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President's FY 1992 Budget Seeks $1.81 Billion For NCI, 5.6% Increase, But $800M Below Bypass

The President's fiscal year 1992 budget recommends funding of $1,810,230 for NCI, an increase of $96,471 or 5.6 percent, above the FY 1991 appropriation of $1.714 billion. The increase is $802 million less

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In Brief

Daniel Ihde Named NCI Deputy Director; Roper Is Carter Consultant; Another Honor For Frei

DANIEL IHDE has been named deputy director of NCI. Ihde, editor in chief of the "Journal of NCI," has served as deputy chief and head of the Clinical Investigations Section of the NCI-Navy Medical Oncology Branch. He replaces Maryann Roper, who moved with her husband William Roper to Atlanta when he was appointed director of the Centers for Disease Control. Div. of Cancer Etiology Director Richard Adamson has served as acting deputy director in the interim. . . . **THE TWO ROPERS,** meanwhile, have found Atlanta very hospitable, according to Maryann, who was back at NCI last week as an ad hoc member of the Div. of Cancer Prevention & Control Board of Scientific Counselors. She is a science consultant for the Carter Center of Emory Univ. . . . **EMIL (TOM) FREI,** director of Dana-Farber Cancer Institute, will receive another honor next month recognizing his pioneer clinical research in chemotherapy and development of clinical trials. Frei will receive the annual Assn. of Comunity Cancer Centers award for outstanding contributions to community clinical oncology at the association's annual meeting in Washington, March 7-9 at the Capitol Hilton Hotel. . . . **CHARLES COLTMAN,** who suffered a mild heart attack during last month's meeting in Bethesda of cooperative group chairmen (**The Cancer Letter,** Jan. 18), has returned to work part time, expects to be working full time soon. . . . **HHS RECEIVED** permission last week to continue the Physicians Comparability Allowance for department physicians who receive up to $20,000 a year above their salaries as inducements to remain in federal service. The program affects 318 physician scientists at NIH, including 93 at NCI. Congress reauthorized the program last year, but legislation empowered the Office of Personnel Management to require departments to justify payments on the basis of whether it was necessary to avoid losing physicians to academia and private practice (**The Cancer Letter,** Jan. 18). Dept. of Defense also obtained permission to continue the program, but retroactive payments to those whose contracts had already expired was not permitted.

FY 1992 President's Budget Seeks $1.81 Billion For NCI, 5.6% Increase

(Continued from page 1)
than NCI's 1992 bypass budget, the unique document in which the institute goes public with its "professional needs."

Following is how NCI intends to spend the amount requested in the President's budget:

▸Research project grants: $846.147 million for FY 1992, $57,175 above the 1991 level of $788.9 million, for a 7.2 percent increase.

▸Cancer centers: $112.772 million, up $2,690 from the 1991 level of $110.082, for a 2.4 percent increase. NCI Director Samuel Broder said the institute expects to fund approximately 59 cancer centers by the end of FY91, though some centers may be "in transition," a euphemism for phase-out of their funding. An estimate for the number of centers to be funded in 1992 was not available by **The Cancer Letter's** presstime this week.

▸Other research grants, which includes the clinical cooperative groups, research careers, cancer education, and minority biomedical research: $89.242 million, up $1.708 million from the 1991 level of $87.584 million, for a 2 percent increase.

▸National Research Service Awards: $37.670 million, up $418,000 from 1991 level of $37.252, a 1.1 percent increase. This will fund 1,435 trainees, the same number as in 1991.

▸Research & development contracts: $191.395 million, up $4.117 million from 1991 level of $187.218 million, for a 2.2 percent increase.

▸Intramural research: $348.873 million, up $19.745 million from the 1991 level of $329.128 million, a 6 percent increase. This includes an NIH management fund increase for items such as the NIH clinical center.

▸Research management and support: $92.295 million, up $11.261 million over the 1991 level of $81.034 million, for a 13.9 percent increase. This includes $7.2 million for NCI's assessment for the National Health Interview Survey, mandated by Congress.

