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Minna To Direct Howard Simmons Cancer Center At Texas Southwestern; 'Major Loss' For NCI

John Minna, who recently announced his departure as chief of the NCI-Navy Medical Onology Branch, said last week that he is leaving NCI "for tremendously positive reasons"--to become director of the new Howard Simmons Cancer Center at the Univ. of Texas Southwestern

(Continued to page 2)

In Brief

FDA Approves G-CSF For Marketing; Waldmann Wins Belgian Health Prize; Green To Head NWTS

FDA APPROVED the use of granulocyte colony stimulating factor, or G-CSF, last week for use in fighting infections caused by chemotherapy regimens. The drug, expected to benefit 225,000 cancer patients each year, was developed and will be marketed by Amgen Inc. of Thousand Oaks, CA, under the trade name Neupogen. FDA Commissioner David Kessler called G-CSF "a pioneer therapeutic product." . . . **THOMAS WALDMANN,** chief of NCI's Metabolism Branch in the Div. of Cancer Biology, Diagnosis & Centers, has been notified he will receive the Artois-Baillet Latour Health Prize, which consists of 5 million Belgian francs, or about $177,000. The prize is given every other year and this year recognizes Waldmann's important contributions to "the use of monoclonal antibodies as diagnostic and therapeutic tools in human medicine." . . . **DANIEL GREEN,** chief of the oncology section in the Dept. of Pediatrics at Roswell Park Cancer Institute, has been elected chairman of the National Wilms Tumor Study Committee, replacing Giulio D'Angio, Hospital of the Univ. of Pennsylvania, who served in that position since the 1969 founding of NWTS. . . . **RONALD DORN** has been appointed medical director of Mountain States Tumor Institute, Boise, ID. He has been with the institute since 1983. . . . **JUNE TAYLOR,** formerly of Fox Chase Cancer Center, has joined the staff of St. Jude Children's Research Hospital in Memphis as director of magnetic resonance spectroscopy. . . **SHARON HILDEBRANDT** has been appointed executive director of the Linda Pollin Foundation, based in Washington. The foundation is dedicated to improving psychosocial services to chronic medically ill patients and their families. . . . **JAMES GLENN,** executive director of Univ. of Kentucky Markey Cancer Center, was named chairman of the Council for Tobacco Research, succeeding **William Hobbs,** who retired after holding the position since 1981. . . . **MARY WOOLLEY** was elected president and CEO of Research! America, a nonprofit promoting biomedical research, succeeding Connecticut Gov. **Lowell Weicker.** She was executive director of Medical Research Institute of San Francisco.

Minna Leaving 'For Positive Reasons': To Build, Direct New Cancer Center

(Continued from page 1)

Medical Center in Dallas. He said he will leave NCI on April 1.

"In this position I will have the opportunity to build from the ground up a cancer center involving medicine, radiotherapy, surgery, clinical and basic research in the setting of what I consider one of the most exciting biomedical research centers in the United States," Minna told the Div. of Cancer Treatment Board of Scientific Counselors last week.

In a farewell address to the DCT board last week, Minna said that when he came to NIH in 1969, he thought he would only stay "three or four years."

Minna first worked with Marshall Nirenberg for six years in the National Heart, Lung & Blood Institute. In 1975, Vincent DeVita, then director of the Div. of Cancer Treatment, recruited Minna to head the NCI-Veterans Administration Branch, and Minna moved off the NCI campus to the Washington VA Medical Center until 1981.

"These were fun years, but I must say it took a lot of courage for many young people to leave the NIH campus to join me in working downtown," he said.

In 1981, the new National Naval Medical Center opened and the branch was moved to Bethesda, becoming the NCI-Navy Medical Oncology Branch.

"If you could have seen our beginnings in a shed out behind the naval hospital, you would have realized I owe a lot to all the people that had the courage to work with me.

"In addition, I greatly appreciate the help of the many Navy staff, doctors, nurses, and support staff over the years that worked side by side with us and from whom I learned a lot about the care of patients."

Minna gave the board his opinion on several issues:

"The NCI-Navy branch should continue and should be strongly supported for several reasons." He cited the branch's scientific productivity, its "many exciting young staff," the "excellent" physical plant at the medical center for outpatient and inpatient care and laboratory research, and the support of the Navy Hospital in professional services.

