THE CANCER LETTER

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Administration To Hold ASSIST Funding To '92 Level; ACS Says Result Is 40 Percent Cut

When NCI and HHS Secretary Louis Sullivan announced the ASSIST awards last fall (**The Cancer Letter**, Oct. 11), they pledged the federal government's all out support for the massive, $135 million, seven year program to cut in half the number of American adults who smoke by the year 2000. Contracts were awarded to 17 state health departments, and the American Cancer Society agreed to add the support of thousands of volunteers and cash totaling another $25 to 30 million.

However, the President's budget request for the 1993 fiscal year that starts Oct. 1 slashed $15 million from NCI's Div. of Cancer Prevention &

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In Brief

Healy To Use 1 Percent Transfer Authority For TB Research; Zoon Heads FDA's CBER

NIH DIRECTOR Bernadine Healy has announced that she plans to use her authority to tap up to 1 percent of any of the Institutes' budgets in fiscal 1992. She told the House Labor-HHS-Education Appropriations Subcommittee last week that she will use her discretionary funds and 1 percent "reallocation authority" to support another group of James Shannon Awards and to respond to "the current epidemic of drug-resistant tuberculosis." Healy already has taken $15 million of NCI's FY92 budget and asked NCI to hold back another $16 million, to fund cancer research sponsored by other Institutes. Those funds came from the $160 million that was added in Sen. Ernest Hollings' amendment to the appropriations bill. In order to get support for the amendment, Hollings agreed to allow Healy to give some of the extra money to other Institutes. Commented **Alan Rabson**, director of NCI's Div. of Cancer Biology, Diagnosis & Centers, "There's an axiom in Washington: If you have an authority, use it or lose it." . . . **KATHRYN ZOON** was named director of FDA's Center for Biologics Evaluation and Research. Zoon has been director of CBER's cytokine biology division since 1988. The center is responsible for ensuring the safety and effectiveness of biological products, and coordinates FDA's efforts against AIDS. **Gerald Quinnan**, who had been acting center director since 1989, will resume the position of deputy director. . . . **PAUL CALABRESI**, chairman of the Dept. of Medicine at Brown Univ. School of Medicine and chairman of the National Cancer Advisory Board, received the Oscar Hunter Memorial Award in Therapeutics from the American Society for Clinical Pharmacology & Therapeutics at the group's annual meeting this week.

ACS Says ASSIST May Be Cut 40 Percent; Backs Bypass Budget

(Continued from page 1)

Control, which funds ASSIST. Although Congress may well restore some or all of that amount, NCI is making plans based on the assumption that the reduction will stand. ASSIST has been tentatively targeted to bear the brunt of the cut.

DCPC Director Peter Greenwald has informed ACS executives that the ASSIST budget for FY 1993 will be held to the same level it is getting this year; ACS says that will amount to a reduction of about 40 percent. ACS staff and board members, attending the meeting of the board last week in Atlanta, expressed dismay and some outrage over what they felt was NCI reneging on its commitment.

"NCI has made the commitment and should abide by it," one senior ACS staff member said. He noted that overall, NCI's total amount in the President's budget was virtually the same as for the current, FY 1992 year. "There is no logical reason why the cancer control budget should be cut that much. Any cuts that have to be made to take care of unavoidable increases such as pay raises should be spread around all the divisions."

Cancer control money is a line item in the budget, however, and NCI may have little or no choice in the matter. The amount designated by the Office of Management & Budget for cancer control is the maximum NCI can spend in that area, unless, of course, Congress adds to it.

ACS, other cancer program advocates, and--off the record--NCI executives hope fervently that Congress does come up with enough additional money to fully fund ASSIST, and a whole lot more.

It was the view of some who discussed the ASSIST cut with **The Cancer Letter** that NCI was attempting to involve ACS in the "Washington Monument ploy." That is a game supposedly played by the Dept. of Interior when faced with budget cuts. "Okay, we can live with the reduction, but we'll have to close the Washington Monument," they say, knowing full well that Congress would never permit such a politically unpopular action and would come up with the money.

In this case, NCI could have targeted programs with more powerful political ramifications, such as the tamoxifen breast cancer prevention trial, the prostate cancer trial, or NCI's share of the Women's Health Trial. All are supported by the cancer control budget in DCPC. "I don't think Sam or Peter want to tangle with the women's health advocates or the members of Congress who are worried about prostate cancer," an ACS board member said. "They're hoping that we'll go to Congress and try to get the ASSIST money put back into the budget."

