THE CANCER LETTER

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Biggest NCI Budget Brings Large Headache: More Commitments, Rising Costs, Opportunities

NCI has the largest budget for the 1990 fiscal year than for any other year in its history, but commitments from previous years, continued increases in the cost of research which outstrip national inflation rates, and the ever growing number of research opportunities place more demands on this budget than in any previous year. The situation with investigator initiated research grants--RO1s and PO1s--appears to be

(Continued to page 2)

In Brief

DeVita, Frei To Share Hammer Cancer Prize; Dessureau To Retire Early; NCI Appointments

ARMAND HAMMER announced his 1990 Armand Hammer Cancer Prize winners: **Vincent DeVita** and **Emil (Tom) Frei** will share the $100,000 award, to be presented at a dinner in Los Angeles Jan. 5. DeVita, physician in chief of Memorial Hospital in New York, was recognized for his role in developing combination chemotherapy for treatment of Hodgkin's disease "and for his inspired leadership as director of NCI and the National Cancer Program." Frei, director of Dana-Farber Cancer Institute at Harvard, was cited for developing combination chemotherapy of leukemia and his contributions in understanding the mechanisms of action in combination chemotherapy. . . . **ALBERT DESSUREAU,** deputy director for administration at the Dana-Farber Cancer Center, announced he is taking early retirement after 32 years in administration. He plans to be involved in research administration as a consultant. Corinne Constantine has been appointed as his successor. . . . **ALAN SCHREIER,** program director of DNA biostudies in the Biological Carcinogenesis Branch of the Div. of Cancer Etiology, will become program director of the Cancer Centers Branch in the Div. of Cancer Biology & Diagnosis. . . . **LARRY WILHITE,** who has been administrative officer of DCBD, has been appointed chief of the newly created Administrative Management Branch of the division. . . . **JOHN MEYER** has been named executive secretary of the Cancer Center Support Grant Review Committee in the Div. of Extramural Activities. Meyer has been at the National Institute of Allergy & Infectious Diseases, and before that at NIH's Div. of Research Grants. . . . **CORRECTION:** Helene Brown is director for community applications of research in the Div. of Cancer Control at the Jonsson Comprehensive Cancer Center at UCLA, not co-director as reported in the Nov. 17 issue of **The Cancer Letter.**

Biggest NCI Budget Brings Large Headache: Competing Vs. Stability

(Continued from page 1)

approaching disaster status, with fewer than 20 percent of approved new and competing renewal grants likely to be funded. Yet research project grants, which included RO1s and PO1s, is a category which, NCI Director Samuel Broder pointed out to the National Cancer Advisory Board Monday, will make out the best of all NCI funding mechanisms this year.

The worst: cancer control; second worst, cancer centers.

Those were the gloomier aspects of the budget message presented by Broder, who had in hand what probably is the closest estimate yet on the final amount NCI will receive in appropriations for the 1990 fiscal year, which started Oct. 1.

The continuing resolution (interim financing approved by Congress while the regular appropriations bill was pending) covered Oct. 1 through Nov. 21. The final bill signed by President Bush had $1.664 billion for NCI, but that was just the start.

First and worst, there is the sequestration mandated by Gramm-Rudman-Hollings. If Congress and the President had not agreed on budget cuts meeting the GRH deficit reduction target (which they did), an across the board cut of over five percent would have been leveled on all federal civilian agencies except Social Security and Medicare. That would have chopped $80 million from NCI's total.

The agreement did keep sequestration in place until February. The first estimate of the cost to NCI was around $30 million, but Broder said subsequent analyses, "which are beyond my understanding," indicate "we are getting a more favorable discount." At the moment, that figure is $22.8 million.

There are other lesser hits on the budget, some of which NCI could get back. For instance, NCI has to contribute $3.6 million to an NIH pool for financing construction and renovation of research facilities. That pool will total $15 million, and the institutes will compete for it.

NCI has a backlog of construction/renovation grant applications, reviewed, approved, and scored in acceptable funding ranges, totaling more than $15 million. "I think we will compete very well for our share of that money," Broder said.

Salary increases and procedural reforms will take more than $2 million. The imposition of a cap on extramural investigator salaries, which was supposed to save money for NIH, will end up costing about $10 million. The government may save that much, but it will revert to the Treasury and not to NIH.