"The spectrum of disease we see is amazing and occurs in a highly motivated patient popultation. We have entered more than 1,500 patients onto NCI trials. Currently we are actively following over 2,200 patients with all types of malignancy. We have 70 outpatient visits daily, 25 of whom get treated, each day." In addition, he said, the radiotherapy service is supervised by Eli Glatstein, chief of NCI's Radiation Oncology Branch. Surgery is handled by Navy staff surgeons.

The NCI-Navy effort has operated under an interagency agreement with the National Naval Medical Center. The Navy provides the facilities, patients, support services and some staff, while NCI provides staff and budget. NCI can admit civilian patients to participate in clinical trials.

"For those of us who have worked at both institutions (and despite growing pains and nurturing) this interagency agreement has ultimately been a 'win-win' situation for the Navy and NCI. It is clear that the NCI fellowship program is greatly strengthened and dependent upon the patient care opportunities provided by the Naval Medical Center. In addition, the Navy is greatly appreciateive of the NCI steadfastness over the years and most recently in helping to prepare for Desert Shield and Desert Storm, which required the mobilization of many of the Naval Hospital staff for the hospital ship 'Comfort.'"

Minna said the current commanding officer, Admiral Hagen, "wants to continue and extend" the medical center's interaction with NCI. "I would strongly endorse this," Minna said.

NCI also has benefited from an interagency agreement with the Uniformed Services Univ. of the Health Sciences, Minna said. Under the agreement, the university provided government positions, which NCI funded.

Daniel Ihde, the new NCI deputy director, was on such a position, as was Barry Kramer, the new associate director for the Div. of Cancer Prevention & Control's Early Detection & Community Oncology Program.

"Currently this mechanism is winding down for budgetary reasons. However, the univeristy has been

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a strong friend and ally of ours over the entire 10 year period and I would stronly recommend keeping the agreement open as an option for future use."

"Within the Clinical Oncology Program there have been major changes over the past three years and branches have been severely damaged by vacuums of leadership during transition periods. My advice is, don't let this happen to the NCI-Navy branch with my departure."

For that reason, Minna said he recommended that NCI appoint Bruce Johnson, who was to have replaced Ihde as Minna's deputy, as the acting branch chief while a search is conducted. The search should also consider Johnson for the position, Minna said.

"Should the NCI-Navy branch be melded together with the Medicine Branch at the Clinical Center? I think not. The main reason is, I have put myself in the place of my Navy counterparts and I see how important it is for them to maintain the sense of identity with the Naval Medical Center. They have given us a great deal of authority and autonomy within the Naval Medical Center which is of vital importance to running our program. They have done this because of our independence as a branch at the Naval hospital rather than being an extension of the Clinical Center."

The future of intramural research at NIH as a whole, Minna said, "is in grave jeopardy over the next decade," and the future of intramural research in the in Clinical Oncology Program "is severely threatened in the next two to three years by the current budget status."

Minna's emphasis on the positive aspect of his departure most likely was prompted by an article in the Feb. 1 issue of "Science" magazine, titled "NIH: The Price of Neglect," which described low morale on the NIH campus, difficulties in recruitment of new faculty and departures of several senior scientists. Minna was named in that article as one of those departing.

"There are significant elements of truth in this picture," said DCT Director Bruce Chabner, who called Minna one of NCI's most prominent scientists. "John's leaving will be a major loss for us. I need not tell you of his remarkable career here.

"However, I do not regard John's leaving as a symptom of a deep seated problem at NIH," Chabner continued. "NCI has recruited a number of outstanding epople in the past year, including Robert Wittes, Edward Sauseville, Lou Malspieis, Michael Grever, and some exceptional younger physician-scientists such as Pat Elwood from Colorado and Steve Channock from Harvard.

"Further, I believe the competitive situation here will improve over the next several years because of major changes in compensation especially for the top scientists.

"Congress has signed into law the Senior Biomedical Research Service, which provides 350 positons for outstandig scientists in HHS, with a top salary of $138,000. It is my hope that the majority of positions will be used for recrutiment and retention of exceptional scientific talent, and not for administrators."

Also, salaries in the Public Health Service have increased because they are tied to the military physician bonus plans, Chabner said. The upper limit on PHS salaries now is $135,000, which, Chabner said, "while not equivalent ot the salaries at universities or in private practice, offer enough compensation to retain most of our upper echelon on physicians."

