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DCPC Board Okays Concept For $10 Mil. Program To Promote Cancer Management In Rural Areas

A new, five year, $10 million program to promote application of state of the art cancer management in rural areas received concept approval from the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control last week. The program would involve six to 10 grants aimed at enhancing links between rural health care providers and

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In Brief

Barbara Britt Assumes ONS Presidency, O'Conner Is President-Elect; Kalt Joins NCI

BARBARA BRITT, clinical nurse specialist at Los Angeles Childrens Hospital, assumed presidency of the Oncology Nursing Society at last week's annual congress of the society. She takes over from Delores Esparza. **Linda O'Conner**, pediatrict hematology-oncolgy clinician at Baystate Medical Center in Springfield, MA, was elected president elect. New directors at large are **Juanita Garrison**, Lexington, KY, and **Karen McDonnell**, Boston. **Catherine Hogan** and **Joanne Hayes** continue as secretary and treasurer, respectively. . . . **MARVIN KALT**, who has been chief of the Scientific Review Office of the National Institute on Aging since 1983, has joined NCI as deputy director of the Div. of Extramural Activities. Kalt received his PhD in anatomy and developmental biology from Case Western Reserve and has carried out research in cellular, developmental, and reproductive biology. . . . **WINNIE LUMSDEN**, NCI's Committee Management Officer for the past 10 years, will retire at the end of this month after 28 years service in the federal government. DEA Director Barbara Bynum has not yet named Lumsden's successor. . . . **RICHARD UNGERLEIDER**, who was named acting chief of the Clinical Investigations Branch in the Div. of Cancer Treatment when Michael Friedman moved up to director of the Cancer Therapy Evaluation Program, has received permanent appointment to that position. . . . **NCI'S GRANTS** Administration Branch, whose chief is **Leo Buscher**, has received the Public Health Service Excellence Award from the Public Employees Roundtable. . . . **NCAB CHAIRMAN** David Korn, who was supposed to have completed his six year term on the National Cancer Advisory Board after last February's meeting along with five other members, opened the meeting last week with the comment: "Welcome to the first reunion of the class of '84." Members may continue to serve until their replacements have been appointed. The White House inexplicably has not only failed to replace those six but also to fill two other vacancies caused by resignations more than a year ago.

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DCPC Board Approves Concept For $10 Million Rural Program

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regional cancer specialists. The board also gave concept approval to new cooperative agreements for development of biomarkers of dietary adherence; master agreements for contracts to establish an early detection research network; contracts for evaluation of a fat modified diet on hormones during adolescence; a contract for acquisition of new computer systems for the division; and an interagency agreement with the National Center for Health Statistics for additional data acquisition.

DCPC Director Peter Greenwald warned that few, if any, of the new initiatives approved by the board could be launched within the next two years unless NCI's prevention and control budget is increased. The President's budget request for NCI in the 1991 fiscal year includes only $75 million for prevention and control, virtually the same as this year's budget. The FY 1992 bypass budget would more than double that, to $182 million.

The board tabled a concept for grants to support research on cancer risk reduction among high risk youth. Members felt it was unfocused and voted to reconsider it when DCPC staff and a committee of the board rewrite it.

Concept statements and board discussion follow:

Interventions to promote application of state of the art cancer management in rural areas. Six to 10 five year grants, total estimated cost, $10 million.

The major goal is to strengthen the application of state of the art cancer diagnosis and management practices in rural areas by enhancing links between rural health care providers and regional cancer specialists. The researchers are to test approaches to link rural providers and regional cancer specialists and evaluate outcomes indicative of changes in cancer diagnosis and management. Researchers are encouraged to be innovative in the development of approaches.

Delivery of cancer care to rural populations faces tremendous obstacles. Access to basic health care is complex. Community resources include hospitals without medical specialty resources, technical equipment, fewer physicians per capita than in urban areas, and poorly developed transportation systems. Even such limited resources are becoming more scarce as small rural hospitals close due to lack of funds. The lack of public transportation, the need to travel long distances to obtain health care, and limited or nonexistent health insurance or medical benefits all combine to form a major barrier to obtaining optimal health care.

The rural population has a higher proportion of elderly than urban areas, a tendency to seek medical care only for burdensome symptoms, and few economic resources to devote to health care plus less insurance or other third party coverage. In some areas, population characteristics include additional features such as a large proportion of migratory farm workers.

Many rural health practitioners are generalists, caring for individuals with a wide variety of diseases. The pressures to keep current in cancer care in many tumor types compete with similar demands in other diseases. Thus, it is unrealistic to expect these physicians to keep up to date with cancer care. In addition, the threat that the oncology specialist will not return patients to the rural physician for followup management is real and acts as a deterrent for referrals. Even when cancer care is provided by a specialist, the continuing care of the patient often occurs in the rural community where the general health provider is the only resource.

There now exists a network of cancer care medical and nursing specialists located in community settings as well as university cancer centers. These individuals and their programs are a resource for state of the art cancer management which need to be linked effectively with practitioners in rural areas.