▸Cancer prevention and control: $89.786 million, up $4.097 million from the 1991 level of $85.689 million, for a 4.8 percent increase.

▸Construction, the only major area to lose funding: $2 million, down by $4.8 million from the 1991 level of $6.8 million.

NIH would receive $8,775,386 for FY 1992 under the President's budget, which also estimated NIH funding for FY 1993 at $9,007,692. The FY93 level was not available for each of the categorical institutes.

NCI Down 6% Since 1980

How does the NCI budget today compare to the NCI budget a decade ago?

While the dollar figure is higher, spending power has dropped significantly in some areas, NCI Director Samuel Broder is telling the institute's advisory boards.

In remarks to the NCAB this week and to the Div. of Cancer Prevention & Control Board of Scientific Counselors last week, Broder said the NCI budget, in 1980 constant dollars, has fallen by 6 percent since 1980.

"The director of NCI in 1980 had approximately $960 million to spend, whereas today the institute has approximately $900 million (in 1980 dollars)," Broder told the BSC.

Meanwhile, the NIH budget as a whole has increased by 27 percent in 1980 dollars. (That figure includes NCI's portion of the NIH budget.)

Some mechanisms have fared much worse than others, and the ones that fared the worst are those mechanisms that NCI uses exclusively or predominantly, that other institutes do not use.

For example, funding for research project grants (RO1s, PO1s) has increased 20 percent in 1980 constant dollars, and intramural research has increased 30 percent. Funding for intramural research rose sharply after 1985 due to funding for HIV/AIDS research, Broder said.

However, funding for cancer centers is 15 percent below its 1980 level, and the clinical cooperative groups and cancer prevention and control are almost 33 percent below the 1980 constant dollar base.

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"I'd like to end the debate between the cooperative group people and the prevention and control people over who suffered the worst decline in the 1980s--I hereby declare it a tie," Broder told the NCAB.

At the very bottom are research and development contracts, which declined by almost 50 percent.

"These comparisons are only meant to show the reality of where the Cancer Program has gone in the past decade," said Broder.

The Biomedical Research deflator was used to calculate the constant dollar figures.

"It's important that we not do business as usual and we come up with meaningful new approaches, recognizing these budget realities," Broder told the DCPC BSC. "My personal view is that it is important to have certain courses of action. Simply saying we don't have enough money is not really going to solve the problems that we need to solve. We need to come in with programs, and we need to deal with trends that are at least a decade old. None of these things have happened overnight. We can't expect that in any one fiscal year we can turn around a decade of a trend. NCI still has the largest dollar budget of any of the institutes and we have a lot of ability to do things. We will need your help."

Gavel Changes Hands At NCAB; 'Rise To Challenges,' Korn Advises

"I'm deeply honored to be here and look forward to working with you for the next several years," said Paul Calabresi, and with that short comment began a six year term as the new chairman of the National Cancer Advisory Board.

Calabresi and the five other new members of the presidentially appointed board took their places at the board's meeting this week, after an "orientation" session over the weekend. The transition was a smooth one: while Calabresi took the official gavel, NCI Director Samuel Broder presented another one, affixed to a plaque, to former chairman David Korn in recognition of his six years on the board.

Before Korn could sit down, the five other former board members gave him a desk clock, "which represents the few minutes you gave this job," as former board member Helene Brown quipped.

"I'm speechless," Korn said, but then launched into the following parting remarks:

"I've had a wonderful time. I think the board has functioned beautifully over the last several years, not only in performing its responsibility of approving grant applications, but also in helping the institute in a variety of very difficult policy decisions, both prospectively and in responding to other pressures. I'm sure that the new members will continue to rise to those kinds of challenges. I think the quality of advisory committees at NIH is a very important issue because the scientific enterprise in under multifaceted attack for a variety of reasons, and sometimes nonfederal employees have a lot more freedom to participate in the political arena in which these policies are formulated than federal employees. So the role is an exceedingly important one. I'm delighted at the quality and experience of the new members, and I do indeed wish you very well."