Another note of optimisism is the creation of the National Foundation for Medical Research at NIH, which was established by Congress to create endowed professorships for top scientists through private funding.

In addition, another impediment to recruitment--the lack of a permanent NIH director--will soon be remedied with the appointment of Bernadine Healy, who is a "forceful and decisive leader, and a champion of clinical research," Chabner said.

"We are still beset by significant problems, but these affect the scientific community as a whole." Issues such as fraud and scientific misconduct, conflict of interest and the "politicization of research agendas" originate from "real problems" that need to be resolved, Chabner said. "But sadly, these matters threaten to dominate an agenda that should be primarily devoted to the pursuit of scientific truth.

"That we spend so much of our time dealing with new policies related to misconduct, fraud and conflict of interest, and debating the level of support for various interest groups, can only detract from the time, attention and support given to the best scientific opportunities.

"The recent debates about the Diet Fit trial [now Women's Health Trial], a trial twice considered and found wanting by the National Cancer Advisory Board, have attracted great attention in the national press and elsewhere, and the very real scientific problems of the proposal have been largely obscured in the ensuing debate.

"It is critical for the health of biomedical science at NIH as well as the extramural community that we return to issues of substance."

Payline Still Not Set For CCOP First Annual Recompetition

NCI has yet to develop a funding plan and establish the payline for the first annual recompetition of the Community Clinical Oncology Program.

The National Cancer Advisory Board at its meeting last month endorsed the initial recommendations for award made by the study section. But it may be a month or more before a payline is established, Associate Director Leslie Ford told **The Cancer Letter** last week.

In last year's "CCOP 3" recompetition, the payline was 211, but that figure is probably irrelevant in the current competition, since NCI has said it intends to fund only five CCOPs in this round. Last year, 47 awards were made. From now on, the competition will take place every year, with roughly one-third of the CCOPs recompeting each time.

Applicants Identified

Following are CCOP applicants for the current competition who were identified to **The Cancer Letter** as receiving priority scores above last year's payline:

Cancer Institute of Brooklyn (NY); Spartanburg (WVa) CCOP, John McCulloch, PI; San Joaquin Community Cancer Center (CA), Marshall Flam, PI.

The Cancer Letter will publish the names of CCOPs whose scores are above last year's payline and invites those not listed above to call at 202/543-7665.

Ford said there were 21 applicants for the five CCOP slots. Competing for this year's awards are any of those who did not get funded in the previous round as well as any new applicants. Ford said the length of the award would depend on whether a CCOP is current or a new applicant. Current CCOPs might get five year awards and new applicants would get three year awards.

In the RFA issued for the program last June, NCI said approximately $450,000 would be available to fund approximately five CCOPs for five, four or three year awards.

CCOP research bases are also up for renewal in this round. Their cooperative agreements expired along with those of the CCOPs in 1989, but were extended administratively to lessen NCI's review burden. In the RFA, NCI said approximately $3.9 million is available to fund 17 research bases, and awards would be made for three, four or five years.

There were 15 applications from research bases, but not all would necessarily be funded, Ford said.

Cooperative Networks In Prostate, Bladder Cancer Ok'd By Advisors

Advisors to NCI's Div. of Cancer Biology, Diagnosis & Centers have given concept approval to a new grant programs that would create a cooperative network for molecular studies in prostate cancer.

The division's Board of Scientific Counselors also approved the recompetition of grants for a bladder cancer cooperative network. The two RFAs would fund, between them, from eight to 11 grants for up to four years each, at a total cost of nearly $2 million in the first year.

The board also gave concept approval to a new contract for master agreements for collection of tumor tissue samples, and committed a total of $6.5 million for five years to the project.

Following are the concept statements approved by the division's Board of Scientific Counselors:

Cooperative network for molecular genetic and cytogenetic studies of prostate cancer. Proposed new RFA, three to five grants of up to four years, estimated cost $1 million for the first year.

While prostate cancer is the most common cancer diagnosed in men, many biological questions remain unanswered. The objective of this program initiative is to expand the knowledge of the biology of prostate cancer by studying the molecular genetics and cytogenetics of these tumors. A cooperative network will be established consisting of basic scientists and clinicians who are willing and able to share prostate cancer tissue, expertise and molecular probes to advance the field more rapidly.

