

THE

CANCER LETTER

P.O. Box 15189 WASHINGTON, D.C. 20003 TELEPHONE 202-543-7665

Vol. 17 No. 20
May 17, 1991(c)Copyright 1991 Cancer Letter Inc.
Price \$205 Per Year US, Canada.
\$230 Per Year Elsewhere

NCI Advisors Discuss Cap On Center Core Grants While Broder Complains Cap Is 'Anti-Intellectual'

Advisors to NCI have begun discussion of the difficult and sensitive issue of placing some type of cap on cancer center core grants. None of the members of the National Cancer Advisory Board's Cancer Centers Committee favored a cap for its own sake. Preferably, Congress would increase the Cancer Center Program's budget, allowing new centers to

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In Brief

Morton Leaves UCLA Surgical Oncology; Rall Resigns As NIH Deputy For Intramural Research

DONALD MORTON has stepped down as director of UCLA's Surgical Oncology Div. to become director of the cancer program at St. John's Hospital in Santa Monica, CA. "While we will be sorry to lose him from our center after the two decades of leadership he has given to Surgical Oncology at UCLA, we can certainly understand Dr. Morton's desire to take on this new challenge," Richard Steckel, director of the Jonsson Comprehensive Cancer Center, said in a letter to friends of the center. Frederick Eilber, a member of the faculty since 1973, will serve as acting chief of the division. Carmack Holmes, a national leader in lung cancer treatment, has been appointed vice chairman of UCLA's Surgery Dept. He will continue his research at the cancer center. Other recent changes: Dennis Slamon was appointed chief of the UCLA Medical Oncology-Hematology Div., and Rodney Withers rejoined the Radiation Oncology Dept., which just opened new treatment facilities. . . . JOSEPH (ED) RALL announced his resignation as NIH deputy director for intramural research. Philip Chen, associate director for intramural affairs, was expected to be named acting deputy director. . . . AMERICAN CANCER Society has restructured its national office. Gerald Murphy was named chief medical officer and group vice president for cancer control. Allan Erickson takes on the newly created position of senior vice president for cancer control. He will oversee five departments: prevention, with Nancy Lins as vice president; detection and treatment, headed by Dan Nixon; nursing and patient services, a new position led by Patricia Greene; international activities, led by Gerry de Harven; and public issues, led by Alan Davis. . . . AMERICAN ROENTGEN Ray Society installed new officers at its annual meeting. They are John Kirkpatrick, president; Everett James, president-elect; Andrew Poznanski, 1st vice president; George Leopold, 2nd vice president; Joseph Ferrucci, secretary; and Beverly Wood, treasurer. The society awarded its gold medal, to Eugene Gedgudas, Jupiter Island, FL, and Elias Theros, Winston-Salem, NC.

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Cap Center Core Grants? If So, Then How? Advisors Discuss Options

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be established and enabling core grants to be fully funded as recommended by peer review.

That view was shared by NCI Director Samuel Broder, who called caps "anti-intellectual," and Brian Kimes, director of the Centers, Training & Resources Program in NCI's Div. of Cancer Biology, Diagnosis & Centers.

"If we got constant increases in the cancer centers budget, we wouldn't be facing this problem," Kimes told *The Cancer Letter*. "The assumption is that we're not going to see huge increases in the budget over the next five years."

The committee members who met last week agreed that, barring a sudden budgetary windfall, something has to be done to "introduce growth" in the program, in the words of committee Chairman John Durant.

"If a new center is to come on, an old one has to go," Durant said of the current funding crisis. "Those that got in the program early were able to escalate their budgets. Their success is viewed as a failure for others. These forces have led to various suggestions for putting caps on cancer centers."

Currently, when a center applies for renewal, it can apply for up to a 50 percent increase over its existing core grant. That system, while holding down overall growth in core grant budgets, seems to have exacerbated the differences in the size of core grants. Centers with the biggest core grants and in the system the longest are getting bigger, faster, while the newer centers or those with smaller core grants are growing at much slower rates.

