THE CANCER LETTER

Vol. 19 No. 13
March 26, 1993

Price $225 Per Year US, Canada.
$250 Per Year Elsewhere

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

Cancer Organizations Continue Reform Lobbying; Target Issues Are Off-Label Drugs, Clinical Trials

Representatives of several cancer professional organizations and patient groups met in Washington last week to share information and coordinate their lobbying on health care reform.

With Hillary Rodham Clinton's May 1 deadline for a complete health care reform proposal only 35 days away, medical organizations and patient groups are striving to make their voices heard in the din of

(Continued to page 2)

In Brief

Wells, Gardner, Brennan Lead Surgical Oncology; Young, Flynn, Are New Officers For Head & Neck

SAMUEL WELLS, Washington Univ., became president of the Society of Surgical Oncology at the organization's annual meeting last week in Los Angeles. **Bernard Gardner**, Univ. of Medicine & Dentistry of New Jersey, is president elect; **Murray Brennan**, Memorial Sloan-Kettering Cancer Center, is vice president; and **David Winchester**, Northwestern Univ., and **Kirby Bland**, Univ. of Florida, continue as secretary and treasurer, respectively. **Donald Morton**, medical director of John Wayne Cancer Institute, completed his term as president and is now chairman of the executive council, replacing **Charles Balch**. . . . **LUCY WORTHAM JAMES** awards presented by the Society of Surgical Oncology went to **Wallace Clark**, Univ. of Pennsylvania, basic research; **Glenn Steele**, Harvard Univ./New England Deaconess Hospital, clinical research; and **Michael Wayne**, son of the late actor John Wayne, film producer and chairman of the John Wayne Foundation, layman's award. . . . **BERNARD FISHER**, Univ. of Pittsburgh/ Pittsburgh Cancer Institute, presented the James Ewing Lecture. . . . **EDWARD YOUNG**, Mt. Sinai Hospital, Toronto, is the new president of the Society of Head & Neck Surgeons. Young took over from **Stephan Ariyan**, Yale Univ., at the society's joint meeting with the Society of Surgical Oncology last week in Los Angeles. Other officers include **Michael Flynn**, J.G. Brown Cancer Center, Louisville, president elect; **Robert Byers**, M.D. Anderson Cancer Center, vice president; and **Ashok Shaha**, Downstate Medical Center, Brooklyn, and **John Saunders**, Johns Hopkins, continuing as secretary and treasurer, respectively. . . . **RONALD SPIRO**, Memorial Sloan-Kettering Cancer Center, presented the Hayes Martin Lecture at the SHNS annual meeting. . . . **'IN BRIEF'** continues on page 8.

Cancer Groups Share Information, Coordinate Lobbying On Reform

(Continued from page 1)
health care advocacy in Washington.

The Assn. of Community Cancer Centers coordinated a meeting of representatives of six cancer organizations and several state oncology societies. The meeting followed from a larger retreat on health care reform that ACCC held in January (**The Cancer Letter**, Feb. 5).

Representatives from the American Society of Clinical Oncology, the Oncology Nursing Society, the American Society of Hematology, the American Cancer Society, the National Coalition for Cancer Survivorship, and the MGMA attended the ACCC meeting.

The purpose of the meeting was to share information, several participants told **The Cancer Letter.** Discussion centered around the issues common to all of the groups: the problem of reimbursement for use drugs for off-label indications and coverage of patient care costs associated with clinical trials. Other issues discussed were the ACS effort to raise the federal excise tax on cigarettes to $2, and the NCCS health care reform statement (**The Cancer Letter**, March 12).

"We're going to continue to meet to do networking and sharing," said Sandra Lee Schafer, ONS president-elect. "We decided to keep it very informal, but keep everyone informed and try not to do anything to hurt our positions."

The representatives plan to meet again at the ONS/ASCO/American Assn. for Cancer Research annual meetings in Orlando, FL, in May.

Other health care reform developments last week:

▶ The American Medical Assn. has organized a lobbying trip to Washington this week in which doctors will get an audience with HHS Secretary Donna Shalala and will take their concerns to members of Congress.

▶ President Clinton approved the revised plan by Oregon to extend Medicare coverage to more people in that state.