The goals of this proposed RFA are: 1) to promote collaborations and interactions between basic scientists and clinicians in order to advance prostate cancer research; 2) to identify molecular genetic and/or cytogenetic alterations that may explain the difference in behavior of clinically silent versus clinically evident prostate tumors; 3) to determine whether there is a molecular genetic basis for differences in prostate cancer incidence between blacks and whites; 4) to explore the biological basis for the striking increase in prostate cancer incidence with age. It is anticipated that cooperative studies will facilitate the application of molecular genetic and cytogenetic techniques to prostate cancer research through the effective use of prostate cancer and normal prostate tissue.

Autopsy studies indicate that nearly a third of males 50 years or older dying from causes other than prostate cancer may have microscopic foci of cancer within their prostates. Only about 1% of these potential patients are diagnosed each year as having prostate cancer. These foci of clinically silent cancer, which seem to progress slowly or not at all in the majority of men, have been called "latent" or "histological" cancer. The major dilemma is that these cancers cannot be readily distinguished from those that will progress rapidly to clinically evident tumors. A means to differentiate those that will remain clinically silent from those that will progress to clinically evident is required in order to treat patients most effectively.

It has been shown with other tumors that genetic characteristics of the tumor can provide information about its behavior. Elegant studies of colorectal carcinoma have shown that specific gene deletions and alterations accumulate as tumors

progress, and that these alterations may be useful in assessing prognosis. Molecular genetic studies of prostate cancer have been limited. One recent study of prostate tumors showed loss of heterozygosity at a number of different chromosomal arms; the highest frequency of loss of heterozygosity was at chromosome arms 10q and 16q. In-depth studies of molecular genetic alterations in prostate cancer are needed in order to determine whether such genetic alterations are also useful in predicting the behavior of prostate tumors. Cytogenetic studies are also needed since these types of studies often identify chromosomal regions important for molecular exploration.

The NCI Roundtable on "Prostate Cancer: Future Research Directions", sponsored by the Organ Systems Program of DCBDC in May 1990, identified areas where research initiatives could help advance the understanding and management of prostate cancer. The major issue identified was the inability to distinguish between tumors that will remain clinically silent and those that will progress rapidly. Research to address this issue is urgently needed to avoid unnecessary morbidity associated with diagnosis and treatment of lesions which will not progress. Additional factors of concern to NCI are the increasing incidence of this disease with age, and the high incidence in blacks. Recent developments in the fields of molecular genetics and cytogenetics have led to identification of a number of markers which appear to have prognostic value in cancer.

This initiative is aimed at encouraging collaborations between basic scientists and clinicians to utilize these new technologies for the better understanding and diagnosis of prostate cancer. The hope is that this initiative will encourage more investigators to focus on molecular studies of prostate cancer, since few molecular biologists and cytogeneticists are presently studying this disease. A network of basic scientists and clinicians will be developed which will share tumor tissues, set priorities for tissue utilization, and coordinate data analysis to improve prostate cancer prognosis and an understanding of its biology. Cooperative studies will facilitate the application of molecular genetic and cytogenetic techniques to prostate cancer research through the efficient sharing of prostate cancer tissue and other resources.

Sheila Taube, chief of the Cancer Diagnosis Branch, said "there really is a very small database, particularly on molecular genetics" of prostate cancer, but that "the field is ripe now to address this." Doris Balinsky will be the program director for the prostate network. The concept was approved unanimously.

Cooperative network for evaluation of prognostic markers of urinary bladder cancer. Proposed recompetition and expansion of an RFA, four to six awards for up to four years, estimated cost $950,000 for the first year.

The objective of this initiative is to extend and expand the Marker Network for Bladder Cancer, an existing inter-institutional network. The goal of the network is to test biochemical, immunologic, genetic and other quantifiable markers for urinary bladder cancer. The current network supports studies by researchers with expertise in urology, pathology and/or quantitative cell biology to evaluate promising quantitative markers of bladder cancer and to define appropriate clinical applications. The network has already completed one retrospective clinical trial, demonstrating the feasibility of such collaborative clinical studies. Additional studies are needed to continue the evaluation of existing markers and to identify and evaluate new markers.