The two centers with the largest core grants--

Memorial Sloan-Kettering Cancer Center and Fox Chase Cancer Center--that together account for 15 percent of the total core grant budget, last year informally agreed to a "sliding scale" cap. Vincent DeVita, physician in chief at Memorial Sloan-Kettering, and Robert Young, president of Fox Chase, discussed that option at a cancer centers workshop last June (*The Cancer Letter*, June 29, 1990). Later, Sloan-Kettering President Paul Marks elaborated on the idea in a letter to Kimes proposing a sliding scale that would limit centers that had been in the program the longest to increases of around 5 percent, while allowing newer centers to apply for 50 percent or even 100 percent increases in their grants.

[Young told *The Cancer Letter* this week that he still favors a sliding scale cap, but cautioned that, "if the Cancer Centers Program gets too far away from peer review, it will ultimately fail."]

Last week's Cancer Centers Committee meeting was the first time NCAB members were brought in on the discussion formally. The meeting was not intended to approve or disapprove any specific proposal, but to open the discussion, Durant said.

NCAB Should 'Seriously Debate' Cap

Kimes referred the committee members to a report he prepared outlining the reasons for asking the NCAB to discuss "budget ceilings" on core grants and setting forth some of the complications. Following is the text:

"It is crucial that at this particular time in the history of the Cancer Centers Program for the NCAB to seriously debate the issue of setting caps on Cancer Center Support Grants (CCSGs).

"The Cancer Centers Program will experience a precipitous decline in the number of cancer centers throughout the nation if there is no significant increase in the budget and the current policies with regard to funding CCSGs remain the same. This decline will occur at a time when there is a greater need for more cancer centers that are positioned effectively to take full advantage of research opportunities in therapy and prevention and to find better ways to move state of the art information into their communities. It is clear that the rapid progress in research in the last 10 years has re-emphasized the important role of cancer centers in technology transfer and translation of research findings into medical applications.... However, the potential of the Cancer Centers Program cannot be realized if the cancer centers decline in number and become concentrated in a few areas of the nation.

"It is important for the NCAB to seriously address the issue of whether or not an NCI policy should be

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established which administratively defines budget ceilings for CCSGs, more equitably distributes the budget between different centers, allows for an increase in the number of cancer centers in the future, and allows for development of new initiatives in the Cancer Centers Program.

"The following information illustrates the nature of the problem:

1. The budget is currently distributed in an extremely disproportionate manner. Fifteen percent of the budget is awarded to two out of 57 cancer centers.

2. The ratio of the size of the cancer center support grant to the size of the NCI supported peer review research base (i.e. "efficiency ratio" for want of a better term) demonstrates no consistent pattern. There appear to be "haves" and "have nots." Cancer centers with one fourth to one third of the CCSG support enjoyed by the larger centers and with an equivalent research base appear to be equally effective to the larger centers.

3. Better "efficiency ratios" have relationship to whether a cancer center is a free standing institution primarily dependent of federal support or a state academic institution which has greater access to the state tax bases.

4. The peer review system is not suited for regulating the relative growth of cancer centers in any consistent way. Peer review is only able to examine a competing request relative to the last year's level. Peer review does not do 0-based analyses that provide a relative standard for all centers. In fact, peer review almost always recommends an increased budget relative to the previous year, thus invariably increasing the average cost of the largest and smallest CCSGs.

5. The peer review system is being asked to make quality distinctions between centers that go beyond its actual capability (i.e., the large majority of active cancer centers supported by NCI are highly meritorious and worth funding; the peer review system seldom tells us that a center is not worth funding because nearly all priority scores range between 125 and 175.

6. CCSGs to basic cancer centers on the average receive better priority scores than CCSGs to clinical and comprehensive centers; thus, as the budget decreases in buying power only the clinical and comprehensive cancer centers are placed in jeopardy.

7. Once a cancer center that has taken years to build is discontinued, there is little, if any, chance that it can be started up again at the same level of capability and productivity.