"The lesson there," NCAB Chairman David Korn said, "is that when scientists try to play hardball with Congress, the scientists generally lose."

Research project grants are not really in as bad shape as the percentage of RO1s and PO1s to be funded make it appear, Broder pointed out. RPGs also include NCI's Outstanding Investigator Grants and the NIH MERIT and FIRST awards.

"Every action has a counter action," Broder said. "The things we did to provide more durability and stability of funding, including extending some grants from three years to five and even seven years, had a price. They put more pressure on the new and competing line. This moved more money from the new and competing pool to the noncompeting pool."

Another factor affecting the competing pool is that "there are many more new investigators coming into the system," Broder said. "There has been a dramatic increase in the number of grant applications."

Members of NCI boards of scientific counselors have become increasingly critical of concepts presented to them for consideration as RFAs (requests for applications, which require set aside money to fund grants resulting from those RFAs). They resent taking money from the RO1 pool for RFAs.

However, Broder said, "RFAs have been flat. They are not significantly detracting from money available for RO1s." He said he feels RFAs are really RO1s, "although they do not meet the true definition of investigator initiated research."

Outstanding Investigator Grants, which are seven year awards, require seven percent of the total RPG budget. They should be considered as RO1s, Broder said. They go to people who would be competing in the RO1 pool if they had not competed successfully for OIG awards. In fact, most of them had several

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NCI 1990 Operating Level (Dollars In Thousands)

1990 Appropriation	$1,664,000
Sequester Estimate	-22,829
Revised 1990 Level	1,641,171
Reductions:	
Procurement Reform	-1,282
Extramural Salary Cap	-2,335
Construction Redirection	-3,576
HHS Salary Estimate	-1,000
Subtotal Reductions	-8,193
Projected Operating Level	$1,632,978

RO1s or PO1s which were rolled into the OIGs.

All the RPG mechanisms together--OIG, MERIT, FIRST, RFAs, PO1s, and Small Business Innovative Research Grants--"do have an impact when added together," Broder said. "But each was designed to fill a need." FIRST is a format to help new investigators compete, and get their careers started. OIG was designed to provide continuity of funding for proven, outstanding scientists. MERIT was set up to stabilize funding for high priority projects.

In constant dollars, Broder said, the amount available for RO1s has fallen since 1985, "but not dramatically." PO1s have been comparatively stable. The others have increased, although "that increase has not been driven by RFAs."

In real dollars, RPGs totaled $517 million in 1985, $723 million in 1989. OIG, a new mechanism in 1985, received $7.9 million that year, $53 million in 1989. MERIT went from zero in 1985 to $32.4 million in 1989. FIRST received $7 million in 1985, $22 million in 1989.

"The newer mechanisms took up 45 percent of the growth," Broder noted.

NCAB member John Durant commented that he has seen NIH study section members "come back from meetings depressed by the number of new grants that can't get funded. What is the impact of increasing time of grant awards from three to have years on the amount available to the competing pool?"

"It makes the curve look worse," Broder said. He did not have specific figures on the total amount shifted to noncompeting by lengthening grant awards.

"Study section members are gloomy. They don't realize it is not as bad as it seems."

"The amount of good research coming in for grants is increasing, but we don't have the money to fund it. That's the bottom line," NCAB member Enrico Mihich said. "It's a paradox. We try to give security of a little bit more stability, at a time when the field is increasing. We should continue to fight for the bypass budget (the budget NCI submits to the President which calls for the optimal amount NCI could use, this year about $700 million more than it will get), but wouldn't it be possible to put a cap on RPGs? You can't do it to RO1s, but you could on RFAs, on FIRST."

Korn noted that there already is a cap on FIRST awards, $350,000 over five years. "There's no substitute for more money, Henry," he said to Mihich. "One instant, we want more new and competing grants, and in the next instant, we want stability."

John Hartinger, chief of NCI's Financial Management Branch, asked to compare the total amounts for RPGs in 1985 and 1989, said that it was $517 million out of a 1985 total for NCI of $1.177 billion; and $723 million in 1989 out of NCI's total of $1.571 billion.

NCAB member Roswell Boutwell commented that it appeared the percentage for RPGs was getting smaller, "although we always hear NCI say that research project grants are important."