▶ The Presidential task force on health care reform will hold its first public meeting March 29 in Washington to hear testimony from invited groups.

"Everybody feels a little impotent right now," said Ellen Stovall, NCCS executive director. "It's like trying to hit a moving target with this task force."

There are 35 working groups advising the President's Task Force on Health Care Reform, involving about 500 people.

NCCS has made contact with the New System Coverage group, chaired by Atul Gawande, based in the Old Executive Office Building. A subgroup of that committee, the Benefits Package group, is chaired by Bob Valdez and Linda Bergthold, and is based in the HHS building.

NCCS Board Chairman Fitzhugh Mullen, a Public Health Service officer in the Bureau of Health Professions, is chairman of the Workforce Development group advising the task force on issues related to health care professionals.

"Like everyone else in Washington, we are trying to get a meeting with the task force," said Stacey Beckhardt, ASCO director of government relations. "We have been talking to key Capitol Hill people particularly on the clinical trials issue.

"It's important to send the message that doctors are not opposed to health care reform," Beckhardt said. "Doctors are concerned about what shape health care reform will take."

ACCC Statement On Health Care Reform

At its annual meeting in Washington last week, ACCC handed out copies of a short statement on health care reform to delegates who visited Capitol Hill.

Following is the statement, "Issues in Health Care Reform Affecting Cancer Patient Care and Cancer Research":

"Managed competition proposals offer cancer patients needed relief, but questions remain about several key issues. We are strongly supportive of proposed managed competition elements that:

1. Assure cancer patients of the elimination of pre-existing conditions clauses and discrimination based on health status which often prevents patients from obtaining any medical insurance or changing jobs.

2. Assure cancer patients of uniform, standardized care benefits throughout the nation so that

THE CANCER LETTER

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

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

Subscription rate $225 per year North America, $250 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter.

chemotherapy available to a patient in one part of the country is available in all parts of the country.

3. Provide incentives for insurance companies to support prevention and early detection services.

4. Eliminate discriminatory practices from self-insured employer plans.

"Among the important issues which need to also be included in any appropriate health care reform package:

1. Taxes on cigarettes. The Administration's $2 a pack tax on cigarettes is strongly supported.

2. Equal access to standard off-label use of anticancer drugs. Congress and half a dozen states have already required the uniform use of three medical compendia, assuring patients of standardized access to FDA approved drugs for labeled and off-labeled indications. We strongly support legislation (such as the Rockefeller-Levin bill) which assures all Medicare patients of equal access to these drugs. This same coverage should be assured for all patients under managed competition.

3. Coverage of investigational treatment. For progress to continue, all patients must be able to access investigational therapies. FDA, NCI and/or the pharmaceutical/ biotechnology companies provide free investigational drugs and cover the costs of data management, but the costs of patient care must also be covered. Some Medicare patients and other patients are being selectively denied access to trials, slowing the progress of the national cancer research effort on critical topics, such as breast cancer, prostate cancer and prevention research.

4. Coverage of NCI prevention trials. Any eligible U.S. citizen should have access to cancer prevention programs being conducted by the National Cancer Institute. Although participants do not have an established malignancy, their participation in pivotal research studies will help develop the tools needed to prevent cancer before it starts. This lowers costs while it saves many lives. A recent survey conducted by the ACCC found that 68% of patients who were denied access to NCI clinical trials were those volunteering for cancer prevention trials. The great majority of these were women working to prevent breast cancer."

ASCO Comments To House Ways & Means

ASCO submitted comments to the House Ways and Means Subcommittee on Health last month. The five-page paper, "Health Care Reform and Its Impact on Cancer Care," is as close to a formal statement on reform that the society has issued to date.

Following are excerpts:

"Health care reform must recognize the needs of the 8 million Americans now living as cancer survivors. People with cancer suffer disproportionately from the deficiencies in the present health care system. The problems encountered by those currently or formerly diagnosed with cancer include:

--discrimination on the basis of health status against individuals diagnosed with cancer or their family members to prevent them from obtaining insurance;

--use of pre-existing condition clauses to restrict unfairly the extent of coverage for those able to purchase insurance;

--pricing policies for insurance based on experience rating rather than community rating, which unfairly penalizes small groups and subjects people with cancer to potential job discrimination;

--exposure to catastrophic out-of-pocket expenses because insurance coverage is inadequate;

--arbitrary denial of coverage for cancer treatment involving either unlabeled indications of drugs approved by the Food and Drug Administration or investigational therapy given pursuant to a clinical trial.