Advances in immunology, molecular biology and genetics have opened new possibilities for developing cell or tissue markers to detect cancer and to predict recurrence, invasion and metastasis. These advances have led to new and more effective approaches to improve diagnostic accuracy, to make prognostic and therapeutic decisions to more effectively monitor response to therapy, to detect cancer at earlier stages and to identify high-risk populations. About 85% of new bladder cancers are early stage at the time of detection, however in about 50% of these cases the tumor will recur after treatment and in about 15% of cases the disease will become metastatic.

There are currently few approches that have shown any utility for predicting prognosis. One important area of research is to define markers that will predict which tumors are most likely to recur or progress. Carcinoma in situ is a form of cancer that is difficult to detect and which often becomes invasive prior to detection. Markers for detection of carcinoma in situ as well as predictors of its progression and metastasis are needed. For later stage disease there is a need for markers to differentiate between more and less aggressive disease and to monitor response to therapy. DNA ploidy studies of exfoliated tumor cells have demonstrated some utility in predicting tumor behavior. The development of additional quantitative cell or tissue markers will expand the repertoire of diagnostic and prognostic measurements available to the clinician.

There is a need in bladder cancer to improve diagnostic accuracy, to more adequately predict prognosis and to more effectively monitor response to therapy. While a number of potential markers exist, there has been little effort to effectively evaluate their utility. The Marker Network for Bladder Cancer was developed by the NCI Organ Systems Program to meet this need by encouraging collaborative studies of markers of bladder cancer. Two institutions were funded in 1988 and two additonal institutions in 1989. Since August of 1989 the network has defined its goals, identified promising markers and developed and carried out a large retrospective study of prognostic markers of recurrence and progression in early stage disease. Additional studies are needed for detection of carcinoma in situ to differentiate more aggressive from less aggressive tumors and to monitor response to therapy. Results of retrospective studies may suggest further prospective studies of selected markers.

Expansion of the network will increase access to patient resources and enhance the technical capabilities of the network. The cooperative approach will optimize research opportunities by using the available patient resources more efficiently, by improving the evaluation of potentially useful markers and by allowing comparison of their utility in different clinical and laboratory settings. These studies will build on the progress of the existing network, the strengths of the participating laboratories and the patient populations available to the network.

While the existing network was funded using traditional (RO1) research grants, it has become apparent that it would function more effectively under the cooperative agreement mechanism. The network activities have involved complex interactions among the cooperating institutions. The participants recognized the need for greater coordination of these studies and asked NCI staff for advice and assistance in coordinating network studies. Use of the cooperative agreement mechanism will allow the NCI to provide appropriate logistical support and coordination of network activities and allow NCI review of protocols for future clinical studies.

Roger Aamodt, program director for pathology-cytology in the Cancer Diagnosis Branch, said the change to the cooperative agreement mechanism was necessary due to the project's complexity. The concept

was approved unanimously.

Tumor tissue resources for evaluation of promising diagnostic and prognostic approaches. Proposed new RFP for master agreements for five years. Anticipated two to four master agreement orders will be issued in the first and second years, and four to six MAOs in years 3-5. Estimated cost of $250,000 per MAO. Estimated total cost $6.5 million.

The objective of this proposed solicitation is to make available to NCI the necessary human tumor samples to effectively pursue the clinical validation of promising new diagnostic and prognostic assays. Under the proposed master agreement, this initiative will create a pool of institutions capable of providing large numbers of tumors (paraffin blocks and/or frozen tissue, where available) with the appropriate patient follow-up data. The institutions will be expected to be able to perform laboratory evaluations and will therefore have to demonstrate clinical laboratory expertise in one or more specified areas.

The NCI Diagnosis Decision and Implementation committee, created in 1989, will identify which assays are ready for evaluation and will set priorities for large-scale clinical evaluations. Once institutions have demonstrated that they meet the required qualifications and master agreements have been initiated, master agreement orders will be written describing each specific study to be performed. Those organizations holding master agreements that are capable of performing a given study will then be invited to submit proposals. The responses will be evaluated and awards made in compliance with standard NIH contract procedures and regulations.

