THE CANCER LETTER

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

FTE Shortage Hurting Cancer And AIDS Research, Advisors Told; NCI Seeks Major Share Of New Slots

Pressures created by the shortage of staff positions at NCI have reached the point where they are seriously compromising both cancer and AIDS research, NCI advisors have been told during the past two weeks. NCI is asking for a major share of

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In Brief

Reauthorization May Be Wrapped Up This Week As House, Senate Work Toward Compromise

BIOMEDICAL RESEARCH reauthorization, including renewal of the National Cancer Act, could be wrapped up before Congress adjourns this week. Chairman Henry Waxman of the House Health Subcommittee tried last week to rush his bill through the House under suspension of the rules but then determined that it was too late for that. He then agreed to go to conference with the Senate, which has passed Edward Kennedy's reauthorization bill that includes nearly all points requested by cancer program constituents. The House passed a bill creating a new NIH National Institute on Deafness. If conferees can agree on a satisfactory merger of the two measures, their report will go immediately to both houses, which are expected to approve them without much dissension. Big question: Will President Reagan sign the compromise legislation? A veto after Congress adjourns cannot be overridden. However, the White House has directed the Office of Management & Budget to drop its opposition to the new deafness institute, making a veto less likely. . . . **BRIAN LEYLAND-JONES**, head of drug evaluation and reporting in the Div. of Cancer Treatment's Cancer Therapy Evaluation Program, has been named director of the McGill Univ. Cancer Center in Montreal. . . . **MACE ROTHENBERG** has been named special assistant for clinical affairs in the office of DCT Director Bruce Chabner. . . . **WYNDHAM WILSON** has moved from the Medicine Branch into Chabner's office as special assistant for AIDS related matters and bone marrow transplants. . . . **LINDA HOGAN**, head of the protocol office in CTEP, will leave Oct. 26 to join Elm Services Inc. as senior associate, consulting on community cancer programs. . . **NEW MEMBERS** of the Div. of Cancer Prevention & Control Board of Scientific Counselors are Shirley Lansky, president and director of the Illinois Cancer Council; Donald McCormack, asociate dean of Emory Univ.; and Wayne Calloway, in private practice in Washington DC.

NCI Seeks Major Share Of New Slots For NIH, Including AIDS Programs

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the 350 additional positions for NIH ordered by Congress in the report on the 1989 appropriations bill. Two hundred of those were designated for AIDS.

"We are running a well funded but seriously understaffed AIDS drug development program with personnel cannibalized from the cancer program," Div. of Cancer Treatment Director Bruce Chabner told the division's Board of Scientific Counselors last week.

"Staff are understandably demoralized and frustrated," Chabner continued. "Neither the AIDS nor cancer drug development programs will function effectively unless the freeze is lifted and we are allowed to hire new staff for these efforts."

The shortage is brought on by the ceiling on positions for NIH institutes, with NCI particularly hard hit, as pointed out by NCI Deputy Director Maryann Roper to the National Cancer Advisory Board (**The Cancer Letter**, Oct. 7). NCI's ceiling is 2,115 positions (full time equivalents) this year, although the institute is carrying about 2,280 FTEs. Because it is over the ceiling, NCI is not permitted to hire anyone until attrition brings the number down to the ceiling.

"The reasons for this overage is obvious," Chabner said. "We are operating with 130 fewer employees than five years ago, despite a 45 percent increase in our budget over that period and the assumption of major new responsibilities for AIDS."

The AIDS positions count against NCI's total, so when a new person is hired for an AIDS slot, which is not covered by the freeze, that FTE is deducted from the NCI total.

"The situation for DCT is particularly difficult," Chabner continued. "In 1988, our assigned ceiling was 565 positions, but we operated at 620 and are consuming FTEs at an annual rate of approximately 600 FTEs at present. Again, the explanation is our new responsibilities for AIDS drug development. For this effort, with an annual budget of approximately $47 million, we have received approximately 24 positions, although according to our most recent estimate 57 additional positions are devoted to AIDS. This shift of personnel from cancer to AIDS has occurred despite our understanding with the (DCT) Board that the AIDS drug development effort would not be allowed to detract from cancer research. The task of establishing an optimal drug screening program for either AIDS or cancer requires not only dollars but people."

Michael Boyd, director of DCT's Developmental Therapeutics Program, said that "at least half of us spend more than half our time on AIDS." DTP has responsibility for identifying and screening potential AIDS therapeutic compounds and for taking them through preclinical development.