"Virtually any approach to reform likely to receive serious consideration will address many of these problems, including discrimination, pre-existing conditions, pricing and rating practices, and maximum out-of-pocket expenditures. However, there is not cause for similar optimism concerning the nature and extent of coverage for cancer treatment to be offered in any reform proposal.

"In a reformed system, benefits for cancer treatment must be at least as comprehensive as those in the Medicare program. This includes coverage for services (including drugs used as part of an anticancer regimen) provided incident to a physician service. However, to ensure access to high quality care, these benefits must be expanded to include explicit coverage for drugs prescribed for indications not specified on the FDA label as well as for patient care costs associated with participation in clinical trials. Optimally, coverage should also be extended to outpatient drugs, prevention services including health education, and diagnostic screening for diseases like cancer that are more readily treatable if diagnosed early.

"Furthermore, the reformed system must ensure every individual with cancer access to a trained oncologist or other specialist in the treatment of that disease. To the extent that managed care is part of the health care reform solution, every plan should be required to provide adequate oncology and other specialty services.

Unlabeled Indications of FDA-Approved Drugs

"Modern oncologic practice requires the frequent use of drugs for indications other than those specifically approved by FDA. Somewhere between one-half and three-fourths of the uses for anticancer drugs involve these so-called unlabeled indications.... FDA itself has always recognized the physician's prerogative to use approved drugs in ways other than contemplated on the label. In a 1982 Drug Bulletin, FDA stated that the Food, Drug & Cosmetic Act "does not...limit the manner in which a physician may use an approved drug." Moreover, "[once] a product has been approved for marketing," according to the agency, "a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling." This view has been supported by the Health Care Financing Administration, the National Cancer Institute, and the Institute of Medicine, as well as national representatives of the insurance industry.

"Coverage for unlabeled indications was studied extensively by the National Committee to Review Current Procedures for New Drugs for Cancer and AIDS (the "Lasagna Committee") appointed by then Vice President Bush. The committee recommended coverage for unlabeled indications where such uses are listed in one of the three medical compendia or otherwise supported by the medical literature.

"In response to the Lasagna Committee report, both the Health Insurance Assn. of America and the Blue Cross/Blue Shield Assn. have liberalized their positions on this issue. In addition, the Medicare program has long pursued a policy, as reflected in the Medicare Carriers Manual, of permitting coverage of unlabeled indications, particularly in the area of cancer treatment. Yet, despite what appeared to be consensus regarding coverage of unlabeled indications, many private insurers as well as several Medicare carriers have refused payment for unlabeled indications on the spurious ground that such uses are "experimental," "investigational," or "not acceptable medical practice."....

"Several recent studies conducted by the General Accounting Office have demonstrated the severity of this problem. In September 1991, GAO released the results of a national survey concerning reimbursement for unlabeled indications. More than half of the respondents indicated reimbursement problems during the previous 12-month period. A followup study was published in July 1992. GAO examined the impact of reimbursement decisions on the setting and cost of chemotherapy administration. GAO observed that some patients are receiving care in hospital settings when, by clinical standards, treatment could have been provided in the office and that financial factors are influencing the choice of treatment setting. GAO concluded that Medicare reimbursement policies for unlabeled indications may negatively affect 'where a cancer patient gets treatment and, as a result, Medicare costs for that patient's care.'

"To resolve this problem, carrier discretion in this area must be curtailed and a national policy adopted to ensure all cancer patients access to state-of-the-art treatment. This policy must affirmatively require carriers to reimburse unlabeled indications of FDA approved agents when such uses are referenced in one of the three authoritative medical compendia or otherwise supported in the peer-reviewed literature.

Patient Care Provided in Clinical Trials

"Substantial progress in treating cancer has been made over the course of the past two decades through clinical research. Patient enrollment in clinical trials not only enables this progress to continue, but also provides access to the best available care to people with cancer. In recent years, however, many third-party payers--including the Medicare program--have targeted clinical research as a means of controlling costs. Many insurers will deny coverage for patient care costs involved in clinical trials even through the care is probably superior to that which would have been received off protocol, particularly in the treatment of cancer....

