THE CANCER LETTER

Vol. 18 No. 42
Oct. 30, 1992

Price $215 Per Year US, Canada.
$240 Per Year Elsewhere

P.O. Box 15189 Washington, D.C. 20003 Telephone 202-543-7665

House Committee Alleges Irregularities In Tamoxifen Trial Informed Consent Forms

At a Capitol Hill hearing two years ago, NIH and NCI officials sat in witness chairs, responding to charges that women are underrepresented in clinical trials.

Last week, NIH and NCI officials were under attack from from the same House committee, but for another alleged misdeed: exposing women to unnecessary and undisclosed risk in the course of the tamoxifen chemoprevention trial. "Exposing healthy women to a

(Continued to page 2)

In Brief

Jordan, Fisher Win Brinker Awards; AFUD Forms 100th Us Too Prostate Cancer Support Group

SUSAN G. KOMEN Breast Cancer Foundation named the recipients of the Brinker International Breast Cancer Awards at a symposium in Dallas this month. The awards recognize completed research which advances either basic research or clinical application in the field of breast cancer research, screening, or treatment. The Basic Research Award was presented to **Craig Jordan**, Univ. of Wisconsin Comprehensive Cancer Center, for his contributions to understanding of the anti-estrogen action of tamoxifen, and for a series of pharmacology investigations. The Clinical Research Award was presented to **Bernard Fisher**, Univ. of Pittsburgh School of Medicine, for his leadership of the National Surgical Adjuvant Breast & Bowel Project, and for his contributions to improve primary breast cancer treatment. The awards include a $10,000 honorarium. . . . **AMERICAN FOUNDATION** for Urologic Disease and Us Too announced the formation of the 100th Us Too prostate cancer support group program, at Memorial Sloan-Kettering Cancer Center and the New York Hospital-Cornell Medical Center. The most recent group is part of the international network of prostate cancer support groups, which originated in Chicago. Information on Us Too may be obtained by calling 800/82-US TOO. . . . **PITTSBURGH CANCER** Institute dedicated new facilities and programs this month at the Univ. of Pittsburgh Medical Center. Pittsburgh Mayor Sophie Masloff and Congressman William Coyne joined PCI Director **Ronald Herberman** in a ribbon cutting ceremony to dedicate the Comprehensive Breast Care Center, the Ladies Hospital Aid Society of Western Pennsylvania Prevention and Early Detection Center, and the Patient and Family Education Center. . . . **EDWARD PARTRIDGE** has been appointed to the new post of associate director for community outreach research at the Univ. of Alabama at Birmingham Comprehensive Cancer Center.

House Committee Alleges Forms For Tamoxifen Trial Omitted Risks

(Continued from page 1)

potentially fatal drug may not be the best way to prevent breast cancer," said Rep. Donald Payne (D-NJ), who succeeded the late Rep. Ted Weiss (D-NY) as chairman of the House Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations.

"It is important to make sure that federally funded research protects the patients who participate from unnecessary risks, and make sure that they are accurately informed of the likely risks and benefits," Payne said in a statement issued prior to the hearing.

"The Public Health Service has a tarnished history regarding the ethical treatment of patients in federally funded research," Payne said. "The most infamous example is the Tuskegee Study, where 400 African American men with syphilis were studied for 40 years, but not given the treatment that could cure their disease."

Payne's accusations were based on a committee staff survey of informed consent forms for the Breast Cancer Prevention Trial that said that nearly 70 percent of forms omitted or altered the key points from a model consent form approved by NCI reviewers in the protocol. The trial is coordinated by the National Surgical Adjuvant Breast & Bowel Project, chaired by Bernard Fisher of Univ. of Pittsburgh.

A recent audit by the NIH Office for Protection from Research Risks found that 6 percent of tamoxifen study forms were inadequate.

"Appropriateness and inappropriateness is a judgment," Susan Nayfield, program director at the NCI Div. of Cancer Prevention and Control, said to **The Cancer Letter.** "There has to be a balance. It's not that you don't want to give a complete disclosure; it's that you want to give a scientifically valid disclosure."

However, Nayfield said, "We have learned from the experience of the hearing, and we are in the process of responding to the concerns expressed." Days after the hearing, NCI mailed a letter to the 270 centers involved in the trial, reminding them about the guidelines for informed consent. "There could be improvements in many forms, but I doubt that it's in the order of 60 to 70 percent," Nayfield said.

In recent years, opposition to tamoxifen studies involving asymptomatic women has been spearheaded by the National Women's Health Network. Several months ago the network found a vocal ally, Samuel Epstein, the guru of those who believe that most cancers are caused by occupational and environmental exposures.

