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## Unorthodox Panel Considers NIH Mandated Role In Study Of Unconventional Medical Practices

A panel that gathered last week to chart NIH research into unconventional medical practices included adherents of "immuno-augmentative therapy," Ayurvedic medicine, the Gerson method, acupuncture, naturopathic medicine and homeopathy.

Represented alongside them was an ethnopharmacologist, a psychosocial oncologist and traditional MDs, including some who work in nonpharmacologic and nonsurgical interventions, homeopathy and Oriental medicine. The 16-member ad hoc committee was gathered because Congress mandated NIH to get involved in nontraditional

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*In Brief*

## GM Prizes: Einhorn, McMahon, Nusslein-Volhard; James, Poznanski Lead Roentgen Ray Society

**GENERAL MOTORS** Cancer Research Foundation announced the winners of its annual $130,000 prizes. **Lawrence Einhorn,** Indiana Univ. Medical Center, was awarded the Charles Kettering Prize for contributions to cancer treatment; **Brian McMahon,** Harvard School of Public Health, won the Charles Mott Prize for contributions to understanding of cancer prevention; and **Christine Nusslein-Volhard,** Max Planck Institute, received the Alfred Sloan Prize for basic science contributions to cancer research. . . . **EVERETT JAMES,** Vanderbilt Univ., became president of the American Roentgen Ray Society at its annual meeting recently in Orlando. **Andrew Poznanski,** Northwestern Univ., was elected president-elect. **George Leopold,** Univ. of California (San Diego) is first vice president and **Ralph Alfidi,** Case Western Reserve Univ. is second vice president. . . . **MARGUERITE DONOGHUE** was appointed to the newly created position of deputy executive director of the National Coalition for Cancer Research. Donoghue has served for the past four years as staff manager for the coalition. She will continue to work with the coalition's Executive Director **Terry Lierman** to direct the group's operations. . . . **KENNETH CULVER** of NCI and **Edward Oldfied** of the National Institute of Neurological Disorders & Stroke inserted a herpes-virus gene into brain tumors in animals and destroyed the tumors with ganciclovir. Their study was published recently in "Science." The investigators are waiting for final approval to conduct studies in humans. . . . **CIGARETTE SALES** appear to be recovering from years of sharp drops for R.J. Reynolds Tobacco Co., according to the May 14 "Wall Street Journal." Sales of three key brands--Winston, Salem and Camel--have stabilized this year, with the biggest improvement in Camel.

## NIH Forms Panel To Chart Research On Unconventional Medical Practices

(Continued from page 1)

practices and gave the institutes $2 million to do the job. The committee heard two days of testimony.

Fittingly for a forum representing such an astoundingly broad range of interests, recriminations began almost immediately.

"NIH does not have the support for the Office on Unconventional Medical Practices that I think it deserves," said panel member Berkley Bedell, an Iowa Democrat who left the House of Representatives in 1987 and sought unconventional treatment for prostate cancer.

According to Congressional sources, Bedell played a key role in convincing Sen. Tom Harkin (D-IO) to amend the Senate version of the appropriations bill to include the mandate for NIH to consider unconventional remedies.

After being appointed to the NIH ad hoc committee, Bedell contacted a number of unconventional practitioners, inviting them to testify. Bedell said that a number of these practitioners declined the invitation, citing fear that an appearance would lead to "persecution by the Food & Drug Administration."

"I think it's a shame," said Bedell, who was treated in Canada by Gaston Naessens, who introduces large amounts of nitrogen into the lymphatic system.

"There are people out there who are afraid of ending up on the wrong side of the weapon," agreed Gar Hildenbrand, another panel member who is the executive director of the Gerson Institute, which operates from Bonita, CA, and Tijuana, Mexico.

"We have convened this ad hoc advisory panel of distinguished members to begin the process and provide a thorough and thoughtful consideration of all the issues surrounding unconventional medical practices," Jay Moskowitz, NIH associate director for science policy and legislation, said to the committee.

The committee's purpose will be to "set an agenda and begin a strategic planning process that will guide the evaluation of unconventional medical practices," Moskowitz said.

Subjects covered by the panelists in their introductions ranged from pharmacological properties of vanishing plant species and the dearth of academics qualified, interested and financed to study them to "alternative causality of AIDS" and therapeutic qualities of garlic and vitamin C.