A meeting of rural health care providers and researchers was held two years ago to delineate the characteristics of rural cancer care and to examine the research issues involved in cancer management. The major point these consultants made was that rural providers should not try to become cancer treatment specialists; however, they are key to case finding and early cancer intervention. The consultants stated that an initiative should be developed with emphasis on easy access to information and cancer specialists, in order to promote high quality care. The 1990 guidelines for comprehensive cancer centers require community service and outreach, and an application from a cancer center under this program would be consistent with these guidelines.

While there is considerable interest and activity in rural health care research, the focus is not on actual management of cancer cases. Thus, it is necessary for NCI to specifically direct and encourage cancer research in rural health care delivery. Demonstration projects and research provide some indication that it is possible to alter cancer care in rural areas and these efforts provide insights into potential techniques for enhancing the links between rural care practitioners and specialty care centers. It is timely to consolidate these leads into a rigorous research effort to improve rural cancer care.

Researchers should consider factors affecting cancer care in rural areas such as distance, availability of relevant health care personnel, referral patterns, and financial barriers. In addition, they should incorporate demographics of the rural environment, the patient population, the rural providers, the cancer specialists, and the nature of pre-existing relationships (if any) between the generalists and specialists into the study design. NCI expects the

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interventions to be designed to strengthen communication between the rural generalist providers and regional cancer specialists, and may include targeted training, visiting specialists, clinical trials participation, and/or innovative economic arrangements. Evaluation should address indicators of changes in cancer diagnosis and management practices, and efficiency of the intervention. Rural in this concept refers to geographical areas characterized by low population density which are remote from sophisticated specialty health care providers. Rural areas are distinguished from medically underserved populations in urban or high population density areas, which are excluded from this initiative.

Research proposals should identify a target rural area and describe the potential population. Rationale for the selection of the area should include unfavorable cancer trends such as:

* Late stage at cancer diagnosis, especially among tumor types with great potential for successful treatment when diagnosed at an early stage.

* Escalating mortality rates from one or more cancers which exceeds the national trends.

* Predominance of a minority population experiencing mortality from one or more cancers at rates greater than national trends.

The key element of the research is the development of methods to strengthen the link between cancer specialists located in community centers of cancer care or university based cancer centers and rural health care professionals. The purpose of the link is to promote the use of state of the art cancer management practices in the rural area and to allow patients to remain in their own communities whenever possible.

Based on the characteristics of the health care providers and the patients in the rural area in which the research is to be conducted, the researchers are to test approaches to link rural providers and cancer specialists to enhance state of the art cancer management practices of physicians and nurses in the selected rural area.

The interventions should incorporate, as appropriate, established resources of NCI, specifically the Cancer Information Service and PDQ. Examples of possible interventions include review of screening and/or biopsy specimens; computer assisted diagnosis and/or management algorithms; free telephone consultation between cancer specialist and generalized provider; PDQ protocols for patient management with specialist consultation available; and telephone hot line service for consultation.

Researchers are to focus the intervention on aspects of current cancer patient management which are well described in the baseline data. For example, a pattern of head and neck cancer diagnosis at stages 3 and 4, or the lack of appropriate chemotherapy for breast cancer.

The research design should consider both process and health outcome measures, as appropriate. While mortality rate changes may be sought, NCI realizes that the research design may not have the power to discern changes. Changes in practice are extremely appropriate outcome indicators.

Anne Bavier, Community Clinical Oncology Branch, is the program director.

The vote to approve the concept was not unanimous; Philip Cole and Ross Prentice were opposed.

"Rurality is not a particular risk factor," Cole said. "I don't understand why research is necessary. There is a perceived problem. You know why it exists. Why not do something about the problem, rather than research it?"

"That's the point," Greenwald responded. "We have to figure out how to address these formidable problems."

"One of our problems in Illinois is that there is zero health care in the southern part of the state," Shirley Lansky said. "The need for primary care is urgent. There aren't enough obstetricians to deliver babies, let alone do pap smears."

"In most rural areas, public health department nurses usually provide the care," William Darity said. "There are very few physicians. Are you addressing the right population group in linking to health departments?"

"Yes, this does not have to be doctor to doctor," Bavier said. She added that that would be made clear in the RFA.

"What do you do when there is no health care provider," Edward Bresnick asked. "Are you developing concepts on how to deal with that?" Bavier said that there are no concepts along that line being developed.

"There are many hospitals in metropolitan areas which have linkages with rural areas," Mary Ashton said. "I suggest that you look at those. They have experience working with public health nurses."

Harmon Eyre made a plea for "a special group, children. There is no group where quality of care impacts more on mortality. There is no pediatric oncologist in the entire state of Montana. You can see a 25 percent decline in cancer mortality in hospitals where pediatric oncologists are in attendance."

Identification and evaluation of biochemical/biological markers to assess dietary adherence. Three to five cooperative agreements, three years, estimated total cost $750,000 a year.