8. Most NCI supported cancer centers are able to leverage the NCI designation into effective fundraising activities that serve critical needs from supporting

feasibility studies to providing services to the community that are essential for reducing incidence and mortality. When a high quality cancer center is lost, these private resources can be jeopardized. By the same token, if new cancers are funded, it is probable that more private funds will become available for cancer research and cancer services. Essentially, additional funds are more readily available through the communities that cancer centers serve than through increases in federal taxes. The multiplying effect of CCSGs cannot be disregarded because it not only makes other resources available to cancer centers, but also helps to establish a true partnership between NCI and cancer centers."

Three Possible Options

The report continued with the following questions for the NCAB:

"Would placing an administrative cap or budget ceiling on cancer centers be preferable to experiencing a rapid decline in the number of NCI designated cancer centers? How can a strong national centers program continue if the geographic diversity of centers declines and becomes concentrated in fewer and fewer institutions? What advice and rationale can the National Cancer Advisory Board provide for instituting or not instituting a cap policy given the current situation, budgetary trends, and potential need for more rather than fewer cancer centers?"

"Several options for capping cancer centers have been discussed in the past with no resolution of the issue. Some of these options were discussed at the Cancer Center Directors' workshop in June 1990:

A. Impose a sliding scale cap on cancer centers which would impose a no growth mode on the oldest cancer centers, allowing the younger cancer centers to grow.

B. Equate the maximum level of CCSG support to an institution to the size of the NCI peer reviewed research base or the NIH peer reviewed research base (i.e., the more research that is supported at the institution, the larger the allowable size of the CCSG).

C. Establish a fixed total dollar cap (e.g., allow no cancer center to receive more than 5 percent of the total budget, thus assuring that there will be at least 20 strong NCI designated cancer centers)."

Broder: 'I Don't Like Caps'

"I don't like caps," Broder told the committee. "That doesn't mean we won't do them. They're anti-intellectual. It's saying that no matter what peer review says, [there is an artificial limit]. The principle goes against my grain. The question is how best can an institution prevent and care for people with cancer, within their community."

"One thing that bothers me about a cap is that the notion develops that this is an entitlement program," Durant said. "The next step is getting rid of the program. I don't think we want that view to take hold."

Broder said he thought the centers program "should be run like a high school orchestra. Anybody can challenge the first trumpeter at any point they feel ready." The system should allow a center to fail if it is not living up to its promise, he said.

Sydney Salmon noted that the Assn. of American Cancer Institutes favors "some sort of cap," a view that was not developed without some controversy in the organization.

Durant asked the committee members to comment on the three options--A, the sliding scale; B, equating the core grant to the research base; or C, a fixed dollar cap.

Kenneth Chan said he opposed a sliding scale. Kenneth Olden said, "I don't like caps either, but we need new centers."

"Caps are generally bad, but there's reality. I like a free market, I'm not eager to get into caps," said Samuel Wells.

"There has been a cap already, in effect. there is a limit on how much an center can ask for beyond the current level," said Salmon. "I know some kind of restructuring is necessary. I'd vote for B if I had to vote."

"I tend not to like C. I could go with A or B. There are advantages to A," said Paul Calabresi, chairman of the NCAB.

Durant said it was clear that the committee did not like the idea of a fixed dollar cap, but that some limitation would be appropriate. He said the problem with the option B was that it did not take into account all peer reviewed grants to a cancer center's members, including those from other NIH institutes, the American Cancer Society, and others.

Complex Problem

Kimes said NCI staff would develop a better model for option B, and get lists from centers of their entire peer reviewed research base and membership. That option and others would be brought back to the centers committee.

"Dealing with a cap is a very complex problem," Kimes told *The Cancer Letter*. "We have many centers that operate in different ways. It is always possible for a center to have a really unique resource. You don't want to use cap to eliminate uniqueness. There has to be some flexibility."

Centers with the largest core grants do not necessarily support the largest amount of research,

Kimes said. Centers with the largest core grants tend to have them because they got in on the program earlier and then received regular increases year after year.

In debating the merits of different cap systems, the NCAB will have to decide whether equitable distribution is the goal.

"I'm not sure the goal is to even out core grants," Kimes said. "The goal is to come up with something that's fair to all centers, not just something based on time. Over the history of the center program, everything has been based on time."

The second option of equating the grant to the size of the resource base also gets into the question of how centers define their membership, Kimes said. "We've never approached how membership is defined."

