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NCAB Task Force Urges New Study Section For Clinical Cancer Research, Sees 'Crisis'

NIH should create a study section devoted exclusively to clinical cancer research, a National Cancer Advisory Board subcommittee said this week.

The NCAB's Clinical Investigations Task Force voted unanimously to recommend that the Board urge the NIH Div. of Research Grants to charter a study section for review of clinical cancer R01 grant applications. The NCAB vote was expected later this week.

"There is a crisis in clinical research," said NCAB Chairman Paul

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In Brief

Henderson Named To HHS Post; Nurses Support Cigarette Tax Increase; FDA Staff Changes

DONALD A. HENDERSON has been named deputy assistant secretary for health and science at the Dept. of Health & Human Services. Henderson, former dean of Johns Hopkins Univ. School of Hygeine and Public Health, was associate director for life sciences in the White House Office of Science & Technology Policy in the Bush Administration. At HHS, Henderson will help direct the Clinton Administration's child immunization initiative. Henderson, who directed the World Health Organization campaign to eradicate smallpox, spoke to the 1991 annual meeting of the Assn. of American Cancer Institutes, addressing the need for greater support of biomedical research (**The Cancer Letter,** Aug. 16, 1991). . . . **ONCOLOGY NURSING** Society Board of Directors issued a statement supporting an increase in the federal excise tax on cigarettes of at least $2 per pack. The tax increase is likely to reduce tobacco use by 23 percent and encourage more than seven million Americans not to smoke, preventing 2 million premature deaths, the society said. . . . **HAROLD VARMUS**, Univ. of California (San Francisco) is rumored to be under consideration for the post of NIH director. . . . **BRUCE BURLINGTON** was appointed director of FDA's Center for Devices and Radiological Health. Since 1988 he has been deputy director of the Office of Drug Evaluation II in the Center for Drug Evaluation and Research. Since 1990, he has been deputy director for medical affairs of CDER. He succeeds **James Benson**, who left FDA. . . . **JEROLD MANDE** was appointed acting associate commissioner of FDA's Office of Legislative Affairs. Mande has served since 1991 as a policy analyst for FDA Commissioner **David Kessler**. He was legislative assistant to former Rep. **Al Gore**. He replaces **Kathleen Holcombe**, who left the agency to work for Rep. **John Dingell** (D-MI). . . . **'IN BRIEF'** is continued to page 8.

NCAB Task Force To Urge Creation Of Clinical Cancer Study Section

(Continued from page 1)

Calabresi, also chairman of the task force.

NCI has tried over the past two years to encourage clinical investigators to submit R01 grant applications. However, the effort has not resulted in substantially improved funding for clinical research through the RO1 grant "pool," the money available for investigator-initiated research, task force members said at a meeting this week.

In the past year, 14 percent of cancer-related R01 applications were funded overall, but only 8 percent of clinical cancer applications were funded, NCI staff said. The success rates for basic and clinical research should be equal, task force members said.

In each of four grant funding rounds in the past year, there were "two to three" clinical applications--12 total--that fell a few points over the payline and were not funded, said Diane Bronzert, in NCI's Div. of Cancer Treatment.

These applications were in competition with basic research applications reviewed in the same study section, Experimental Therapeutics 2 (ET2). Anytime basic and clinical applications are reviewed together, the basic research always fares better, NCI staff and task force members said.

"It is not a level playing field," said NCAB member Sydney Salmon. Though 11 reviewers on ET2 are members of the American Society of Clinical Oncology, there are "six to seven other people who are not involved in clinical research," Salmon said. "If you have identified 12 applications that should have been funded, then there is a problem."

Only a permanent study section will address the issue of sustained, reliable funding for clinical research, task force members concluded.

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Appeal To NIH Director

If the full NCAB agrees, the advisors will have to take the case for a new study section to the Div. of Research Grants (DRG).

In 1991, DRG Director Jerome Green turned down NCI's request for a clinical study section, stating that the relatively low number of clinical applications submitted did not warrant forming a new peer review group.

The request was made by NCI Director Samuel Broder.

NCI advisors and staff argued that the number of applications would increase as soon as investigators felt the review process became equitable to clinical research. NCI then embarked on a campaign to encourage clinical investigators to submit R01 applications in the hopes of forcing ET2 to become entirely clinically-oriented (**The Cancer Letter**, March 8, 1991).

The goal was to "flood the system" with clinical applications, forcing ET2 to "reorient" itself entirely to clinical research. NCI executives now acknowledge that the effort was not successful.

Most likely, the Board and clinical investigators who support the idea of a new study section will have to make themselves heard by the NIH director. Bernadine Healy leaves that job June 30.

Call For Radical Change

"The [peer review] system has to be revised," Emil (Jay) Freireich, chairman of the Dept. of Hematology, M.D. Anderson Cancer Center, said to the task force. Freireich spent a year at NCI in 1990 studying the problem of clinical research funding and training.