That would be contrary to ACS policy. While the Society strongly supports NCI's bypass budget ($2.7 bill, $700 million more than in the President's budget), it will not lobby for individual projects or programs, especially one such as ASSIST in which ACS is a participant.

The number of adult Americans who smoke has been declining about one percent a year and now stands at about 28 percent. The goal of ASSIST (American Stop Smoking Intervention Study) is to speed that rate up so that the total is under 15 percent by the year 2000. The ASSIST contractors will implement many of the 60 or more cessation and smoking prevention intervention methods developed and tried in DCPC supported trials during the 1980s.

Neither Broder nor Greenwald were available for comment by **The Cancer Letter's** deadline this week. DCPC Deputy Director Edward Sondik said that holding ASSIST to the same amount in this year's budget should not be considered a "cut" in the program but agreed that it would amount to a substantial reduction from that previously planned for FY 1993.

ACS Board Supports Bypass Budget

The ACS board formally asked Congress for the bypass budget figure:

"In consideration of the National Cancer Institute's contribution to the advances in cancer research, prevention, and treatment, and in recognition of the continued high funding levels necessary to carry out its work as the largest federally funded cancer program, the American Cancer Society adopts the following resolution as its 'Citizen's Budget' request

THE CANCER LETTER

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for fiscal year 1993 funding for the National Cancer Institute.

"Resolved: The American Cancer Society agrees in general with the National Cancer Institute's 1993 bypass budget submitted to President Bush. The Society recommends that the U.S. Congress appropriate, and the President approve, funding for the National Cancer Institute of at least $2.775 billion, for the fiscal year 1993. This figure represents that portion of our national resources that the American Cancer Society believes should be committed by the federal government to the National Cancer Institute's role in the battle against cancer."

In the discussion on the resolution during the meeting of the board's Public Issues Committee, ACS President Walter Lawrence pointed out that "every other group that lobbies Congress for NCI funding has a vested interest. ACS does not. The bypass budget is a needs budget, the amount needed to take advantage of all the research opportunities and leads. It is the optimal amount that can be spent, and it is realistic."

Committee member Eldon Ulmer offered the only negative comment. He argued that ACS should be concerned about the federal deficit and that it should "take a realistic view."

John Seffrin, immediate past chairman of the board, responded that "we can't resolve the federal deficit with the cancer budget. Last year, NCI could fund only 12 percent of approved new grants. Cancer costs Americans $70 billion a year. We feel that NCI has carefully thought through the bypass budget, and the amount asked can be spent responsibly."

Former board Chairman Kathleen Horsch said, "We're not talking about increasing the federal budget but only a reallocation of priorities."

FY93 Budget For Construction, Prevention & Control Criticized

Members of the House Labor-HHS-Education Appropriations Subcommittee expressed some displeasure with the President's fiscal 1993 budget request for NCI in the two areas that will suffer cuts: extramural construction and cancer prevention and control.

NCI Director Samuel Broder had to defend the President's budget at the House appropriations hearing last week, but he made it clear that in his professional opinion, more money is needed, especially in those two areas.

The President requested $2.01 billion for NCI in FY93, a 3 percent increase, or $59 million, over the Institute's FY92 operating level of $1.951 billion. The request represents only a 1.5 percent increase over the amount Congress appropriated for NCI this year, $1.989 billion.

NCI's professional needs budget (the bypass budget) requested $2.7 million for FY93.

Spending for prevention and control--a separate line item--increased by almost $21 million in FY92, but the Administration proposes cutting prevention funds by $15 million in FY93.

There are no funds for construction in the Administration's request, down from $12 million this year.

"I'm uncomfortable with the drop in the prevention and control line and construction," Broder said when Subcommittee Chairman William Natcher (D-KY) asked for his opinion.

"I think you are right," Natcher said. "Will this result in cutbacks in ongoing programs?"

"It is highly probable that ongoing programs will be cut back or eliminated," Broder said. (See related story, page 1.)

NCI's FY93 bypass budget requested $204.6 million for prevention and control, while the President's budget seeks a total of $91 million.

The bypass budget also calls for $86 million to support peer-reviewed extramural construction as well as make repairs and improvements to the Frederick Cancer Research & Development Center.