Boyd explained that while much of the work being done in cancer and AIDS drug development is performed by contractor employees at the Frederick Cancer Research Facility, "contractor staff can't do all the functions of DTP staff."

Chabner added, "We need a level of supervision and coordination that we can't do with the limit on FTEs."

"The contractor's people involved in the program are absolutely terrific," Boyd said. "They are frustrated just like we are."

Board member Emil Frei asked if the FTE shortage was just causing delays in the program, or compromising quality. "Both," Boyd answered.

NCI has requested 130 additional positions for AIDS programs and 100 for cancer staff. The NCAB supported that request in a letter drafted by Howard Temin, chairman of the NCAB AIDS Committee. The letter was addressed to Anthony Fauci, NIH associate director for AIDS research and director of the National Institute for Allergy & Infectious Diseases.

"On behalf of the National Cancer Advisory Board, I urge you to consider and approve the National Cancer Institute's request for 130 new AIDS FTEs for FY 1989," Temin wrote.

"NCI has made considerable contributions to AIDS research, most notable of which are the codiscovery of HIV as the causative virus of AIDS, the technology underlying the development of the first commercial HIV test kit, and the identification of the first--and still the only--antiretroviral drug effective in AIDS patients. These discoveries have formed the foundation on which many other AIDS programs have been built. NCI operates the largest AIDS intramural research program on the NIH campus, an activity which is more FTE intensive than the conduct of extramural programs.

"At this time, NCI devotes an estimated 143 FTEs to AIDS research. However, only 53 of these FTEs have been officially designated and received from NIH as AIDS FTEs; the rest

have been borrowed from the cancer program. Because of the increasing opportunities and the continued pressing need for cancer research, as well as the overall decrease in NCI FTEs, it will be increasingly difficult to continue this borrowing. Of particular importance is the need for additional FTEs for the AIDS drug development program. These FTEs could be transferred to NIAID when the entire AIDS drug development program shifts.

"Therefore, on behalf of the NCAB, and with its full approval, I urge you to honor NCI's request for new AIDS FTEs. These FTEs are desperately needed to staff both the intramural and extramural AIDS program of this Institute in order that the full potential of these programs be realized.

"Thank you for your consideration in this very important matter."

Fauci was not available for comment by **The Cancer Letter**'s press time this week.

Chabner pointed out that the problem also is affecting clinical programs at NIH. "We were assigned the 12-East ward last year to expand our clinical service for AIDS and cancer," he said, "but were given only five additional FTEs to cover the need for physicians, clinical fellows and data managers for a 12 bed AIDS component."

Chabner said he planned to meet with Fauci, and later this month (Oct. 31) with the AIDS Task Force. "I will tell them the same things I have told you."

Frei expressed concern about the mention in Temin's letter that all AIDS preclinical drug development eventually would be transferred to NIAID. "The science of AIDS and cancer overlaps tremendously," he said. "To split off AIDS drug development would be scientifically counterproductive. The science of AIDS research relates to cancer, in the laboratory and the clinic. I think it would be a dreadful mistake to separate drug development of AIDS and cancer."

NCAB, Hammer Agree How $1 Billion Will Be Handled: No Strings Attached

When someone wants to give you $1 billion, do you object when he wants to put a few strings on it, perhaps tell you how he wants at least some of it spent, and asks for your endorsement of his effort to raise that money?

You do if you are the National Cancer Institute, the National Cancer Advisory Board has decided. And Armand Hammer, who has promised to raise that much money (half of it in federal matching funds) but had asked for some strings, went along with the Board's position.

Hammer submitted a draft of a "memo of understanding" which he said had been cleared with former NCI Director Vincent DeVita and the NIH legal counsel. Among other things, the memo suggested that the primary recipient of the money Hammer intended to raise would be research on biological therapy of cancer, with emphasis on what Steven Rosenberg calls "adoptive immunotherapy," the name he gave to his interleukin-2/LAK cell and tumor infiltrating lymphocyte regimens.

The memo also requested certain NCI support, mostly in the form of literature and other materials that could be used in fund raising.

The fund raising campaign, which Hammer has designated, "Stop Cancer," started this week with a glittering, big money gala in New York. Promotional material on the gala noted that the money raised in the campaign would be used to support research on adoptive immunotherapy.