There was also a Native American who called on physicians to use a more vivid allegorical representation of cancer. "Why can't those guys out there color it red, put some eyes and ears on it and a nose and stuff, and let the mind go after it," said Anthony Ortega, a consultant to the Indian Health Service. "People don't use the mind anymore."

### "Losing War on Cancer"

"We are losing the war on cancer and AIDS!" shouted committee member Frank Wiewel, executive director of People Against Cancer, an Otho, IA, group. Wiewel is the former head of the IAT Patients Assn., a group supporting Lawrence Burton, the operator of a clinic in the Bahamas.

"A cancer patient's chance of survival today is no better that 40 years ago," Wiewel said. Meanwhile, "alternative" practitioners are saving thousands of lives, he said. "We would like to establish an independent permanent office of alternative medicine," he said, taking exception to the word "unconventional" in the name of the existing NIH office. As other panelists, Wiewel said the word had negative connotations.

"The time has come to dismantle the repressive systems of the past and begin to build reform!" Wiewel concluded, drawing applause from a group of sympathetic spectators and panel members.

Panel member Karen Olness, professor of pediatrics at Rainbow Babies and Children's Hospital, said the dividing line between quackery and therapy does not coincide with the line between the establishment and unconventional medicine. Quacks can be found on both sides of the line, she said. Olness uses nonpharmacologic interventions.

Another panel member, Deepak Chopra, called on the NIH to conduct studies and set up fellowships in Ayurvedic medicine, which represents the human body as an interaction of fields of energy and defines health as a "state of non-change in the field of change."

Chopra, whose title among followers of Maharishi Ayur-Veda is "Lord of Immortality of Heaven on

**THE CANCER LETTER**

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Earth," also called for third-party reimbursement of Ayurvedic medicine and its "general acceptance by the medical profession, so they would not think of it as an import from a foreign culture or cultish." Chopra was a subject of an article in the "Journal of the American Medical Assn." (Oct. 2, 1991).

Committee members were brought in as "professional services contractors" and were paid the standard per diem of $150. In that capacity they did not have to file conflict of interest statements or promise to refrain from using their advisory status in advertising of their products and services, said Stephen Groft, assistant to Moskowitz.

Groft said the panel members were chosen by a committee of NIH employees, declining to name members of that group. About 50 potential members were considered, Groft said.

"We have to go through what was presented at the meeting and lay out the plan of what our next step is," Groft said to **The Cancer Letter.** At the next meeting, tentatively scheduled for September, the ad hoc committee will focus on the problems of deriving methodology for screening unconventional practices.

"There is a need for good science," Groft said. "If we are to fund anything, it would have to be good scientific research."

"I fully expect that good methodologies could be developed to test the more promising alternative healing methods," said committee member Barrie Cassileth, adjunct professor of medicine at the Univ. of North Carolina and Duke Univ.

Cassileth, a widely published scholar of unconventional medicine, suggested that unconventional therapists include the names of reviewers they would consider qualified to review their grant applications. Several of those candidates would then be chosen for the peer review panel.

"The fact that the committee can exist is surprising and very impressive," Cassileth said. "The work of this committee is consistent with the mood of the country, with the great disaffection that people feel for medical institutions and for the health care system. It is also consistent with the pervasive desire to move into new and more promising arenas.

"Regardless of the politics and rationale behind the development of this committee, I applaud the fact that the committee exists and I assume it will do its best job," she said.

Panel member Michael Balick, an ethnobotanist with the New York Botanical Gardens said he was impressed by the range of views represented. "As a person who studies traditional medicine, I know that there is more than one way to address a particular health problem," he said. "We need to look at problems in interdisciplinary perspective, to look at what is worthwhile for inclusion into the mainstream."

**Sounded Out, But Not Picked**

Several of the physicians and scientists who frequently challenge unconventional medicine were invited to submit their curricum vitae, but not picked for the panel.

William Jarvis, Saul Green, William Renner, Victor Herbert and Stephen Barrett told **The Cancer Letter** that they had been sounded out, but not selected. None of the five had been informed by the NIH that they were not on the panel, they said.

"I assumed I was on the panel," said Victor Herbert, oncology professor at Mt. Sinai and Bronx VA medical centers. By the time Herbert read in "USA Today" that the meeting was to take place, the deadline for registering to testify had long passed.

"They didn't even inform me when the open meeting would take place," Herbert said. The meeting was announced in the "Federal Register."