The collaboration between Epstein and the network has become so close that the testimony presented by Adriane Fugh-Berman, the network's medical advisor and former board member, had been distilled from an opinion piece she and Epstein had submitted to "Lancet."

Epstein said he did not attend the hearing because he was "spread thin." In a telephone interview with **The Cancer Letter** he characterized the tamoxifen trial as a "travesty of science."

"The risk was trivialized and misrepresented to the point of representing malpractice," he said.

Epstein, whose periodic forays into Washington attract attention from the press, is a professor of environmental and occupational medicine at the Univ. of Illinois. His views on the tamoxifen trial were expressed in a June 22 opinion piece in the "Los Angeles Times."

Informed Consent

Payne's criticism of the tamoxifen trial was based primarily on a staff survey, a copy of which was obtained by **The Cancer Letter.**

The survey examined 268 informed consent forms from medical centers participating in the trial and compared them with the model informed consent form on a number of points. The staff findings follow:

--68% of the forms omitted one or more of the key points from the model consent form.

--49% fail to mention that the treatment for endometrial cancer is a hysterectomy, often coupled with radiation therapy.

--52% minimize the risk of liver cancer.

--26% fail to warn women that they cannot use IUDs, oral contraceptives, or both.

--15% minimize potential eye damage.

--11% neglect to warn women that they cannot start or must discontinue estrogen replacement

THE CANCER LETTER

Editor: **Kirsten Boyd Goldberg**
Founder & Contributing Editor: **Jerry D. Boyd**
Associate Editor: **Paul Goldberg**

PO Box 15189, Washington, DC 20003
Tel: (202) 543-7665 Fax: (202) 543-6879

Subscription rate $215 per year North America, $240 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter.

therapy to participate in the trial.

--62% provide misleading information or no information about thrombo/embolic risks (3 predicted deaths for the present study and two deaths from NSABP's B-14 study.)

--Consent forms vary widely in the proposed length of the study: 24 forms talk about a five-year trial; 85 forms describe a 6-year trial; 137 forms describe a 7-year study; 13 forms describe an 8-10-year commitment and nine forms stated that women would be followed for life.

The memo further stated that "while this trial is designed to examine the effects of tamoxifen in a representative sample of women, it may in fact exclude low-income and uninsured women because of related costs."

According to the memo, "185 forms (69%) indicated that women will be solely responsible for costs not covered by insurance, including routine tests, exams and all treatment of tamoxifen-induced illness and side effects."

Minority Recruitment

"The NSABP was in total compliance with all federal guidelines governing informed consent," NSABP Chairman Bernard Fisher said to **The Cancer Letter.** "Second, ongoing reviews of the participants' consent forms by the NSABP headquarters identified 6 percent who had omitted one or more of the more serious toxicities and we have suspended acrrual until the consent forms were straightened out, and that occured before the hearing. Third, the consent forms [the committee staff] reviewed were not necessarily the most current consent forms."

NCI's Nayfield said that while the Institute strives to have as complete an informed consent document as possible, that document is not the only source of information for participants.

Generally, potential volunteers attend group meetings to hear a broad overview presentation about the trial. After that, volunteers go through individual counseling sessions, where the risks and benefits are described specifically and in a manner relevant for every participant.

"Many women like the choice we are offering, and are 'voting with their feet' in support of this trial," DCPC Director Peter Greenwald said in remarks submitted to the committee.

"Today, 4.5 months after the trial opened, nearly 30,000 women have had initial risk assessments; approximately 20,000 have been found eligible based on risk to continue the enrollment process and are awaiting final medical exams; and about 3,000 have already been entered onto the trial and are receiving tamoxifen or placebo," Greenwald said.

Greenwald said accrual will remain open until minority women are adequately represented.

Mason Asks For Better Technology Transfer In Prevention, Detection

The federal government's top health official has called on the country's health establishment to "do a better job of applying what we already know" in cancer prevention and detection.

Assistant Secretary for Health James Mason, addressing the closing session of the 8th International Symposium in Charleston, SC, sponsored by the International Council for Coordinating Cancer Research, said that "I'm disappointed by the way we use, or I should say the way that we don't use, what is already known."

Referring to cancer risks of tobacco use, high fat and low fiber diets, high levels of alcohol consumption, and excessive sunlight exposure, Mason said these known factors and unused screening procedures such as mammography, Pap test, and colon cancer screening could result in significant cancer death reductions "with better application.