"It is critical that any health care reform proposal include, as part of the minimum benefits requirement, provision for reimbursement in connection with care provided in clinical trials. By doing so, a reformed health care system can encourage advances in medicine and evaluate the relative outcome and effectiveness of treatments. At the same time, this coverage policy would allow desperately ill patients access to optimal care, regardless of their ability to pay.

"To ensure access to high quality cancer care, the cost of medical care provided when a patient is entered on a Phase I, II, III, or IV (post-marketing) clinical trial--including hospital, physician, and other health care services as well as the cost of approved agents for labeled or unlabeled uses which might be part of the regimen--should not be denied coverage and reimbursement when all of the following are demonstrated:

--Treatment is provided with therapeutic intent;

--Treatment is being provided pursuant to a clinical trial which has been approved by NCI, any of its cancer centers, cooperative groups or community clinical oncology programs; FDA in the form of an investigational new drug exemption; the Dept. of

Veterans Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants.

--The proposed therapy has been reviewed and approved by a qualified institutional review board;

--The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;

--There is no clearly superior, noninvestigational alternative to the protocol treatment;

--The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the alternative.

"Coverage policy based on these standards would strike an appropriate balance for any third-party payment system because it recognizes that therapy which has not been definitively established as the standard of care should be reimbursed only in a carefully controlled context where ethics, potential effectiveness, and contribution to medical progress are taken into account. This position is supported not only by the physician and research community, but also by patients and survivors of cancer as represented by the National Coalition for Cancer Survivorship."

Immunobiology Of AIDS Lymphomas Wins Concept Approval By DCBDC

Advisors to NCI's Div. of Cancer Biology, Diagnosis & Centers have given concept approval to a new RFA to stimulate research on the biologic and immunologic mechanisms in the development of AIDS-related lymphomas.

The DCBDC Board of Scientific Counselors approved a set-aside of $1.5 million per year for four years to fund seven to eight R01 grants.

Following is the concept statement:

Immunobiology of AIDS lymphomas. Proposed new RFA, $1.5 million per year, four years. Seven to eight R01 awards. Program director: John Finerty, Cancer Immunology Branch, DCBDC.

The intent of this initiative is to stimulate research on biologic and immunologic mechanisms involved in the development of lymphomas in AIDS patients. Specifically, this initiative will encourage development and testing of hypotheses about the mechanisms of lymphomagenesis in the unique immune environment induced by HIV infection. This environment is characterized by defects in immune regulation, loss of specific immune cell subsets, presence of abnormal cytokine levels, changes in the architecture of germinal centers and other lymphoid tissues and an apparent loss of immune surveillance. Any or all of these factors may play a role in the high incidence and distinctive characteristics of AIDS associated lymphoma. The dysregulation may lead to an increase in the rate of generation of transformed lymphocytes and/or to enhanced capacity of these cells to escape surveillance and cause disease. Before effective therapies can be designed, it is necessary to understand the basic mechanism of lymphomagenesis in AIDS.

The incidence of NHL has increased steadily during the past decade, with the most dramatic increase occurring in the AIDS associated B-cell lymphomas. As AIDS patients are living longer, NHL has emerged as a major clinical problem in AIDS. The causes of this are poorly understood. Yet, during the same decade, tremendous progress was made in elucidating mechanisms of B and T lymphocyte regulation in both normal and immunodeficient paitents. Initially, the emphasis was focused on elucidating the cellular and molecular mechanisms that govern the function of the immune system in normal individuals. Comparisons have been made between immune mechanisms in non-immunodeficient and immunodeficient individuals. It is obvious that deficiencies in the functioning components of the immune system, e.g., B or T cells, could readily account for the lack of resistance to infectious diseases in immunodeficient animals and patients. But no such explanation is readily available to explain the etiology and pathogenesis of AIDS associated lymphomas. Studies have shown that similar immune abnormalities exist among congenitally immunodeficient, iatrongenically suppressed and AIDS patients. For example, low numbers of CD4+ T cells can be found in the peripheral circulation of all three groups of patients. Similarly, abnormal cytokine levels are detected in both non-AIDS and AIDS patients. This is best exemplified by high levels of interleukin 6 detected in the common variable immunodeficiency syndrome and AIDS patients. This apparently reflects lack of normal B cell function in both groups of patients. However, other studies have shown distinct differences between AIDS patients and other immunodeficiencies. For example, Epstein-Barr Virus was reported to induce essentially all of the B lymphomas in post-transplant recipients, whereas EBV appears to play a lesser role in AIDS associated lymphomas. Other studies indicated that HIV and other retroviruses do not play a direct role in inducing AIDS lymphomas.

