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Search For New NCI Director Focuses On California; Possibilities Include Korn, Beahrs, Gale, Others

White House sources, who earlier this month had indicated that President Reagan did not intend to leave appointment of a new NCI director to his successor (**The Cancer Letter** *Bulletin*, Sept. 2), are saying now that the successor to

(Continued to page 2)

In Brief

Wittes To Join Bristol-Myers As VP; Friedman Named Acting CTEP Director; Carl Pinsky Leaves

ROBERT WITTES, director of the Cancer Therapy Evaluation Program in NCI's Div. of Cancer Treatment, will join the exodus of key NCI staff members leaving for greener (U.S. currency shade) pastures. Wittes will depart in November to become senior vice president for cancer research in the Pharmaceutical Research & Development Div. of Bristol-Myers. Stephen Carter, who had held that position, moved up earlier this year to senior vice president for pharmaceutical and developmental medicine. **Michael Friedman**, chief of the Clinical Investigations Branch, has been named acting director of CTEP by DCT Director Bruce Chabner. . . . **CARL PINSKY**, chief medical officer for NCI's Biological Response Modifiers Program, has left to join IMRE Corp. as vice president for medical affairs. Seattle based IMRE is a pioneer in the field of immunoadsorption, with an FDA approved product, the PROSORBA column, and the newer MAbSORBA column designed to remove antimouse antibodies from the serum of patients treated with monoclonal antibodies. . . . **DAVID RALL**, director of the National Institute of Environmental Health Sciences, has received the World Health Organization's "Health for All 2000" medical. . . . **WILLIAM BENEDICT**, professor of pediatrics and opthalmology at the Univ. of Southern California School of Medicine, has moved to Baylor College of Medicine's Center for Biotechnology as professor of biotechnology. He will head the Human Cancer Genetics & Tumor Biology and Clayton Cancer Programs. Benedict is a member of the Board of Scientific Counselors of NCI's Div. of Cancer Etiology. . . . **PACIFIC NORTHWEST** Research Foundation has moved into its new, 45,000 square foot building in Seattle. The $6.1 million facility, built with private funds, has 27 laboratories and 36 offices located near Swedish Hospital, Seattle Univ. and Northwest Kidney Center, "all of which we plan to work with closely," according to William Hutchinson, PNRF founding president and director.

New Director Could Be Californian; Cancer Act Commitment May Be Issue

(Continued from page 1)

Vincent DeVita may be a Californian. It could be the last opportunity for the President to name a fellow Golden Stater to an important position.

The sources are continuing to say that the new director will not be a current NCI staff member.

So far, the sources are not mentioning any names, but the possibilities include:

* **David Korn**, dean of the Stanford Univ. Medical School and present chairman of the National Cancer Advisory Board.

No one outside of NCI knows the Institute and the National Cancer Program better. Korn has been a member of the NCAB since 1982 and chairman since 1984. Before that, he was chairman of the Div. of Cancer Biology & Diagnosis Board of Scientific Counselors. A pathologist with impeccable scientific credentials, he heads the medical school considered by many to be the best in the nation.

Whether he would give up that position for one with considerably less pay and zero job security is a factor. The White House reportedly is leaving off its list of prospects those who indicate they are not interested.

Korn would be the second former DCBD board chairman to ascend to the NCI director's office, Arthur Upton being the first, in 1977.

DCBD, in fact, is well represented on high, with Div. Director Alan Rabson presently serving as acting director of the Institute. Rabson's appointment to that role was made official Aug. 31. Ihor Masnyk, DCBD deputy director, is serving as acting director of the division.

***Oliver Beahrs**, chief of surgery emeritus at Mayo Clinic, who headed the team which has performed major surgery on the President.

Beahrs has lived in Minnesota so long that even he might be surprised to be on a list of "Californians." But he grew up in Pomona, and did his undergraduate work at Chaffey College (Ontario, CA) and the Univ. of California (Berkeley).

In addition to the leadership roles he has played in the field of surgery, including the American College of Surgeons, Beahrs has served on NCI advisory groups. He was a member of the Cancer Control Advisory Committee in the mid-1970s, before it became a board of scientific counselors, and he headed the committee which reviewed mammography screening when that became a controversial issue. His committee developed some landmark recommendations which helped establish the standards for mammography screening.

