

Recognizing that NCI has not been given the money it needs to get all the parts into place in time to achieve a major mortality reduction by 2000, as spelled out in the NCI bypass budgets of the last three years, Hammer said he approached House Speaker Jim Wright with an offer: If the government will put up an additional half billion dollars for NCI, Hammer will match it with privately raised funds. NCI's total budget in the current fiscal year $1.469 billion.

Hammer said that Wright was agreeable and suggested that if Congress could raise $900 million for AIDS this year, it certainly could raise $500 million for cancer.

"We will leave it up to Dr. DeVita and the Cancer Institute" on how to spend it," Hammer said. "I'm sure they will find good use for it."

Hammer said he has enrolled entertainer Bill Cosby in the fund raising effort and already started rounding up pledges. Hammer recently appeared on Cosby's television show, which prompted DeVita to congratulate him for starting a new career as a comedian.

DeVita later told **The Cancer Letter** that if the additional money is forthcoming, he will ask for multiple year authority in spending it. He said he would follow the bypass budget on how the money should be used; this year's appropriation is about a half billion dollars under the bypass request.

The bypass budget calls for funding 45 percent of approved grants at their full recommended levels, plus more money for cancer centers, cooperative groups, substantially more for cancer control, and construction, which is not getting any money under the regular appropriation.

***DeVita told the NCAB that the Executive Committee has decided not to put any more money into the Women's Health Trial.**

The DCPC Board of Scientific Counselors had recommended against going forward with the full trial, which under the present protocol would have involved 32,500 women and cost $90 million over 10 years.

The DCPC Board did recommend that the present three clinical units, statistic unit and nutrition unit all be funded to continue following the 1,700 women enrolled so far in the study, or at least a sample of them.

Greenwald presented the DCPC Board's recommendation to the NCAB. He has said that he favored some continued support for the present investigators and eventually a full scale trial to test the hypothesis that reduction in dietary fat will lead to reduced incidence of breast and perhaps other cancers.

DeVita noted Greenwald's position when he related the decision of the Executive Committee not to continue any support. That decision was based primarily, DeVita said, on the absence of a reliable marker to document adherence to the diets. He agreed that the effect of dietary fat on cancer incidence eventually should be tested, although probably under a different protocol.

NCAB Organ Systems Committee Recommends Moving OSCC To NCI, Dispersing Portfolio

The National Cancer Advisory Board's Committee on Organ Systems Programs went along with NCI staff proposals to bring the Organ Systems Coordinating Center, now operating out of Roswell Park Memorial Institute, into NCI; and to distribute the program's grant portfolio among the various NCI divisions. If the full NCAB, which was scheduled to act on the recommendation the following day, goes along, that means the OSCC cooperative agreement will not be recompeted.

NCAB member Howard Temin said he was "disturbed" by the termination of the trial in view of the continuing increase in breast cancer incidence. He noted that a "natural experiment" is going on with a trend to voluntary diet modification. The impending availability of fat substitutes may also be a factor, he suggested.

Greenwald said that to continue funding the five units as they are presently constituted and to follow the 1,700 woman cohort would cost $270,000 a month. They are now funded through March at that level. Some DCPC Board members had asked that that funding be continued while the investigators worked on modifying the protocol, streamlining the trial and developing a new proposal.

"There are a number of investigators who would like to get $270,000 a month to develop a grant proposal," President's Cancer Panel member William Longmire commented.

NCAB member Victor Braren said that $270,000 a month "is a lot just to spin rubber. If there is some value in keeping something going, we could consider a small sample."

Richard Bloch's motion to approve the

recommendation not to go forward with the full trial was tabled after Korn insisted that no NCAB action was needed.

Board member Nancy Brinker commended the WHT investigators for their work and said she hoped they would continue. "It's a political situation, with such a large group of women involved who were very excited about the Women's Health Trial."

"It's not because we didn't want to," DeVita said. "The hypothesis just is not supportable now. We felt this was not the best way to spend our money."

NCAB member Roswell Boutwell, a member of the DCPC ad hoc committee which developed the recommendation for that Board, cited his reservations. The trial was limited to women ages 45-69, which Boutwell said may be too short a time to have an impact; genetic factors which could impact controls and intervention group and override fat reduction results; lack of a marker to determine if controls reduced fat intake in significant amounts; and the issue of whether calorie reduction is at least as important as fat reduction in lowering incidence.