"Empowering our people so that information and tools available are put to work is our continuous challenge," Mason said. "We need to move new information, from the laboratories and from clinical trials, out into the field more quickly. We need to transfer our current research knowledge into common medical and personal health practices sooner."

Mason added that "we need to better target our efforts to the disadvantaged and underserved," citing figures that show the disparity in cancer survival among white and black patients.

ICCCR To Continue

ICCCR's future was jeopardized earlier this year when its chief sponsor, the French Assn. for Research on Cancer, announced it was reducing substantially its support. Jacques Crozemarie, who heads ARC, founded ICCCR and has served as its chairman.

Crozemarie did not attend the Charleston symposium and sent a letter in which he said his decision to step down as chairman of ICCCR was due to his "numerous commitments in France as well as Europe." He said that ARC "is also concerned with all research programs related to cancer in the European community" and "in order to coordinate ARC's action in Europe, I have accepted the position of president of the European Assn. for Medical Research based in Brussels."

Peter Fischinger, vice president for research at the

Medical Univ. of South Carolina, assumed the presidency of ICCCR when Vincent DeVita resigned a few months ago. In his letter, Crozemarie inferred that it will be up to Fischinger whether or not ICCCR remains in business. "I am pleased that Dr. Peter Fischinger has accepted the leadership role as the new president of ICCCR and will define ICCCR's actions," Crozemarie wrote.

Fischinger, who is also acting director of MUSC's new Hollings Oncology Center, was confident that ICCCR will continue as a viable organization. He announced that the next symposium would be held within one and a half to two years, "in a country that can make good use out of information that will come out of the meeting."

South Carolina Politicos Join In Dedication of Hollings Center

The Hollings Oncology Center was dedicated in a bipartisan lovefest that came in the midst of what may have been one of the bitterest political seasons South Carolina had experienced since the carpetbaggers and Reconstruction.

The state, considered at the start of the campaign to be solidly in President Bush's camp, appeared close to going over to Bill Clinton. And Democratic Sen. Ernest (Fritz) Hollings was in the fight of his life, challenged by a Republican working the anti-incumbent theme for all it was worth and attempting to cash in on Hollings' vote against the Gulf war.

Republican Strom Thurmond, 90-year-old patriarch of the U.S. Senate, was there, warmly praising Hollings for his contributions to the state and country and congratulating him for his "hard work" in establishing the new center at the Medical Univ. of South Carolina.

Former Republican Gov. James Edwards, now MUSC president, thanked both Hollings and Thurmond for their support. Fitzhugh Mullen, chairman of the National Coalition for Cancer Survivorship, said Hollings "to many of us is a hero" for using the Senate Appropriations Committee to support cancer research. The center is "a monument to your efforts, and will be a model for cancer centers in the 21st Century," Mullen told Hollings.

NCI Director Samuel Broder, keynote speaker at the dedication, gave Hollings credit for "single handedly securing an additional $200 million for us this year, every penny of which is being spent to reduce the toll of cancer."

In his remarks, Hollings reminded his fellow Charleston citizens that "when we lost Mendel (one of the longest serving and most powerful Congressmen ever from South Carolina, Mendel Rivers, who died of cancer in 1970), he didn't die here. He died in Birmingham." Hollings noted that the Univ. of Alabama had a cancer center and suggested that it was not a coincidence that Alabama Sen. Lister Hill was then chairman of the Appropriations Committee.

"I said to Dr. Sam (Broder) that you fund three cancer centers in North Carolina (at Duke, Univ. of North Carolina, Wake Forest Univ.). Why not support one here?" Hollings was careful to add that the planning grant the university received for the center was awarded on a competitive basis.

Thurmond got his pitch in. "Dr. Broder, you couldn't find a better place in the world than Charleston to put some cancer money." Broder responded, "I heard you. Don't worry."

Gynecologic Oncology Section To Be Formed In NCI Surgery Branch

NCI's Div. of Cancer Treatment plans to form an intramural gynecologic oncology group within the Surgery Branch. The goal of the new section will be to strengthen research and training, and establish clinical protocols in gynecologic oncology at the NIH Clinical Center.

"This is a major step in gynecologic oncology," Rodrigue Mortel, chairman of obstetrics and gynecology at the Hershey Medical Center, Pennsylvania State Univ., said to **The Cancer Letter.** "For any extramural area to be strong, there has to be an intramural component."

Mortel, a member of the DCT Board of Scientific Counselors, said the effort to establish the new section began about two years ago with a meeting between the leadership of the Society of Gynecologic Oncologists and NCI staff. He was vice president of the society, and now heads the Gynecology Cancer Foundation, which has begun raising money to support a research fellow to be trained in the new gynecologic oncology section.