"Research project grants have been constant at about 50 percent," Broder said. "You could say that we need more, but it is not fair to say we have not continued to consider them as high priority. They fare better than anything else."

The percentage for RPGs did increase since 1985, from 44 percent to 46 percent.

"If centers are such a high priority," Boutwell continued, "maybe we should reallocate a little to centers, which support investigator initiated research."

William Longmire, member of the President's Cancer Panel, suggested that efforts should be made to increase support for cancer research from nongovernment sources.

"There is no substitute for NIH supported research," Broder said, pointing out that the total NIH budget is $7.5 billion.

"I couldn't agree with you more," Longmire said. "But couldn't we look for some help from others?"

Korn commented that most of the research supported by other sources "is pretty much targeted."

NCAB member Erwin Bettinghaus observed that the amount of money in the centers budget has remained relatively stable, but that the pressure on that budget has been increased because there are more centers.

"Shouldn't we say that, with a level budget, we will fund new centers only if we take out others who can't pass peer review?"

"We've reached that stage," Broder said. He added that additional pressures come from increases in amounts requested and approved for center core grants being renewed. "The budget will go up for centers, but that does not necessarily mean that more centers will be funded."

Bettinghaus also suggested that the Centers for Disease Control could be asked to take over NCI cancer control projects which have been demonstrated effective. "I think the Div. of Cancer Prevention & Control has several activities which are ready for CDC."

DCPC Director Peter Greenwald said that DCPC does a minimal amount of applied research, most of which is in AIDS. As for the prospect that the private sector could be tapped to help support cancer control, Greenwald said that most for profit enterprises are not particularly interested in prevention, or in basic research.

Greenwald has made a case in the past that the fruits of basic research must be applied to health problems, or Congress and the American people may lose interest in supporting it.

He repeated that suggestion and added that a shift in emphasis, to apply the results of research, should be considered.

"We will need to change priorities when we have to apply research," NCAB member Helene Brown commented.

NCAB Approves New Guidelines For Comprehensive Center Review

The National Cancer Advisory Board made it official Monday: By approving review guidelines for the new system of designating cancer centers as comprehensive, the board put into place the final elements of the new program.

The 20 centers now recognized by NCI as comprehensive will have up to two years to undergo formal review to determine if they meet all eight of the newly adopted criteria for comprehensiveness. The existing comprehensive centers have had from 10 to 17 years with that status, the only requirement after going through a somewhat informal review by NCI staff and the NCAB being that they had to maintain their NCI core grants.

All other centers with NCI core grants that wish to seek comprehensive designation and whose core grants are not timed appropriately for review during the two year period may also request to seek the administrative review, as it is called, as opposed to normal peer review.

Both the normal and administrative peer review will be conducted by the Cancer Center Support Grant Review Committee, which at present is chaired by Joseph Simone, director of St. Jude Children's Research Center.

In the normal process, a center seeking initial or continued designation as comprehensive will have that review in a separate session immediately after its core grant review. Whether a center is successful in achieving comprehensive status will have no bearing on its core grant.

NCAB member Roswell Boutwell asked what the rationale was for the two year "window" rather than permitting centers to keep their comprehensive status until the next time their core grant is reviewed.

"Because we don't want to have two different levels of comprehensiveness," NCI Director Samuel Broder said. "I can't imagine that the existing comprehensive centers will fail to get that renewed."

Representatives of some existing comprehensive centers have expressed concern about whether they can meet the new strict requirements for community outreach and clinical trial participation.

NCAB member John Durant asked about those comprehensive centers which were initially recognized in partnerships, such as Georgetown/Howard Universities in Washington DC and Fox Chase/Univ. of Pennsylvania in Philadelphia. In those cases, the institutions have separate core grants with different renewal dates.

"We'll have to work that out," Broder said. Barbara Bynum, director of the Div. of Extramural Activities, added that a special review could be done to accommodate those situations.

NCAB member Enrico Mihich suggested that it is conceivable, under the new system, that a center could meet the requirements for comprehensiveness but fail to get a fundable priority score for its grant.

Broder did not think so. "It is just not conceivable that you could have comprehensive center recognition without a core grant."

Broder noted that he had received a letter from Fox Chase President Robert Young, requesting review for comprehensive designation. "That is the first under the new guidelines; so it's historic," he said.