Rep. Carl Pursell (R-MI), the ranking Republican on the subcommittee, questioned Broder about the construction funds cut, especially in regard to cancer centers. "If we don't fund [extramural] construction, who picks up the cost?" he asked.

"In some cases, no one," Broder said. "This is a big problem." Broder called improvements in academic infrastructure a larger issue that involves the controversy over indirect costs. "Our construction line can only handle a small amount" of the problem, he said.

Breast Cancer Groups Seek $400 Million

Natcher began the hearing asking for changes in cancer mortality and survival rates since 1971. "We don't expect any outstanding results in just a few years, but we do expect you to be judged on changes in mortality rates," he said.

Broder discussed the improved mortality rates for persons under age 65 for many common cancers, including ovarian, stomach, uterus, Hodgkin's and testicular cancer, and the "areas where we are losing ground" in those over age 65, such as lung cancer among women.

He listed some current five year survival rates: lung cancer, 13%; breast, 80%; colorectal, 58%; pancreas,

2.8%; leukemia (all ages) 38%; Hodgkins, 80%, and prostate, 78%.

Each year, 7.6 million person-years of life are lost due to cancer, Broder said. This is based on the average years of life lost per person of 15 years. Lung cancer alone results in 2 million person-years of life lost.

The appropriations committee is "under pressure to add money to certain cancers," especially for breast cancer, Natcher said. Breast cancer patient advocacy groups have lobbied for $400 million for research in FY93, he said.

Broder noted that NCI's FY93 bypass budget requested $200 million for breast cancer research. "I would hope that budget decisions would be driven by the science and clinical opportunities," he said.

The President's budget allocates $137 million for breast cancer research in FY93; NCI will spend about $133 million on the disease this year, and spent almost $93 million in FY91.

Under the President's request, NCI would spend $20 million on ovarian cancer, roughly the same amount as this year. Broder noted that ovarian cancer funding has increased by 158 percent since he was named director. The money will be spent on research on early diagnosis, genetic research, and clinical research.

He also discussed NCI's "crash program" to develop taxol for ovarian and breast cancer. He said the Institute will soon sign a Collaborative Research and Development Agreement with the French firm Rhone-Poulenc for development of taxotere. Bristol-Myers Squibb Co. expects to submit a new drug application to FDA for taxol approval this June, Broder said.

NCI will spend $28.5 million under the President's budget for prostate cancer, compared to $27.6 million this year and $13.8 million in FY91.

Natcher also asked Broder how he has changed the cancer program since he assumed the directorship in 1989.

"We have all raised our level of consciousness in the areas where we have not made progress," Broder said. Since 1989, the Institute has embarked on gene therapy, chemoprevention trials for breast and prostate cancer, and will award the new SPORE grants later this year, he said.

Pursell asked about NCI's community outreach programs. Broder discussed the outreach requirement for comprehensive cancer centers, and the Community Clinical Oncology Program, which involves smaller hospitals in clinical trials. Also, NCI will award 12 grants to institutions to help them plan how to become full-fledged cancer centers.

In addition, NCI has two programs to involve minority leaders in cancer control, the Black and Hispanic Leadership Initiatives on Cancer. This year, NCI plans to begin a similar program for Appalachia.

Pursell asked for an example of "a center with good outreach." Broder said the Medical College of Virginia is a small cancer center, but has "made it its goal to reach the population that is reading-impaired." The innovative program sends cancer center staff and volunteers around the state to discuss prevention, diagnosis and treatment.

Natcher, Hoyer Didn't Support 'Forward Funding'

Rep. Steny Hoyer (D-MD) noted that he was "not a supporter of the forward funding effort"--the successful attempt led by Sen. Ernest Hollings last year to provide NCI with a $160 million increase, most of which will not be available to the Institute until Sept. 30 (thus the terms "forward funding" or "delayed availability"). Natcher, too, did not support the amendment, Hoyer said. "I supported our chairman, but he lost."

In the past few years, the House committee has usually added to the President's budget request for NCI, but not as much as the Senate Appropriations Committee. The final appropriations usually is a compromise between the two figures.

Natcher asked Broder how he plans to spend the new money allocated for FY92. Broder said the Institute "attempted to integrate scientific opportunities and areas of Congressional concern," and will fund more gene therapy trials, chemoprevention studies, the Specialized Programs of Research Excellence for breast, prostate, and lung cancer, and other "high-priority" research such as taxol development.