"The one thing we are pretty convinced of is that a center grant has a catalytic effect," Kimes said. "NCI designated cancer centers have been able to use their grant as a leverage in the community. If we don't keep centers going, we stand to lose more than just the core grant."

"There have been a lot of centers who were on the line and said to us, 'Just give us something so can be a NCI designated cancer center.'"

NCI expects to lose some cancer centers under the FY92 President's budget, Kimes said, but he could not predict how many.

NCI also is beginning to rewrite the core grant guidelines. The goal of this process is to "make sure peer review criteria are clearly laid out," and to expand the flexibility of the core grant, Kimes said. "We get some inconsistent peer review because we haven't laid out anything in writing. This will make sure every site visit team looks at the same thing."

A draft of the guidelines will be presented to an NCI cancer centers workshop next month in Baltimore, prior to the Assn. of American Cancer Institutes annual meeting.

The guidelines then will be reviewed by the DCBDC Board of Scientific Counselors.

Regional Enhancement Centers

Another issue the centers committee took up was the proposed development of "regional enhancement centers," a way to fund institutions in areas of the country that are not served by NCI supported cancer centers.

The purpose of these centers, according to Kimes' proposal, would be to "take advantage of the cancer research excellence of small institutions in underserved geographic areas of the country that do not have the breadth and depth of research support to qualify for

the traditional cancer center support grant."

If the NCI budget remains "in a no growth situation," Kimes wrote, "it is unlikely that these smaller institutions will have many opportunities in the future to become eligible for CCSGs."

Following would be the general conditions for support of these regional centers, in Kimes' proposal:

"1. They are located in critically under-represented, underserved areas of the nation relative to the distribution of other cancer centers.

"2. They have a peer reviewed research base which can serve as a cancer research focus for the region, which can identify and participate in the exploration of new research opportunities related to the population in the region, and which has the potential to develop programs that will improve care, prevention, and outreach activities for the region.

"3. They have developed a formal arrangement with an NCI designated comprehensive cancer center that will permit the full exploration of research opportunities in the underserved area through collaborative research with the comprehensive cancer center scientists and through access to fully developed, expert shared resources of the comprehensive cancer center.

"The idea of the RECC is to provide limited core resources at minimal costs through small CCSGs awarded to institutions in the underserved regions of the nation."

Cancer Centers Committee members said the proposal did not sound much different from the existing center planning grants program, and did not specify the states where new centers are needed.

The committee voted to have NCI staff to develop a clearer description. Kimes said the concept then would be presented to the DCBDC Board.

Cancer Information Service Renewal, Restructuring Approved By NCAB

The National Cancer Advisory Board gave concept approval last week to the recompetition and restructuring of the Cancer Information Service.

The concept represents a major change in the way the CIS will function. Since the program was founded in 1975, CIS has operated as a group of regional contracts, mostly with comprehensive cancer centers, and a national office under a separate contract.

Under the restructuring approved in concept last week, the CIS will cover the entire U.S. through 15 to 20 regional offices, eliminating the national office. One of the regional offices would provide evening coverage until 10 p.m. for the whole country.

The board committed \$16.1 million to the program for FY 1993, and amounts increasing to \$19 million by FY 1997. The program's current contracts total \$10.4 million for FY 1992. This budget would provide a 20 percent increase in phone service, WATS lines and staff, as well as expansion of CIS outreach.

NCI staff told the board that the new concept would provide a more equitable level of service across the country, would promote program stability, and would expedite the coordination of NCI and cancer center outreach efforts. The contract period is proposed for 10 years with full review after five years.

NCI intends to hold a workshop, with the tentative date of June 14, to allow all interested parties, including Congressional staff, to comment on the identification of the 15 to 20 regions.

Following is the text of the concept statement:

Cancer Information Service. Summary Comments: Over the past five years the CIS program has experienced substantial growth. Since 1985 the call volume has increased over 40 percent. In addition, AT&T estimates that an additional 166 lines are needed to address the current busy signal rate of 58 percent. This demand coupled with the Institute's desire to reach populations underserved by the CIS phone service, as well as the need to contain escalating costs, prompted the Office of Cancer Communications to undertake a management review of the CIS program prior to seeking concept approval for the CIS program.