While Rosenberg and others involved in biological approaches to cancer treatment might be pleased at the prospect of getting $1 billion over the next four years (the campaign will end on the 500th anniversary of Columbus' discovery of America), others may feel differently, including most NCAB members.

The Board declined to go along with Hammer's memo. After discussions extending through the Board's recent meeting, Chairman David Korn agreed to meet with Hammer to determine if something else could be worked out.

Hammer, as he had said he would be, was very flexible. Instead of a detailed memo of understanding, he accepted a letter from Korn which stated that NCI would be pleased to accept funds from "Stop Cancer" and that those funds would be "fruitfully and diligently spent" along with any additional matching funds which might be provided, "in support of the Institute's research mission."

No commitment to any specific program or type of research, and no endorsement of the fund raising effort.

When Hammer first brought up the idea of raising a half billion dollars if Congress would agree to match it, DeVita said he would use the money to make up the difference between what NCI is getting from Congress and the bypass budget. At present, the shortfall is about a half billion dollars, so $1 billion would

lift NCI's budget to the bypass level for two years.

Hammer talked congressional leaders into going along with the idea, although no formal appropriation action has been taken. Hammer made it clear to them that this was to be money in addition to that which they would be expected to appropriate.

Hammer engaged Denver Frederick, who headed the successful fund raising campaign to restore the Statue of Liberty, to manage this effort.

Hammer, who as chairman of the President's Cancer Panel attends most meetings of the NCAB, indicated at the last meeting that he was flexible on how the money would be used. "It will be the responsibility of NCI to allocate it, based on established guidelines," he said. But he also said DeVita had agreed that priority would be given to research in cancer biology and the use of biologics in treatment, mentioning Rosenberg's work as an example.

Hammer has long expressed concern about the fact that NCI generally funds only about one third of approved competing grants. "That's disgraceful," he told the Board. "We can do better, and with Stop Cancer, we will do better."

He added that $8 million had been raised so far from eight individual donors, "including myself."

Board member Howard Temin was somewhat skeptical of the project. "Since we've been spending a billion a year for I don't know how long, with only moderate success, what leads you to believe that an increase of $250 million a year will lead to the solution of cancer?" he asked.

"Dr. DeVita believes that we should put to work those two thirds of scientists who aren't funded," Hammer responded.

The one third that are funded "are the top grants," Temin said. "There is a fundamental misunderstanding. One third of the grants are not necessarily one third of the people. To move the payline up would fund less qualified grants, as judged by peers."

"It's one thing to be cynical, another to do something about it," Hammer responded. "Why should we sit back while 500,000 people die every year from cancer?"

"If I had an extra billion dollars, I would spend it all on stopping smoking," Temin said.

"I agree that is important but it is not the only cause of cancer," Hammer insisted.

Board member Enrico Mihich said he disagreed with Temin. "These days, the borderline between funded and not funded is so tough. There are many excellent grants that are not funded."

Board member Louis Sullivan expressed concern about another provision in the proposed memo of understanding which would establish an advisory panel to recommend projects to be supported with the money raised in the campaign. "I'm concerned about what that would do to the peer review process of NIH."

"In my statement I said we would follow established rules of NIH," Hammer said.

"All of us would welcome more investment in high quality research," Korn said. He thanked Hammer "for stretching our imagination and challenging all of us."

Board member Gertrude Elion noted that the memo states that donors may designate specific projects their money would support. Considering that matching funds from Congress would be involved, "How would you tell which is which?"

Hammer agreed that was a factor to be considered in further discussions.

Board member Phillip Frost suggested that assigning biologics as the primary beneficiary "is a tad too limited. Biologics might be a high priority now, but it may not be two years from now."

Board members continued the discussion later in the meeting, after Hammer had left.

Sullivan expressed concern about appropriateness of designation by the donors of the research to be supported. Richard Adamson, director of the Div. of Cancer Etiology, noted that the National Cancer Act specifically gives the NCI director authority to accept gifts, and that there is precedent for designation by the donors.

Board member Louise Strong pointed out that in this case, active fund raising is involved, which would make it desirable to reach some understanding in advance with the fund raisers. "If somebody just wants to donate to NCI individually, that is fine. It can be handled in a more casual way. But this is different. Somebody is going into the private sector, claiming to raise funds for the National Cancer Institute. I think it is a very different situation that we have had before."