Beahrs' age (70s) might be held against him, but certainly not by the oldest person ever to serve as President of the United States. Nor by someone else with some influence, 90 year old Armand Hammer, chairman of the President's Cancer Panel.

* **Robert Gale**, the UCLA expert in bone marrow diseases who became a world figure when he led a team of American doctors who treated victims of the Chernobyl nuclear disaster.

It was Hammer who financed Gale's expedition. As the one American who has had a consistenly good rapport with the Soviet Union since the days of Lenin, Hammer might well believe that Gale's appointment would further strengthen relations with the USSR.

How much influence Hammer will have in the final selection is something that only Ronald Reagan and perhaps a few close advisors know. The President's Cancer Panel is supposed to advise the President on matters of importance to NCI and the National Cancer Program. What could be more important than the person who heads them?

* **Brian Henderson and Richard Steckel**, directors of California's two comprehensive cancer centers, at the Univ. of Southern California and UCLA, respectively.

Both have proven to be fine administrators. Both have served on various NCI advisory panels and are nationally recognized leaders in their fields.

* **Lester Breslow**, director of cancer control at the UCLA Jonnson comprehensive cancer center. He has served as chairman of the Div. of Cancer Prevention & Control Board of Scientific Counselors, chaired the committee that developed the Year 2000 goals, and chaired the committee that looked at how NCI measures progress in cancer treatment and developed recommendations for improving those measures.

Breslow was considered by the Carter Administration for the position of assistant secretary for health.

* **William Longmire**, chairman emeritus of surgery at UCLA School of Medicine and a member of the President's Cancer Panel. Through the Panel's hearings at locations around the country, Longmire has come into contact with most of the major players in

cancer research and treatment, and has heard all the problems and all their solutions.

* **Jonas Salk**, director of the institute in La Jolla that bears his name. Although the most famous of all the above, the man who developed the first effective polio vaccine is probably the least likely to be interested.

Why limit the choice to Californians?

Politics is politics, and California's 47 electoral votes probably will decide the election. It is unlikely that very many votes would be swayed by appointment of a Californian, but Dukakis and Bush are running neck and neck there, and a handfull of votes could decide it. White House advisors no doubt feel that at least they wouldn't be hurt by going with one of the well qualified Californians and they might be helped.

If politics is a consideration, Texas could still be in the picture. The Democrats have never won the presidency without winning Texas, so it would be in the best interests of a Republican Administration to prevail there. The obvious choice would be Charles LeMaistre, president of the Univ. of Texas M.D. Anderson Cancer Center. If he is not interested, there are other outstanding clinicians and scientists on his staff and elsewhere in the state.

It would seem unlikely that the President would appoint an NCI director without at least considering the recommendations of NIH Director James Wyngaarden and Assistant Secretary for Health Robert Windom. However, the National Cancer Act of 1971 made the NCI director a presidential rather than a departmental appointee, and others frequently have more influence with the White House.

Those who don't like the National Cancer Act might possibly see the search for a new NCI director as an opportunity to sabotage it. Implementation of the act requires a strong director, with the will and character to fight it out with those who in his opinion are blocking progress in cancer research, and the ability to carry that fight to Congress and the public, when necessary.

The Cancer Act gives the NCI director the opportunity to bring intra-NIH and intradepartmental squabbles out of the closet and into the open, at open meetings of the President's Cancer Panel and the National Cancer Advisory Board.

DeVita understood that process and used it frequently and effectively, even to the point of criticizing actions of the White House staff, particularly the Office of Management & Budget. While he was adroit enough not to go too far against OMB, he took on Wyngaarden so often that the NIH director finally exploded and called for elimination of most if not all of NCI's special authorities (**The Cancer Letter**, March 18).

Wyngaarden said then that he hoped the problem, as he sees it, could be corrected through the reauthorization legislation. But even if all the special authorities of the Cancer Act are left in place, they are useless without an NCI director committed to using them.

Wyngaarden reportedly has organized two search committees, both of which were dissolved for one reason or another. **The Cancer Letter** was unable to learn whether they came up with recommendations which went to the White House.

There has been no dearth of recommendations flowing into 1600 Pennsylvania Avenue. Sources said they are pouring in from around the country.

Reagan Signs 1989 Appropriations Bill; Congress Hung Up On Reauthorization

President Reagan last week signed the Labor-HHS-Education 1989 fiscal year appropriations bill, 10 days before the start of the new fiscal year Oct. 1.