This review included discussions with current CIS program and field staff, cancer center directors and senior NCI staff. In addition, the study examined other 800 services and explored technological and fiscal opportunities currently available. The final report summarized the structural, technological and fiscal alternatives for the CIS program. The final report was reviewed by the OCC Plans Board and their recommendations are reflected in the concept presented.

The proposed reorganization of the CIS program is designed to create a more equitable level of service to the American public by serving the entire country with regionally based offices.

--This concept capitalizes on the effectiveness of a decentralized program structure while taking advantage of the available technology to ensure the most efficient operation of that structure.

--The concept represents a measured approach to alleviating the current busy signal rate by allocating the phone lines more efficiently and increasing the current level of service 20 percent by adding an additional 17 lines nationwide.

--Program stability will be enhanced through local coverage and use of a 10 year contract cycle.

--The outreach capacity of the CIS program will be expanded and will include the specific mandate to coordinate outreach activities with NCI designated cancer centers, DCPC health department grantees and other NCI programs such as NBLIC.

Concept: OCC proposes the development of a completely decentralized CIS program including:

--15-20 regional CIS offices serving 15 to 20 million individuals.

--The Statement of Work will maintain and expand the three program areas (Phone Service, Resource Development and Outreach).

--Regions will be designated. Offerors must bid for an entire region.

--Staffing levels will be standardized across offices based on population.

--The national CIS office located at Biospherics will be eliminated. National coverage will be maintained through full local coverage.

--Advanced call routing technology will allow calls to be redirected on a planned or emergency basis to previously designated locations.

--Nighttime coverage will be handled at a "Super Office" located in one of the regions, eliminating the duplication of resources in the national office.

--The level of service will be increased by 20 percent nationwide.

--Two full time equivalency positions in each office will be dedicated to outreach activities. It is anticipated that these FTEs will be distributed among satellite sites throughout the designated regions. Satellite sites might include NCI designated cancer centers or state health departments.

Proposed staffing: Program management: 1 contract coordinator, 1 evaluation specialist, 2 support staff. Phone service: 1 CIS phone service manager, 2 senior information specialists, 8 information specialists, 1 resource specialist. Community outreach: 2 outreach facilitators. Staffing configuration is presented for an average size office. Actual staffing will be calculated in consideration of the population base and demographics of the designated region. Appropriate increases and decreases in staff size will be made as necessary.

The NCAB also gave concept approval to the recompetition of a support program for NCI's public inquiries program. Following is the concept statement:

Technical writing and publications distribution support for the OCC Public Inquiries Program. Recompetition. Total amount \$13.7 million over five years; \$2.47 million in year one. Current contract expires Feb. 1993.

Publications ordering service: A centralized, computerized service that takes orders for NCI publications from patients, the public, and medical institutions. Operated as part of the 1-800-4-CANCER telephone service, the POS receives 180,000 calls a year on five WATS lines.

Warehouse: Storage of 35 million NCI publications and distribution of 18 million publications each year. Maintains computerized inventory of materials. Includes storage and fulfillment services for ICIC and SEER programs. Provides secure storage for NCI personnel files.

Technical writing services: Provides support services to NCI in written responses to 7,000 public inquiries, controlled correspondence, congressional correspondence, Gift Fund acknowledgments yearly. Supports Reports and Inquiries Branch in preparing patient education booklets, fact sheets, and other special writing projects. Provides quality control for editing and proofreading NCI materials produced by OCC.

NCAB Congratulates M.D. Anderson On The Center's 50th Anniversary

The National Cancer Advisory Board passed the following resolution last week on the event of the "Golden Jubilee" of the Univ. of Texas M.D. Anderson Cancer Center:

"Whereas 50 years ago cancer was a dark mystery

and the cure for cancer only a distant wish; and

"Whereas today through the brilliant basic scientists and clinical researchers we are achieving a unified genetic theory of cancer and coming ever closer to effective prevention, diagnosis, and treatment of cancer; and

"Whereas the Univ. of Texas M.D. Anderson Cancer Center has throughout half a century, exemplified the best of cancer research and cancer patient care.