Board member David Bragg agreed that it could "set up a very dangerous precedent," encouraging Congress to rely more on contributions to support NCI and cutting appropriations to the Institute.

Board member Helene Brown said that "half

of me says we ought to go ahead with this benign agreement. The other half of me, as a public fund raiser for cancer programs all of my life, says that it is enormously wrong for the governfment, who takes from our tax pocket. We have got two pockets. One is our tax pocket, and one is the pocket from which we give voluntary contributions to the community. The government, NCI, is the product of our tax dollar. The voluntary sector, that sector where cancer centers raise money, along with ACS and others, is uniquely the pluralistic part of our society. . . If we, the government, are now on the street in the voluntary sector raising money, I don't believe that is right or correct."

Korn commented that "we should have learned our lesson by now that anything that suggests that any specific increment of dollars over a finite period of years will stop anything is dangerous. I don't believe, and I don't think anybody believes, that having another several hundred million dollars over the next few years is going to assure some magical result in cancer control, disease prevention, or anything else."

Frost agreed, suggesting that the name "Stop Cancer" be changed to "Wage War on Cancer," or "something like that. Five years from now or 10 years from now when there is still cancer, you may have a hard time if anybody wants to have a second campaign to raise a half billion dollars."

"Stop it again," Korn suggested.

Board member Louis Gerstner said that he agrees "it is hard to look a half billion dollars in the eye and say you don't want it, when we meet and talk about all of the things we would still like to do but we can't get done. The issue I would like to raise related to Helene's comment. I think that it is safe to say that $500 million coming from the private sector will not be totally incremental. Five hundred million dollars that will go into this cancer program, this cancer fund raising effort, will divert funds from other fund raising efforts in the cancer community.

"I raise this for the Board's consideration," Gerstner continued, "since I have no idea as a new member whether the NCAB cares. But I suspect that the American Cancer Society is going to care, that every private hospital in the country that raises money for cancer is going to care, that all of the legitimate private sector organizations that are raising money will at least have to consider whether this will have a profound effect on their fund raising activities over the next few years. . . I suspect this will not all be new money. There will be a diversion of the private sector money into this program. That may be good or bad. I don't have enough experience with this Board to know whether that is an issue we should be concerned about."

Mihich responded, "As for the question of diverting funds, I think that this would be the case if the technique is one of going to the small donor, to the private donor of various kinds. But as someone was discussing the other day, corporations have been been very illuminated in this respect, in contrast to foundations and private donors. If Dr. Hammer, even by gentlemen's agreement, were to direct his efforts towards corporations, then there might be a greater proportion of new money."

Korn raised another point about whether a formal agreement should be concluded between Hammer's organization and NCI.

"If we adopt the position that we are willing to tell anybody that asks that we think Dr. Hammer is doing a noble thing and we wish him well and applaud him, but there is nothing else overt or covert between us, there is also then the possibility that Dr. Hammer may raise some significant amount of money and be quite free to do anything he damn well pleases with that money. He might choose to invest it in particular projects he thinks are interesting that may have nothing to do with NCI. I am not saying there would be anything wrong with that. If he goes out and raises a bunch of money, he can do whatever he wants with it, I suppose.

"But remember there is a piece of this agreement which ties his fund raising to support of NCI programs and under a whole lot of regular procedure to avoid anything that would be untoward."

William Longmire, member of the President's Cancer Panel, said he believed that "really what Dr. Hammer wants is a stamp of approval from NCI, and that he wants to raise money to give to NCI."

"If Dr. Hammer raises the money and makes a donation to the Cancer Institute with no strings attached, that is the best of all possibilities," Board member Samuel Wells said. "But to set it up as a co-arrangement, I just think we can't do that as a public institution. I think you can have a general understanding with anybody who wants to donate money, but we shouldn't specify this arrangement."

Korn agreed to meet with Hammer, with the result noted above.

DCPC Board Gives Concept Approval For Largest Antitobacco Effort Ever

The largest, costliest and most intensive antitobacco effort ever undertaken, one designed to provide the "knockout blow" to tobacco use in the United States, received concept approval last week from the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control.

Titled the "American Stop Smoking Intervention Study," with the acronym ASSIST, the project will involve 20 regional coalitions around the country, with NCI and the American Cancer Society joining in partnership to organize and support the local coalitions of public agencies, community organizations and business.