Major objectives are to identify and evaluate potential biochemical/biological indicators of adherence in subjects on self selected low and high fat diets, and to identify and evaluate biochemical/biological indicators of adherence to low fat diets in post menopausal women in controlled feeding and/or metabolic studies.

A major challenge in studying effects of diet on health and chronic disease risks is the difficulty of assessing dietary intake. Current methods for dietary assessment and adherence monitoring have different levels of precision and accuracy and all have the inherent limitation of relying on self reported data.

Two recent reports, the Surgeon General's report on nutrition and health and the National Research Council's report on diet and health have listed as research recommendations the need for identification and development of biochemical markers of dietary intake and of exposure to dietary fats. Identification of biochemical and biological indicators of dietary exposure would circumvent the current dietary assessment methodological short comings which limit interpretation of data and often prevent derivation of precise conclusions about the association of dietary patterns and/or specific dietary components with the risk of cancer and other chronic diseases.

The fatty acid composition of plasma and body tissues including erythrocytes, platelets, adipose tissue, and cheek cells have been used to assess the types of fatty acids consumed.

However, no single parameter or battery of biochemical/biological parameters have been identified to reflect total fat intake, to validate self reported dietary intake, or to monitor adherence to low fat diets.

Specific and sensitive biochemical/biological indicators of dietary intake, in particular total dietary fat, would greatly facilitate the design, conduct, and interpretation of dietary intervention trials, epidemiologic studies, and diet health survey studies which attempt to determine the role of diet in cancer risk and prevention. In studies involving dietary modifications, the extent to which the results may be influenced by varying degrees of adherence, is an aspect which is both important and difficult to evaluate. Thus, evaluation and validation of potential biochemical/biological indices of dietary intake will require controlled human feeding studies using well defined diets and precise measures of actual intake.

This initiative seeks to identify and establish a network of institutions or organizations with scientific expertise, facilities, and capabilities to conduct controlled feeding studies, metabolic studies, and field studies. The specific objective of this initiative is to encourage investigations designed to identify, characterize, and evaluate biochemical/biological markers of dietary adherence.

The proposed initiative will involve short term (six to 12 weeks) controlled clinical and/or metabolic studies and field studies. These studies will be designed to identify, characterize, and evaluate minimally invasive, specific and sensitive biochemical/biological indicators for monitoring adherence to low fat diets. Emphasis will be focused on dietary patterns which are nutritionally adequate and are characterized by reduced levels of total fat and saturated fat, increased levels of complex carbohydrates and fiber, and include a variety of foods typically present in the U.S. diet. In addition, the influence of varying the levels of fat intake while keeping fiber intake constant, weight loss, and energy balance should be taken into consideration in the study designs.

Characteristics of an ideal biomarker should include the following:

* Specimens for analyte measurements should be readily accessible and involve minimally noninvasive procedures.
* Analyte should be stable during prolonged storage.
* Analyte assays should be precise, accurate, and inexpensive.
* Analyte should be sensitive to fat quantity and quality.
* Dose response range should be detectable.
* Minimal intra and interindividual variation with defined intake.
* Minimal diurnal variation/seasonal variation.
* Minimal sensitivity to confounders.
* Defined time course of response.
* Practical and low cost.

Applicants responding to the RFA will be required to document the availability of multidisciplinary scientific expertise, appropriate facilities and the ability to recruit volunteer human subjects. Specifically the applications should provide the following:

--Multidisciplinary scientific expertise.

--Appropriate facilities to conduct either controlled human feeding studies and/or metabolic studies, or field studies.

--Access to existing cohorts of postmenopausal women with different dietary patterns, e.g., customary high and low fat diets or participants previously enrolled in other dietary modification research studies or diet programs.

--Ability to recruit and enroll volunteer postmenopausal women into controlled feeding studies and/or field studies.

--Access to laboratory facilities with capabilities of performing analytical assays in biological specimens and foods.

This project will be supported through the cooperative agreement mechanism. An assistance relationship will exist between NCI and the awardees to accomplish the purpose of the activity. The planning, direction, and executive of the proposed research will be the responsibility of the awardee, with involvement of NCI in specific areas.

A working group will be formed to assist, advise, and interact with the investigators. The working group will be comprised of all successful applicants, NCI staff, and outside experts. This group will meet as soon as possible after awards are made to discuss approaches, consider ways in which specific protocols might be improved, to identify areas of cooperation and to facilitate the exchange of information and material. Subsequently, the working group will meet periodically to exchange information and to seek means of resolving any problems which may have arisen.

Carolyn Clifford, Diet and Cancer Branch, is the project officer.

The concept was approved unanimously, after Greenwald agreed to Bresnick's suggestion that the title be changed to reflect the limitation of the study to postmenopausal women, and to add a statement encouraging investigation of defined racial and ethnic groups as recommended by board member Rumaldo Juarez.

Cole suggested that the project be further limited by relating it to postmenopausal breast and colon cancer, and Greenwald agreed.