For the record, here are the short biographies of each of the new board members:

--Paul Calabresi, who succeeds David Korn as chairman, is professor and chairman of the Dept. of Medicine at Brown Univ., and physician in chief and vice president for academic affairs at Roger Williams General Hospital.

--Frederick Becker, who succeeds Roswell Boutwell, is vice president for research and scientific director of the Tumor Institute at the Univ. of Texas M.D. Anderson Cancer Center.

--Kenneth Chan, who succeeds Louise Strong, is director of the Pharmacoanalytic Core Laboratory at the Univ. of Southern California Comprehensive Cancer Center and associate professor of pharmacy for the School of Pharmacy.

--Marlene Malek, who succeeds Helene Brown, is a member of the Lombardi Campaign Executive Committee for the Vincent Lombardi Cancer Research Center of Georgetown Univ. Hospital and has served as a registered nurse at the Georgetown Univ. Hospital.

--Sydney Salmon, who succeeds Enrico Mihich, is professor of medicine and director of the Arizona Cancer Center at the Univ. of Arizona College of Medicine in Tucson, AZ.

--Kenneth Olden, who succeeds Louis Sullivan (who left the board two years ago when he was appointed Secretary of HHS), is director of the Howard Univ. Cancer Center and is professor and chairman of the Dept. of Oncology at the Howard Univ. Medical School.

The seats held by Gertrude Elion and Lou Gerster (who left the board more than two years ago) have not yet been filled.

Sources have told **The Cancer Letter** that one of those seats will probably be filled by an oncology nurse, and that the additional appointments would be made before the board's next meeting, scheduled for May 6-8.

DCPC Advisors Hit NCAB Decision On Diet Trial; Resolve To Move On

Advisors to NCI's Div. of Cancer Prevention & Control expressed frustration at the National Cancer Advisory Board's decision last December to approve a three year feasibility study for the Women's Health Trial, rather than approving the full scale trial. However, the BSC restrained from asking NCAB for clarification of its decision and resolved to move forward with the pilot phase.

Members of DCPC's Board of Scientific Counselors last week, in their first meeting since the NCAB decision, aired their feelings about what some saw as an undermining of their authority to approve contracts. The BSC last fall approved the concept for the proposed $106 million, 15 year trial, which seeks to measure reduction in mortality of breast and other cancers in women as a result of a low fat diet.

Like Daniel In Lion's Den

"Now I know how Daniel felt when he was led into the lion's den," said BSC Chairman Edward Bresnick, describing his effort to help DCPC Director Peter Greenwald present the trial to the NCAB in December. The last minute NCAB "request" to provide advice on the trial "was totally unexpected," Bresnick said.

NCAB approved a preliminary phase of the Women's Health Trial, not to exceed $7.5 million for three years. The board also wants to see the results and evaluation of the feasibility study before any decision to implement the full trial (**The Cancer Letter,** Dec. 7).

NCI Director Samuel Broder faced the BSC members' ire last week. In a question and answer session with Broder, BSC member Charles Hennekens asked whether NCAB has authority over contracts.

"I think it's unwise to frame an important debate between people of good will [in terms of] who has legal authority over what," Broder said. While NCAB has statutory authority to approve or disapprove grants, it is also appointed by the President to provide oversight and advice on the NCI budget, he said.

"In a technical, legal sense, they do not have the authority to disapprove or approve contracts, but I don't think that is a very productive approach," Broder said. "We should try to achieve a scientific consensus." However, Broder conceded that there are such differences of opinion on the issue of diet and cancer that it may not be possible to achieve consensus.

BSC member Ross Prentice asked whether the feasibility study is likely to be successful and lead to the full trial.