"To what extent does the FY93 bypass budget influence your decisions?" Natcher asked.

"The bypass budget is the starting point for discussions," Broder said, but emerging scientific opportunities and "earnest expressions of Congressional concern" also are taken into account.

Natcher said that despite the FY92 increases, individual research project grants (R01s) "are still being cut 13 percent" through "downward negotiations," the term NIH used to use for across the board cuts in recommended grant budgets.

"We don't do downward negotiations anymore," Broder said. "We do careful grant by grant scientific review."

He noted that the grant success rate for FY92 is projected to be about 34 percent, but NCI would not be able to fund the targeted number of grants as set by Congress "without careful, appropriate review of each grant."

For FY93, the President's budget would result in a success rate of slightly under 30 percent. (For an overview of the scientific opportunities that would be missed under the President's budget, see story on NCI's bypass budget in the Feb. 21 issue of **The Cancer Letter.** Also, a full report on the President's budget appears in the Feb. 7 issue.)

Pursell asked whether, "over the next 10 years, is there any way we can jump-start the total NIH funds?" He asked Broder for his "real world" view of the budget.

"Having lived inside the Beltway for 20 years, I'm not sure what I know about the real world," Broder said. NIH spends about $7 billion a year on health, 10 percent of which goes to NCI, he said. "NCI's budget should have some proportionality to the incidence of the disease. I've said before that I'd like to announce at a hearing like this one that we have found a cure and not to appropriate more money to us. We need a good, vigorous research agenda and a way of translating that research agenda to the public."

"Are we dedicating too much to AIDS generally?" Hoyer asked. "We are hearing discussion in the committee that we should increase [AIDS spending] less and devote more to other diseases."

NIH Director Bernadine Healy said the AIDS budget for FY93 would increase at the same rate as the NIH budget, about 4.8 percent. "I would turn the question around to ask, are we overinvesting from a research perspective," Healy said. "The answer is no. There are opportunities for important research" in AIDS, cancer and heart disease.

Cancer Letter Founder Jerry Boyd Receives ACCC Achievement Award

The Cancer Letter's founder and Contributing Editor Jerry Boyd received the annual Award for Outstanding Achievement of the Assn. of Community Cancer Centers at the organization's meeting last week in Washington.

ACCC honored Boyd for his "long-standing dedication to improving cancer care communications" through his founding of the independent newsletter in 1973.

ACCC President Lloyd Everson called **The Cancer Letter** "the glue that helps keep all of us together" by informing cancer centers, community hospitals, academic researchers, government officials, and cancer program advocates of one another's activities. The newsletter has covered ACCC since its inception in 1974.

Boyd said ACCC asked him to discuss new developments in cancer research and treatment in his acceptance speech. "What do I know about cancer research? Only what I hear from people in the business," he said. "Fortunately, over the years, I have been privileged to hear many of the best."

Boyd summarized what four prominent scientists think will happen in the next five to 10 years:

Bernard Weinstein, director of the Columbia Univ. Comprehensive Cancer Center, and immediate past president of the American Assn. for Cancer Research. "Dr. Weinstein is a basic scientist whose interest has been primarily in carcinogenesis and prevention, but one who feels strongly that prevention and treatment go hand in hand. Particularly in the overlapping areas of prevention and early detection," Boyd said.

"We are moving the clock backward, he told me, in identifying cancers at earlier stages. In a sense, prevention and therapy are coming together, permitting intervention at earlier stages, or preventing development to the malignant stage. In basic research, we have identified a whole new repertoire of genes that control cell cycle. Already there is evidence that this can be manipulated.

"Molecular biology is helping us understand the causes of specific forms of cancer, Dr. Weinstein said. This area has become known as molecular epidemiology, utilizing specific biomarkers in combination with epidemiological studies. A variety of highly sensitive and specific markers are now available to identify specific factors related to genetic and acquired host susceptibility, metabolism, and tissue levels of carcinogenesis.

"We should never allow cancer to get to advanced stages, Dr. Weinstein said. The tools being developed now will in the next few years lead to more effective screening of high risk persons, better determination of who is at high risk, and detection at the stages where chemotherapy, radiation therapy, and surgery can produce cures. These markers and tools also will be useful in determining which patients have been cured by primary therapy and who do not need adjuvant treatment.