NCAB Notes: The terms of six members expired with this meeting, if President Reagan makes the new appointments before the Board's next meeting in May. One, Howard Temin, probably will be reappointed since he has served less than a year in filling out the term of the late Tim Lee Carter. In most cases, the National Cancer Act limits members to one term. Outgoing members are Richard Bloch, Victor Braren, Ed Calhoon, Geza Jako and Barbara Shook.

Korn's second two year term as chairman also ended, although he has two more years left on his appointment as a member of the Board. He told **The Cancer Letter** he would welcome reappointment as chairman.

Eighty four responses have been received to date from the letter sent out by the NCAB Cancer Centers Committee soliciting suggestions on various centers related issues. The committee, chaired by John Durant, will sponsor a workshop either in late June or mid-July to develop recommendations. The workshop will be in Bethesda. The committee will meet April 23 or 26, probably in Kansas City, St. Louis or Chicago, to draw up plans for the workshop. Issues include updating characteristics of comprehensive centers, and location of the centers program within NCI, among others.

Durant "Going Home" To Birmingham As Senior VP, Medical Center Director

For 20 years, John Durant has been a major player on the national cancer scene. He went to the Univ. of Alabama (Birmingham) in 1968 as a young medical oncologist and helped develop the cancer center there which soon achieved NCI recognition as a comprehensive cancer center; he was its first director.

During his 15 years in Birmingham, Durant served as chairman of a major cooperative group, the Southeastern Cancer Study Group. He has served as president of the American Society of Clinical Oncology, the American Radium Society and the Assn. of American Cancer Institutes.

He left Alabama in 1982 to become president of Fox Chase Cancer Center, another NCI recognized comprehensive center (in affiliation with the Univ. of Pennsylvania). Durant is a member of the National Cancer Advisory Board and has served on other NCI advisory groups.

In April, Durant will enter a new phase of his career, in which cancer will only be a part. He will return to Birmingham as UAB senior vice president for health affairs and director of the medical center. He will oversee all six of the university's health professional schools and its nationally ranked, 1,000 bed University Hospital.

The medical center is Birmingham's largest employer, with an operating budget of $400 million a year. Its various health units received more than $82 million a year in extramural research and training support, with more than 3,500 students enrolled.

Morris Dorrance, chairman of the Fox Chase board, said Durant's departure "is a loss for both Fox Chase Cancer Center and Philadelphia." He praised Durant for his success "in building a strong program of clinical research, recruiting major talent from all sections of the country, and he has put into place the most advanced technology for medical sciences and secured well deserved recognition for the center's high standards of patient care."

Durant will succeed Charles McCallum at UAB, who was named president of the university last year.

Durant will continue serving on the NCAB, and he said he intends to continue his interest in cancer research. "I'm moving into the mainstream of medicine; maybe I can help bring cancer into the mainstream."

Durant has personal reasons for returning to Birmingham. His wife, Marlene, has strong ties there, and his daughter is living there. "We're going home," he said.

New Colorado Center Awarded Core Grant, With Paul Bunn As Director

Colorado has rejoined the ranks of NCI supported cancer centers, a success story built on the rubble of a center that NCI had recognized as comprehensive but which couldn't make it under any designation.

The new center, a program of the Univ. of Colorado School of Medicine, officially became eligible this week for funding of its NCI cancer center support grant, or core grant, as it is usually called.

Paul Bunn, an 11 year veteran of NCI and former head of the Cell Kinetics Section in the NCI-Navy Medical Oncology Branch, is director of the center. He went to the university in October, 1984, as head of the Div. of Medical Oncology.

The grant had been approved for funding last fall by the National Cancer Advisory Board, with a priority score well within the funding range. The core grant award had been held up pending the final decision on NCI's FY 1988 budget, which came in January, with the centers program getting $100 million. NCI then had to develop its funding plan, based on how it would spread the money over the core grants which were waiting to be funded. The plan for centers: all competing renewals and new grants will be funded at 91 percent of their recommended levels. Noncompeting (type 5) grants will be funded at their current negotiated levels and will not have the cuts previously made from recommended levels restored.

In the mid-1970s, NCI awarded a core grant to a freestanding cancer center with loose ties to the university and other institutions in Colorado. This was the era when NCI, stimulated by an intepretation of language in the National Cancer Act of 1971 which encouraged support of regional cancer centers around the country, was in the process of "recognizing" those determined to be "comprehensive." The National Cancer Advisory Board established characteristics for comprehensive cancer centers and the Board reviewed those seeking that recognition. Twenty one eventually received that highly prized imprimatur, some more deserving than others.

The Colorado Comprehensive Cancer Center was not one of those most deserving that status. There was little commitment of support from the participating institutions, limited space and facilities, money other than the core grant was scarce, and it failed to recruit sufficient numbers of qualified people.