A report by the Institute of Medicine published earlier this year, "Strengthening Research in Academic OB/GYN Departments," mentioned the absence of gynecologic research at NIH. Mortel was a member of the IOM committee that produced the report.

"There has been a paucity of people doing research" in gynecologic oncology," he said. Board certification in gynecologic ongology will begin in 1994; it is the one area of oncology in which one specialist cares for a patient "from beginning to end," he said.

Last year, Congress told NIH to pay more attention to women's health, and specifically asked NCI to

conduct more research on cancers that affect women.

"At a time when women's health issues are of such importance, the establishment of this section is very timely," Mortel said.

Surgery Branch Chief Steven Rosenberg will recruit a senior gynecologic oncologist to head the new section, and there will be one technician and one fellow.

DCT Director Bruce Chabner said Rosenberg intends to build the section into "a significant research team."

DCT Board Oks MRS Announcement; Contracts For BRM Clinical Trials

NCI's Div. of Cancer Treatment Board of Scientific Counselors gave concept approval to a new program announcement on magnetic resonance spectroscopy and the recompetition of contracts for clinical trials of biological response modifiers.

Following are the concept statements:

MRS biochemical markers and tumor cell biology. Proposed program announcement for investigator-initiated R01s (no funding set-aside).

Over the past few years, Magnetic Resonance Spectroscopy of human tumors has revealed metabolic characteristics with potentially important biological and implications. These include high levels of phospholipid metabolites, a pH the same or more alkaline than in normal tissues, and a low level of phosphocreatine. A frequent early event induced by cancer treatment is a change in phospholipid metabolites. These observations raise important questions about human cancer cell biology that were formulated by the December 1991 workshop of the Diagnostic Imaging Research Branch, Radiation Research Program:

1) What is the nature of phospholipid metabolism in cancer? Are the observed phospholipid metabolites related to membrane turnover in proliferating cells? to changes in the tumor cell membrane composition associated with invasion and metastasis? to signal transduction events associated with the phospholipid breakdown?

2) Why do human cancer cells typically have a higher pH than normal cells? Is this related to metabolic demands, to altered traosport mechanisms, or to transport phenomena?

3) What is the influence of tumor physiology on MRS metabolic characteristics? What is the nature of vascular perfusion, blood flow, vascular permeability, and interstitial space of tumors?

4) Can any of the metabolic characteristics be correlated with known prognostic and biologic variables, such as growth receptors or drug resistance phenomena?

5) Can MRS be used to study tissue pharmacokinetics of cancer drugs?

The goal of this proposal is to stimulate multidisciplinary MRS research in order to bridge the currently existing gap between MRS phenomena and fundamental tumor cell biology. It is expected that this proposal will stimulate the development of MRS as a noninvasive biochemical basis for patient management.

Clinical trials of biological response modifiers (Task A/Task B). Annual amount $1.5 million (3 awards); total $7.5 million over five years.

The Biological Response Modifiers Program sponsors clinical trials of biological response modifiers through grants and contracts. Since 1988, BRMP has maintained seven 5-year, incrementally funded contracts to perform phase 1 clinical trials of BRMs. Three of these focus on studies of monoclonal antibodies and other targeting agents (Task A), and four focus on studies of BRMs including cytokines, cancer vaccines, and adoptive immunotherapy (Task B). The contractors were selected for their demonstrated ability to perform multiple trials of BRMs. These contracts allow the institutions holding them to remain prepared to do clinical trials with the required immunologic monitoring and so are ideal for conducting a series of closely related trials.

Five-year, incrementally funded contracts will be competed for the performance of multiple clinical trials of BRMs. Offerors will be required to demonstrate their capability to perform, within appropriate timeframes, phase 1 clinical trials of BRMs, emphasizing excellent patient accrual, trial design, and conduct of laboratory studies of biologic correlates. Proposals should document (1) the expertise of key clinical and laboratory personnel; (2) the experience of the investigators in the design and execution of BRM clinical trials, with particular emphasis on hypothesis-driven studies of mechanism of action; and (3) the experience of the institution with BRM clinical trials in the last 3 years. A sample clinical protocol will be required with the proposal.

Under the technical direction of the project officer, the contractors will design, write, and develop clinical protocols for the BRMs identified for study. NCI will supply agents for clinical trials and hold the INDs (investigational new drugs). All contract clinical protocols will require NCI approval. Contract clinical trials will be monitored by NCI's Clinical Trials Monitoring Service. These trials will focus on initial phase 1a/1b studies of new BRMs, and on studies specifically related to issues mechanism of action. Each contractor shall perform up to three clinical trials per year.