Sydney Salmon, director of the Univ. of Arizona Cancer Center, might dispute that. It was his letter asking for review, under the old comprehensive center guidelines, which prompted then Director Vincent DeVita to start the process of revising and revitalizing the program, more than two years ago.

The new review guidelines were summarized in The Cancer Letter, Nov. 24; the new criteria were published in the Nov. 17 issue.

NCAB Votes Not To Fund Diet FIT 'On Grounds Other Than Merit'

The National Cancer Advisory Board voted unanimously not to concur with the initial review group's recommendation for funding the Dietary Fat Intervention Trial "on grounds other than scientific merit."

NCAB Chairman David Korn read a statement following the closed session at which the action was taken this week, which stated that the grounds for denial of funding included allocation of NCI resources.

The RO1 investigator initiated proposal, called Diet FIT, was projected to cost $60 million over five years. The trial proposed to randomize 24,000 women aged 55-69 to either a low fat diet (in which fat is reduced from about 40 percent of caloric intake to 20 percent) or control. The hypothesis was that over a 10 year period, there would be a drop in incidence rates of breast, colon, rectal, ovarian and endometrial cancers, as well as coronary heart disease.

The proposal was submitted by Ross Prentice and Maureen Henderson, both of the Fred Hutchinson Cancer Research Center.

The board's action came after a nearly two hour open session in which Div. of Cancer Prevention & Control Director Peter Greenwald argued strenuously in support of "some kind of dietary fat prevention trial." Greenwald referred to a number of studies which support the hypothesis of dietary fat relationship to breast cancer incidence.

"We have a strong hypothesis justifying a study involving a major public health problem," Greenwald said. "I don't see how we will ever clear up this question without some kind of clinical trial."

Greenwald pointed out that at the October meeting of the DCPC Board of Scientific Counselors, the board indicated its support for a dietary fat cancer prevention trial. The board took no formal action. Greenwald suggested that possibly other sources for sharing costs of the trial might be available.

Dorothy Canter, who represents the National Institute of Environmental Health Sciences as a ex officio member of the NCAB, asked since endpoints other than breast cancer were included in the trial "that we're not supposed to be talking about," whether the National Heart, Lung and Blood Institute had been asked to contribute.

Greenwald said he had talked to NHLBI Director Claude Lenfant about the trial, and Lenfant said he was very interested, but before he could commit NHLBI money, it had to clear that institute's advisory council. He would need details of the grant application in order to make a presentation to the council.

Greenwald said "it would certainly help" if NCAB endorsed the Diet FIT trial.

Several NCAB members brought up many of the criticisms that had been made against Diet FIT in the past: possible confounding of results by dietary changes in the control group, whether epidemiology data involves calories rather than fat consumption, whether the power of the trial would be enough to demonstrate the significance of results and whether a 15 percent reduction in incidence would translate to the desired reduction of 15 percent mortality.

Those points apparemtly had little to do with the board's decision, however; the size of the grant had everything to do with it. Back in open session, the board discussed appropriateness of the RO1 mechanism for funding a $12 million a year grant.

"We struggled with this on that last issue," Korn said. "It could destroy the system," Howard Temin added. Korn said the matter of limiting the size of investigator initiated grants would be brought up at the board's January meeting.

Clinical Oncology Program Shows Depth In Year End Overview

Gregory Curt, director of the Clinical Oncology Program in the Div. of Cancer Treatment, who left NCI last year to become chief of clinical pharmacology and director of medical education at Roger Williams General Hospital in Rhode Island, gave his first program overview to the National Cancer Advisory Board this week since his return to NCI earlier this year.

Curt presented highlights of the work of each branch in COP, demonstrating the depth of the program. Earlier this year, the NCAB heard reports from Steven Rosenberg, chief of the Surgery Branch, on the gene transfer experiement with tumor infiltrating lymphocytes, and Charles "Snuffy" Myers, chief of the Clinical Pharmacology Branch and the Medicine Branch, on his work with suramin.

The Medicine Branch has made "major accomplishments" in the area of drug resistance, and is seeking to determine which, if any, of the preclinical markers for drug resistance might be important in the clinic, Curt said. Some of the agents the branch is studying are P-170 glycoprotein in

lymphoma, the role of GST in breast cancer and ERCC-1, a DNA repair gene, in platinum resistance in ovarian cancer. The branch has made a major effort to determine if antisense compounds may be useful as therapeutic agents in cancer and AIDS, Curt said.