The NCAB had adopted a policy of requiring comprehensive centers to have NCI core grants to maintain their recognition. Failure to get a core grant renewed was supposed to trigger an automatic review by the NCAB, at which time the comprehensive recognition could be withdrawn.

In 1978, Colorado lost its core grant. NCI was faced with what would have been the extremely difficult and embarrassing task of announcing that the center no longer was officially recognized as comprehensive. Before then NCI Director Arthur Upton had to take that step, and even before the NCAB could bite the bullet and initiate a review, the center was disbanded.

That left a huge gap in mid-America without a cancer center, comprehensive or otherwise, a fact that had been primarily responsible for the premature recognition. NCI cancer centers staff members have been hoping ever since that somehow that gap would be filled.

The state and community felt likewise, and a series of reports, by the university, the school of medicine and the state all concluded that Denver should have a cancer center, and initial steps were taken to get that under way. Joseph St. Geme, who had been chairman of pediatrics at UCLA and was a member of the Institute of Medicine, was brought in as dean of the school of medicine. One of his charges was to start a cancer center.

St. Geme appointed a steering committee and started recruiting people. In addition to Bunn, the center staff includes David Patterson and David Pettijohn, basic science; David Crawford, clinical activities; Donald Iverson, cancer control; Richard Bakemeier, education; and Gail Siffer, administrator.

Tragically, St. Geme did not live to see the results of his efforts. Shortly after the core grant application was submitted last August, he suffered congestive heart failure. He appeared to be recovering but died suddenly in October.

Eugene Jacobsen, who was dean of the Univ. of Kansas School of Medicine, is the new dean

at Colorado. Bernard Nelson is chancellor of the Health Sciences Center, and Gordon Gee, "an incredibly strong supporter of the cancer center," according to Bunn, is president of the university.

The center is built on a solid foundation this time, with strong ties with a number of institutions, including the VA hospital and Children's Hospital. The Health Sciences Center has $53 million a year currently in peer reviewed outside grants and contracts, $21 million of that at the cancer center.

There are six million people living in the region served by the center, and the Health Sciences Center is involved in treating 32 percent of the state's cancer patients. Cancer center investigators have 400 patients on clinical studies, both institutional and cooperative groups. They are members of Southwestern Oncology Group, Lung Cancer Study Group, Childrens Cancer Study Group and the Gynecologic Oncology Group.

GAO Backs DeVita On Why Advances Aren't Reducing Mortality Rates

NCI Director Vincent DeVita normally has little use for reports coming out of the General Accounting Office. In the first place, GAO studies "are designed to be negative," he has said. And in the second place, GAO is an arm of Congress and cannot directly require a member of the Executive Branch to do anything.

Indirectly, through Congress, GAO can and has had major impacts on various agencies, including in the past, NCI. And now there is a newly issued GAO report that DeVita says "is very interesting."

At the request of Congressman Henry Waxman (D-CA), who is chairman of the House Health Subcommittee which will write that body's version of biomedical reauthorization legislation this year, including the National Cancer Act, GAO undertook a study of why survival rates for many forms of cancer "have not improved as rapidly as we had hoped," Waxman said.

"Such improvements are necessary if we are to achieve NCI's goal of cutting cancer mortality rates in half by the Year 2000," Waxman continued in a statement accompanying the report.

"In their first preliminary response, GAO tells us that there is reason to fear that many cancer patients do not receive state of the art therapies identified by NCI" (Ed. note: DeVita has been harping on that subject for years).

"Our hopes for the War on Cancer were that, through research, breakthroughs in treatment would be found that would extend the lives of cancer patients and hopefully lead to cancer cures," Waxman said. With respect to a number of common forms of cancer, the GAO report illustrates that there may be a serious problem in disseminating the results of clinical trials into general medical practice. As a result, thousands of cancer patients may not now be benefitting from the treatment breakthroughs that have resulted from the work of so many dedicated researchers.

"GAO looked at whether cancer patients are receiving what NCI believes is the appropriate and highest quality form of treatment for certain cancers. It is distressing to learn that many may not.

"Breakthroughs in cancer treatment are not easily gained. They are few and far between and require a long term commitment of resources and people to a goal that we all share. When such breakthroughs are found, if they are not incorporated into accepted medical practice, lives will be lost unnecessarily and the scientific effort will have been futile.

"We need to find out whether GAO's findings are as serious as they sound. If so, we need to take steps to assure better dissemination of research findings. The fruits of NCI research must become available to all patients if victory in the War on Cancer is to be achieved."