On one level, the factors that lead to lymphomagenesis in AIDS are understandable, but the data that support this understanding are largely correlative and details are lacking. Factors that have been suggested to play a role in AIDS lymphomagenesis include, but are not limited to, loss of immune surveillance, infection by EBV and other viruses, chronic antigenic stimulation, high levels of stimulatory cytokines (especially IL-6), low levels of inhibitory cytokines, oncogene activation, other increases in DNA damage and alterations in DNA repair mechanisms. For every factor, important questions remain unanswered and will remain so until incisive, mechanistic studies are undertaken.

This initiative is designed to encourage development of new, hypothesis-driven experimental approaches to the AIDS lymphoma problem. The tremendous progress made in recent years in elucidating mechanisms of B and T lymphocyte regulation in normal and immunodeficient individuals, and the development of appropriate animal models and experimental techniques, should facilitate this undertaking.

This initiative focuses on encouraging formulation and testing of hypotheses based on the observed characteristics of AIDS lymphomas, the known pattern of immunopathology

in AIDS and state-of-the-art concepts in immunology and lymphocyte biology.

NIH Issues Interim Guidelines For Research Using Fetal Tissue

NIH last week issued interim guidelines for supporting and conducting therapeutic human fetal tissue transplantation research.

The guidelines are in response to the Jan. 22 executive order from President Bill Clinton ending the moratorium in effect since 1988 banning the federal funding of research involving transplantation of fetal tissue from induced abortions.

HHS Secretary Donna Shalala on Feb. 1 directed NIH to develop interim guidelines, based on the recommendations of the 1988 Human Fetal Tissue Transplantation Research Panel, to ensure that Federal funding of therapeutic human fetal tissue transplantation research does not encourage the choice of abortion.

Following are the NIH interim guidelines:

Separating Abortion from Research

--The decision to terminate a pregnancy and the abortion procedures should be kept independent from the retrieval and use of fetal tissue.

--The timing and method of abortion should not be influenced by the potential uses of fetal tissue for transplantation or medical research.

Prohibiting Payments and Other Inducements

--Payments and any other forms of remuneration, compensation or benefit associated with the procurement of fetal tissue should be prohibited, except payment for reasonable expenses occasioned by the actual retrieval, storage, preparation, and transportation of the tissues.

Informed Consent

--Potential recipients of such tissues, as well as research and health care participants, should be properly informed about the source of the tissues in question.

--The decision and consent to abort must precede discussion of the possible use of the fetal tissue and any request for such consent that might be required for that use.

--Fetal tissue from induced abortions should not be used in medical research without the prior consent of the pregnant woman. Her decision to donate fetal material is sufficient for the use of tissue, unless the father objects (except in the cases of incest or rape).

--Consent should be obtained in compliance with state law and with the Uniform Anatomical Gift Act.

Prohibiting Directed Donations

--The pregnant woman should be prohibited from designating the transplant-recipient of the fetal tissue.

--Anonymity between donor and recipient should be maintained, so that the donor does not know who will receive the tissue, and the identity of the donor is concealed from the recipient and transplant team.

--Experimental transplants performed with fetal tissue from induced abortions provided by a family member, friend or acquaintance should be prohibited.

Abiding by State Laws

--Researchers in states with statutes appearing to ban fetal tissue transplants should seek clarification of the law.

Ethical Review of Research

--Customary review procedures should apply to research involving transplantation of tissue from induced abortions.

Determining When Progress to Clinical Studies Is Justified

--Sufficient evidence from animal experimentation is needed to justify proceeding to human clinical trials. Acceptable preliminary data must be presented to an appropriate Institutional Review Board, NIH Initial Review Group, and National Advisory Council before Public Health Service funds would be available.