The program will start in the 1991 fiscal year with phase 1 planning, to cost an estimated $8.5 million over two years. The implementation, phase 2, will get under way in FY 1993 at an estimated cost of $20 million a year. Implementation will end in FY 1997 and a followup year will cost an estimated $1.7 million.

"This is a historic day in the Smoking, Tobacco and Cancer Program," DCPC Deputy Director Joseph Cullen said. Cullen heads the program, which is the federal government's major antitobacco effort. "After 100 meetings, today marks completion of the planning."

Cullen noted that all of STCP's existing trials will be completed by 1992, when ASSIST implementation is scheduled to begin. That will free up money to support ASSIST.

"NCI is a biomedical research outfit that is trying to do cancer prevention and control," Cullen continued. "We can't do that without an army, and the American Cancer Society has the army. ACS will be a leading partner with us in this effort."

ACS participation has been approved by its Executive Committee and will be presented to the Board of Directors at its November meeting.

Harmon Eyre, current ACS president, told the DCPC board that the Society "welcomes this opportunity to participate. We will not receive any federal funds. In fact, we will contribute several million dollars and hundreds of thousands of volunteers."

ACS already has in place its program designed to produce a "smoke free America" by the Year 2000.

DCPC Director Peter Greenwald commented that lung cancer, along with other smoking related diseases, "is the major epidemic of this century." Board Chairman Paul Engstrom agreed that ASSIST "is a historical event, a major cancer control program."

Board member Donald Iverson, making the motion to approve the concept, said that "the key to success is ACS involvement."

Board member Frank Meyskens, while supporting the project, suggested that the tobacco industry seems prepared to counter a major antismoking effort by pushing the idea that "smoking isn't smoking, with the testing of so called smokeless cigarettes." Board member Kenneth Warner, criticizing what he called "the Balkanization of NIH," suggested that other NIH institutes and other health agencies of the federal government should be involved in the program. He also was apprehensive about the program becoming known as an "NCI-ACS effort," leaving out other health constituencies. "The notion that cancer is coming in and taking over could be detrimental."

Cullen said that discussions have been held with the American Heart Assn. and American Lung Assn., which strongly support ASSIST. "We've already dealth with that issue. It seems to me that it's appropriate for ACS and NCI to haver their names on the marquee. We're the leading anticancer agencies in the world."

Warner made the suggestion that the two phases be separated in the concept approval process, with the board withholding approval of phase 2 until phase 1 has been completed. Cullen said that an oversight committee will work with project participants and NCI staff, and will bring any concerns which arise to the board. The committee will include members of the board, from the National Cancer Advisory Board, and representatives of ACS, AHA and ALA.

Warner noted that the cost benefit of the project "looks promising." It is designed to reach at least 15 million smokers. "If it achieves 2.5 percent more cessation than otherwise would happen, that is 375,000 additional quits. The cost would be $300-400 per quit. Of course, that does not include volunteer time and time of state and local staffs, but even if the cost were twice as much, that is not bad."

Cullen said the cessation rate of existing STCP trials is at five percent.

Answering Board member William Darity's question on why the project was being supported with contracts rather than grants, Cullen said that it was determined that greater

NCI control would be required with so many organizations involved.

As to involving other federal agencies, Cullen said "We've tried that. But when it comes to putting on a large program, it is very difficult to work with another institute. We do work with them, and we have very good relations, but for a program like this, this is more workable."

Ed. note: Announcement of an RFA on smoking cessation strategies for minorities issued by the National Heart, Lung & Blood Institute appears on page 8 of this issue.

ASSIST will support large scale demonstrations in states and large metropolitan areas. Community based coalitions composed of institutions and organizations capable of coordinating and delivering effective tobacco control interventions within a geographic area will be developed and/or strengthened.

ASSIST will be implemented in two phases. Phase 1 will involve organizing coalitions aand developing detailed action plans to mobilize relevant and appropriate community resources in accordance with contract specifications. These plans will be implemented in phase 2 in order to achieve a significant reduction in smoking and tobacco use prevalence in the geographic regions selected.

Organizations include in coalitions will vary from site to site, but will include a broad range of organizations and community groups capable of working together to coordinate the area's tobacco control resources and to implement the intervention strategies. Members of the coalitions will represebt community institutions and organizations with the capacity to reach the general public as well as specific target groups that have been defined as appropriate for special intervention focus.