GAO asked NCI for a list of all breakthroughs in cancer treatment that met the following criteria: they occurred by 1982, to allow determination of patterns of use with the available data on treatment; they had been proven to increase patient survival in a large randomized clinical trial; and they were relevant for an identifiable group of cancer patients.

GAO excluded from the NCI submission treatment of osteosarcoma and soft tissue sarcoma, because there were too few patients with those types of cancer to allow for reliable analyses. The seven remaining treatments were adjuvant chemotherapy for breast cancer, adjuvant chemotherapy for colon cancer, adjuvant radiation therapy for rectum cancer, chemotherapy for small cell lung cancer, chemotherapy for testicular cancer, chemotherapy for Hodgkin's disease

and chemotherapy for non-Hodgkin's lymphoma.

NCI defined the types of patients who should have received each of the seven treatment breakthroughs (adjuvant chemotherapy for premenopausal women with breast cancer whose tumors are smaller than 5 centimeters and who have positive lymph nodes was an example). Patients for whom it was not clear whether a treatment should have been given were excluded. Patients were selected from NCI's SEER data.

"We examined the percentage of those patients who did not receive the treatments in question," the report says. "We based our decision to focus on the nonreceivers on the fact that the SEER data on treatment are not sufficiently precise to inform us as to whether state of the art therapy was actually given. For example, SEER data will tell whether or not a patient received chemotherapy but do not indicate the exact type of chemotherapeutic regimen administered. We can be sure that patients who did not receive chemotherapy did not receive the breakthrough treatment in chemotherapy, but we cannot be sure that patients whose treatments included chemotherapy actually received the breakthrough treatment. . .

"If there is a limitation in the data, it is that SEER data are drawn exclusively from hospital records. As a result treatments given outside of hospitals may be missed. This is less serious a problem because SEER does collect data on the first course of treatment, even if it is given outside the hospital."

GAO's findings for the seven treatments cited in the report:

Adjuvant chemotherapy for breast cancer. More than one third (36.9%) of the premenopausal patients deemed suitable for adjuvant chemotherapy did not get it, although there has been about a threefold increase in that treatment since 1975.

Adjuvant chemotherapy for colon cancer. More than 90 percent of suitable colon cancer patients did not receive this treatment. The figure was 90 percent in 1980, and 94 percent in 1985.

Adjuvant radiation therapy for rectum cancer. In 1985, 60 percent of the patients who might have benefitted did not receive this, although unlike with colon cancer, the trend has been down, with a fourfold increase since 1975.

Chemotherapy for small cell lung cancer. Twenty five percent who might have benefitted from the treatment did not receive it in 1985. That represents a significant drop since 1975, when it was 56 percent.

Chemotherapy for testicular cancer. Fifty eight percent did not receive it in 1975, 50 percent in 1985. GAO acknowledged that may be due to the fact that later treatment is so effective that withholding it initially may be justified.

Chemotherapy for Hodgkin's disease. Although the percentage receiving this treatment has grown from 73 in 1977 to 80 percent in 1985, "and it is clear that chemotherapy has been incorporated into the general clinical management of most HD patients, it is also true that at least 18 percent of eligible patients diagnosed in any year following 1977 did not receive chemotherapy."

Chemotherapy for non-Hodgkin's lymphoma. There was a 10 percent decline in the percentage of patients not receiving chemotherapy from 1979-1985. But by the end of that period, 20.2 percent of eligible patients still were not being given chemotherapy.

GAO is working on another report, on LAK/IL-2 therapy. "I expect that will be the usual negative report," DeVita said.

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda MD 20892. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring MD, but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CM-97554-30

Title: Large scale isolation of antitumor agents from natural sources--Master agreement announcement
Deadline: April 15

The Developmental Therapeutics Program of NCI's Div. of Cancer Treatment is interested in receiving proposals from, and establishing master agreements with, offerors with the capability to extract bulk plant and animal materials to provide primary extracts; and/or isolate and purify natural products from primary extracts of plant and animal materials on a pilot plant scale.

Two separate work areas are available for offerors. Separate proposals will be required from those responding to both work areas.

Work area No. 1--Offerors must provide a pilot plant facility capable of storing and processing up to 5,000 kg of bulk crude material, including frozen storage for up to 1,000 kg marine materials. The government will supply the plant and animal materials

to be processed.

Work area No. 2--Offerors must provide equipment for large scale isolation and purification of natural products and have frozen storage capacity for up to 750 gallons of primary extract. They must have experience in process development of natural products isolations. The government will supply all primary extracts of plant and animal products to be processed. The antitumor agents isolated must be of high purity suitable for subsequent manufacture of clinical dosage forms. All work must be carried out under current good manufacturing practices standards.