"If the Div. of Cancer Prevention & Control comes in with a recommendation that within its budget, that it is prepared to move ahead with the Women's Health Trial, that will be given careful attention," Broder said. "These are complex issues. I think we should try to respect each other's differences."

But those answers did not satisfy Prentice, who brought up the trial several times throughout the board meeting. Prentice was one of the principal investigators on the original Women's Health Trial and subsequently was involved in the investigator initiated Dietary Fat Intervention Trial, which NCAB disapproved in 1989.

Who Has Final Say On Trial?

After Broder left the meeting, Prentice asked Greenwald whether Broder's comments meant the final decision whether to implement the full scale trial would rest with DCPC.

Greenwald said the trial would have to be funded within the prevention and control line of the DCPC budget, "and that's what he meant that it's our decision within that line."

"My view is that in order to do a trial costing $10 million a year, I would have trouble if we just got a $10 million increase and had to allocate 100 percent of that to the Women's Health Trial, or any other trial. That does not fit in my idea of how to build programs," Greenwald continued. "I would be afraid of the consequences on all of the programs." He said the WHT Policy Board would have to "up front" establish clear rules on whether to stop the trial or to continue.

The "window of time" for the trial is closing, Greenwald said. It has been six years since the beginning of the first Women's Health Trial, and it will be three more until the current WHT full scale trial begins. In that time, public education has already begun to have some effect on fat consumption, which could impact the scientific basis for the trial. "I'm not sure where we'll be three years from now.... I'm ready to go ahead if we have all the pieces in place and adequate funding. But there's a real possibility that we won't."

DCPC is now moving forward to develop the Requests for Proposals for the trial's coordinating center and three clinical units including one each in predominantly black and hispanic groups, Greenwald said. These would be issued in the pilot phase, scheduled to begin early in FY 1992. The pilot phase would also establish a WHT Policy Board, develop a final protocol, and begin accruing study subjects to the clinical units.

The WHT concept is scheduled to be presented on Feb. 15 to the National Heart, Lung & Blood Institute Advisory Council for its recommendations, which will

determine the extent of that institute's involvement in the trial's cardiovascular endpoint.

Prentice asked Greenwald whether it would be necessary to get NCAB approval to go ahead with the trial after the three years, if the policy board were to give a positive recommendation.

"NCAB expects that after three years we will go back to them with that information, and it would be my intent to do so," Greenwald said.

Prentice suggested the BSC should ask NCAB for a "clarification" of its recommendation, but that idea did not sit well with other BSC members.

"I'm not sure much jockeying around with requests for clarification or anything else would lead to anything that would have any constructive effect and will simply galvanize them" in opposition to the trial, Chairman Bresnick said. "Peter [Greenwald] has three years of work to do, and the work has to be done with the NCAB, which has changed with the appointment of six new members."

Some of the six former members "were very opposed" to the trial, Bresnick said. "My view is to go at it slowly. Anything we do now for further clarification from them is going to be counter-productive."

'Not Clear We Should Be Silent'

But Prentice pressed the issue. "It strikes me as somewhat of a crisis for public health," he said. He accused NCAB of "ignoring scientific peer review" and "overlooking the unanimous views of this board."

"It's not clear we should be entirely silent," Prentice said.

That provoked James Holland. "Mr. Chairman, I'd like to endorse your posture emphatically. I think that nothing could doom the activity more than to have Dr. Prentice as the leader of opposition in something he is so closely, personally identified with, and could even raise the question of conflict of interest."

"I think that's true, Ross," Bresnick said. He then discussed his own feelings:

"After I left the NCAB meeting and got home, I was a little upset. I don't think I could be called a strong adherent or proponent of this WHT, but I felt there had been sufficient scientific review, and I felt to have a body that had not gone into great detail on this proposal cast doubt on the scientific validity of the process.

"To me it was almost a real cheap shot."

But then Bresnick decided, "I would not try to do anything about it. All we would be doing is undercutting our role, not only in this area, but in other areas. We have the ball--it might be minus a little air--but we still have a ball to play with, so let's go ahead and do it and show that we can get something done."