[Reports on concept reviews by the boards of scientific counselors of NCI divisions provide readers with advance notice of the Institute's spending plans. Notices of Requests for Proposals, Requests for Applications, or Program Announcements are published in **The Cancer Letter** as they are released; proposals need not be submitted until that time.]

Grant Programs In Prevention, Public Education, Ok'd By DCPC

NCI's Div. of Cancer Prevention & Control Board of Scientific Counselors has given unanimous concept approval to a grant program that would establish cancer prevention research units and a grant program to study public and professional education regarding skin cancer.

The board also voted 6-3, with two abstentions, to approve a concept for a program announcement that will seek regluar investigator-initiated (R01) applications for interventions that improve early detection of breast cancer in women over age 65.

Board member Carol D'Onofrio, one of the "no" votes, argued that the concept should have RFA set-aside funding. A similar PA issued last year resulted in a 14 percent funding rate for applications submitted,

which were reviewed by the NIH Behavioral Medicine study section. The average NCI funding rate is 23 percent, according to Suzanne Haynes, chief of the Health Education Section, who presented the concept.

"Endorsing another program announcement knowing the Behavioral Medicine study section's track record is pretending there is not a problem," D'Onofrio said.

DCPC Deputy Director Edward Sondik said the NCI Executive Committee "made it clear they want to know the results and if they were not satisfied they would look at the grants individually [to consider them for exception funding]."

Following are the concept statements:

Interactive cancer prevention research unit. Proposed RFA for interactive R01 applications, $5 million per year, four years, total $20 million, up to six IRPG awards. Program director: Sherry Mills, Prevention & Control Extramural Research Branch.

The Cancer Control Science Program, through Interactive Research Project Grants (IRPGs), seeks to stimulate the establishment of programs in primary and secondary cancer prevention, health promotion and prevention services research. Investigators with related research objectives will be required to submit a minimum of three concurrent, collaborative, crossreferenced individual research project grant applications (R01s) that share resources and a common research focus. Applications may be submitted from a single institution or may include arrangements with multiple institutions, if appropriate. Applications from or involving minority institutions, individuals and women will be encouraged.

These ICPRUs will focus on problem- or program-oriented cancer prevention and control research studies, involve multidisciplinary participation, and, for Phase IV and V studies, demonstrate access to appropriate populations in order to measure the population impact of cancer control activities.

The ICPRU concept involves a multidisciplinary environment of scientists interacting closely in the research program. These can include new, as well as experienced investigators in relevant fields and disciplines, such as disease prevention and control medicine, public health, health education, health promotion, epidemiology, nutrition sciences, health policy and economics, health services research, community organization, health communications, and biostatistics.

The goal of this RFA is to 1) maintain, redirect, focus, and recruit highly competent investigators into cancer prevention and control research, 2) stimulate an intermediate level of interdisciplinary collaborative efforts to build stronger research bridges between cancer prevention and control science and the disciplines that closely related to basic and clinical research for development and evaluation of new approaches to cancer prevention and control.

Within DCPC, similar cancer control research has been funded for several years under the P01, as the Cancer Prevention Research Units (CPRU). In 1988, the CPRU RFA was announced and receive significant interest from the research community. There are currently three funded CPRUs from the original RFA conducting research in cancer prevention and control in such areas as enhancing adherence to cancer control interventions (e.g. mammography). Several specific cancers are being addressed including breast, cervix, and tobacco-related cancers. Within the CPRUs, developmental research projects have also been supported and resulted in several funded R01 projects. These program projects have fostered the collaboration of cancer control researchers within large research institutions, as well as between worksites, health departments and major universities.

Investigators may choose from the full range of scientific approaches. Many Phase II studies may contribute to the design, implementation or evaluation of future Phase III-V studies, e.g., descriptive baseline surveys, testing, modification, and validation of surveys or program materials for use in the proposed population groups, testing of recruitment or compliance procedures for participants, or testing of biochemical or dietary methods for objectively monitoring participation in studies. An example of such a research sequence might focus on biomarkers for esophageal cancer, cessation of tobacco and alcohol use in high risk groups and prevention of tobacco and alcohol use among th children of individuals in high risk groups. The research may occur in a variety of settings ranging from the laboratory to communities, schools, health departments and worksites.