The branch is conducting number of dose intense clinical studies using GM-CSF in breast and ovarian cancer. The first trial is testing 5-FU, leukovorin, adriamycin and cytoxin. The dose regimen is about 50 to 100 percent more dose intense than previous combination chemotherapy used in the branch.

As of this week, 21 patients have been treated and all of the patients have had at least a partial response. Some of the partial responses may become complete at the end of the trial, Curt said. About 35 percent of the patients have had complete responses to date. All have advanced stage 3 or 4 breast carcinoma.

Investigator Eddie Reed is studying high dose CBDCA, a platinum analog, in cisplatinum refractory patients with ovarian carcinoma. "Here again, there seems to be a steep dose response curve," Curt said. About 30 percent of these patients have had substantial response using GM-CSF in combination with CBDCA. "It is likely that this regimen would be moved into treating patients who were previously untreated for ovarian cancer," Curt said.

Myers' studies of suramin have found that the drug inhibits the IP3 receptor. These studies have found that hormonally nonresponsive prostate cancer cells have a number of markers which have previously been undescribed, Curt said.

"If you treat hormonally refractory prostate cancer cells in vitro with ATP and ATP analog, you can actually inhibit the growth," Curt said. "This is a potentially new target for treatment in a common solid tumor."

Myers has reorganized the Medicine Branch into disease specific clinics, which have been useful for teaching first year fellows, Curt said. Myers is responsible for the Special Studies clinic, or phase 1 clinic. Other clinics are for breast cancer, GI malignancies, ovarian cancer, AIDS and lymphomas.

The Medicine Branch also is the "window" for collaborative trials with other investigators, Curt said. Some of the collaborative trials include use of PE-MoAb for treatment of ovarian cancer. The monoclonal antibody was developed by Ira Pastan, chief of the Laboratory of Molecular Biology in the Div. of Cancer Biology & Diagnosis. B72.3 moloclonal antibody is being tested in GI cancer. A phase 1 study is planned for L651582, discovered by Lance Liotta, chief of the Laboratory of Pathology in DCBD. Liotta recently found the drug inhibits gene peptides.

The Pediatric Branch, headed by Philip Pizzo, has used an animal model for candidiasis to identify a new agent, itraconazole, an effective antifungal agent, Curt said. The branch also has found a 48 Kd cytoplasmic antigen which may be useful as a diagnostic agent. In clinical trials, this antigen is found in 80 percent or more of patients who have candidiasis.

The branch also is studying the potential role of growth factors, particularly IGF-II, for treatment of rhabdomyosarcoma. "There are good reasons to think that IGF-II is a curative growth factor in rhabdomyosarcoma," Curt said. The branch is conducting studies in children at the clinical center.

A single application of 1 microgram per mil of the monoclonal antibody significantly inhibits the growth of the rhabdomyosarcoma cell line in vitro, Curt said. The studies are also looking at transretinoic acid, and there is preliminary data that it can significantly inhibit the growth of the cell line.

The Pediatric Branch has been responsible for a series of studies on the optimal management of patients with neutropenia. A recently completed randomized study of monotherapy showed that monotherapy is an inexpensive and convenient alternative to other therapies, Curt said.

Other phase 1 studies in children are testing IL-2, AZT, ddI, and other agents for cancer and AIDS.

Nicotine Stimulates Lung Cancer Cell Growth

At the NCI-Navy Medical Oncology Branch, there is "a young group of investigators and molecular biologists interested in the molecular biology and treatment of nonsmall cell and small cell lung cancer," Curt said.

A recent Navy study has shown that nonsmall cell and small cell cell lines expressed nicotine receptors, Curt said. "Nicotine stimulates the growth of lung cancer cells. It does that at physiologically relevant concentrations. Whether or not it is clinically important to the treatment of lung cancer patients who smoke is unknown," he said.

The branch also has made some interesting findings in receptive oncogenes, Curt said. The branch has focused on p53, which may function as an anti-oncogene in a number of solid tumors. The gene is located on the short arm of chromosome 17, a area of frequent activity in lung cancer, breast cancer, colon cancer. In one study, transgenic mice transvected with a mutant p53 spontaneously developed lung cancer.