"I am not disappointed that I was not there this time, but I would be extremely disappointed if after years of accumulation of expertise on the subject I am not an advisor to it," Herbert said.

"My biggest concern is the politicization of scientific issues," Jarvis said. "Politicians don't like anyone screaming in their faces, and they will give in on important principles to keep people from screaming in their faces."

Barrett said some panel members could end up using their NIH advisory status in their future promotions. "I am concerned that the promoters of unproven methods appointed to the panel will trumpet their appointment to the world as evidence that whatever it is they promote is valid," he said.

"I am also concerned about what the panel's role would be in shaping any report that would be issued under the NIH imprimature," he said.

*In Congress*

## House Aims To End Budget Markup By July 4; Natcher Sees Difficult Year

The House Appropriations Committee is expected to complete the markup of the FY 1993 budget before the July 4 recess, Congressional sources said.

If this occurs, full House would be able to consider the bills by mid-July. Senate markup is expected to start in early September.

Rep. William Natcher (D-KY), chairman of the Labor, HHS, Education Appropriations Subcommittee,

said recently that the budgetary process will be the most difficult he had seen in 38 years on the committee.

Natcher and other House Democrats point to the 12 year trend of non-defense discretionary spending being squeezed by the interest on national debt, growing entitlements and military spending.

## ASCO Hit On Two Sides; AACR Decision Criticized; Moses Responds

The decision by the American Assn. for Cancer Research to discontinue holding its annual meetings in tandem with the American Society for Clinical Oncology (**The Cancer Letter**, May 29) probably had as much to do with perceptions by AACR leadership of the directions ASCO is taking as it did with logistics.

Some members of one or both organizations also harbor suspicions that the split was brought on by AACR ambitions to become preeminent in clinical cancer research as well as basic research, or at least to better compete with ASCO for clinician members.

ASCO's reaction, as expressed by some of its leaders, ranged from coolness to outright opposition to the split. Also, ASCO has found itself caught between its academic members who feel the organization is being dominated by practicing oncologists at the expense of science, and those who feel the organization is not doing enough for the practicing medical oncologists. Some of the latter, in fact, are threatening to leave ASCO for a new organization based on individual state medical oncology societies.

Logistics, including the burden of eight consecutive days for those who attend both annual meetings, was undoubtedly a factor in the AACR board's decision to break away, if not the primary justification. Relatively few members have been staying around for all eight days, and many who belong to both organizations have skipped the AACR meeting entirely.

James Holland, long a member of both, has been the most vociferous proponent of the view that the joint meetings are too much of a burden. His argument along that line at last year's AACR meeting prompted the association to establish a committee to study the issue. Holland skipped the AACR business meeting this year, when the committee's report urging the split was discussed, to attend his son's graduation. Sharon Murphy, who chaired the committee, received this letter from Holland:

"I commend you and your committee for having reached the conclusion that it is in AACR's best interests to meet apart from ASCO. A continuous bombardment for eight days far overtaxes the average mortal's ability to comprehend and retain or even to sustain interest. After reaching a saturation dose, the rest just spills over the brim.

"A separate AACR meeting will allow greater emphasis on fundamental science and its relevance to human disease, and its potential for implementation. Academically oriented physicians will participate enthusiastically, not wrung out from a preceding, gruelling three day meeting-cum-bacchanalia. AACR should have access to the best of clinical investigation as an intrinsic art, as it did before ASCO arose.

"ASCO, for its part, should also benefit. The important aspects of new science relevant to clinical practice will be presented directly, and not be delayed until the practicing clinicians have gone home, for presentation at AACR.

"I suggest you consider holding AACR's meeting in the fall. October seems like a good target, after the academic year has started, and before holidays and difficult travel conditions. A liberated AACR can meet in many attractive cities which were excluded by the size of the conjoint assemblage. It can focus on all those scientific approaches that bring a phenomenon, procedure, or product to a full level of understanding, up to and including initial clinical efforts. The surveys and clinical implementation and usefulness in practice can be presented in overview lectures, which should help the bench scientist see a little over the horizon.

"ASCO can focus on that science and those translations that apply directly to human cancer, including the clinical trials and medically related topics.

"Both the Association and the Society must resist the temptation to expand their meeting time. Increased quality, not quantity, must be the goal of the meetings.

"Any arrangement, even a divorce, that improves both parties and leads to more benefits than debits must be considered a good deal.