"Be it therefore resolved that the National Cancer Advisory Board commends and congratulates M.D. Anderson Cancer Center as that great institution celebrates its Golden Jubilee, and expresses appreciation for its major and far reaching contributions to cancer research and cancer control."

Changes In Cancer Control Science Corrected In Cancer Letter Directory

Reorganization of NCI's Div. of Cancer Prevention & Control, Cancer Control Science Program, was inadvertently left out of The Cancer Letter's Directory of NIH-NCI Frequently Called Numbers.

The "Smoking, Tobacco & Cancer Branch" listed on page B11 of the Directory no longer exists. NCI's smoking control program is now located in the Cancer Control Science Program. Here is how the Directory should look on page B12:

Cancer Control Science Program

Associate Director Dr. Claudia Baquet, EPN Rm 243.....496-8594

NCI Smoking and Tobacco Control Program

Coordinator, Dr. Donald Shopland, EPN Rm 243.....496-8679

Prevention & Control Extramural Research Branch

To be announced, EPN Rm 330.....496-8520

Public Health Applications Research Branch

Chief, Dr. Katherine Marconi, EPN Rm 233.....496-8584

Special Populations Studies Branch

Chief, Dr. George Alexander, EPN Rm 240.....496-8589

National Outreach Initiatives Branch

Acting Chief, Dr. George Alexander, EPS Rm 500.....496-8680

Recent appointments in the Cancer Control program: Lawrence Bergner was named chief of the Public Health Agency Section in the Public Health Applications Research Branch. Marc Manley was named chief of the Applications of Prevention and Early Detection Section, Public Health Applications Research Branch.

Also in DCPC, two new branches were established in the **Early Detection & Community Oncology Program:**

Biomarkers and Prevention Research Branch

Chief, Dr. James Mulshine, Navy Bldg. 8 Rm 5101.....496-0901

Preventive Oncology Branch

To be announced, EPS Rm T41.....496-8640

Mulshine was chief of the Biotherapy Section at the NCI-Navy Medical Oncology Branch, and is still located in the Navy building, but plans to move to rental space sometime this summer.

Another correction: The phone number for the Div. of Cancer Prevention & Control's Biometry Branch is 301/496-8556, and the branch's EPN room numbers do not end in "A".

Other NCI staff news: In the Div. of Cancer Etiology, there have been two departures.

John Lechner, chief of the In Vitro Carcinogenesis Section, Laboratory of Human Carcinogenesis, has joined the Inhalation Toxicology Research Institute, Lovelace Biomedical and Environmental Research Institute Inc. in Albuquerque, NM. Curtis Harris is the acting chief.

Joseph Bolen, chief of the Biochemical Oncology Section, Laboratory of Tumor Virus Biology, has joined the Bristol-Myers Squibb Co.

That laboratory, in the Div. of Cancer Etiology, was inadvertently left out of the directory. Here is the listing:

Laboratory of Tumor Virus Biology

Chief, Dr. Peter Howley, Bldg. 41 Rm C111.....496-7608
Viral Oncology Section

Acting chief, Dr. Peter Howley, Bldg. 41 Rm C111.....496-7608
Cellular Regulation and Transformation Section

Chief, Dr. Carl Baker, Bldg. 41 Rm D511.....496-2078

Biochemical Oncology Section
Acting chief, Dr. Peter Howley, Bldg. 41 Rm C111.....496-7608

In the Div. of Extramural Activities, Elise Kriss has been appointed chief of the Administrative Management and Planning Branch; and Carolyn Strete, formerly chief of the Prevention, Epidemiology and Control Review Section, Grants Review Branch, has been appointed deputy director for extramural activities in the National Institute of Mental Health.

McDonald's Charity Commits \$5 Mil. To Support Pediatric Research

The Ronald McDonald Children's Charities, a charity arm of the McDonald's Corp., has committed \$5 million to support pediatric cancer research. The group issued the following request for applications for program project grants on neural tumors of childhood.

Interested investigators may contact Ken Barun, executive vice president and managing director, phone 708/575-7048.