Curt gave an update of a clinical trial of limited stage small cell lung cancer trial using chemotherapy

and radiation: The actuarial survival of these limited stage patients is 94 percent at one year and 63 percent at two years, with a mean followup of just over two years.

"Survival is about twice was has been reported in previous studies. The hyperfractionation of the radiotherapy makes the combined modality treatment much more powerful," Curt said.

The branch also has documented that for nonsmall cell lung cancer, neuroendocrine markers are prognostic for better response. "If you have nonsmall cell lung cancer with neuroendocrine markers your likelihood of response is about double that of pathologically similar nonsmall cell without neuroendocrine markers," Curt said.

In the Surgery Branch, Rosenberg is continuing his work in tumor infiltrating lymphocytes. Since the NCAB received an update of the gene transfer trial earlier, Curt discussed the work of Marston Linehan, chief of the Urologic Oncology Section, in renal cell carcinoma. Linehan's work on the molecular biology of renal cell carcinoma suggests that antioncogenes may be important in the pathogenesis of this solid tumor, Curt said.

In the Radiation Oncology Branch, Curt discussed the work of investigators James Mitchell and Tom Delaney, who are interested in photodynamic therapy.

In the laboratory, the branch has identified a nitroxide, "a truly unique class of radiation protecting compounds," Curt said. The branch also has begun work on water soluable chemoluminescence, also called "liquid light."

The series of compounds was developed by Angelo Russo, chief of the Experimental Phototherapy Section, and Mitchell, chief of the Radiation Biology Section. Because the compounds are small, they are able to enter cells, Curt said.

The compounds are not toxic and are able to protect against damage from free radicals. They could be used for protection against x-ray damage and oxygen injury. Most tissue damage that occurs during a heart attack, Curt said, occurs not from the interruption of the blood supply, but from free radical damage.

The branch is continuing phase 1 clinical trials of photodynamic therapy and also is using IMDR, a radiation sensitizer.

The phase 1 trials use dihematoporphyrin, which is selectively retained in tumor cells and then radiated with light, which causes formation of free radicals which can kill cells.

"It has been remarkably effective. It is now considered standard therapy for some lesions," Curt said. The branch now is studying ways to more evenly distribute the red light to the tumor in ovarian carcinoma and Kaposi's sarcoma. With more even distribution, "you can increase the dose and decrease the time between administering the dihematoporphyrin and the light," Curt said.

There has been no toxicity to date in the phase 1 study. Four of the nine cytology positive patients remain cytology negative two to four months after therapy.

AACR Announces New Deadlines For Submitting Member Applications

The American Assn. for Cancer Research will establish three new deadlines for the submission of applications for active and corresponding membership, the association annouced last week.

The new deadlines will be March 1, July 1 and October 1 of each year. The purpose of the change is to provide an additional opportunity each year for the submission of applications and to decrease the amount of time between deadline dates, the association said.

Except for the change in deadline dates, the qualifications and procedures for submission of applications remain the same. Application forms that show the previous deadlines of August and December may still be used, but the new deadline dates should be observed. If the deadline falls on a weekend, applications will be accepted on the following Monday.

Applications received by each deadline will be submitted to the appropriate membership committee for review and then to the Board of Directors for election.

Candidates will be notified according to the following schedule: Candidates whose applications are received March 1 will be notified in May, those whose applications are received July 1 will be notified in September, and those whose applications are received by October 1 will be notified in December.

Applicants elected in May will be responsible for payment of that year's dues; applicants elected in September and December will pay dues the following year.

Applicants elected in May and September will be eligible to sponsor an abstract for the next annual meeting. The association said that every effort will be made to afford the same opportunity to applicants elected in December.

Application forms and additional information are available from Robin Felder in the association office, phone 215/440-9300; Fax: 215/440-9313.

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 Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CM-07323-23

Title: Computer support for the Cancer Therapy Evaluation Program

Deadline: Approximately Feb. 26

NCI is seeking support for the computer system of the Cancer Therapy Evaluation Program. There are three major systems:

1) The CTEP Information System which provides computer capabilities to index, track, select, sort and locate clinical trials by recorded data items.