The American Cancer Society and state and local health departments will be required leaders for the coalitions. ACS, because of its strong local presence, will be an effective partner in activating and maintaining a high level of community involvement. The health departments, because of their disease control focus and existing public health structure, will be the recipient of project funds and will act as fiscal agent for the demonstration.

Planning and community organization during phase 1 will produce a detailed action plan for comprehensive community tobacco control. Action plans will specify how the coalition member organizations will deliver the interventions required by the project protocol. Plans will be based upon a detailed demographic and epidemiologic analysis of the target populations, public health resources and available dissemination channels.

Upon NCI project officer and staff approval of the action plan developed during phase 1, phase 2 of the demonstration will continue for a period of five years. The demonstration will consist of carrying out the detailed action plan developed ruing the planning process. Throughout phase 2 STPC staff will provide technical assistance and monitoring to ensure adherence to intervention protocols.

Activities will include the training of health care professionals to deliver cessation counseling; the provision of targeted cessation interventions in worksites and other locations; the implementation of tobacco use prevention curricula in schools; and the activation of print and electronic media to cover smoking issues. Minorities, women, heavy smokers, low income smokers and youth will be targeted in this effort.

As a means of keeping demonstration sites informed of progress and programs across sites, the STCP will convene the investigators and coalition leaders periodically to encourage a full exchange of information among and between the various demonstra- tion sites. These meetings will also serve to surface problems and identify solutions.

ASSIST demonstration sites will be evaluated using the current population survey conducted by the Bureau of the Census through an interagency agreement. Baseline and followup surveys of smoking and tobacco use prevalence will be measured in each geographic area funded, independent of the initiative. Approximately $3 million will be required to fund a baseline survey, a midproject survey and one post implementation survey.

As a supplement to the above evaluations, the project will draw upon a number of existing prevalence and process monitoring resources such as the NHIS survey, the CDC behaviour risk factor survey, and state specific cigarette consumption data published by the IRS. These data are available at no cost to the project.

It is proposed that approximately $5-6 million will be required to support phase 1 planning. These funds would be used for overall planning, including the establishment, organization and coordination of local coalitions and development of detailed action plans for phase 2 implementation. Phase 2 will involve approximately 20 geographic sites and will require an estimated $20 million annually.

ASSIST will require a data and coordination center contract costing an estimated $700,000 initially, increasing to $1.1 million annually. The center will be used for tasks related to overall project management and administration, coordinqtion, training, resource development, and data analysis. The contract will have the capacity to conduct small scale evaluations of specific project initiatives at the local level.

RFAs Available

RFA 88-CA-19
Title: Studies of chronobiological effects in cancer treatment with biological response modifiers and/or drugs
Application receipt date: Dec. 12

The Biological Response Modifiers Program and the Cancer Therapy Evaluation Program of NCI's Div. of Cancer Treatment are seeking grant applications from investigators for well focused studies relating timing variables to increased efficacy of cancer treatment with BRMs and/or cytotoxic agents.

Chronobiology is the study of the effect of periodic variations and cycles of time on biological phenomena. In the field of cancer treatment, preclinical and clinical chronobiological studies have resulted in observations of significant effects on the tumor response and on toxicity of at least 15 different therapeutic agents when the circadian schedules of treatment were varied. The basis for these findings is for the most part unknown but cell cycle kinetics and accompanying cell physiological changes, variations in pharmacokinetics, diurnal changes in growth and other factors may play an important role. By understanding the differences in the circadian dependence of the response of normal and tumor cells to therapeutic agents, antitumor effects may be optimized while minimizing normal tissue toxicity.

Proposals in response to this RFA should focus on in vitro and in vivo preclinical investigations of chronobiological effects on tumor therapy using BRMs and/or drugs. Hypotheses to be tested must have a solid basis and must be studied in clinically relevant tumor bearing animal models. Clinical protocols are not responsive to this RFA but supportive laboratory assays which measure chronobiological effects in ongoing clinical studies are responsive.

The following areas of cancer therapy investigation

are encouraged:

* In vivo chronocytokinetic studies relating the timing of administration and dose of BRMs and/or drugs with the cell cycle of tumor cells or developing bone marrow and other precursor cells.

* Chronopharmacokinetic studies in animal models of BRMs and/or drugs. Studies which include adoptive immunotherapy are encouraged.

* Chronobiological effects on lethal or organ toxicity of BRMs and/or drugs.