Development of final guidelines

NIH is beginning to develop formal guidelines for this area of research. Until final guidelines are issued, the provisions outlined above will constitute NIH's interim policy guidance for the support and conduct of therapeutic human fetal tissue transplantation research.

Comments on this interim policy will be considered in the preparation of the final guidelines.

Comments and questions about the interim guidelines may be directed to: F. William Dommel Jr., Senior Policy Advisor, Office for Protection from Research Risks, Building 31, Room 5B59, Bethesda, MD 20892, Tel. 301/496-7005.

NCI Advisory Group, Other Cancer Meetings For April, May, Future

Diagnosis & Treatment of Neoplastic Disorders, Medical, Surgical & Radiotherapeutic Aspects--April 1-2, Baltimore, MD. Contact Johns Hopkins Office of Continuing Education, phone 410/955-2959.

President's Cancer Panel--April 1, San Francisco, CA. Topic: Breast cancer SPORE and the relationship with area breast cancer patient organizations. Iris Schneider, acting executive secretary, 301/496-1148.

European Assn. for Cancer Research Biennial Meeting--April 4-7, Brussels, Belgium. Contact Prof. M. Roberfroid, tel. 32-2-764-73-69; fax 32-10-45-40-99.

National Council on Radiation Protection and Measurements--April 7-8, Arlington, VA. Contact NCRPM, phone 301/657-2652.

Reconstructive Surgery & Microsurgery for Cancer Patients--April 12-16, Keystone, CO. Contact Conference Services, M.D. Anderson Cancer Center, phone 713/792-2222.

Anticarcinogenesis & Radiation Protection--April 18-23, 1993, Baltimore, MD. Contact Dr. J. Corn, Room 6001, Johns Hopkins School of Hygiene & Public Health, 615 N. Wolfe St., Baltimore, MD 21205, phone 410/955-9334.

Loss of Genomic Integrity in Neoplasia--April 21-23, Chapel Hill, NC. Contact Vickie McNeil, UNC Lineberger Comprehensive Cancer Center, phone 919/966-3036.

Anticarcinogenesis and Radiation Protection--April 22, Baltimore, MD. Contact Virginia Rutter, Johns Hopkins Univ., phone 410/955-6878.

Mechanisms of Carcinogenesis--April 23, Memphis, TN. Contact Dr. James Hamner, Univ. of Tennessee, phone 901/528-6354.

American Radium Society Annual Meeting--April 24-28, Aruba. Contact Office of the Secretariat, phone 215/574-3179.

American Roentgen Ray Society Annual Meeting--April 25-30, San Francisco, CA. Contact ARRS, phone 703/648-8992.

Breast Cancer Research: Current Issues, Future Directions--April 25-28, Atlanta, GA. Contact Continuing Medical Education, Emory Univ. School of Medicine, 1440 Clifton Rd NE 107 WHSCAB, Atlanta, GA 30322, fax 404/727-5667.

International Assn. for Breast Cancer Research--April 25-28, Alberta, Canada. Contact Continuing Medical Education, Univ. of Calgary, phone 403/220-7240, fax 403/270-2330.

International Cancer Chemoprevention Conference--April 28-30, 1993, Berlin, Germany. Contact Dr. Waun Ki Hong, M.D. Anderson Cancer Center, Neck & Thoracic Medical Oncology, 1515 Holcombe Blvd Box 080, Houston, TX 77030, phone 713/792-6363.

National Cancer Advisory Board--May 4-5, NIH Bldg. 31 Conf. Rm. 10.

NCI Div. of Cancer Prevention & Control Board of Scientific Counselors--May 6-7, NIH Bldg. 31 Conf. Rm 6.

Administrators in Oncology/Hematology Assembly--May 6-8, Nashville, TN. Contact W. Robert Cooper, phone 309/672-5681.

Oncology Nursing Society Annual Congress--May 12-15, Orlando, FL. Contact ONS, phone 412/921-7373.

American Society of Clinical Oncology Annual Meeting--May 16-18, Orlando, FL. Contact ASCO, phone 312/644-0828.