It will be a rare experience for NCI, NIH and other agencies covered by the bill to start a fiscal year with the regular appropriations in place, without being required to live on a stopgap "continuing resolution" for a few weeks or months, or as has happened on occasion, the entire year.

The bill gives NCI a budget of $1,571,879,000. While that is an increase of $105 million over the 1988 fiscal year, nearly $34 million of that is for AIDS research and $5 million is for NCI staff payraises.

It was a close call on whether the President would get a bill that he would not veto. The Senate measure had included language on Medicare/Medicaid payment for abortions somewhat broader than in the House bill. The President said he would veto it unless the House language prevailed, which limited payment only when abortions were deemed necessary to save the life of the mother. The Senate would have permitted payment in cases of rape and incest.

The Senate eventually backed down.

Biomedical research reauthorization, including renewal of the National Cancer Act, remains on hold. The Senate has passed the Kennedy bill maintaining all authorizations intact, and correcting some problems in the Cancer Act. The House has passed only the bill authored by Rep. Claude Pepper (D-FL) creating a new National Institute on Deafness.

Rep. Henry Waxman (D-CA), chairman of the House Health Subcommittee, has considered going to conference with the two bills, accepting the Kennedy reauthorization if the Senate goes along with the Pepper bill. That would be acceptable to the Senate, but so far, the House has refused to agree to a conference.

Time may be running out, with Congress anxious to adjourn and get on with the campaigns. Plans to close up by Oct. 1 appear to have been shelved, with Oct. 15 more likely. If reauthorization has not been pushed through by adjournment, the bills will die and the process will have to start all over again with the new Congress.

Even if Congress does complete the process, threat of a veto remains. Reagan vetoed rauthorization last time, only to see it overturned by overwhelming margins. But if the measure is approved and Congress adjourns immediately thereafter, the President could pocket veto it, with no opportunity for Congress to override.

Wynder, Doll, Hill To Share Ochsner Award For Landmark Tobacco Studies

Ernst Wynder, president and founder of the American Health Foundation, will receive the Alton Ochsner Award Relating Smoking and Health at ceremonies Oct. 4. The award, which will be presented during a meeting of the American College of Chest Physicians in Anaheim, will be shared by two physicians from England, Richard Doll and Austin Hill.

The Alton Ochsner Award, which recognizes individuals and organizations attempting to further understand the medical and economic impacts of smoking, has been given to the three in part for 1950 studies providing major evidence linking cigarette smoking with lung cancer. These studies were done independently by Wynder, his mentor, Everett Graham at the Washington Univ. School of Medicine in St. Louis, and by Hill and Doll in Great Britain.

Wynder is further recognized for his own subsequent work in which he established the biological proof that tobacco smoke acts as a cancer producing substance, and his epidemiological studies linking a variety of other cancers, including orval cavity, esophagus, larynx, pancreas and bladder, with excessive tobacco usage. In cooperation with Dietrich Hoffmann, he also obtained chemical evidence for the carcinogenic potential of tobacco smoke and tobacco itself. This effectively closed the circle of evidence linking cigarette smoking to various cancers.

The Wynder/Graham study, reported in the May 27, 1950 issue of the "Journal of the American Medical Assn.," determined that smoking was the dominant factor in more than 600 men who had developed lung cancer. Of these, 97 percent were heavy smokers while only two percent were nonsmokers.

Doll and Hill, working independently of Wynder, collected data on lung cancer victims in 20 London area hospitals. Their results were virtually identical to Wynder's, clearly establishing the association of heavy smoking with lung cancer.

Those studies buttressed the work in the 1930s by Alton Ochsner and Michael DeBakey.

Historical note:

Frequently overlooked in accounts of investigations which helped establish tobacco smoking as a major etiologic factor in cancer is the work of Morton Levin, now professor emeritus of epidemiology at Johns Hopkins Univ.

In the same issue of "JAMA" in which Wynder's report was published, an article by Levin, "Cancer and Tobacco Smoking: A Preliminary Report," also related the association of tobacco and cancer.

New Analysis Of HIP Study Supports Mammographic Screening Age 40-49

Screening with mammography plus a breast exam by a health professional significantly reduces breast cancer deaths for women both over and under age 50, an NCI study shows.