"If the most recognizable downside is the cost of a second trip, I'd venture to guess that the lower cost of hotels and food in smaller meeting cities will go a long way to offset that. Furthermore, the clinicians who will come to AACR are likely to be those whose academic opportunities are such that the travel differential will be well worth the shorter time away in one continuous absence.

"Since I have served as president of both organizations and have enjoyed over 60 years of total combined membership, I hope my motivation is not suspect. Again, my congratulations and gratitude for your having made AACR and ASCO both better by the action your committee has taken."

**'Split Is Unnecessary'**

John Yarbro, also a member of both AACR and ASCO and immediate past secretary-treasurer of the latter, sees the issue differently.

"The split is unnecessary," Yarbro commented to **The Cancer Letter.** "It's origin is not in the professional membership of the two organizations but rather with the staff, especially the staff of AACR. I believe that it has its basis in the jealously of AACR staff over the rapid growth of ASCO which gave ASCO staff more clout in negotiating arrangements for annual meetings. These kinds of petty differences led AACR staff to continually nag the leadership of AACR to split from ASCO.

"The split is unfortunate," Yarbro continued. "I believe that in the long run, it will be bad for cancer research and cancer care."

Yarbro is director of the Memorial Medical Center regional cancer center in Springfield, IL, and former director of hematology/medical oncology at the Univ. of Missouri.

(AACR President Harold Moses responds to Yarbro's remarks in a guest editorial on Page 6.)

**'Mundane Phase 2, Phase 3 Trials'**

ASCO has been criticized by some for allegedly moving away from science toward an emphasis on research which has immediate prospects for clinical implementation. "The practicing docs are taking over, and all we're getting is the routine stuff, without much creativity," one ASCO member said. "Better cancer therapies are still in the laboratories. How are we going to stay on top of that if all we hear at our scientific meetings are reports from mundane phase 2 and phase 3 trials?"

Much of the criticism along those lines has come from those who hold memberships in both organizations and feel that AACR, which has always scheduled clinical sessions, has been getting away from the laboratory-clinic "bridging" aspects of the annual meeting. They feel they have not been getting what they need from either organization. In fact, a number of academicians in ASCO have been talking about forming a new society, to focus on clinical aspects of basic research.

ASCO is getting it from both sides, it seems. Practicing medical oncologists got together during the San Diego meeting in May to consider still another organization which would serve their needs in such matters as reimbursement issues.

That organization, in fact, exists. Its members have named it, "State Oncology Society Coalition," and the acronym, SOS, reflects what some of its members feel is the emergency nature of problems medical oncologists are facing, primarily with reimbursement for cancer chemotherapy.

Medical oncologists in about 40 states have established oncology societies. So far, 12 of those state organizations have joined the national coalition, SOS. Individual oncologists from other states have contributed to SOS or have otherwise indicated interest.

John Burrows of Michigan is SOS president. Other officers and board members, all medical oncologists (as is Burrows) are:

Vice president, Dale Cowan, Ohio/West Virginia; secretary, Bruce Avery, Tennessee; treasurer, Robert Burger, Virginia; executive committee--Dudley Anderson, North Carolina; Sharon Ondreyco, Arizona; Roger Shiffman, California; and Roscoe Morton, Iowa.

Board members are Edward Ambinder, New York; Dinesh Desai, Illinois; Donald Filip, Georgia; David Gray, Indiana; Gary Gross, Texas; Patricia Legant, Utah; Alan Lippman, New Jersey; Stanley Lowenbraun, Kentucky, James Smith, Georgia; and Charles Winkler, Kentucky.

Martin Neltner, Cincinnati, whose company, Neltner Billing and Consulting, manages eight state oncology societies, serves as a coordinator for SOS. He told **The Cancer Letter** that most urgent task SOS has undertaken is to "patch up the problems we're having with HCFA." SOS will provide data to HCFA which Neltner said ASCO did not, the absence of which is leading HCFA to adoption of CPT codes that will deny reimbursement for the professional component of chemotherapy. That denial "will be a big disaster for medical oncologists," Neltner said.

Other issues SOS intends to look at include drug purchasing and pricing, off label uses and their reimbursement, problems in dealing with HMOs and PPOs, and "the whole spectrum of procedures" which impact oncologists in private practice, Neltner said. "The coalition will be the avenue to addressing these issues for the practicing oncologists in the trenches."