Alfred Haynes and Charles Hennekens endorsed that view, but asked about the NCAB's discussion of the trial's ethics. Some NCAB members raised the issue of whether the trial, by allowing the control group to continue its high fat diet, would be unethical in light of federal nutrition guidelines recommending a diet with 30 percent calories from fat.

Greenwald said the issue is comparable to the early research on smoking. If there is circumstantial evidence to give advice on a risk factor, "then in my view you should give advice, but then that doesn't mean you shouldn't do confirmatory research."

'Principally A Budgetary Argument'

"I still come away believing that the reason this hasn't gone forward is more budget that any question of is the study valid," Harmon Eyre said. "Am I hearing something different now? Do you think the NCAB tried to raise the ethical issue to cover up budgetary concern?"

"I think you're absolutely right," Bresnick said. "It takes a tremendous amount of dollars you're going to throw in to this one thing, and other things have to shrink. I think depending on how strongly you feel about that, you try to scare up all these straw creatures. What we're seeing as a lot of so-called support [for that issue] is principally a budgetary argument."

"As a concerned scientist who supports Peter [Greenwald]," said Hennekens, "the frightening consequence of these events, in my mind, is to give a message to the research community that if you want your research funded, go directly to [Rep.] Pat Schroeder." [The Colorado Democrat has pushed NCI to fund the WHT and has said that NCI and NIH do not spend proportional amounts on women's health.]

"This is a very bad possibility for us. The system is breaking down," Hennekens said.

"One may not like peer review, and I think it's not good for us to be talking about the NCAB throwing straw men," Holland countered. "These are not inconsequential people; they use their best judgement."

"I don't believe the peer review system has ever been faultless," Holland continued. "The NCAB may make mistakes, but it is a worse mistake to have advocacy at the level of Congress or elsewhere by members of this panel as if they were representing the Board of Scientific Counselors.

"It is not a 'cheap shot' for NCAB to exercise its prerogative, and therefore it seems to me we shouldn't make any cheap shots back."

NCI Requests DRG Study Section On Cancer Prevention And Control

NCI has asked the NIH Div. of Research Grants to consider creating a study section for the review of research project grants in cancer prevention and control.

The creation of a study section would give prevention and control research proposals a better shot at funding from the research project grant pool, NCI Director Samuel Broder said.

The Div. of Cancer Prevention & Control Board of Scientific Counselors unanimously endorsed the effort at its meeting last week.

Broder said he has asked Jerome Green, head of the Div. of Research Grants, to consider establishing a study section for prevention and control in the research project grant pool.

Since the RPG pool has had regular budget increases in real terms over the past ten years, Broder said, "We need to do more to come in with investigator initiated projects in the RPG pool."

Broder said he believes that ultimately, prevention is the "most cost effective" way to deal with cancer.

"I don't think it is practical to simply focus on the prevention and control line [of the NCI budget] and say, 'That's our prevention effort.' We need to look for innovative ways to do investigator initiated research within prevention and control. We can't have a system where the community is expecting Peter Greenwald or staff to come up with proposals," Broder told the DCPC Board.

"I can't promise you we will succeed in this approach; I can only promise you that we are trying."

Board Chairman Edward Bresnick said the study section "will go a long way toward stimulating RO1s in prevention," and suggested that the board pass a resolution supporting the effort. The board drafted a letter to DRG to that effect.

"We will really work on this area," Broder said. "This is part of the larger issue of clinical investigation in general, that we need to have appropriate ways of dealing with investigator initiated approaches to form knowledge-generating activities in the world of clinical research."

High Risk Youth Targeted In Cancer Prevention Concept Approved By BSC

Advisors to NCI's Div. of Cancer Prevention & Control gave concept approval last week to a new grant program that would fund three four-year grants for research on cancer risk reduction in "high risk" youth, at a total cost of $5 million.