The Cancer Control Science Program supports the development an testing of primary and secondary intervention strategies to modify personal, social, and life-style factors known to contribute to the development and/or increased risk of cancer. This research includes the health promotion sciences, special population studies, and applications research, as well as implementation studies for proven technologies such as breast and cervical screening. Research on health services is encouraged since it impacts on obtaining optimal application of the interventions in community settings. Interventions aimed at reducing cancer incidence related to smoking and tobacco use is also emphasized (e.g. Phase IV and V research in achieving the goals of the Year 2000 for smoking). Linkages between laboratory research and applied cancer prevention and control research are encouraged, i.e., laboratory research in support of these prevention studies. Basic laboratory research without this linkage is discouraged.

Investigators must address the specific aims and hypotheses, the background and significance of the proposed work, results of any preliminary studies, experimental design and methods, any theoretical concepts which underlie the intervention research, human subjects involvement and protection, and relevant literature.

Research in public and professional education for the prevention and control of skin cancer. Proposed RFA, $1 million per year, four years, total $4 million, three awards. Project officers: Michael Anderson, Suzanne Haynes, Public Health Applications Research Branch.

Goal of this project is to conduct research on *educational* strategies for the prevention of melanoma and non-melanoma skin cancers through controlled studies in defined populations.

Objectives are: A) to study the effects of public education interventions aimed at increasing use of sunscreens and protective clothing, limiting exposure to solar radiation, avoiding artificial methods of tanning, teaching skin self-examination, and improving other behaviors relat to skin cancer risk reduction. B) To study the effects of professional education interventions aimed at increasing caregivers' awareness of skin cancer, their ability to provide advice, and their knowledge on the importance of screening and early detection for the prevention and control of skin cancers.

Most research will take place through a facility capable community-based cancer prevention research, and will consist of intervening and measuring change in a sample drawn from a population shown to be at risk. This includes pilot testing survey instruments and techniques for feasibility and acceptability,

validating instruments, and assessing participation and adherence rates. Investigators may develop their own, or select from or adapt existing materials or strategies that have been shown to be effective in reducing exposure to ultraviolet radiation, and informing health professionals about the risks associated with skin cancer, and the use of screening and early detection. Techniques for validating effectiveness of methods and materials will also be the responsibility of investigator.

To ensure results that are representative, investigators should randomize subjects into intervention and control groups. These groups should be matched on risk factors such as skin pigmentation, age, sex, ethnicity; type of UV radiation exposure (solar, artificial, high altitude, etc.) and current or past exposure habits. Experimental groups must also be of sufficient size to provide the statistical power to detect significant differences between groups on variables of interest.

Investigators may represent a variety of research organizations, including universities, colleges, medical centers, voluntary organizations, government agencies, or similar organizations. They must be capable of assembling multidisciplinary team including health education specialists responsible for public education interventions trained medical personnel knowledgeable in skin cancer screening and early detection procedures for professional education interventions, and associated statisticians, research designers, communication specialists, etc., for the successful implementation and reporting of a full-scale research project.
Interventions should be based on appropriate scientific theory. They should also be built on the results of previous interventions shown to be efficacious in changing health related knowledge, attitudes, and behaviors, as well as studies that have demonstrated successful strategies for increasing and evaluating appropriate cancer screening and early detection referrals.

Evaluations should be designed to test questions such as: (1) what are the most effective educational conditions that lead to a quantifiable reduction in skin cancer risk behaviors in specific populations?; and (2) what are the most effective educational conditions for increasing professional knowledge on primary prevention, screening, a early detection of skin cancer?
The use of intermediary organizations and the formation of public/private partnerships will be strongly encouraged. Investigators should strive to bring together diverse groups such as producers of sunscreen products, voluntary organizations, and organizations such as swimming pools, c golf, yacht, or tennis clubs.

Investigators must be prepared to summarize and publish process and outcome results from these studies, and to demonstrate how these results may be generalized to other cancer prevention and control interventions, particularly those that involve multidisciplinary teams of behavioral, medical, and social scientists.

Interventions to improve the early detection of breast cancer in women 65 years and over. Proposed program announcement. Project officer: Suzanne Haynes, chief, Health Education Section, Pulbic Health Applications Research Branch.

The goal of this program announcement will be to support research that develops innovative interventions to increase and improve the early detection of breast cancer in asymptomatic women aged 65 and over. Applicants are encouraged to evaluate cost-effective strategies for women 65 years and older to increase participation in mammographic screening.

Specific objectives are: (1) To document the barriers to mammography referral among women age 65 and over and their primary care physicians, particularly internists and family practice doctors, for the purpose of designing innovative interventions to overcome these barriers and increasing breast cancer screening. (2) To test and compare the cost effectiveness of interventions to increase the adoption and regular compliance with procedures for the early detection and follow-up of breast cancer in women aged 65 and over.