*Chronobiological effects on host effector functions.

In all studies proposed, the antitumor effect of the agent must be measured. Hypotheses to be tested must be addressed by employing well defined, well controlled, reproducible immunological and biological assays in order to provide a rigorous experimental basis for understanding chronobiological effects in cancer therapy using BRMs and/or drugs. New and novel approaches which may include collaboration between investigators in several disciplines is encouraged. The long term goal is the development of clinical protocols based upon the findings resulting from these studies.

Approximately $500,000 in total costs per year for five years will be committed to specifically fund applications submitted in response to this RFA. It is anticipated that two to three awards will be made. The earliest feasible start date for the initial awards will be July 1, 1989.

Copies of the RFA and further information may be obtained from Dr. Toby Hecht, Program Director, BRMP, DCT, NCI-FCRF, Bldg 321 Rm 7A, Frederick, MD 21701, phone 301/698-1098.

RFA 88-HL-26-P

Title: Smoking cessation strategies for minorities

Application receipt date: Jan. 23, 1989

The Prevention & Demonstration Research Branch of the Div. of Epidemiology & Clinical Applications, National Heart, Lung & Blood Institute, is seeking grant applications on the above subject.

Smoking remains the chief preventable cause of cardiovascular and respiratory disease and death among Blacks, Hispanics, Asians and Native Americans, as it is for all Americans. Among some minorities, high rates of smoking or high prevalence of other cardiovascular disease risk factors are reflected in smoking related mortality rates suggesting the need for minority specific cessation approaches. Language or cultural barriers may inhibit the success of currently available smoking cessation programs. However, little is known about smoking cessation strategies that might be most effective in achieving increased rates of smoking cessation in a defined minority population. Consequently tailored smoking cessation programs are needed to meet particular needs of minorities in reducing smoking related morbidity and mortality.

This program inmvites grant applications for demonstration research projects to develop and test minority specific strategies for recruitment to smoking cessation, for achieving cessation, and/or for maintaining smoking abstinence. Applications must include cardiovascular disease or respiratory disease variables in the proposed research design.

This solicitation may be of interest to investigators from a broad range of disciplines such as epidemiology, public health, cardiology, physiology, pulmonology, sociology, psychology, health education and communication sciences. Multidisciplinary approaches involving several specialties are appropriate. Applicants must demonstrate access to a defined target population, a control or comparison group, and expertise within the proposed team to carry out research sensitive to the sociocultural elements or language needs of a minority population.

It is anticipated that up to five grants, of three years each, will be awarded under this program with total first year costs for all grants of $1,750,000.

Copies of the RFA and further information may be obtained from Katrina Johnson, PhD, PDRB, NHLBI, NIH, Federal Bldg Rm 604, Bethesda, MD 20892, phone 301/496-3503.

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-CB-95601-61

Title: Maintenance of NCI diagnosis serum bank

Deadline: Approximately Dec. 10

The contractor will maintain existing collections of sera totaling approximately 553,000 vials and collect sera from patients with cancer, patients with benign diseases and from normal individuals. Specifically, collection and maintenance will be required for approximately 25-50 serum specimens in the following categories:

1. Twenty specified organ site categories from patients who have not entered therapy or have been in therapy more than six months.

2. Twelve categories of benign tumors that approximate the sites of cancers.

3. Pancreatic adenoma and renal adenoma tumor categories until serum from a total of 25 patients for each rare benign tumor category is obtained.

4. Eleven specified nonmalignant diseases.

5. At least 100 healthy control subjects in each of four groups: males age 30-50, males over age 55, females age 30-50 and females over age 55.

The serum specimen shall be divided into 10 one milliliter aliquots and stored in sterile glass vials. A replacement sample shall be collected whenever five or fewer vials remain.

Maintenance of a computerized data system (IBM compatible) will be required.

The contractor will assemble and distribute serum panels to requestors in the U.S. and abroad.

The contractor must provide approximately 2,600 square feet of appropriately air conditioned storage space at the initiation of the contract to house a minimum of 79 existing freezers containing about 553,000 vials of serum specimens which the government will provide. It is essential that the contractor provide proper storage space in order not to jeopardize this irreplaceable resource.

This is a recompetition of the contract held by the Mayo Foundation. A five year award is anticipated.

Contract Specialist: Charles Jackson

RCB Blair Bldg Rm 114

301/427-8888

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

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