Title: Ronald McDonald Children's Charities Request for Applications from program project research grants relating to neural tumors in children
Letter of Intent Receipt Date: Sept. 1

Application Receipt Date: Oct. 30

Ronald McDonald Children's Charities invites applications from interested investigators for research proposals relating to neural tumors in children. The purpose of this RFA is to promote multidisciplinary research programs focused on malignancies of the central and/or sympathetic nervous system as they relate to children. The intent is to foster interrelated research within or among institutions similar to a program project grant. Building on the leadership of the principal investigator, and on the interactions of participating investigators, individual projects focused on malignant neural tumors of children are to be integrated in a way that accelerates the acquisition of knowledge beyond that expected from the same projects conducted separately. Proposals that relate laboratory research to therapeutic studies will be reviewed favorably.

In children, cancer of the nervous system, including brain tumors and neuroblastoma, account for one third of the pediatric patients with malignant disease. Results of treatment of these patients have been less successful than the experience noted for virtually all other childhood cancers. Although innovative treatment programs have increased the response rate and survival duration of these children, relatively few children with an aggressive brain tumor or neuroblastoma have been cured.

Ronald McDonald Children's Charities (RMCC) hopes to foster collaborative interactions between laboratory scientists and clinicians to characterize more precisely the molecular and genetic features of tumors in the central and/or sympathetic nervous system which could lead to more effective treatment of these diseases. The results obtained from such studies not only will affect the outcome of children with these diseases, but basic knowledge gained may also increase the understanding of central nervous system tumors occurring in adults.

The major goal of this RFA is to support one or two program project grants containing between 3-5 highly focused studies integrated into an effective collaborative effort to achieve economy through the sharing of personnel, facilities, equipment, data, ideas, and concepts. The project need not include clinical studies, but the research should demonstrate ways in which results could lead to innovative therapies for pediatric neural tumors. Ideally, the research should be carried out within a single institution or university campus. However, under certain circumstances, a well integrated program project application that includes more than one institution would be accepted for review.

Awards will be made for three years with opportunity for renewal once for a subsequent two years. Depending on the quality of the applications two grants will be awarded for the maximum of \$450,000 each for direct costs with 10 percent additional funds for indirect costs.

Applicant organization should be located in the U.S. or Canada and should be nonprofit.

On receipt, applications will be reviewed initially by the staff of RMCC to determine that they meet the basic criterion of an integrated research effort focused on a central theme, neuro-oncology.

Then an ad hoc committee of experts will be recruited to review the applications and make recommendations to the board. No site visits will be made, but the review committee may wish to meet with the principle investigators. Members of the board of RMCC will vote on the recommendations of the review committee.

Review criteria. The facts to be considered in evaluating the scientific merit of each response to this RFA will be: 1) extent to which the proposed research addresses the goals of the RFA, 2) the scientific merit of the proposed approach, including adequacy and quality of the methodological approach, the research design and evidence of collaboration between investigators, 3) the

coordination, interrelationships and synergy among the individual research projects as related to the common theme of the program project application, 4) experience, training, time availability, clinical and research competence of the investigators involved, 5) the adequacy of available facilities, 6) provision for the adequate protection of human subjects, and the humane treatment of animals, 7) appropriateness of the budget and period of support for the scientific effort proposed.

The USPHS research grant application PHS-398 must be used in applying for grants. Submit a signed, typewritten original of the application, including the check list, and four signed exact photocopies in one package to:

Ronald McDonald Children's Charities, One McDonald Plaza, Oak Brook, IL 60521, Attention: Medical Advisory Committee. Deadline is Oct. 30.

Applicants are asked to submit by Sept. 1, a letter of intent that includes a descriptive title of the proposed research, the name and address of the principle investigator, the names of other key personnel and the participating institutions.

RFAs Available

RFA CA-91-10

Title: Cooperative network for molecular genetic and cytogenetic studies of prostate cancer

Letter of Intent Receipt Date: June 10

Application Receipt Date: Sept. 6

The Cancer Diagnosis Branch of the Div. of Cancer Biology, Diagnosis and Centers at NCI invites applications for cooperative agreements from institutions capable of and interested in participating in a cooperative network for studies of molecular genetics and cytogenetics of prostate cancer.