The contractor shall maintain the CTEPIS with the Local Area Network that is now being developed. This will require use of Oracle's software support and DEC's support of VMS, DECNET and the Microvax 3400 server. The CTEPIS is undergoing continual modification to meet the changing needs of CTEP. As a result, the development of additional functions has been and shall continue to be a part of this project.

2) The Drug Management and Authorization Section Drug Computer System is used to verify the accuracy of investigational drug requests, to transmit and record drug shipment information to the program.

The DDCS is a database requiring the support of professional personnel with expertise in systems analysis and computer programming and nontechnical personnel who are familiar with the system and interact extensively with the database. The DDCS contains data on nearly 2,000 active protocols for which DMAS provides drugs, 5,600 active cancer investigators, 9,700 inactive investigators and 145 investigational drugs.

Approximately 150 drug orders are verified and authorized daily. The system is a Local Area Network designed to use the VMS Oracle relational database management system on a Microvax 3400 file server and DECNET Ethernet network. Several enhancements to the system need to be undertaken by the contractor starting in year one of this award.

3) The Adverse Drug Reaction System which utilizes the database management program dBase III+ and the Clipper compiler to monitor adverse reactions reported on CTEP sponsored clinical trials.

Additionally the contractor shall provide programming and data management support for the Biometrics Research Branch staff, as needed, in the performance of projects. This will require knowledge of SAS (TSO and Batch), Graphics (SAS or other languages), WYLBUR and FORTRAN.

One award is anticipated for an incrementally funded five year period.

All responsible small businesses conforming to the size standard of $7 million annual receipts (Standard Industrial Classification #7376) may submit a proposal.

Contracting Officer: Carolyn Swift
RCB Executive Plaza South Rm 603
301/496-8620

Program Announcement Available

Title: NCI/MARC Summer Training Supplement

Application Receipt Date: Feb. 1

The Comprehensive Minority Biomedical Program of NCI's Div. of Extramural Activities invites interested grantee institutions that have Minority Access to Research in obtaining laboratory research experience at NCI. This programm announcement shall be reissued on an annual basis.

NCI, through a cofunding agreement with the Minority Access to Research Centers program of the National Institute of General Medical Sciences provides support for reseazrch training to minority individuals and institutions, as well as conference grant support, to further address and enhance the mission of the National Cancer Program. The NCI/MARC Summer Training Program is an extension of the cofunding process.

The objectives of the program are to increase research training opportunities in NCI for underrepresented minority scholars and increase the number of minority scholars entering into cancer related research careers through the influence of short term laboratory training at NCI.

Funding provisions: The supplement will provide the following: 1) A subsistence of $250 per week ($2,500 for a maximum 10 week period), and 2) round trip transportation from student's academic institution to the NIH and return. Indirect costs may be awarded to the institution for up to a maximum of 8 percent of the direct costs.

Mechanism of support: A MARC honors training grant to the academic institution requesting support for a student will be administrateively supplemented. Unless otherwise noted, all PHS and NIH grants policies apply to applications received in response to this announcement.

Evaluation criteria: Applications in response to this annoucement will be considered by NCI staff, after which final selection of a studnet for laboratory experience shall be made.

All domestic institutions with active MARC research training grants are eligible to apply.

Method of applying: In lieu of submitting a Standard Form PHS 398 the principal investigator must submit a letter, countersigned by an authorizing official of the grantee institution, requesting support of a student for short term laboratory training at NCI. This letter shall constitute an application and must include or be accompanied by the following:

A statement from the student that describes his/her research interests and career objectives along with a brief resume, two letters of recommendation, a current official college transcript, the student's selection of three NCI laboratory choices prioritized by level of interest, the title of the announcement, a copy of the face page of the active MARC grant, including the grant number and period of award, a description of the personnel to shich the student shall report his/her NCI laborat[illegible] experience.

A list of NCI laboratory choices w[illegible] available to applicants through the CMBP office. The 10[illegible] may be between May 15, 1990 and Au[illegible]der this announcement, funding is av[illegible]

More than one supplem[illegible]itted by the grantee institution, b[illegible]n will be cted for summer labor[illegible]ications to active MARC und[illegible]bmitted directly to the CM[illegible]

For more [illegible]ompre-hensive Min[illegible]ctivities, NCI, 900[illegible]da, MD 20892; [illegible] Access to Re[illegible]d Bldg Rm[illegible]