James Cox, physician in chief at M.D. Anderson Cancer Center and chairman of the Radiation Therapy Oncology Group. "Jim believes that most of the important improvements in radiotherapy on the horizon will come from more effective administration of radiation, through fractionation and scheduling," Boyd said. "The addition of chemotherapy to radiotherapy is one piece of the puzzle, he told me. Dose and schedule manipulation will lead to major changes in clinical practice.

"Jim said, 'I don't personally see a lot of benefit

coming from protons and heavy particle radiation therapy. I think that sophisticated dose distribution, with conventional x-rays, can provide results equal to that of protons and heavy ions.'

"Neutron therapy has proven advantageous in only one malignancy--advanced, unresectable salivary gland cancer, Jim said. Intraoperative radiotherapy has some prospects for certain diseases, but it's hard to randomize patients, even with RTOG, and improved results will be difficult to prove.

"While radiosensitizers may become very useful, radioprotectors probably will not be of much value, except possibly in preventing some modest morbidity.

"Current work in laboratories could have profound effect on radiation oncology, Jim said. This includes looking for genetic mechanisms that control repair of radiation damage. There are one or two new drugs with interesting possibilities as radiosensitizers. There is a lot of work in lab assays in predicting what tumors will respond to standard radiotherapy, and what will do well with fractionation.

Steven Rosenberg, chief of the NCI Surgical Branch, best known for development of techniques to increase the immune system's ability to fight cancer, with interleukin-2 and LAK cells, and the first to treat cancer with gene therapy. "Steve gave me a brief update on his gene trials," Boyd said. "The first gene trial, involving introduction of foreign genes into tumor infiltrating lymphocytes, has been accomplished, with six patients. Three more patients have undergone treatment with gene modified tumor cells. Ten patients have received marker genes.

"Future trials, Steve said, will involve the isolation of genes that code for tumor antigens, which may permit development of methods for immunization against recurrence, and possibly also for prevention of cancer. Those are tantalizing prospects, aren't they? Could put most of you out of business," Boyd said.

Rosenberg will be giving a plenary lecture at the AACR meeting in San Diego in May.

Vincent DeVita, former NCI director, more recently physician in chief at Memorial Hospital and now professor of oncology at Cornell, gave Boyd a summary of "what to expect up to the year 2000:

"The revolution in molecular biology is hitting the clinic full blast, overcoming many limitations in cancer treatment. One of them is in dealing with residual disease. Tests now available, such as those using polymerase chain reaction, can help determine which patients will recur. In measuring residual disease, following surgery, for example in breast cancer, you remove the lump and nodes. Are they free of disease? Has metastasis occurred? Or is it something in between? We can now take the tumor cell, and measure genes. That is well within our grasp. It will change the whole scope of cancer treatment.

"There are means being developed to overcome multiple drug resistance. This is enormously important. In the next 10 years, we will see much more effective use of existing drugs because of our ability to 'manage the pump,' as Vince put it, the pump being the tumor cell mechanism which expels the drug before it can do its job.

"Vince had a word for radiotherapists. He pointed out that, historically, they treat patients on five of seven days. No logic to that, except that it fits neatly into a Monday-Friday schedule. 'Unfortunately, tumors work on weekends,' he said. Medical oncologists do the same, treating on days 1 and 8, he was careful to add. We need the ability to measure residual cells, to determine when to start treatment, finding out how many tumor cells are alive. That can be measured by MR spectroscopy, a big step in that direction. PET scanning can measure functions. All this can be of help in determining radiotherapy fractions at various intervals, as well as drug dose and scheduling."

Bypass Budget Could Be Strengthened

"To me, all these developments are tremendously exciting," Boyd continued. "When I got into this field 20 years ago, I expected to see progress, probably faster than has in fact happened. Although I think that increasing survival from less than 40 percent to more than 50 percent is mind boggling, when you consider the numbers of lives that represents. Maybe as many as 150,000 more Americans each year survive cancer than would be the case without that improvement. A half million a year survive the disease.

"How many more of us will beat cancer by never getting it, because we don't smoke, or have changed our diet, is difficult to determine. But those numbers will grow as the impact of the antismoking and other lifestyle change efforts waged by NCI, ACS, and others, continues to spread.