Breast cancer screening proposals should focus on developing, implementing and evaluating interventions aimed at older women, their physicians, and radiologists, to promote quality and sustained use of breast palpation and mammography. Unless exceptions can be justified, the intervention trials should focus of geographically defined populations. The interventions should not be restricted by an upper age limit. The defined population should allow determination of whether it is representative of other larger populations, for example, in terms of its incidence and mortality profile. Investigators will be required to document that they have access to and can recruit the target population of women aged 65 years and over.

In developing interventions, barriers to the utilization of breast cancer screening procedures in the target population must be identified. It is of critical importance that the research be able to assess barriers for repeat mammograms and test innovative interventions that will ensure sustained utilization of these early detection procedures. Furthermore, for all cases that do not have normal screening results, investigators will be required to plan and implement procedures that will assure compliance with appropriate follow-up recommendatiobs. Innovative computer reminder systems may be proposed to target older women, using health departments, physicians offices, or other community resources. Applicants are encouraged to propose interventions that build creatively upon the existing research base (The NCI Breast Cancer Screening Consortium, 1990). These projects, which were targeted only to women 50-74 years of age, have demonstrated significantly greater increase (about 10%) in screening rates in the intervention as compared to the control communities. Experiences from the three pilot supplemental studies on women 65-74 by Rimer (1992), and Fox, Urban (unpublished data) should be utilized, subject to the availability of final result in 1993. Such interventions should be designed to maximize the potential for both impact and generalizability. Applicants are encouraged to test and compare multiple innovative strategies (e.g., mass media, individual, and physician interventions) and assess their relative effectiveness.

It is anticipated that separate, but complementary, interventions will be designed for the women and their health care providers. If subgroups of women do not have established sources of care, special attention should be given to expediting their access to early detection services within the existing health care system. Interventions directed at radiologic services that provide mammography should include strategies to encourage low cost services and acceptance of Medicare reimbursement for mammography. Interventions should include strategies to inform physicians, radiologists, and women about the Medicare benefit for screening mammography. No funds in the grant are to be used to offset the cost of screening procedures, screening equipment, or stationary or mobile facilities; however, funds can be used to stimulate plans for lowering costs.

Due to the special barriers that may prevent successful recruitment of older women into screening programs, transportation, access to appropriate health care, comorbid conditions, functional status, social supports, and economic factors should be considered in the design of interventions. The pain incurred during mammographic exams for women 65+ should be documented for anatomic sites (breast, neck, shoulder, etc). This should be correlated with age, socioeconomic status, repeat exams, menopausal status, and use of pain medications. Any complications should be documented by patient exit

interviews or other appropriate survey techniques. Educational materials should be design to accommodate the visual and literacy skills of the target population. Collaboration with gerontologists or aging experts should be documented in the application. In addition, high priority will be given to research designs that assure continuation of the intervention beyond the funded period.

Comparison of interventions using different innovative strategies are encouraged, with particular focus on cost-effectiveness studies, such those published by Brown (1992). During the baseline period, before any intervention is undertaken, survey or medical audit data should permit an assessment of current usage patterns for mammography and breast palpation within the target population.

To control for secular change in breast cancer screening that occurs independent of the intervention strategies, applicants may address the issue of control communities or subcommunities.

NCI Advisory Group, Other Cancer Meetings For Nov., Dec., Future

Leukemia Society of America Medical Symposium--Nov. 1-2, Phoenix, AZ. Contact Hillary Brotman, 212/573-8484 ext. 138.

Gene Therapy of Cancer--Nov. 5-7, San Diego, CA. Contact Cass Jones, phone 619/565-9921.

Surgical Pathology Review Conference--Nov. 6, Fox Chase Cancer Center, Philadelphia, PA. Contact Kathy Smith, conference coordinator, phone 215/728-5358.

American Society for Therapeutic Radiology and Oncology--Nov. 8-13, San Diego, CA. Contact ASTRO, 703/649-8910.

New Advances in Treatment of Hematologic Malignancies--Nov. 11, Cleveland, OH. Contact Education Coordinator, Ireland Cancer Center, phone 216/844-7858.

Chemotherapy Foundation Symposium X--Nov. 11-13, New York City, Holiday Inn Crowne Plaza. Contact Jaclyn Silverman, Mount Sinai School of Medicine, phone 212/241-6772.

Politics of Health Care: How it Affects Cancer Patients--Nov. 12, New York City, Holiday Inn Crowne Plaza. Contact Jaclyn Silverman, Mount Sinai School of Medicine, phone 212/241-6772.