American Assn. for Cancer Research Annual Meeting--May 19-22, Orlando, FL. Contact AACR, phone 215/440-9300.

Future Meetings

American Cancer Society National Conference on Breast Cancer--Aug. 26-28, Boston, MA. Contact Andy Cannon, ACS, phone 404/329-7604, fax 404/636-5567.

Living Fully With Cancer--Sept. 10-11, Houston, TX. Contact Jeff Rasco, MD Anderson Cancer Center, phone 713/792-2222.

Immunocytochemistry Pathology Review Workshop--Nov. 3-5, Philadelphia, PA. Contact Kathy Smith, Fox Chase Cancer Center, phone 215/728-5358.

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-37816-64

Title: Production of clones producing chimeric monoclonal antibodies and other genetically engineered targeting molecules for the treatment of human malignant disease

Deadline: Approximately May 21

NCI will receive proposals from qualified organizations to be selected for unfunded three year Master Agreements. All Master Agreement holders will be eligible to apply for other Master Agreement Orders in response to future RFPs issued under this Master Agreement mechanism. In addition, offerors who respond to the specific MAO which is being issued together with this solicitation may receive a funded award. However, response to the MAO is not mandatory. Both nonprofit and for profit organizations may apply.

NCI's Biological Response Modifiers Program desires the capacity to produce genetically engineered targeting molecules of clinical grade in large quantities. These targeting molecules include, but are not limited to, mouse-human chimeric monoclonal antibodies, humanized chimeric monoclonal antibodies, fully human monoclonal antibodies, truncated antibody molecules (such as ▲CH2 antibodies), single chain antigen-binding agents, and fusion proteins (such as antibody/cytokine constructs.

The present RFP solicits proposals from qualified contractors for the generation of cell clones capable of large scale production of specific antigen-binding targeting molecules. As a first MAO to this MA, the BRMP desires the production of a CH2 domain deletion (▲CH2) monoclonal antibody secreting clone from a cell line called SdR24.15.4.21 (chR24). This cell line is the mouse/human chimeric clone derived from the murine anti-disialoganglioside GD3 monoclonal antibody R24 and the human yl heavy chain. The resulting clone shall produce a targeting molecule having the same antigen binding activity as ChR24, both in terms of reactivity with GD 3+ tumor cell lines and the ability to stimulate GD 3+ T-lymphocytes. Specifically the MA holder shall generate: 1) Clones of cells capable of producing the desired targeting molecule, 2) 25 to 50 mg of purified chimeric antibody or other targeting agent produced by each delivered clone, and 3) the results of product testing and evaluation of these clones and their products. The MA holder shall deliver the specified clones to NCI within 15 months of the award of the MAO.

Contract specialist: Carl Newman, RCB Executive Plaza South Rm 603, phone 301/496-8620.

RFA Available

RFA CA/ES-93-024

Title: **Environmental factors and breast cancer in high-risk areas**

Letter of Intent Receipt Date: April 16

Application Receipt Date: May 20

The Extramural Programs Branch of NCI's Div. of Cancer Etiology and the Div. of Extramural Research and Training, National Institute of Environmental Health Sciences, invites grant applications for innovative epidemiologic studies to better understand the etiology of breast cancer in high risk areas including Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Washington, DC. These studies are to be designed to take known risk factors into consideration and must focus on markers or indicators of environmental exposures that may influence geographic differences in rates and temporal changes in incidence and mortality.

Support will be through the NIH research project grant (R01). Because the nature and scope of the research proposed may vary, it is anticipated that the size of an award will vary also. The average award will be approximately $250,000 total costs. Total project period may not exceed four years. Approximately $1 million per year in total costs for four years will be committed by NCI. In addition, $250,000 will be committed by NIEHS to fund at least one application. The expected range of number of awards is three to five.

This RFA responds to the FY 1993 Senate Appropriations Subcommittee Report for NIH which specifies that "NCI is directed to conduct a study with four years of follow-up to determine the factors contributing to the high breast cancer mortality rates" in the above mentioned areas.