"But there are still, now, a half million Americans who die of cancer each year. That's a terrible toll. The exciting prospects described by these four eminent scientists and clinical investigators provide terrific opportunities for reducing that toll. Those opportunities are being limited, however, by the failure of Congress and the White House to adequately support the cancer program.

"An article in the Dec. 18 issue of the 'Journal of the National Cancer Institute' quoted an unnamed staff member of the House Appropriations Committee," Boyd said. "This person said that

Congress does not pay any attention to NCI's bypass budget in determining how much money NCI receives each year. Neither do they pay any attention to 'emotional appeals' from cancer advocacy groups, he said.

"Now isn't that just dandy. If you were to believe that committee staff member, Congress ignores completely the mechanism it established itself, in the National Cancer Act of 1971. That act created the bypass budget, as a tool for NCI to publicly state the amount of money it needs to optimally fund the National Cancer Program. The bypass budget goes directly to the President, without change by the brass at NIH or the department. It is more than a collection of figures. It is a carefully prepared document, spelling out how the money will be spent, describing the programs and projects that will be funded. It tells us how much money would be needed to fund the research programs, including clinical trials, that are feasible, practical, and can be undertaken, programs and projects to move the Cancer Program along at the fastest possible rate. And here we have a staff member who says that Congress pays no attention to its own creation, one that charts precisely as possible how the problem of cancer can be overcome, and how much money is needed to do that.

"That same staff member is quoted further along in the 'JNCI' article as saying that there is 'impatience and frustration with the rate of progress' in the cancer program. Furthermore, Congress expects, he said, that the program should produce, 'in a 25-30 year time frame, from when the Act was passed, some fundamental leaps forward in terms of prevention, treatment, or cure.'

"If this is how most members of Congress view the bypass budget and the National Cancer Program, then we've got a massive education job on our hands," Boyd said. "We must convince them of the validity of the bypass budget, that progress can be speeded up drastically if those needs are met. We also need to point out that there have been fundamental leaps forward, in all three of those areas. Actually, the NCI directors, other staff members, and cancer program advocates have done that repeatedly at budget hearings before the House and Senate appropriations committees. But perhaps they were ignored because they were viewed as 'emotional appeals.'

"Those comments, by a member of the House Appropriations Committee staff, more than likely represent his own views and not those of members of Congress," Boyd said. "Unfortunately, he does have a lot to say about the outcome of the appropriations process. It will take a lot of discussion, a lot of persuasion, a lot of work with the members of that committee and especially its chairman, William Natcher of Kentucky, to overcome the negative attitude of that key staff member.

"I think that the bypass budget process could be strengthened, perhaps making that mechanism more acceptable to the White House and more believable in Congress, by bringing in more outside help in developing it," Boyd said. "Harold Moses, the current AACR president, has called for greater involvement of the extramural community when the bypass budget is being written. Dr. Moses asked NCI to permit AACR, at least, to have a role in determining funding allocations. Presumably, ACCC, ASCO, ONS, ASTRO and others would also be invited to participate.

"The point I want to make here is that for 20 years NCI has been telling Congress, the cancer research community, and the country, exactly what it can optimally spend," Boyd said. "No one has ever, to my knowledge, disputed those figures or the justifications for them. The figure is on the table now, for the fiscal year that starts next Oct. 1. That figure is $700 million more than the White House has asked.

"I think we should say, over and over, to anyone who will listen: If you want the fastest progress possible, toward saving as many of those 500,000 lives a year as possible, then give us this much, the full $2.7 billion in the FY 93 bypass budget. We have spent well the money you have given us in the past, as proven by the half million Americans who beat cancer each year, and by the astounding progress in human biology and genetics which resulted from the cancer program in the last 20 years. You never gave us all that we could have used, and we'll never know how much that has cost, in lives that could have been saved but were not.

"Let's put ourselves in the position in which we can say, when we observe the 30th anniversary of the National Cancer Act, in 2001, we gave it absolutely our best shot, with ever dollar that could be wisely spent. I'm confident that, if we can do that, we will see the kind of progress and improvement that will make major inroads on the toll of cancer."

Boyd noted that the current editor of **The Cancer Letter** is his daughter, Kirsten Boyd Goldberg, who joined the family business in 1989. Her daughter, Katherine, 22 months old, has already been subjected to speculation among her grandparents as to what career she might choose.