**Reimbursement Issue**

William Dugan, Indianapolis medical oncologist whose private practice includes a rural outreach program, is treasurer of the Indiana State Medical Oncology Society. That group has voted not to join SOS and maintaining its affiliation with the Assn. of Community Cancer Centers, one of several state societies to do so.

Dugan, therefore, feels that it would be a conflict of interest for him to join SOS as an individual, but the organization has his enthusiastic support nevertheless.

"You can't take away from the things ASCO has

done, but they have so many things on their plate," Dugan said. "Oncology reimbursement is not a high priority with them."

Dugan said that ASCO "didn't support the professional component of chemotherapy reimbursement, and that hurt us. There is a crisis in oncology reimbursement. . . ASCO failed to recognize the importance of understanding chemotherapy costs." If the situation is not corrected, he insisted, "private practice as we know it will fold. We will have to give patients their prescriptions and tell them to go to hospitals or somewhere else (for administration of the drugs).

"Vince DeVita's Community Clinical Oncology Program was brilliantly conceived. The key to its success has been the participation of private doctors. But private practitioners, who already have to eat the costs of research they do in CCOPs, can't afford to do that (if deprived of the professional fees from chemotherapy). This will flat destroy research in private practice."

Rural outreach efforts such as that done by his group will also be hurt, Dugan said. "We've taken major hits in reimbursement for our outreach patients in the last five years. We just absorbed those losses, but we can't continue to do that if the CPT code excluding chemotherapy professional component fees stands."

Dugan is a past president of ACCC. He said he sees no reason why that organization, which has undertaken its own efforts representing oncologists before Congress and HCFA, can't coexist with SOS, ASCO, and other professional groups.

SOS' business office is located at the offices of the Michigan Society of Hematology and Oncology, 721 E. Huron St., Ann Arbor 48104. The phone is 313/996-9219.

### Not A 'Crisis Situation'

Bernard Fisher, current ASCO president, told **The Cancer Letter** that he does not believe "a crisis situation exists" with the organization.

"My own view is that ASCO must continue to do the things for which it was started," Fisher said. "We can be responsive to the many constituencies without sacrificing our role of maintaining the highest scientific, intellectual, educational integrity. ASCO can be, and is, responsive to those groups who feel that it can have a voice on those issues that oncologists face. But there is no need to prioritize them, and I prefer not to do that. Some people in ASCO feel very strongly about certain issues, and I feel they have exerted great skill in dealing with them.

"If AACR attracts enough clinical people, they may be faced with the same problems," Fisher said, the irony not escaping him.

Fisher noted that he is a member of both organizations and has served on the AACR board. "I'm dedicated to the interrelationship of medicine and science. There's a big middle group in AACR interested in attracting more clinical investigators, and there is a group in ASCO that feels it should have more laboratory scientists. There's not much difference in that middle ground of both groups."

Fisher emphasized that the split of the annual meetings was initiated by AACR and "is not in ASCO's interest." But he agreed with comments from AACR leaders that laboratory and clinical collaborations and "translations" could be enhanced through a series of small, single topic meetings held at times other than during the annual meetings. "The time has come to come up with innovative ways to do that."

*Guest Editorial*

## Separation Will Make Basic-Clinical Interaction Easier, Not Harder

**By Harold Moses**

The decision to separate the AACR annual meeting from that of ASCO was made by the leadership of AACR in order to strengthen its overall commitment to clinical cancer research. The Board of Directors made this decision after lengthy deliberation on the basis of recommendations made by a number of committees and task forces that have met over the last five years. The decision has the strong support among the present and past leadership of AACR and among many prominent ASCO members as well.

Since its inception, AACR's purpose has been to encourage communication between labortory and clinical cancer researchers that results as quickly as possible in strategies for the prevention, diagnosis, and treatment of cancer in humans. Recent developments in basic sciences, particularly molecular biology and genetics, promise to be of exceptional clinical relevance. Continued progress along these lines requires increased **two-way** communication between clinical and basic researchers. However, the growing complexity and size of **both** AACR and ASCO make the consecutive annual meetings less and less effective as a means of encouraging this communication.

Dr. Yarbro and some others who have not been in favor of this decision are not aware of the extensive discussions among AACR members which led up to it. I can comment on these deliberations because I have

served continuously on the AACR Board of Directors since May 1986, first as a director from 1986 to 1989 and then, beginning in May 1990, as president-elect, president, and now past president. As long ago as 1988, a Task Force on Clinical Investigations chaired by Emil (Tom) Frei, who has been presidnet of both AACR and ASCO, recommended that the two annual meetings be separated.