The DCPC Board of Scientific Counselors also gave concept approval to recompetition of a contract for support services in diet and nutrition research for the Cancer Prevention Research Program, expected to cost a total of $2.25 million.

Following are the concept statements and board discussion:

Research on cancer risk reduction for high risk youth. Concept for a new RFA, estimated total cost $5 million over four years, three awards.

The major objectives of this project are: 1) to develop and test through community institutions, methods and interventions for the primary prevention of cancers related to poor diet, smoking, alcohol use, and early sexual activity, in adolescents aged 10-18 from low socioeconomic groups; 2) to summarize and publish process and outcome results of effective interventions, in an NCI document for dissemination to community organizations that serve high risk youth.

Over 12 million American children under age 18 live in poverty. Of these, 7.8 million are white, 4.1 million are black, and 2.5 million are hispanic. These young people are extremely vulnerable to multiple, unhealthy behaviors.

For the purposes of this concept, the working definition of high risk youth is: children or youth aged 10-18 years who are economically disadvantaged, i.e., living in families or households with incomes below the poverty level.

Behaviors related to these conditions may lead to cancer in several sites.

The interventions funded through this proposed RFA should be planned for, implemented, and evaluated through community based organizations. These organizations, each of which is a source of high risk subjects, may include but are not limited to schools, community health centers, the juvenile justice system, or community youth organizations.

Inner city schools, hispanic ghetto schools, poor rural schools, and other schools heavily populated by high risk youth may be considered as study sites. Activities may include but are not limited to instituting and enforcing nonsmoking policies, implementing healthful cafeteria changes, holding drug free parties, improving sex education curricula, developing educational video materials, using incentives and discounts to realize project goals, educating about how advertisers manipulate young people, and implementing existing curricula that have been tested elsewhere for high risk youth.

Community health centers, where low income adolescent mothers and others within the age range specified for this research seek care, may be the site of activities such as instituting nonsmoking policies and education, healthy food preparation training, parental involvement in adolescent programs, one on one counseling, educating about advertising techniques, and as a distribution point for condoms and responsible sex education.

The juvenile justice system, through which over 500,000 young people pass each year, virtually all of whom may be considered high risk, is another site where these programs may be instituted.

Where appropriate, youth oriented community organizations such as the YMCA, YWCA, Big Brothers, Boys and Girls Clubs, and many others may serve as access points for high risk adolescents.

Two types of evaluation should take place under this proposed RFA. 1) Outcome or summative evaluation which has the primary

purpose of judging how effectively the intervention has worked, and 2) process evaluation, consisting of a) formative evaluation which has the primary purpose of identifying ways of improving the program, and b) implementation evaluation which has the primary purpose of determining how much of the program is being implemented as planned. Investigators will be required to give full details of how they intend to accomplish these types of evaluation, and explain how they will track what is likely to be a hard to reach and highly mobile population.

Outcome evaluation should be designed to answer the following questions: In dietary interventions, to what degree did fruit and vegetable consumption increase, and fat consumption decrease? In tobacco use interventions, to what degree was tobacco use onset prevented, and tobacco use decreased? In alcohol use interventions, to what degree was alcohol use onset prevented, and alcohol use consumption decreased? In interventions on sexual activity, to what degree did the age of onset of sexual activity increase, and to what degree did unprotected sexual activity decrease?

Process evaluations should be designed to answer questions such as: What are the successful elements of prevention programs for high risk youth? What are the culturally specific or special needs of these populations, and how can programs be made sensitive to their needs? What role can non school channels play in reaching these youth? How were community organizations recruited? How were high risk youth recruited? To what extent was the program adopted by the institution in which it was implemented?