"One thing I know she won't be, and that is the third generation editor of **The Cancer Letter**," Boyd maintained. "For the simple reason that there will be no **Cancer Letter**. It will go out of business when the

cancer program is dismantled because it has achieved its goals, and biomedical research can focus on other problems. If we all do our jobs--you, the four people I quoted today, all their colleagues, and Congress--then cancer will be something that Katie, your grandchildren, and their generation, will not have to worry about."

ACS Announces Fellowships, Career Development Awards For 1993

The American Cancer Society announces the availability of the following awards for 1993: the Clinical Oncology Fellowship (COF), the Clinical Oncology Career Development Award (CDA), and the Cancer Control Career Development Award for Primary Care Physicians (CCCDA).

The COF is a one-year institutional award intended to support a multidisciplinary training experience for physicians and dentists preparing for a leadership career in academic oncology. The fellowship is expected to provide unique training in addition to that which is normally provided in postgraduate training programs designed to fulfill requirements of specialty boards. The COF stipend is $10,000 per year.

The CDA is a three-year award given to promising junior faculty who will pursue academic careers in clinical oncology. A successful application must describe in detail a supervised program that will develop the candidate's clinical expertise and his/her capacity to perform independent clinical/laboratory research. The annual stipend for the CDA is $25,000 for the first year, and $30,000 and $35,000 for the second and third years, respectively.

To encourage and support activities in cancer control, the Society offers a limited number of CCCDA's to physicians specializing in primary care. It is anticipated that physicians trained under these two year grants will improve cancer control through involvement in primary care practice, education, and research activities related to cancer control. These awards are intended to develop academic leaders in primary care specialties emphasizing cancer control.

Candidates for these awards must be citizens or permanent residents of the U.S. The application deadlines are: July 1 for the Clinical Oncology Fellowship; Aug. 1 for the Clinical Oncology Career Development Award; and Aug. 15 for the Cancer Control Career Development Award.

For additional information contact Virginia Krawiec, Dept. of Detection and Treatment, American Cancer Society, 1599 Clifton Rd. NE, Atlanta, GA 30329-4251, phone 404/329-5734.

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-37813-19
Title: Analysis of chemicals and pharmaceutical formulations
Deadline: Approximately May 7

The Pharmaceutical Resources Branch in NCI's Div. of Cancer Treatment, is seeking a contractor to supply analytical services for the analysis of bulk pharmaceutical substances and formulated drug products. Reports of these analyses will be used as a basis for assessing the suitability of these materials for use for screening, pharmacological studies, toxicological studies, formulation studies, or for clinical trials. Data provided in these analytical reports will be supplied to the Food & Drug Administration as part of the Investigational New Drug filings for new anti-AIDS agents. The contractor selected should be experienced in the analytical assessment of bulk pharmaceutical substances and clinical drug products and will be expected to have operational equipment and capabilities. The contractor's principal investigator should be trained in chemistry (analytical, pharmaceutical, organic, etc.), preferably at the Ph.D. level and should be thoroughly familiar with the analysis of bulk pharmaceutical substances and clinical dosage forms. The contract period is for three years beginning about March 1993. Incumbent contractor is Midwest Research Institute.
Contract specialist: Zetherine Gore
RCB Executive Plaza South Rm 603
301/496-8620

RFP NCI-CB-21001-32
Title: Master agreement for tumor tissue resources for evaluation of promising diagnostic and prognostic approaches
Deadline: Approximately May 4

NCI is seeking experienced organizations which are able to access and provide needed large numbers of paraffin embedded tumor tissues (or where available, frozen tumor specimens) with associated patient followup data to be used for the validation of promising new diagnostic and prognostic assays. The tumor tissue required and the assays to be performed will be defined by master agreement orders issued during the period of performance. The MAOs will be awarded based upon competition between members of the master agreement pool.

MA holders selected for award shall provide a minimum number of paraffin blocks (and/or frozen tissue, where available) of breast, colorectal and/or bladder tumor tissue of specific tumor stages with a minimum number of years of clinical followup. MA holders shall perform evaluations of promising new diagnostic and prognostic techniques as defined by individual MAOs. Offerors may qualify to perform one, all, or any combination of the following methodologies: flow cytometry studies of cell proliferation, molecular biology studies, and/or immunohistochemical assays. Multiple MAOs may be issued.
Contract specialist: Richard Hartmann
RCB Executive Plaza South Rm 620
301/496-8611