Alfred Haynes objected, pointing out that dietary studies related to prostate cancer warrant investigation and thus require markers.

"This should be a highlight of what is to come," Bresnick said. "There is only $750,000 a year in this concept, with only three awards. I agree we need to get a biological marker for prostate cancer and adherence to diet, but we can start with this one. It's imperative to get a marker, if we're going to do a $150 million study." He was referring to the proposed low fat diet trials to test impact on breast cancer incidence which NCI has declined to fund.

Board Chairman Frank Meyskens added that "it is very unlikely a large trial will be approved without a biological marker."

Early detection research network. Master agreement contracts, with an estimated three to five tasks a year. Five years, total estimated cost $5 million.

Objective of this initiative is to establish a network of institutions with the facilities, resources, personnel, and interest to undertake research in the early detection of cancer.

Research in the area of the early detection of cancer is unique in many of its characteristics which has given rise to the view that a more realistic perspective is needed in establishing evidences of benefit. This applies as much to new research questions as to those that currently exist. Among the latter are questions of a very basic nature, such as how cancers are presently being detected and for what specific sites, and variations in stage of disease by different detection modalities, socioeconomic groups, and races. This information would only be of value when coming from a population based registry to avoid selection bias.

New developments have been reported which may revolutionize early detection research. Progress in molecular biology is raising research questions requiring specialized resources and scientific expertise. The identification of a network of institutions

whose scientific personnel and resources can respond quickly to existing and new research issues is important.

Establishment of a network of uniquely qualified institutions, under the mechanism of a master agreement with NCI, is intended to bring within the orbit of early detection research, organizations with a multidisciplinary group of scientists possessing the unique skills and resources needed. This type of contract is designed to accomplish specified urgent tasks designated by NCI in an accelerated time frame, and provides a possibility of aggregating large asymptomatic populations. The award of a master agreement does not by itself ensure any funding to an institution. Funding is committed only when a master agreement order is issued by NCI to an institution which holds a master agreement.

Generally speaking, organizations will be selected on the basis of the suitability of their expertise and resources. Interested organizations will be requested to provide evidence of past or current research which reflects capabilities and interest in the early detection of cancer. Since the network is expected to have as a major goal the advancement of early detection research, each organization will be required to include in its proposal a succinct statement on areas of greatest promise, major deterrents and problems in early detection research, and recommendations for their solution.

Specifically, organizations in this network of master agreement holders will have the following:

* Resources in epidemiology and biostatistics, with particular relevance to early detection research.

* Access to multidisciplinary scientific expertise.

* Collaboration potential with a population based registry, including data on stage at diagnosis and extent of disease.

* Access to, or data on, large asymptomatic populations, in particular the denominators for the registry.

* Access to medical records and death certificates.

As part of the master agreement proposal, offerors will be required to submit study plans for two of the three sample master agreement orders. All offerors must respond to the first sample master agreement order, and either the second or the third. The three sample MAOs will have the following general characteristics:

--A descriptive study to determine stage of disease by detection modality for one of the following sites: lung, colorectal, breast, prostate, cervix, uterus, ovary, and melanomas.

--A study utilizing population based registries to determine the distribution of risk factors in diagnosed populations to help define subpopulations that would benefit from early detection.

--A case control study to show evidence of benefit from early detection procedures.

Charles Smart, chief of the Early Detection Branch, is the program director.

Some board members had reservations about use of the master agreement mechanism for this project. Virginia Ernster and Prentice abstained, although the concept was approved.

Eyre discussed a study of breast cancer detection in Utah, of which he was an author. He said that 64 percent of tumors that were self detected were either local or in situ; 70 percent of those detected by physicians in physical exams were local or in situ; and that 86 percent of those discovered by mammography were local or in situ.

Evaluation of the effects of a fat modified diet on hormones during adolescence. Seven five year contract awards are anticipated, with a total estimated cost of $726,000.

This proposed study is ancillary to the Diet Intervention Study in Children (DISC), an ongoing clinical trial sponsored by the National Heart, Lung & Blood Institute. DISC is a randomized trial designed to evaluate the feasibility, safety, and efficacy of a fat modified diet during adolescence to lower LDL cholesterol. The primary objective of the NCI sponsored ancillary study is to evaluate the effect of this fat modified diet on sex hormones during adolescence. The effect of the diet on total concentrations of hormones and bioavailable fractions of hormones will be evaluated. A secondary objective of the ancillary study is to identify characteristics of adolescents, including age, Tanner stage, anthropometric measures, physical activity, and dietary intake that affect sex hormone levels and bioavailability of sex hormones. Since a family intervention is being used, the effect of the intervention on sex hormone levels of parents of participants will also be assessed.

Sex hormones may play an important role in the etiologies of both breast and prostate cancers. Diet, especially dietary fat intake, has also been implicated in the etiologies of breast and prostate cancer. A current hypothesis is that diet influences the risk of breast and prostate cancer through its effect on the hormonal milieu.