This finding, from a new analysis of data from a clinical trial of the Health Insurance Plan of Greater New York, considerably strengthens the evidence that women ages 40-49 benefit from mammographic screening. Previous analyses of the HIP data found significant reductions in breast cancer mortality from mammography only for women 50 and over. The investigators attribute the new finding to longer followup and more efficient statistical methods.

The new study is published in this week's

issue of "Journal of the National Cancer Institute."

Major cancer organizations, including NCI, the American Cancer Society and the American College of Radiology, now recommend that all women ages 40-49 have a mammogram every one to two years, and that upon reaching age 50 they have one annually.

"These recommendations are based on strong evidence that mammography has improved in detecting cancers in both older and younger women and that radiation has decreased to a point of negligible risk," said Charles Smart, chief of the Early Detection Branch in NCI's Div. of Cancer Prevention & Control and a coauthor of the study.

"In the HIP study in the 1960s, mammography was only able to detect 39 percent of the cancers in the 40-49 age group and 60 percent of the cancers in the 50-59 age group," Smart said. "An NCI analysis of the Breast Cancer Detection Demonstration Project in the 1970s showed that mammographic technique had improved to where 91 percent of cancers among women ages 40-49 and 92 percent of cancers among women ages 50-59 were detectable by mammography."

The BCDDP was an ACS/NCI screening project involving more than 280,000 women who were examined with mammography and physical breast palpation at yearly intervals for five years.

Kenneth Chu, lead author of the NCI HIP analysis, noted, "With the new HIP results available, we have stronger evidence than ever before of the benefit of screening for women 40-49. Perhaps the new data will encourage those people who do not currently advocate mammography for women under 50 to reassess their position."

The new HIP analysis examined breast cancer cases occurring within six years of entry into the trial--the point at which the number of breast cancer cases detected in the control group caught up with the number of cases detected in the study group (371 each). Women in the study group had been screened within the first four years of the trial. Waiting for the catch up point increased the likelihood that the cases detected in both groups were comparable (i.e., that mammography did not pick up benign breast disease as cancer), an important factor for an unbiased analysis. The equaling of cases at six years showed that the same number of cancer cases occurred in the two groups, but that in the study group, cases were detected earlier.

In the 742 patients who were followed for at least 18 years after trial entry, the researchers found 24 percent fewer breast cancer deaths among women who were screened at ages 40-49 than in nonscreened controls. Among women screened at ages 50-64, they found 21 percent fewer deaths.

Ten year followup of the HIP data showed a 30 percent reduction in breast cancer mortality in women ages 50 and over who were screened. This figure reflects the benefits of the four year active phase of screening.

Although mortality reductions were similar between the two age groups, the time required to demonstrate a significant reduction was shorter for the 50 and older group than for the 40-49 group (four years of followup vs. nine).

Explaining the reasons for this difference, Chu said that benefit from screening occurs when there are more deaths in the control group than in the study group. The greater the number of screen detected cases in the study group, the more opportunity there is to save lives. Therefore, because the 50-64 age group had more screen detected cases than the younger group, their benefits became evident earlier, Chu said.

Smart added, "Length of followup is probably a key factor in seeing mortality reduction in women 40-49."

Other studies that do not show benefit of screening for younger women, including trials in Sweden and in The Netherlands, have shorter followups--seven and eight years, respectively--periods that the NCI investigators suggest may not be long enough to demonstrate mortality advantage.

A recent analysis of the BCDDP data supports the new HIP findings that mammographic screening lowers mortality for the 40-49 age group. However, this study, unlike the HIP analysis, was not a randomized, controlled trial. Because of this methodological weakness, the BCDDP trial does not stand alone as definitive evidence of screening benefit for young women, Chu said.

A strength of the new HIP analysis, Chu added, is its unique methodology. While other research has focused on the number of breast cancer deaths among the total population in the study, Chu and his colleagues analyzed breast cancer deaths only among breast cancer cases, a more powerful test.

The researchers said they hope that this study will help settle the under 50 screening debate. They believe that the analysis provides

the most important piece of evidence available thus far that women 40-49 benefit from mammographic screening plus breast exam by a health professional.

ASCO Appoints Planning Committee, Contracts With CDP For Support

A Strategic Planning Committee chaired by Sydney Salmon has been appointed by American Society of Clinical Oncology President Charles Coltman to implement the directive by the ASCO Board of Directors to develop a strategic planning process.