This RFA encourages applications for epidemiologic studies of breast cancer that include assessment of markers or indicators of environmental or occupational exposures, and include persons residing in the high-risk areas. These studies are to be designed to take known risk factors into consideration while focusing on environmental exposures that may account for geographic differences in rates, as well as temporal changes in incidence and mortality. Investigators must include innovative approaches to the quantitation of environmental and/or occupational exposures and the evaluation of biologic levels in exposed persons. Collaborations of multiple disciplines and research institutions are particularly encouraged. Whenever possible, research designs should make use of existing resources, such as specimen repositories.

Investigators may propose studies for evaluating the mechanisms by which environmental, nutritional, or occupational exposures could act in the initiation or promotion of breast cancer, such as through effects on hormonal or metabolic pathways. Projects should be proposed as traditional R01s. Proposals may build upon ongoing research projects, utilizing already collected specimens or epidemiologic data.

Inquiries may be directed Drs. A.R. Patel or Kumiko Iwamoto, NCI Div. of Cancer Etiology, 6130 Executive Blvd, Executive Plaza North Suite 535, Rockville, MD 20892; Tel. 301/496-9600; or Dr. William Suk, Div. of Extramural Research and Training, NIEHS, PO Box 12233, Research Triangle Park, NC 27709; Tel. 919/541-0797.

In Brief

Surgical Society Launches Journal; Carbone Is Assoc. Dean At Wisconsin

(Continued from page 1)

. . . . **NEW JOURNAL**, the "Annals of Surgical Oncology," will be published by the Society of Surgical Oncology beginning in January, 1994. Charles Balch is the editor, with Edward Copeland, Murray Brennan, and Donald Morton as associate editors. Subscription rate for the bimonthly is $122.50 in the U.S., $142.50 elsewhere. Contact Raven Press, Dept. 1B, 1185 Ave. of the Americas, New York 10036. Manuscripts are being solicited and may be sent to Balch, Dept. of Educational Publishing Services, M.D. Anderson Cancer Center, 1515 Holcombe Blvd., Houston, TX 77030. . . **PAUL CARBONE**, director of the Univ. of Wisconsin Comprehensive Cancer Center, has been appointed associate dean for program development in the UW Medical School. In addition, Carbone has been named the Virginia Wattawa Bascom Professor in Cancer Research by the Board of Regents. The professorship was created to advance the quality of cancer research and patient care within the medical school by supporting a faculty member in the cancer center. . . **WILLIAM HAIT** has been named director of the Cancer Institute of New Jersey. Gov. Jim Florio announced the appointment recently. Hait, formerly associate director of the Yale Univ. Comprehensive Cancer Center, also has been appointed professor of medicine and pharmacology and chief of medical oncology at UMDNJ-Robert Wood Johnson Medical School. The Cancer Institute of New Jersey is a partnership of UMDNJ, New Jersey's Univ. of the Health Sciences; UMDNJ-Robert Wood Johnson Medical School; Robert Wood Johnson Univ. Hospital; St. Peter's Medical Center; and New Brunswick Affiliated Hospitals. Last year the institute received a $720,000 planning grant from NCI's Cancer Centers Program and a $10 million federal appropriation for capital expenditure. The institute plans to break ground early this year for a 75,000 square foot building in new Brunswick to house outpatient treatment areas and research laboratories. . . . **ROBERT JONES** has been named chairman of the Dept. of Anesthesiology and Critical Care at M.D. Anderson Cancer Center. Jones, formerly of Univ. of Colorado School of Medicine, succeeds Hollis Bivens, who retired last August. . . . **FASEB AWARDS:** The Federation of American Societies for Experimental Biology named **Ronald Kaback** and **Peter Nowell** recipients of the 3M Life Sciences Award. Kaback, Howard Hughes Medical Institute and Univ. of California (Los Angeles), pioneered the use of membrane sacs and provided evidence in support of the theory of how membranes use and store energy. Nowell, Univ. of Pennsylvania School of Medicine, made the discovery that phytohemagglutinin stimulated growth and division of white blood cells, enabling the study of human chromosomes; and with David Hungerford, he described the chromosomal abnormality associated with myeloid leukemia, the first firm evidence that cancers develop as a result of genetic changes in otherwise normal cells. **Susan Leeman**, Boston Univ. School of Medicine, will receive the FASEB Excellence in Science Award for her discoveries in neuroendocrinology. She is credited with discovering the neuropeptides neurotensin and substance P.