Adolescence may be a particularly vulnerable time for exposure of the breast to carcinogens. Exposure to ionizing radiation during adolescence is associated with the development of breast cancer in adulthood. Additionally, age at menarche is a well known risk factor for breast cancer. Whether adolescent diet is also related to the development of breast and prostate cancer is unknown. However, body weight during adolescence and adult stature, which is determined in part by early nutrition, have been associated with risk of breast cancer.

Metabolic feeding studies and the Women's Health Trial have shown that serum concentrations of estrogens and bioavailability of estrogens are influenced by dietary fat intake. Women fed isocaloric low fat diets for two months experience a decrease in serum estrone sulfate concentration. When low fat diets were continued for three months, a decrease in serum estradiol concentration was reported. Participants in the Women's Health Trial also had decreased concentrations of total and bioavailable fractions of serum estradiol after a minimum of 10 weeks on a low fat diet.

Metabolic feeding studies indicate that sex hormones in men are also affected by dietary fat intake. In one study, men fed an isocaloric low fat diet with an increased P/S ratio experienced reductions in serum concentrations of total and free testosterone.

The effect of the fatty acid composition of the diet on sex hormones is unclear. Unsaturated fatty acids inhibit the binding of estradiol to sex hormone binding globulin. Addition of oleic or linoleic acids, but not palmitic acid, to plasma in vitro results in an increase in free estradiol. Therefore, the type of fat in the diet may be important in determining concentrations of sex hormones.

Difficulties associated with dietary data collection limit the usefulness of case control and cohort studies to examine the association of diet and cancer. A randomized clinical trial is the most appropriate design for assessing this association. Because of the long time from exposure during adolescence to diagnosis of cancer in adulthood, cancer is an unrealistic endpoint. Studying the effect of a modified fat diet on hormones that are influenced by dietary fat and that have been associated with breast and prostate cancers is a realistic alternative that could improve understanding of the etiologies of these cancers.

DISC is a multicenter randomized clinical trial conducted as a cooperative agreement between NHLBI, six clinical centers, and

a coordinating center. The first participants were randomized into the feasibility study in the spring of 1988. Based on results of the feasibility study, NHLBI decided to proceed with the full scale trial, which is now in progress and is funded through 1993.

DISC's recruitment goal is to enroll a minimum of 600 children into the trial by the summer of 1990. Five of the six DISC clinical centers have agreed to participate in the NCI-sponsored ancillary study on hormones. These centers anticipate recruiting approximately 540 participants equally divided between the intervention and control groups. Children enrolled must be girls 7.8-10.1 years old or boys 8.6-10.8 years old who have LDL cholesterol levels between the 80th and 98th percentile, who are within the 5th and 90th percentile of weight for height, and who are Tanner stage 1. Dietary goals for the intervention group are to limit fat intake to 28 percent of calories and increase the ratio of polyunsaturated to saturated fats to approximately 1.1. Cholesterol intake will be restricted to 75 mg/1000 calories. Children in the control group follow their usual diets.

Data collection visits are scheduled prior to randomization and at annual intervals thereafter. The following assessments are carried out: demographic and medical history, anthropometric measurements, Tanner stage evaluation, general physical exam, 24 hour recalls (3 around the time of each visit), physical activity, and psychosocial assessments and biochemical determinations after an overnight fast. Blood samples are drawn prior to randomization and at the one year and three year followup visits.

An extra 5 mls of blood are being drawn for the ancillary study on hormones. Because DISC is an ongoing study and some participants have been enrolled for over a year, blood samples for hormone analyses will not be available at all points in time for all children at participating clinics. The numbers of participants for whom blood samples will be available prior to randomization and at one year and three year followup visits are 78, 400, and 540, respectively. Hormones to be analyzed include estradiol, estrone, estrone sulfate, dehydroepiandosterone, androstenedione, testosterone, sex hormone binding, globulin, progesterone (girls only), and dihydrotestosterone (boys only). Bioavailable fractions of estradiol will be determined in serum from girls and boys and fractions of testosterone will be determined in serum from boys.

Because of the small number of participants on whom baseline blood samples will be available for the ancillary study, hypothesis testing will focus on a comparison of hormone levels in children after one year and three years of intervention. With the projected sample sizes the study will have 80 percent power to detect ($p<=.05$) a 34 percent difference in girls' serum estradiol levels at the one year visit. At the three year visit, a difference of 18 percent will be detectable with the same power and significance level. In addition to hypothesis testing, descriptive analyses will be performed to characterize the distributions of concentrations of total and bioavailable fractions of sex hormones and sex hormone binding globulin during adolescence. Exploratory analyses of the associations of hormones with constitutional and behavioral characteristics of adolescents will also be performed.

An RFP will be issued for a contract to perform hormone analyses. Supplemental funding will be added to existing NHLBI grants for DISC clinical centers. A sole source contract will be awarded to the coordinating center.

Joanne Dorgan, Philip Taylor, and Richard Costlow of the Cancer Prevention Research Program are project officers.