This research will take place in three stages. Stage 1 (12 months) will consist of developing methods of drawing a sample, intervening and measuring change in a local pilot population. This includes pilot testing survey instruments and techniques for feasibility and acceptability, validating instruments, assessing participation and adherence rates, adapting existing materials to cultural sensitivities, and analyzing costs. Investigators may develop their own, or select from or adapt existing health education materials that have been shown to be effective when used with populations of high risk youth. The goal of stage 1 is to develop materials and evaluation techniques sufficient for effective large scale implementation in stage 2. Techniques for validation of the effectiveness of methods and materials will be left up to investigators. Investigators will, however, be expected to work cooperatively with each other and with NCI staff so that at the minimum, it will be possible to report results collectively. The foundation of this cooperation will be developed in meetings held during stage 1.

Stage 2 (24 months) will consist of controlled intervention trials on a sample chosen to represent a larger population. To ensure results that are representative, investigators will randomize community organizations into intervention and control groups. These groups should be matched on risk factors, age, ethnicity, school attendance status, and socioeconomic status. Experimental groups must also be of sufficient size to provide the statistical power to detect significant differences between groups on variables of interest. During the stage 2 pre-intervention period, a baseline survey of subjects will be conducted to determine risk activity through techniques such as questionnaires or interviews. It is during this stage that the intervention will take place on at least two of these four risk factors: poor diet, tobacco use, alcohol use, and early sexual activity as chosen by investigators in their application. In the stage 2 postintervention period, repeat surveying will be conducted to measure effects on risk factors as described above.

In Stage 3 (12 months), investigators will come together to compile process and outcome findings for publication in an NCI guide to cancer prevention and control interventions with high risk youth. Making these findings widely available is the ultimate goal of this research endeavor. High priority will be given to research designs that show consideration for treatment and control communities by ensuring continuation of the intervention beyond the funded period.

Last May, the board tabled an earlier version of this concept. A committee of the board met and suggested revisions, which were incorporated into the current concept. Board member James Holland expressed concern about whether a study section would look favorably on the research proposals submitted in response to the proposed RFA, since, he said, this research area is "embryonic."

"We think it is well focused," DCPC Director Peter Greenwald said. The proposals could be reviewed by an ad hoc review committee, he said. DCPC will try to get this program funded through the research project grant pool rather than prevention and control.

Board member Ross Prentice asked about the availability of suitable materials for high risk youth.

"There is room for more development of materials," said Michael Anderson, of the Cancer Control Science Program. Existing materials, such as NCI's "Know Your Body" program could be adapted, he said.

Board member Maryann Roper asked whether the scope of the concept could be narrowed to focus on fewer cancers. "With only three awards, it seems like a lot of ground to cover," she said.

Greenwald said that studies in youth need to address the major risk factors of smoking, alcohol, and drug abuse, and possibly diet, though there is less evidence available.

"If diet is the exception, then maybe it should be excluded," Roper said.

"Diet is more complicated, but it is important for this generation of youngsters," Greenwald said. "It's better to give them the best advice we have."

Board member Shirley Lansky again raised the issue of the concept's scope, which she called "a sweeping approach to an entire population." She said efforts in younger children may be necessary. "In some areas we're starting too late," she said.

"We'd be happy to come in next time with a lower age group," Anderson said.

Board member David Alberts said he supported the concept, but agreed with Lansky. "In the inner cities, by age 12 we've already lost the battle. I hate to see a program like this go forward and be a complete bust."

"I find this a very exciting proposal," board member Michael Perchuck said. He commended the "very aggressive" efforts in cities including New York and

Washington to educate teenagers about tobacco advertising.

Anderson said NCI is seeking collaboration on the concept from the National Center for Nursing Research, the National Institute of Child Health & Human Development, and others for additional awards.

"I'm very pleased with the improvement of the concept," said board member Alfred Haynes. "It would be nice to start at an early age, but this is a good project." He said that from a community health standpoint, the more risk factors a study examines, the better the response from the participants.

The concept was unanimously approved, with the stipulation that the board be informed of the progress of the research proposals through the review process.