It was clear to me from ensuing Board and committee discussions as well as from informal communications with members, that many investigators in both basic and clinical research found the current format of the two meetings to be unsatisfactory. I believe this dissatisfaction has grown considerably in the last five years both because of the increasing complexity of our field and the remarkable growth in both societies. AACR's membership and annual meeting registration figures have both doubled in the last six years, and we are very pleased with these achievements.

At the 1991 business meeting in Houston, I announced the formation of the current Task Force on Clinical Investigations that would have as its first initiative the consideration of whether the AACR was meeting the needs of clinical researchers who make up a significant portion of our membership. In collaboration with Sharon Murphy, who has my sincere thanks for accepting the difficult job of chairing this task force, I appointed a group of outstanding clinical and basic researchers to served on this task force. All of the task force members have participated in a variety of AACR activities over the years, including the program committee. In addition, three of them either have served or are serving on ASCO's Board of Directors, and one of them has been the president of ASCO. My goal was to make sure that any proposal emanating from the task force would be the considered recommendation of distinguished scientists who were thoroughly familiar with the activities of both AACR and ASCO. I believe that this goal was achieved.

During the past year AACR staff has provided informed and impartial support to the task force. The data it presented to the task force and the Board included complete information on the demographics of membership, meeting registration patterns, the logistics of putting on the combined meetings, and the possible financial risk to the AACR of holding a separate meeting.

After the task force met, its recommendations were discussed at a meeting of AACR and ASCO officers, and at meetings of the Task Force on Carcinogenesis, the Task Force on Preclinical Pharmacology and Experimental Therapeutics, and the Finance Committee. The other task forces and the Finance Committee all supported the Clinical Investigations Task Force's recommendation. I consider the support of these other AACR committees to be a significant indicator of the support of the membership.

The separation will make it easier, not harder, for the essential interaction between clinical and basic cancer researchers to take place. Each year, the AACR annual meeting program contains the most important recent findings in basic cancer research. It also contains a great deal of exciting new clinical research, but the interaction between the clinical and basic researchers is limited by the former's inability to attend eight consecutive days of meetings.

For many years AACR and ASCO had accepted data collected from registration form questionnaires that indicated that 1,500 to 2,000 individuals attended both meetings. An analysis of the actual registration lists from the 1991 meeting in Houston showed that only 791 (16%) out of 5,082 member and nonmember AACR registrants had also registered for ASCO.

The task force had been concerned that any decision to separate the meetings would make it especially difficult for foreign scientists to attend the meeting. In fact, in 1991 only 222 of the 791 joint registrants were from outside North America. This is just under 20% of the 1,113 scientists from abroad who registered for AACR in 1991.

These figures show that a separation of the meetings will have a far smaller impact on **each** meeting's registration than we had all originally thought. More important, however, they show that the current format is **not** encouraging the intended degree of interaction between clinical and basic researchers.

Some clinical investigators in addition to the ones who register for both meetings are undoubtedly attending only a few sessions on the transition days and then returning home, but this practice limits to a day or a day and a half both the exposure of these leading clinical researchers to new discoveries in basic research and, just as important, the interaction of basic scientists with their clinical colleagues.

Since this decision was made, many AACR members have called or written to me to express their support. Although some had previously been apprehensive about this change, they now agree that the separation will encourage progress in both cancer research and patient care. It is anticipated that the clinical researchers who are not attending the AACR meeting will now be able to do so and will be able to extrapolate this new knowledge rapidly to patients.

# RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. 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 NCI-CM-37823-71**

Title: Assistance to the Developmental Therapeutics Program

Deadline: Approximately Aug. 17

The purpose of this project is to provide direct assistance on a recurring basis to NCI's Developmental Therapeutics Program in the Div. of Cancer Treatment, Action Point and Decision Point Committees and Related Subcommittees responsible for the progressive preclinical evaluation and selection of candidate anticancer and anti-AIDS agents.