Bresnick commented that "for a piggyback, this is not a bad study, at a low cost." Dorgan said that of the estimated budget, $627,000 was earmarked for the laboratory analyses, $49,000 for the clinical center supplements, and $50,000 for the coordinating center.

Board member James Gaylor pointed out that the study "couldn't be done without a medical justification." The children enrolled in the study all have high cholesterol levels.

The concept was approved unanimously.

Cancer Act Renewal, Reauthorization May Not Be Controversial This Time

Renewal of the National Cancer Act, which will be included in legislation reauthorizing biomedical research, appears not to be the controversial item it was two years ago when the Administration and the NIH director had indicated they supported major changes in NCI's special authorities.

James Wyngaarden and the White House softened their attitude and went along with reauthorization, which maintained NCI's authorities intact. President Reagan signed the bill, having learned his lesson three years earlier when his veto was resoundingly overridden.

The Senate Labor & Human Resources Committee is not planning to have hearings on reauthorization, intending to turn out a bill with few if any modifications. The House Health & Environment Subcommittee of the Committee on Energy & Commerce probably will have a hearing, possibly as early as next month.

Among the topics which might be considered for the new bill are, according to Dorothy Tisevich, NCI legislative liaison, are inclusion of women in clinical trials; prevention activities; minority and underserved populations; medical rehabilitation research; financial conflict of interest; fetal tissue and transplantation research; laboratory break ins; Senior Health Research Service; and training.

The Office of Technology Assessment has concluded a review of NIH funded clinical trials to determine the degree to which trials encourage the participation of women, and their actual participation. This review was undertaken at the request of Reps. Olympia Snowe, Patricia Schroeder, and Henry Waxman. The results from that review have not yet been reported.

Broder Names Adamson Acting Deputy, Starts National Search

Richard Adamson, director of NCI's Div. of Cancer Etiology for nearly 10 years, has been named acting deputy director of the institute. He will continue as DCE director.

"I don't know whether an apology from me or a

thank you or both are in order," Director Samuel Broder said.

Broder has initiated a national search for a replacement for Maryann Roper, who left NCI to join her husband, William Roper, in Atlanta, where he is director of the Centers for Disease Control.

"We welcome your suggestions for this position," Broder told the National Cancer Advisory Board. "We want a broadly based search in order to select the very best person. Women, veterans, members of minority groups, and handicapped individuals are encouraged to apply." Broder said candidates and advice are being sought from inside and outside the federal civil service, the PHS commissioned corps and those eligible for it, recommendations from senior federal officials and professional organizations, schools of medicine and public health, and minority schools and women's colleges and universities.

Broder continued, "The candidate must possess experience and competence in assuming leadership in:

--Assuring that national and agency policy and objectives are considered in making program decisions.

--Working effectively within NCI and with outside organizations.

--Developing policy and leading programs and projects.

--Acquisition and administration of financial and material resources.

--Personnel issues and implementation of EEO objectives.

--Assuring that program and policies are being implemented and appropriate results are achieved."

Alan Rabson, director of the Div. of Cancer Biology, Diagnosis, & Centers, is chairman of the search committee. Other members are former NCI Deputy Director Jane Henney, vice chancellor for health programs and policy of the Univ. of Kansas Medical Center; Ken Olden, director of the Howard Univ. Cancer Center; Adamson; and Vida Beaven, NIH assistant director for program coordination.

Applications will be accepted until July 6.

"Candidates must have high professional qualifications and demonstrated abilities to originate, administer and coordinate a broad program of fundamental and clinical research in cancer or a closely related field," Broder said.

Applications should be sent to Dolores Guido, Personnel Management Branch, NCI, Bldg 31 Rm 3A16, Bethesda, MD 20892, phone 301/496-8182.

Donald Christoferson, NCI deputy executive officer, is executive secretary of the search committee. Those wishing to make recommendations may contact him at NCI, Bldg 31 Rm 11A48, Bethesda, MD 20892, phone 301/496-5737.

NCI Advisory Group, Other Cancer Meetings For June, July, Future

Association for Practitioners in Infection Control Annual Conference--June 3-7, Washington Hilton, Washington, D.C. Contact APIC, 505 E. Hawley St. Mundelein, IL 60060, phone 708/949-6052).

Radiation Physics for Clinical Radiotherapy--June 3-8, Leuven, Belgium. Contact ESTRO Secretariat, Dept. Radiotherapy, VH St. Rafael Capucijnenvoer 35, 3000 Leuven Belgium.

NCI Div. of Cancer Treatment Board of Scientific Counselors--June 4-5, NIH Bldg 31 Rm 6. Open 8:30 a.m. June 4, 9 a.m. June 5.

Critical Issues in Tumor Microcirculation, Angiogenesis & Metastasis--June 4-8, Pittsburgh, PA, Carnegie Mellon Univ. Contact Hilda Diamond, Associate Director, Biomedical Engineering Program, Carnegie Mellon Univ., Pittsburgh, PA 15213-3890, phone 412/268-2521.