Details of extraction and isolation processes will be provided by the government, but their applicability to pilot plant scale work will vary widely. The experience and ingenuity of the offerors in process development for pilot plant extractions and isolations using standard or novel techniques will be important factors in the evaluation of the proposals.

It is anticipated that multiple master agreement awards will be made, for a period of 60 months each. Master agreements are competitively negotiated and awarded to more than one contractor. It is planned that such agreements will be awarded on or about Jan. 10, 1989, but will not be funded per se. After award, groups of qualified master agreement holders will be invited to propose competitively on master agreement orders that will be designed to accomplish a specific task to be designated by the project officer.

Contract Specialist: Elsa Carlton
RCB Blair Bldg Rm 224
301/427-8737

RFAs Available

RFA 88-CA-06

Title: Cancer Prevention Research Unit program
Letter of intent date: March 30
Application receipt date: Aug. 24

The Div. of Cancer Prevention & Control invites grant applications for establishment and support of Cancer Prevention Research Units. The objective is to establish a group of multidisciplinary cancer prevention reserch programs as a national long term resource in cancer prevention research.

CPRUs will conduct primary and secondary prevention, health promotion and preventive services research aimed at developing new intervention approaches in all areas of cancer prevention, or applying proven or state of the science interventions in the smoking and screening areas.

The CPRU concept envisions a multidisciplinary environment of scientists interacting closely in the research program. These can include new as well as experienced investigators in relevant fields and disciplines, such as disease prevention and control, medicine, public health, health education, health promotion, epidemiology, nutrition sciences, health policy and economics, health services research, behavioral and social sciences, community organization, communications and biostatistics.

A total of $4 million has been set aside from FY 1989 funds for this RFA. Up to five awards will be made, subject to availability of funds. Awards will be up to five years each.

Areas of research interest relevant to this RFA are:

--Cancer primary prevention research in chemoprevention, diet and nutrition.

--Smoking and other tobacco use prevention and cessation (phases 4 and 5 only).

--Secondary prevention. All areas are eligible; however, if breast and cervical cancer screening studies are proposed, they must be phase 4-5.

--Health promotion sciences, applications research and research on health services, since the latter impacts on the application of the interventions in community studies.

--Linkages between laboratory research and applied cancer prevention and control research are encouraged.

--Applied epidemiology studies also are allowed.

The CPRU requires a major program theme to focus the research effort and form the basis for multidisciplinary and interinstitutional collaboration and synergism. Themes previously used in large cancer control program grants have varied, from single cancer site (breast cancer prevention) to risk factor focus (tobacco reduction in an HMO) to intervention focus (educational intervention; adherence to cancer control regimens; improving early detection methods; chemoprevention; commmunity intervention for cancer prevention).

The Cancer Prevention Research Unit should include the following components or elements:

*A qualified leader with an appropriate time commitment.

*A multidisciplinary group of prevention oriented scientists who can conduct this type of research.

*A rationale for why the CPRU method is appropriate for the intended research program.

*An emphasis on cancer prevention and health promotion and prevention services research.

*One major specific research theme to focus the CPRU efforts, and at least three research projects within the theme area. Other themes are optional.

*Research in breast and cervical screening and in smoking prevention and control is optional, but if included, will be required to be phase 4 or 5 studies.

*Applied epidemiology projects are optional.

*Specific developmental projects are allowed as an optional category for up to 15 percent of the direct costs of the CPRU. These projects will undergo peer review as part of the overall CPRU application review process.

*Research or administrative core units or shared resources necessary to more efficiently conduct the research program. These are optional.

*Evidence of collaborative arrangements with the appropriate organizations or population groups necessary to conduct the studies.

*Advisory committees for program planning and monitoring are allowed.

Prospective applicants are strongly encouraged to consult with the program director before and during preparation of their letters of intent and applications on questions of policies, procedures and guidelines.

Prospective applicants are requested to submit letters of intent by March 30. Purpose of the letter of intent is to establish communications between applicant groups and appropriate NCI administrative and program staff concerning the scientific content and objectives, theme or focus and size of the organization. Letters of intent are not mandatory, are not a precondition for applying under this RFA, and are not part of the formal review process.

For copies of the RFA and further information and consultation, contact Carlos Caban, PhD, CPRU Program Director, DCPC, NCI, Blair Bldg Rm 4A01, Bethesda, MD 20892, phone 301/427-8735.

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

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