Serving with Salmon on the committee are Robert Young, president elect of the society; Karen Antman, Denman Hammond, Samuel Hellman, Cary Presant, Stephen Schimpff and James Gantenberg, executive director of ASCO.

CDP Services Inc. of Atlanta was selected in competition with five other nationally recognized planning firms to assist the committee in the strategic planning process. The technical assistance and facilitation of the program will be provided by CDP under the direction of co-project directors David Fulcher and C. (Dunk) Pruett.

The board's decision to develop a strategic plan was made in recognition that the Society has undergone substantial change in the 25 years since it was founded. These changes include a large growth in membership as well as a major expansion in the cross section of the various oncologic subspecialties represented in the Society from both academic institutions and private practice.

"Development of a realistic and implementable strategic planning process will help the Society ensure that its mission and programs are consistent with the needs and expectations of its members and the cancer patients they service in these times of rapid advances in cancer care technology."

One of the first tasks to be undertaken by the Strategic Planning Committee is a membership survey which will provide information from the membership concerning their views about ASCO programs and services.

Oncogene Variations May Explain Familial Cancer, USC Study Finds

Scientists at the Univ. of Southern California have found variations in a cancer gene which they say may help explain why some populations have a susceptibility to cancer and why cancer runs in some families.

The research used the domestic cat as a model system and focused on the c-myc oncogene, a gene that has been associated with the development of lymphoma in several species, including humans, and with feline leukemia.

In cloning the feline c-myc oncogene, the researchers found two "alleles," or slight variations in the gene, that may exert deleterious effects to varying degrees, according to Pradip Roy-Burman, professor of pathology and biochemistry at the USC School of Medicine and a member of the hematology-oncology team at USC's Norris Cancer Hospital & Research Institute.

One variation of the c-myc oncogene was designated CM2; the other, CM3.

To determine show the two alleles were distributed in the general domestic cat population, investigators studied tissue from cats in California, Colorado and New York. Veterinarians in those states provided placental, testicular and uterine tissue obtained in routine spaying and neutering procedures.

Of 243 cats studied, the most common allele pairing was CM3/CM3, which was found in the tissue of 140 cats. A CM2/CM3 combination was also quite common, found in 100. Suprisingly, the CM2/CM2 combination was found in only three.

In breeding experiments conducted elsewhere, mating cats with the CM2/CM3 combination produced no progeny with the CM2/CM2 combination, USC blood cell genetic studies subsequently revealed.

"This result deviates tremendously from the basic laws of genetics," Roy-Burman said. "If random distribution occurred, according to the Mendelian system of heredity, 25 percent of the progeny should have inherited a CM2 from each parent."

The rarity of the CM2/CM2 combination suggests that nature selects against the CM2 allele, Roy-Burman said. "CM3 is a strong allele. CM2 is weak. A CM2/CM2 combination is so weak, it is almost never compatible with life."

The investigators' most recent findings, yet to be published, show that CM2 is in fact a defective allele.

In experiments involving recombinant DNA constructions, the researchers tested the function of the two c-myc alleles. Regulating sequences of DNA that controlled the transcription of each allele were linked to a bacterial gene and put into a cell to see what

(Continued to page 8)

RFAs Available

RFA 88-CA-17
Title: National cooperative natural products drug discovery groups
Letter of intent date: Oct. 21
Application receipt date: Dec. 9

In FY 1983 and 1984, NCI requested applications for national cooperative drug discovery groups whose goal was the discovery of improved cancer treatment on the basis of novel mechanism of drug action. In 1986, the program requested applications focused on exploitation of specific and unique characteristics of lung and colon cancer. The NCDDG approach to modern anticancer treatment discovery was broadened further in 1987 by RFAs inviting applications for the creation and evaluation of both general mechanism of action based and specific disease oriented anticancer treatments as well as for the development of innovative preclinical models for determining antitumor selectivity.

The Div. of Cancer Treatment Board of Scientific Counselors gave concept approval last February to the NCDDG approach to development of anticancer agents from natural products (**The Cancer Letter**, Feb. 26). The board approved setting aside $3 million for first year funding of cooperative agreements awarded as a result of this new RFA, contingent on receipt of a sufficient number of scientifically meritorious applications and availability of funds.