In order to meet the year 2000 goals for decreasing cancer mortality, efforts must focus on decreasing cancer incidence and improving cancer treatment. Several statistical analyses have suggested that identification of subgroups of patients who would benefit from more aggressive treatment will have a major impact on cancer mortality even with the available treatment modalities. Diagnostic techniques that detect cancers at an earlier stage or provide more complete information about the nature of a given tumor should also have a significant impact on mortality by allowing physicians to provide the most effective treatments. Therefore, promising new diagnostic and prognostic techniques must be definitively evaluated in a timely manner. The Cancer Diagnosis Branch has taken the lead within NCI to assure that promising new approaches will be moved more rapidly into clinical practice.

In order to perform appropriate validation studies of new diagnostic and/or prognostic approaches, large collections of well characterized tumor tissue with associated clinical follow-up information are needed. Such tissue collections do exist, generally acquired in the course of clinical trials. These collections of archived tumor tissues with clinical follow-up data need to be made readily avialable so that new technologies can be rapidly evaluated retrospectively before embarking on large-scale prospective trials.

The recent (July 1990) Consensus Development conference on Treatment of Early Stage Breast Cancer emphasized the need to develop and utilize new and existing tissue and clinical data banks for the study of prognostic factors of early stage breast cancer. The DDIC has identified validation of early stage breast cancer prognostic indicators as its highest priority. Some examples of assays that need carefully designed evaluations include comparison of different methods of measuring cathepsin D as a prognostic indicator in cases of node negative breast cancer, expression of NM23 as a marker of the metastatic potential of breast cancer, and further study of S phase fraction as a prognostic indicator. New assays will be evaluated when feasibility studies indicate that they may provide important new insights into tumor behavior and response to therapy.

Similar repositories of archival material are needed for other solid tumor (e.g., prostate, colon, ovarian, and lung tumors) to facilitate research on diagnosis, prognosis, and early detection these cancers. As clinical needs in each organ system are defined, priorities for clinical trials of promising diagnostic tests will be altered, and collections of other types of tumor tissue with clinical follow-up data will be required. A master agreement to make available large collections of well-characterized archival tissue would give the Diagnosis Program the flexibility to respond quickly to changing needs and to rapidly evaluate promising new diagnostic and prognostic approaches for breast and other types of cancers in retrospective cases.

The master agreement is proposed for a period of five years. There will be annual resolicitation which will allow new groups to qualify. No funds will be expended until a master agreement order is issued. It is anticipated that 2-4 MAOs will be issued in the first and second years and that 4-6 MAOs will be issued in years 3-5. Based on an estimated cost of $250,000 per MAO, we are requesting $1,000,000 each for FY 1992 and 1993 and $1,500,000 each for FY 1994, 1995 and 1996.

In response to other board members' questions about the master agreement format, board member Albert LoBuglio described the "make believe" application process, in which the applicant "puts together a whole response to a study you're not going to do." If judged to be capable, the applicant becomes a master agreement holder and has the right to respond to future solicitations. "It's somewhat frustrating," he said.

"My experience is that many if not most of the institutions that reasonably address the basic questions are considered," said Sheila Taube, Cancer Diagnosis Branch chief.

Board member Ross McIntyre asked whether a cooperative group could apply.

"Those are exactly the groups we're trying to get--cooperative groups, cancer centers doing large trials--they have the tissue and the clinical laboratory expertise, or have relationships with scientists in the field," Taube said.

"It seems to me some upfront money needs to go to the groups so the specimens will be there when they're needed," McIntyre said.

Taube said the groups do not have to have the samples at hand, but must show they have access to them. She emphasized that the project "is not really research; it is technical evaluation [of new assays]."

NCAB Supports ACS Effort To Work With Centers, Avoid Duplication

The National Cancer Advisory Board has expressed to the American Cancer Society its support for the society's recent appeal for cooperation between its

divisions and the nation's cancer centers.

The NCAB unanimously passed the resolution, proposed by board member Walter Lawrence, following a presentation by ACS Executive Vice President William Tipping at the board's meeting last month.

Tipping said the ACS effort, which was launched with a joint meeting with cancer center directors in January in Houston (**The Cancer Letter,** Jan. 25), seeks to encourage ACS statewide divisions and local units to work more closely with cancer centers on all aspects of cancer prevention, control, service to cancer patients, and public education.

"We are looking to extend and improve our range of activities within the diverse communities we already serve and those we should be serving, like the poor, the socioeconomically disadvantaged," Tipping said.