The goals of this RFA are: 1) to promote collaborations and interactions between basic scientists and clinicians in order to advance prostate cancer research; 2) to identify genetic alterations that may distinguish the behavior of clinically silent prostate cancer from that of clinically evident cancer; 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.

Groups participating in the network will attempt to assess biological differences in prostate cancer using molecular genetic and cytogenetic approaches with the long-term goal of developing a more informative classification system. Cooperative studies will facilitate the application of molecular techniques to prostate cancer research through the efficient use of prostate cancer and normal prostate tissue.

Awards will be made as cooperative agreements that create an assistance relationship with substantial involvement of NCI staff during the performance of the project, as outlined in the RFA. This mechanism is used when the NCI wishes to stimulate investigator interest and proposes to advise or assist in an important and opportune area of research.

Applicants will be responsible for the planning, direction, and execution of the proposed project. It is essential that there be good liaison between basic scientists and clinicians. Each group responding to this RFA must describe existing and proposed collaboration/cooperation between basic scientist(s) and clinician(s).

NCI anticipates making three to five awards for project periods of up to four years. A total of \$1 million is expected to be set aside for the initial year's funding.

While inclusion of women is not relevant to this RFA, special emphasis should be placed on the need for inclusion of minorities, particularly Blacks, who are disproportionately affected, in studies

of prostate cancer. If minorities are not included or are inadequately represented in the study populations for clinical studies, a specific justification for this exclusion or inadequate representation must be provided. Applications without such documentation will not be accepted for review.

A copy of the complete RFA describing the research goals and scope, the cooperative agreement mechanism, the review criteria, and other application requirements is available from:

Dr. Roger Aamodt, Program Director for Pathology/Cytology, Cancer Diagnosis Branch, DCBDC, NCI, Room 638, Executive Plaza South, 6120 Executive Boulevard, Rockville, MD 20892-9904, phone 301/496-7147, fax 301/496-8656.

RFA CA-91-09

Title: Cooperative network for evaluation of prognostic markers of urinary bladder cancer

Letter of Intent Receipt Date: May 31

Application Receipt Date: July 31

The Cancer Diagnosis Branch of the Div. of Cancer Biology, Diagnosis and Centers at NCI invites applications for cooperative agreements from institutions capable of and interested in participating in the "Cooperative Network for Evaluation of Prognostic Markers of Urinary Bladder Cancer."

The objective of this RFA is to invite applications for cooperative agreements to support a network of laboratories to cooperatively evaluate promising diagnostic and prognostic markers of urinary bladder cancer.

The network will perform collaborative studies requiring expertise in urology, pathology, and/or basic cancer biology to evaluate appropriate quantifiable markers of urinary bladder cancer and to define relevant clinical applications.

This network will continue and expand to collaborative studies of urinary bladder cancer markers currently supported by the "Marker Network for Bladder Cancer."

Awards will be made as cooperative agreements that create an assistance relationship with substantial NCI programmatic involvement with the recipients during the performance of the project, as outlined in this RFA.

The cooperative agreement mechanism is used when the NCI wishes to stimulate investigator interest and proposes to assist in an important and opportune area of research. Applicants will be responsible for the planning, direction, and execution of the proposed project.

NCI anticipates making four to six awards for project periods of up to four years. A total of \$950,000 is expected to be set aside for funding these activities in the initial year.

For projects involving clinical research, NIH requires applicants to give special attention to the inclusion of women and minorities in study populations.

If women or minorities are not included or are inadequately represented in the study populations for clinical studies, a specific justification for this exclusion or inadequate representation must be provided. Applications without such documentation will not be accepted for review.

A copy of the complete RFA describing the research goals and scope, the cooperative agreement mechanism, the review criteria, and other application requirements is available from:

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For fiscal and administrative matters, contact:

Robert Hawkins, Grants Management Specialist, Grants Administration Branch, NCI, EPS, Room 216, Bethesda, MD 20892, phone 301/496-7800, ext. 13.