President's Cancer Panel Special Commission on Breast Cancer--Nov. 12, Bethesda, MD. NIH Building 1 Wilson Hall. Topic: hormonal factors.

President's Cancer Panel--Nov. 13, Bethesda, MD. NIH Building 31 Conference Room 6. Topic: prostate cancer.

Cancer Management Course--Nov. 13-14, New Orleans, LA. Contact John Bolton, 401/739-8010.

American Geriatrics Society/American Federation for Aging Research Annual Meeting--Nov. 14-18, Washington, DC. Contact AGS, phone 212/308-1414.

FDA Oncologic Drugs Advisory Committee--Nov. 16-17, Rockville, MD. Parklawn Building Conference Rms D&E, 8:30 a.m.

Controversies in the Management of Infectious Complications of Neoplastic Disease--Nov. 18-20, New York City. Contact Barbara Lovit, Science & Medicine, 212/213-7172.

American Assn. for Cancer Education--Nov. 18-21, Houston, TX. Contact Carol Harreld, 713/792-2222.

Pittsburgh Cancer Conference--Nov. 19-20, Pittsburgh, PA. Contact Diane Applegate, Univ. of Pittsburgh, 412/647-8263.

Cancer Management Course--Nov. 27-28, Rio de Janeiro, Brazil. Contact Marcos Moraes, American College of Surgeons, 312/664-4050.

NCI Div. of Cancer Biology, Diagnosis & Centers Board of Scientific Counselors--Nov. 30, NIH Bldg. 31 Conf. Rms., Bethesda.

American Society of Hematology Annual Meeting--Dec. 4-8, Anaheim, CA. Contact ASH, 202/857-1118.

San Antonio Breast Cancer Symposium--Dec. 9-10, San Antonio, TX. Contact Lois Dunnington, symposium coordinator, 512/567-4745.

American Endocurietherapy Society Mid-Winter Meeting--Dec. 9-12, Beaver Creek, CO. Contact AES, phone 215/574-3158.

National Cancer Advisory Board--Dec. 14-15, NIH Bldg. 31 Conference Rooms.

Future Meetings

Breast Cancer in Premenopausal Women--Jan. 13-14, Bethesda, NIH Masur Auditorium. Contact Dr. Edward Trimble, 301/496-2522.

Radiation Therapy Oncology Group Semi-Annual Meeting--Jan. 15-17, New Orleans, LA. Contact Nancy Smith, RTOG, phone 215/574-3205.

Queen's Cancer Institute Symposium on Women and Cancer--Jan. 27-29, Honolulu, HI. Contact Grace Iwahashi, Queen's Medical Center Cancer Institute, 1301 Punchbowl St., Honolulu, HI 96813, phone 808/547-4660, fax 808/537-7819.

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-CP-33042-18

Title: Record linkage studies utilizing resources in population based tumor registries

Deadline: Approximately Dec. 7

NCI's Div. of Cancer Etiology wishes to contract with population based tumor registries in the U.S. and in other countries in order to collaborate in the conduct of record linkage and subsequent analytical investigations. The duties required in support of the record linkage studies include: develop a study plan which includes the evaluation of existing records that are potentially valuable for record linkage; develop or apply the appropriate record linkage procedures to link a "population file" with the cancer registry files; and provide results of the record linkage study to the project officer either on computer tape or in tabulated form as requested.

After the record linkage study has been completed, it may be desirable to consider additional analytical investigations that require beyond that found on computer tapes. Offerors should have cancer incidence data for all patients diagnosed within a defined geographic locale for at least five years during the previous decade, 1980-89, and have the ability to ascertain all cancer cases within the registries catchment area of women of all age groups and U.S. minority populations, as appropriate.

The offerors must have experience in the collection of cancer data from a variety of medical sources and multiple institutions, and must have legal authority to collect medical data within the given geographic area or be able to demonstrate the willingness of all medical facilities within that area to participate in data collection and patient followup activities. Master agreements will be awarded to all respondents whose technical proposal is considered acceptable. The initial master agreement award is nonmonetary, and is exclusively for the purpose of establishing a pool of contractors who are qualified to perform services for epidemiological studies of cancer utilizing the resources of population based tumor registries.

Each MA holder will be eligible to compete for awards of master agreement orders (MAO) to carry out specific record linkage and subsequent analytical studies. Master agreement holders receiving an MAO award will be selected from among those with a master agreement who choose to compete for the MAO RFP, based on technical merit and on budgetary considerations for the specific tasks involved.

Contract specialist: Catherine Baker
RCB Executive Plaza South Rm 620
301/496-8611