"We share with comprehensive and community cancer centers the focus on prevention as not only principled, but practical in terms of today's health programming. Two audiences in particular are likely to benefit most rapidly from prevention and should be approached more effectively--our minority populations and women," Tipping said.

"A majority of Americans are willing to make lifestyle choices, indeed, they are begging us for more ideas on what choices are available to them."

Tipping asked the NCAB, "Don't we and you hold the same concern for making the public aware of the facts? Don't we share the same charge to provide concrete guidance? Yes." Though the centers, NCI, and ACS have "different spheres of influence," he said, that provides "different strengths."

ACS and the cancer centers "are on the same wavelength about the methods of communicating to the public...and that presents both opportunity and overlap," Tipping said. "It would be unconscionable to disregard the opportunities to work together in our communities and unfortunate to wind up with competing activities during a time of financial constraints.

"We know how to get together on the medical side, in the treatment and rehabilitation process. Now, let's get together on the day to day interaction we need to undertake to protect the lives of our citizens."

Minority Health Professional Training Initiative Gets NCAB Concept OK

The National Cancer Advisory Board has given concept approval to the "Minority Health Professional Training Initiative," a series of three awards programs that would fund up to seven awards for career development of minority researchers.

The estimated cost for the first phase of the program is about $1 million. Each award recipient would receive a $50,000 salary and $10,000 to $20,000 each in supplies.

The goal of the program is to strengthen clinical oncology faculty and curricula in minority medical schools and encourage junior clinical faculty to serve special populations, said Lemuel Evans, director of the Cooperative Minority Biomedical Program in the Div. of Extramural Activities.

Following are the descriptions of the awards:

▶K07 Minority Oncology Leadership Award for faculty will free up research time, improve the curriculum and research opportunities, and pay one additional professional to do research. It is limited to minority health professional schools and can be viewed as a research development tool. A four year award with one possible three year competing continuation is envisioned.

▶K08 Clinical Investigator Award for research on special populations will encourage newly trained clinicians to develop research interests and skills in the basic and applied sciences relevant to cancers and risks for cancers that have a high prevalence or incidence in special populations that may be underserved by limited access to current knowledge and medical care.

▶K14 Minority School Faculty Development Awards to encourage the development of faculty investigators at minority schools and to enhance their research capabilities in specified health and health related areas.

The initiative was approved unanimously.

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 NIH-ES-91-14

Title: Role of enhanced cell proliferation in chemical carcinogenesis

Deadline: April 11

The National Institute of Environmental Health Sciences has issued this RFP. The purpose of this contract is to provide the government with the skills, experience, and facilities to perform experiments addressing the role of enhanced cell proliferation in chemical carcinogenesis. Studies designed to assess the extent of cell proliferation and cell death in rats and mice will be

performed under similar conditions as the carcinogenicity studies of each chemical being evaluated (e.g., animal species and strain, route of exposure, dose, diet, environmental conditions). Standardized procedures will be utilized for necropsy and histology, clinical chemistry, immunohistochemistry, histopathological evaluations of stained tissue sections, stereological analyses of altered hepatic foci, and cell proliferation analyses using osmotic minipumps to deliver the DNA precursor label.

It is expected that the results of these studies will provide greater insight on the role of chemically enhanced cell proliferation in chemical carcinogenesis and will provide guidance for risk assessment processes in determining how carcinogenicity data obtained in animal models should be extrapolated to assess the risk of human cancer due to exposure to nongenotoxic chemicals.

NIEHS plans to make one award from this solicitation.

Requests for the complete RFP must reference the RFP number and may be forwarded to: NIEHS, Contracts and Procurement Management Branch, ATTN: Thomas Hardee, Contracting Officer, 79 TW Alexander Drive, 4401 Bldg., PO Box 12874, Research Triangle Park, NC 27709, phone 919/541-7893.

RFAs Available

RFA CA-91-07

Title: Molecular analyses of radiation induced genetic damage
Application Receipt Date: May 24

NCI's Div. of Cancer Etiology invites applications from interested investigators for molecular studies on the mutagenic effects of ionizing radiation on mammalian DNA, in vitro and in vivo.