Research support services for diet, nutrition, and cancer prevention projects in the Cancer Prevention Research Program. Recompetition of a contract held by Prospect Associates; estimated award $450,000 per year for five years, one award.

Research support services are increasingly important to the rapidly expanding activities in the area of diet and cancer prevention. Support services requested by this concept will assist the Cancer Prevention Research Program with 1) literature searches and the evaluation of dietary hypotheses on cancer prevention, 2) the development, compilation and organization of materials, 3) logistical assistance for scientific meetings and workshops.

This support contract includes assistance in gathering, analyzing, synthesizing, and integrating information pertinent to preclinical and clinical issues fundamental to achieving the goals and objectives of the CPRP. Scientific expertise is needed in a wide range of fields that includes among others nutrition, epidemiology, biology, physiology, and toxicology. The types of tasks involved in this project include but are not limited to:

--Scientific literature searches relevant to diet, nutrition, and cancer prevention research.

--Compilation and critical analyses of scientific data.

--Preparation of documents for ad hoc advisory groups and programmatic reviews.

--Preparation of reports and in house documents.

--Assistance in planning and organizing scientific meetings and workshops.

In order to be as cost effective and as efficient as possible with fast turn around time, each task will be specified in detail, supervised and monitored closely on an ongoing basis by the NCI work initiator assigned to each task to ensure accurate and high quality performance, and to avoid unnecessary effort, materials, and inappropriate procedures.

Mark Messina, of DCPC's Diet & Cancer Branch, is the project officer for this program. The concept was approved unanimously.

DCPC will be rereleasing an RFA on "Public Health Approaches to Breast and Cervical Cancer Screening." The rerelease was approved by the NCI Executive Committee. Three grants were awarded from the first RFA, and DCPC hopes to make three or more new awards in FY 1992 at a cost of $1.2 million.

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-27704-30

Title: Collection and taxonomy of shallow water marine organisms

Deadline: Approximately April 12

NCI's Developmental Therapeutics Program in the Div. of Cancer Treatment, wishes to establish contracts for the collection and identification of marine organism samples from the Indo-Pacific region, for evaluation as sources of potential antineoplastic and anti-AIDS agents, with the ultimate goal being the discovery of novel structural types which can be developed for the selective treatment of cancer and AIDS in man.

The successful offerors will be expected to provide qualified personnel, materials, and equipment for the collection, identification, storage, and shipping of 1,000 frozen marine samples per year to an NCI designated extraction facility. Collections will comprise approximately 0.3-1.5 kg (wet weight) of each sample, collected from depths safely accessed by SCUBA techniques, and each sample will be identified as far as possible at the time of delivery. Properly prepared voucher specimens of each organism will be collected for the purposes of unambiguous identification, and for permanent deposition at a minimum of two repositories designated by NCI.

The contractor will be expected to provide detailed documentation, including complete identification of each sample collected. The collection team should include qualified taxonomists, personnel experienced in SCUBA techniques as well as experienced in marine organism collection. The principal investigator should be trained in marine biology, or a related field, and have at least five years of experience in marine organism collection and identification.

It is anticipated that recollections of up to 50 marine samples per year, in quantities of 10-50 kg, will be required. The number of initial small scale collections will be reduced in proportion to the number and size of the large scale recollections undertaken. Collections will include species from as wide a variety of families and phyla as possible. The collection will be heavily weighted for invertebrates will allowance for up to approximately 20 percent marine plants and with the specific exclusion of vertebrates. A list of species and genera extensively screened by NCI will be provided in order to aid in the determination of priorities in the collection program to the successful contractor.

The contractor will be responsible for obtaining all necessary permits including visas, collecting, shipping, and export permits from foreign governments and agencies, for delivery of samples and voucher specimens to facilities in the U.S. Where necessary, the government will provide letters of support. This is a recompetition of a contract with the Australian Institute of Marine Science. The government anticipates the award of one contract funded on an incremental basis for a five year period, beginning approximately Nov. 30, 1991.

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