Interleukins Seminar--June 5-6, Venice, Italy. Contact European School of Oncology, Via Venezian 1, 20133 Milan, Italy.

National Tumor Registrars Assn. Annual Meeting--June 5-9, San Antonio, TX, Hyatt Regency Riverwalk. Contact NTRA, 505 E. Hawley St., Mundelein, IL 60060, phone 708/566-0833.

International Lymphoma Conference--June 6-9, Lugano, Switzerland. Contact Olga Jackson, Via Quiete 13, 6900 Lugano, Switzerland.

Third Wave of Asbestos Diseases: Exposure to Asbestos in Place--June 7-9, New York City, Crowne Plaza Holiday Inn. Contact Conference Coordinator, Collegium Ramazzini, PO Box 50, Solomons, MD 20688, phone 202/842-7830.

International Congress on Breast Diseases--June 10-14, Boston. Hynes Convention Center. Contact Secretariat, c/o Office of Continuing Education, Tufts Univ. School of Medicine, 136 Harrison Ave. Box 36, Boston, MA 02111, phone 617/956-5657.

New Trends in Human B Cell Neoplasia--June 11-14, Paris, France. Contact Eruopean School of Haematology, Centre Hayem, 1, avenue Claude Vellefaux, 75475 Paris Cedex 10, France.

Radiotherapy 2000: Research Strategies for the Next Decade--June 11-15, Cadro/TI, Switzerland. Contact European School of Oncology, Via Venezian 1, 20133 Milan, Italy.

Molecular Basis of Human Cancer--June 13-16, Frederick, MD. Contact Margaret Fanning, Conference Coordinator, FACS, PO Box 249, Libertytown, MD 21762, phone 301/898-9266.

European Assn. of Urology Congress--June 13-16, Amsterdam, The Netherlands. Contact IMEDEX USA Inc., 5815 Wills Orchard Rd., Cumming, GA 30130, phone 404/751-7332.

NIH Consensus Conference: Treatment of Early Stage Breast Cancer--June 18-21, NIH Masur Auditorium. Contact Prospect Associates, 301/468-MEET.

Acrylonitrile Study Advisory Panel--June 20, Rockville, MD. Executive Plaza North Conference Rm 8, 10:30, open.

International Conference on Reach To Recovery--June 20-22, Dublin, Ireland. Sponsored by Irish Cancer Society. Contact Avril Gillatt, Reach To Recovery, PO Box 2484, Dublin 4, Ireland.

Assn. of American Cancer Institutes Annual Meeting--June 20-22, Rochester, MN, Kahler Plaza Hotel. Contact Robert Gluek, 507/284-2511.

4th Drug Delivery Systems Symposium & 6th ISGIID Meeting--June 20-23, Nice, France. Contact Secretariat Cardiostim 90, Departement de Stimulation Cardiaque, Centre Chirurgical Val

D'Or, 16, rue Pasteur 92211 St. Cloud Cedex, France, phone (1)46.02.70.72.

NCI Div. of Cancer Etiology Board of Scientific Counselors--June 21-22, NIH Bldg. 31 Rm 10. Open 1 a.m. on June 21, 9 a.m. on June 22.

Breast Reconstruction Seminar--June 21-23, Venice, Italy. Contact European School of Oncology, Via Venezian 1, 20133 Milan, Italy.

Cancer Management Course--June 22-23, Reno, NV. Contact Dr. Edwin Savlov, American College of Surgeons, Cancer Dept., 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

Complications of Treatment of Children and Adolescents for Cancer--June 22-24, Buffalo, NY. Contact Daniel Green, Dept. of Pediatrics, Roswell Park Cancer Institute, Elm & Carlton Sts., Buffalo, NY 14263, phone 716/845-2333.

Candlelighters Childhood Cancer Foundation 20th Anniversary Conference--July 22-25, Sheraton Washington, Washington, D.C. Contact Candlelighters Childhood Cancer Foundation, PO Box 15263, Washington, D.C. 20003.

Annual Meeting on Oncogenes--June 26-30, Frederick, MD. Contact Margaret Fanning, Conference Coordinator, FACS, PO Box 249, Libertytown, MD 21762, phone 301/898-9266.

Pain Treatment in Oncology--June 26-27, Venice, Italy. Contact European School of Oncology, Via Venezian 1, 20133 Milan, Italy.

Recent Advances in Urological Cancer Diagnosis & Treatment--June 27-29, Paris, France. Contact Dr. Saad Khoury, Clinique Urologique, Hopital de la Pitie, 83, Bd. de L'Hopital, 75634 Paris Cedex 13, France, phone 45.70.38.62, fax 45.70.30.78.

Sapporo Cancer Seminar--July 6, Sapporo, Japan. Contact Secretariat, Lab. of Pathology, Cancer Institute, Hokkiado Univ. School of Medicine, Kita-ku, Sapporo 060, Japan.