The purpose of this RFA is to encourage research to characterize the distributions of mutations in the DNA of mammalian cells exposed to ionizing radiations. The objective will be the quantitative analyses of mutations by their locations and frequency of occurrence in defined DNA targets (or chromosomal locations for large scale genetic events) with sufficient sensitivity to be applied directly to small populations of somatic cells. Primary emphasis should be placed on basic studies with cultured mammalian cells, including human cells. Such research could involve a variety of genetic endpoints and techniques including the use of specific gene targets, repetitive DNA sequences, and chromosome specific DNA probes. This RFA will permit a wide range of research, including, but not limited to, the following studies:

--To determine if mutation spectra based on point mutations, deletions, and/or other mutational endpoints may be uniquely characteristic of exposure to radiation and can be used to discriminate between cellular exposures to the different forms of ionizing radiation, between exposures to ionizing radiations versus exposure to other types of mutagens, or between mutations induced by exposure to ionizing radiation and those of spontaneous origin.

--To determine the feasibility and merit of amplifying mutations directly from somatic cels without using genetic selection and subculturing to amplify mutated DNA for molecular analyses. In vivo studies sould consider the possible complications that may result from clonal expansion of mutations in progenitor cells into populations of somatic cells.

--To investigate mutational responses in radiation exposed somatic cells as functions of varying doses and dose rates.

--To compare and validate radiation induced mutation spectra obtained with cultured cells exposed in vitro with mutation spectra obtained from somatic cells exposed in vivo.

NCI intends to fund six individual research grants (RO1s), with total program costs not to exceed $950,000 for the first year.

Copies of the complete RFA may be obtained from Dr. R.A. Pelroy, Radiation Effects Branch, NCI, Executive Plaza North Suite 530, 9000 Rockville Pike, Bethesda, MD 20892, phone 301/496-9326.

RFA CA-91-08

Title: Cooperative agreements for prevention clinical trials utilizing intermediate endpoints and their modulation by chemopreventive agents
Letter of Intent Receipt Date: April 1
Application Receipt Date: May 24

NCI's Div. of Cancer Prevention & Control invites applications for cooperative agreements to support clinical trials directed toward examining the role of various chemopreventive agents and/or diet in the prevention of cancer.

The major objective of this solicitation is to encourage cancer chemoprevention clinical trials that utilize biochemical and/or biological markers to identify populations at risk and/or to provide intermediate endpoints that may predict later reduction in cancer incidence rates.

These studies may be developed in phases, inlcuding a pilot phase, that could later proceed to a full scale intervention. The main emphasis should be on small, efficient studies aimed at improving future research designs of chemoprevention trials, providing biologic understanding of what is happening in the trials, or providing better, more quantitative and more efficient endpoints for these trials. After successful completion of the pilot phase (i.e., demonstrated modulation of marker endpoints by the intervention), subsequent studies can include phase 3 clinical trials involving the designated agent, the utilization of the monitoring test system, and a cancer incidence or mortality endpoint.

Investigators may apply at this time for the pilot phase or submit an application for both phases. However, if the application is for the pilot phase only, the proposed study must describe its relevance to a clinical application and utilize a chemopreventive agent, marker test system, and study population that could later be the subject of a full scale, double blind, randomized, risk reduction clinical trial.

Applicants funded under this RFA will be supported through the cooperative agreement mechanism. The recipients will have primary responsibility for the development and performance of the activity. However, there will be government involvement with regard to: 1) assistance securing an investigational new drug approval from FDA, 2) monitoring of safety and toxicity, 3) coordination and assistance in obtaining the chemopreventive agent, and 4) quality assurance with regard to the clinical chemistry aspects of the study. Awards will not be made until all arrangements for obtaining the IND, agent, and its delivery are completed. Final awards will also consider not only the costs of the clinical trial, but also the cost of the agent and its formulation if necessary.

Requests for the full RFA may be directed to Dr. Marjorie Perloff, Chemoprevention Branch, Executive Plaza North Suite 201, NIH, 9000 Rockville Pike, Bethesda, MD 20892, phone 301/496-8563.

NCI Contract Awards

Title: Study of precancerious gastric lesions in relation to stomach cancer in china
Contractor: Beijing Institute for Cancer Research, $82,012.

Title: Thyroid nodularity following exposure to diagnostic I-131
Contractor: Karolinska Institute and Hospital, $490,000.