The Cooperative Natural Products Drug Discovery Groups are intended to stimulate the scientific community to select and isolate on a rational basis new potential anticancer treatments from natural sources and to evaluate them in preclinical models designed to select those with the most favorable prognosis for clinical usefulness. This program is designed to assist leading investigators in diverse scientific disciplines to interact as a unit, regardless of their individual institutional affiliations or prior direct involvement in cancer related research. The purpose is to mobilize, with NCI support, the outstanding talents required for exploitation and extrapolation of leads from fundamental studies to the discovery of improved anticancer treatment.

An NPDDG is envisioned as being composed of a principal investigator and a number of program leaders who will conduct interdependent and synergistic preclinical laboratory programs to identify and isolate novel anticancer leads from natural sources, conduct preclinical tasks required to select materials worthy of development based on activity in pertinent laboratory models as perceived by the group, and provide the basis for identifying new agents and strategies for development to clinical trial. An NPDDG may be made up of scientists in academic, nonprofit research, and commercial organizations.

Awards will be made as cooperative agreements. Assistance via cooperative agreement differs from all research grants in that the cooperative agreement mechanism anticipates substantial NCI staff participation during performance. However, the applying group must define its objectives in accord with its own interests and perceptions of approaches to the discovery of new models. The role of NCI as a member of the group is described in the RFA. Essentially, the extramural NCI staff concerned with the administration of grants and contracts will apply its experiences and appropriate resources to facilitate and stimulate the realization of group objectives. The active participation of industry is encouraged because it will allow this segment of the scientific community to contribute its considerable intellectual and material resources.

The principal investigator's institution will be responsible for the group's application. Awards will be made to the applicant institution on behalf of the group as a whole and not to individual laboratory programs within the group. The PI's institution will provide a central operations office for the group and will be responsible for the performance of the entire group and be accountable for the funds awarded.

NCI plans to make multiple awards for project periods of up to five years.

Further information and copies of the RFA may be obtained from J.A.R. Mead, PhD, Program Director, NPDDGs, Executive Plaza North, Suite 832, Developmental Therapeutics Program, DCT, NCI, Bethesda, MD 20892.

RFA 88-CA-18
Title: Identification and evaluation of molecular probes for pathological classification of human astrocytomas
Letter of intent receipt date: Oct. 17
Application receipt date: Jan. 16

The Diagnosis Research Program of NCI's Div. of Cancer Biology & Diagnosis invites applications for cooperative agreements from institutions interested in identifying and evaluating molecular probes to improve the pathologic classification of astrocytomas.

Astrocytomas are the most common primary tumors of the central nervous system, but precise pathologic diagnosis is often difficult, and the current classification scheme does not permit reliable predictions of clinical outcome. Recent advances in the field of molecular biology suggest that opportunities exist to develop a classification scheme using molecular probes. This should lead to a better understanding of the disease and hopefully to improved therapy.

This RFA is designed to promote collaborations and interactions among researchers from a variety of basic scientific and clinical disciplines (e.g. molecular biology, cell biology, immunology, biochemistry, cytogenetics, neuropathology, clinical medicine) to facilitate correlation of results using molecular probes with results using standard histopathological analysis and with patient response to specific therapies.

Awards will be made as cooperative agreements. These create an assistance relationship in which substantial involvement of NCI staff is anticipated during performance of the project, as outlined in the detailed RFA. This mechanism is used when NCI wishes to stimulate investigator interest and proposes to advise or assist in planning in an important and opportune area of research. Applicants will be responsible for the planning, direction and execution of the proposed project. It is essential that there be good liaison between basic scientists and clinicians, as the goal of this RFA is to apply the knowledge and techniques of basic science to the clinic in the areas of diagnosis and prognosis. Each group responding to this RFA should describe existing and proposed collaboration/cooperation between basic scientists and clinicians.

NCI anticipates making three to five awards for project periods of up to five years; total direct costs of $750,000 have been set aside for the initial year's funding. Although this program is provided for in the financial plans of NCI, the award of cooperative agreements pursuant to this RFA is contingent on the availability of funds appropriated for fiscal year 1989.

The DCBD Board of Scientific Counselors approved the concept for this RFA at its most recent meeting, which was reported in the July 22 issue of **The Cancer Letter**.