Surgical Advances in Cancer of Head & Neck--July 11, Mexico City, Mexico. Contact Dr. J. de la Garza, Instituto Nacional de Cancerologia, Ave. San Fernando No. 22, Tlalpan, 14000 Mexico D.F., Mexico.

Mammography & the Search for Breast Cancer--July 13-14, Rochester, NY, Radisson Hotel. Contact Dr. Wende Logan-Young, 1351 Mt. Hope Ave. Rm 121, Rochester, NY 14620-3992, phone 716/442-8432.

Cancer Management Course--July 13-14, Cincinnati, OH. Contact American College of Surgeons, Cancer Dept, 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

International Photodynamic Assn. Biennial Meeting--July 18-21, Buffalo, NY. Contact J. Felski, Roswell Park Memorial Institute, 666 Elm St., Buffalo, NY 14263-0001.

Challenging the Course of Cancer--July 20-22, Sept. 14-16 or Oct. 26-28, Leadville, CO. Contact Colorado Outward Bound School, Health Services Program, 945 Pennsylvania St., Denver, CO 80203, phone 303/831-6974.

Candlelighters Childhood Cancer Foundation 20th Anniversary Conference--July 22-25, Washington, Sheraton Washington Hotel. Contact CCCF, 1312 18th St. NW Suite 200, Washington, DC 20036, phone 1-800-366-2223.

Cancer Nursing for the '90s--July 24-25, Honolulu, Hawaii. Contact Karen Taoka, Queen's Cancer Institute, 1301 Punchbowl St. Honolulu, HI 96813.

Queen's Cancer Institute Symposium: Gastrointestinal Malignancies--July 24-26, Honolulu, Hawaii. Contact Karen Taoka, Queen's Cancer Institute, 1301 Punchbowl St. Honolulu, HI 96813.

Differentiation of Normal & Neoplastic Cells--July 29-Aug. 2, Vancouver, Canada. Contact Venue West Inc., 801-750 Jervis St., Vancouver, B.C. V6E A9, Canada.

FUTURE MEETINGS

Professional Development Invitational for Social Workers, Doctors, Nurses & Clinicians in Oncology--Aug. 10-12, Denver, CO. Contact Colorado Outward Bound School, Health Services Program, 945 Pennsylvania St., Denver, CO 80203, phone 303/831-6974.

International Consensus on Supportive Care in Oncology--Aug. 21-24, Brussels, Belgium. Abstract deadline June 15. Contact ICSCO Secretariat, c/o Symedco, Two Research Way, Princeton Forrestal Center, Princeton, NJ 08540.

Chromosomal Growth Factor Abnormalities in Leukemia--Oct. 14-18, Chatham, MA. Contact American Assn. for Cancer Research, Public Ledger Bldg. Suite 816, 6th & Chestnut Sts., Philadelphia, PA 19106, phone 215/440-9300.

San Antonio Breast Cancer Symposium--Nov. 2-3, San Antonio, TX. Contact Lois Dunnington, Symposium Coordinator, 512/567-4745.

Current Controversies in Colon & Rectal Cancer--Nov. 3, Research Triangle Park, NC, Sheraton Imperial Hotel. Contact Nancy Barnes, Office of Continuing Medical Education, Campus Box 7000, Univ. of North Carolina, Chapel Hill, NC 27599, phone 919/962-2118.

4th International Workshop on Monoclonal Antibodies & Breast Cancer--Nov. 5-6, San Francisco, Miyako Hotel. Contact Dr. Joyce Taylor-Papadimitriou, Imperial Cancer Research Fund, PO Box 123, Lincoln's Inn Fields, London Wc2A 3PX, UK.

In Vitro Toxicology Mechanisms & New Technology--Nov. 27-29, Baltimore, MD. Contact International CAAT Symposium, Office of Continuing Education, 720 Rutland Ave., Turner Bldg., Baltimore, MD 21205-2195, phone 301/955-2959.

Platinum & Other Metal Coordination Compounds in Cancer Chemotherapy--Jan. 23-26, 1991, San Diego, CA. Contact Cass Jones, Professional Conference Management, 7916 Convoy Ct., San Diego, CA 92111, phone 619/565-9921.

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.

NCI-CO-03894
Title: Pamphlet printing
Deadline: Approximately July 4

Single award for a fixed price contract. Production area, assumed 125 mile radius of zero milestone, Columbia, MD. Offerors outside area must furnish documentation of their ability to meet schedule. Inspection of source materials will be from June 26-28, 8 a.m.-5 p.m. local time at NIH, Bldg. 31 Rm 10A30, 9000 Rockville Pike, Bethesda, MD. For an appointment contact Erin Lange one week prior to source review. Pamphlet. Face and back three panel folder, 500,000 copies. Printed with black and PMS 3395 green inks. Operations include printing, folding, binding, packaging, shipping and f.o.b. destination to Columbia, MD. Contractor furnish paper. Quality attributes level II for printing and finishing. Bid request on firm's letterhead. Telegraph/fax request not acceptable.

Contract Specialist: Erin Lange
RCB Executive Plaza South Rm 635
301/496-8628