Following are representative of the tasks which may be required: 1) attend all meetings, prepare and distribute action item reports, summaries and/or draft and complete minutes. Maintain related computerized drug development tracking systems on a continuing basis. 2) Assist in the evaluation of test results from the anticancer and anti-AIDS screening programs and perform related followup functions in support of the major action points of the evaluation process. 3) Assist in the maintenance of on line computer files which contain summary data on all compounds of interest. 4) Develop and prepare for internal distribution any supporting information required by the committees. 5) Interact with staff of other DTP contracts to facilitate the development and application of modifications and improvements to the systems in use to support the data management and review activities. Such interaction shall occur at the direction of the project officer. It is anticipated that an incrementally funded cost reimbursement/plus fixed fee contract will be awarded. Period of performance will be for five years beginning approximately Jan. 19, 1993. This is a 100 percent small business set aside.

Contract specialist: Joseph Bowe
RCB Executive Plaza South Rm 603
301/496-8620

# RFA Available: Ovarian Cancer

**RFA CA-92-18**

Title: **Contemporary approaches to ovarian cancer biology research**

Letter of Intent Receipt Date: July 17

Application Receipt Date: Oct. 9

NCI's Div. of Cancer Biology, Diagnosis & Centers, Cancer Biology Branch, invites applications for grants to study the basic tumor biology of ovarian cancer of epithelial and nonepithelial origin. There remains a significant lack of understanding about the underlying factors, both intrinsic (genetic and cellular) and extrinsic (epigenetic), that contribute to the development of ovarian cancer. This initiative is designed to foster the application of recent advances in molecular and cellular biology, particularly those that use cells derived from samples of normal and malignant human tissues or that aid in the development and use of animal models, to study the generation and spread of ovarian malignancies.

Research grant applications (R01s) may be submitted by domestic and foreign for profit and nonprofit organizations, public and private. Total project period may not exceed four years. Anticipated award date is Aug. 1, 1993. Approximately $1.5 million in total costs per year for four years will be committed to fund approximately eight to 10 awards.

This RFA is intended to encourage a variety of investigator initiated research projects. It may include collaborations among basic and clinical scientists, and it likely will embrace an array of molecular and cellular approaches. Evidence of the establishment of reliable cellular systems or relevant models should be included in the applications.

Inquires and letter of intent may be directed to Dr. Cheryl Marks, Program Director for Molecular Biology, Tumor Biology Program, Div. of Cancer Biology, Diagnosis & Centers, NCI, Executive Plaza South Rm 630, Bethesda, MD 20892-9904; phone 301/496-7028; fax 301/402-1037.

**RFA TW-92-01**

Title: **International cooperative biodiversity groups**

Letter of Intent Receipt Date: Sept. 1

Application Receipt Date: Nov. 17

NIH, the National Institute of Mental Health (NIMH), the National Science Foundation (NSF), and the U.S. Agency for International Development (USAID), invite applications for the establishment of "International Cooperative Biodiversity Groups (ICBGs)." The purpose of these Groups will be to address the interdependent issues of biodiversity conservation, sustained economic growth, and human health in terms of drug discovery for cancer, infectious diseases including AIDS, cardiovascular diseases, mental disorders, and diseases of primary concern to developing countries.

Public and private non-profit institutions, Governments and their agencies, and foreign institutions are eligible. Applicant institutions must be in the U.S. or in a participating developing country. For-profit institutions may participate as members of the Group. Awards will be made as cooperative agreements (U01).

A Group, under a single Group Leader is expected to be a consortium of Associate Programs working together to form a multidisciplinary and/or multi-institutional team from academic, non-profit, and/or commercial organizations. At least one of the Group's Associate Programs must be located in a developing country. Interaction of academic and non-profit research institutions with commercial (including industrial) organizations and the sponsoring Government agencies will favor development of novel approaches to drug development, biodiversity conservation, and sustained economic growth. Active participation of the private sector is encouraged. Interaction of academic and non-profit institutions with industry and Government will encourage the creation of innovative, interdisciplinary approaches. The Government anticipates making three awards for project periods of three to five years. Approximately $1.5 million (total costs) for first-year funding has been set aside. The goals of the ICBG Program are to:

--Discover, isolate, and evaluate, preclinically, agents from natural sources to treat and prevent cancer, infectious diseases including AIDS, cardiovascular diseases, mental disorders, and other diseases and medical conditions of primary concern to developing countries.

--Undertake inventories of biological diversity and develop collection practices compatible with conserving biodiversity and produce documentation of all collected material.

--Support research training targeted toward the needs of developing or other countries represented within the Group and related to the scope of the RFA, and to augment field experience and training of U.S. scientists in areas unique to the developing country.

--Assist in improving the scientific infrastructure within participating developing country(ies) where the biodiversity resources are found.

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