A copy of the complete RFA may be obtained from Doris Balinsky, PhD, Program Director for Biochemistry and Immunodiagnosis, Div. of Cancer Biology & Diagnosis, NCI, Westwood Bldg Rm 10A10, NIH, Bethesda, MD 20892, phone 301/496-1591.

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-CP-95604-32
Title: Field centers for studies of breast cancer in women under age 45
Deadline: Approximately Oct. 4

The Environmental Epidemiology Branch of the Epidemiology & Biostatistics Program of NCI's Div. of Cancer Etiology is seeking contractors who will support the branch by conducting epidemiologic studies of women under age 45 with newly diagnosed cases of breast cancer.

The primary responsibilities under this contract will be the accrual of new cases and data collection. The scope of work for this project includes acting as a liaison for NCI with collaborating hospitals and obtaining required clearances; identifying study subjects; help develop specific data collection instruments; collecting data utilizing abstractors and interviewers; and obtaining anthropometric measurements.

Some contracts may include collection and transportation of blood samples (only collection and transportation of the samples will be handled under this contract; specific assays will be the responsibility of NCI). Contractors will be required to accept supervision and guidance of field activities from a coordinating center. The coordinating center shall be a separate contractor performing work under a separate contract.

It is anticipated that an incrementally funded, cost reimbursement, completion type contract will be awarded for a two year period. Multiple awards are anticipated for this project.
Contract Specialist: Richard Hartmann
RCB Blair Bldg Rm 114
301/427-8888

RFP NCI-CP-95605-32
Title Coordinating center for studies of breast cancer in women under the age of 45
Deadline: Approximately Oct. 4

The Environmental Epidemiology Branch of the Epidemiology & Biostatistics Program of NCI's Div. of Cancer Etiology is seeking a contractor who will support the branch by coordinating activities of field centers conducting epidemiologic studies of women under age 45 with newly diagnosed cases of breast cancer.

The primary responsibilities under this contract will be the coordination of a study to be performed for NCI by contractors (referred to as field centers) performing work under separate contracts.

The scope of work for this project includes acting as a liaison for NCI with field centers; developing standardized procedures for random digit dialing; development of study procedures, materials and manuals; training of personnel involved in data collection; information management of status of data collections; monitoring activities of field centers; and data preparation and processing.

It is anticipated that an incrementally funded, cost reimbursement, completion type contract will be awarded for a two year period.
Contract Specialist: Richard Hartmann
RCB Blair Bldg Rm 114
301/427-8888

NCI Contract Awards

Title: Storage and distribution of clinical drugs for AIDS
Contractor: ERCI Facilities Service Corp., $3,634,554

Title: Studies on the epidemiology of potentially oncogenic and immunosuppressive viruses in West Africa
Contractor: Univ. of Ghana Medical School, $45,000

Title: Chemical synthesis of anti-AIDS compounds by small business
Contractor: Starks Associates Inc., $781,474

Title: Antifolate screen for drugs against opportunistic infections in patients with AIDS
Contractor: Indiana Univ., $1,324,065

Title: Primary screening of HTLV-3/LAV
Contractor: Southern Research Institute, $3,098,080

Title: Epidemiologic studies of cancer in China
Contractor: Chinese Academy of Medical Sciences, $320,184

Title: Cancer Information Dissemination and Analysis Center for Cancer Diagnosis and Therapy
Contractor: Information Ventures Inc., $2,213,206

Oncogene Variations In USC Study

(Continued from page 6)
activity would take place. The CM3 regulating sequences made the gene function. However, the CM2 regulating sequences were functionally defective.

While the CM2/CM2 combination is rare, the CM3/CM3 combination is quite common and appears to increase the risk for feline leukemia and lymphoma.

In leukemia and lymphoma, a portion of chromosome usually has moved from one position to another. Studies in Roy-Burman's laboratory of tumor tissue excised by veterinarians from cats with lymphoma show that whenever chromosomal breaks and translocations occur in relation to the c-myc oncogene, they occur next to a CM3 allele.

Further studies are required to define how the allelic forms of the c-myc oncogene might interact with various types of retroviruses in the multistep process of carcinogenesis.

Some evidence already suggests that, in feline lymphoma, oncogenes might be activated by elements of endogenous retroviruses--viruses inherited by the animal rather than infecting from the outside.

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