"All other subspecialties have study sections" except for oncology," Freireich said. "There are 10 AIDS study sections.

"It is very evident that we're not attracting young people," Freireich said. "We've come to believe that clinical research is working on samples from patients." Clinical research should be defined as "research on whole patients," he said.

"Crisis number one is, we've got to stop kidding ourselves about what is clinical research. In conquering disease, all relevant observations are not made in the laboratory," Freireich said.

The second problem is training. MD/PhD training programs, designed to encourage clinical science, have instead moved many clinicians into basic research, Freireich said.

"The teaching of clinical science also is faltering in the medical schools," Freireich said. "Medical schools are dominated by PhDs."

Brian Kimes, director of NCI's Centers, Training and Resources Program, said NIH peer review is organized primarily for review of basic research.

"Eighteen years ago, there was no uniformity in how basic science was reviewed," he said to the task force. "A standing study section establishes a rigorous standard for a field. It is an educational tool."

As the basic science peer review became more standardized, applications began to improve, and there was less variation between applications with fundable priority scores and those with lower scores, Kimes said.

Preparing a clinical application is more complex than preparing a basic research application, said Kimes. When clinical investigators are denied funding, it is more difficult for them to get their groups together to resubmit their applications.

"The issue is not how many clinical investigators we're not funding, but how many we are not even seeing in the system," Kimes said.

The Cancer Centers Program asked NCI-supported clinical cancer centers to establish internal protocol review systems to standardize clinical research within each center, Kimes said. Also, centers have established clinical training programs.

"We are trying to set up cultures of rigor," Kimes said.

"This is the first time I've ever heard this," NCAB member Samuel Wells said. There is "a huge difference" in quality among clinical grants, he said.

"Unless we get a study section, we are never going to upgrade," Wells said.

If a new clinical study section is created, it should consist of new reviewers, have a new executive secretary, and a clearly defined charge, Kimes said. "You are fighting a cultural thing. Start out clean," he said.

'People Are Frustrated'

Task force members and some NCI staff said the time for study and analysis was over.

"People are frustrated," Cancer Therapy Evaluation Program Director Michael Friedman said. "If this body feels it is important to have a clinical study section, that should be your recommendation."

Friedman advised the task force to draft its recommendations and then meet with DRG officials. "More than likely, they will say no for a variety of reasons, and then you will decide how vigorously to pursue this," he said.

"I feel very strongly about this," Calabresi said. "There seems to be no question in our minds that we are going to pursue this."

NCAB member Charles Wilson suggested the task force "use a stronger word than 'request'" for a new study section. "Something short of demand."

President Clinton's executive order to reduce the number of federal advisory panels by a third could present a problem--or an opportunity--said Marvin Kalt, deputy director of NCI's Div. of Extramural Activities.

As a result of the order (**The Cancer Letter**, April 2), NIH is rethinking how it uses outside advisors, he said.

"This may be a time that change can be addressed," Kalt said. "There may be forced radical changes in peer review."

Calabresi said the task force will ask to meet with DRG Director Green.

Komen Foundation Shifts Emphasis To Access By Medically Underserved

In recent months the Susan G. Komen Breast Cancer Foundation has changed its national agenda to emphasize the issues of access to mammography screening by the medically underserved.

The shift coincides with the change of Administrations and the emergence of another patient advocacy group, the National Breast Cancer Coalition, which took the lead in lobbying for an increase in appropriations for breast cancer research last year.

"We don't need to duplicate the Breast Cancer Coalition in lobbying for an increase in appropriations for breast cancer research," a source said to **The Cancer Letter.** "We can support their efforts." Though Komen has at times worked closely with the Breast Cancer Coalition, it never formally joined that group.

Sources said that for the past 18 months, the foundation has been reconsidering its programs to emphasize the issues of access to breast screening by minorities and the economically disadvantaged. However, implementation of these programs began earlier this year, sources said.

Last year, the foundation raised $5.8 million. More than half of that amount, $3 million, was raised through "Race for the Cure," held in 35 cities in the U.S. In 1994, Charleston, SC, will become the 36th city to hold such a race.

Altogether, 75 percent of the funds raised through the races, stay in the communities where the money is raised. "Most cities use the money to provide better access to mammography screening by the medically underserved," Elin Greenberg, the foundation's 1993 chairman said to **The Cancer Letter.** The remaining 25 percent is sent to the foundation's headquarters in Dallas to fund national programs.

On the national level, the foundation's priority is to fund research by postdoctoral fellows, who receive up to $30,000 a year for three years.

"What we've done is take what has been on the agenda on the local level in 35 cities and extended it to the federal level," Ginger Pape, a Komen board member said to **The Cancer Letter.** Pape's consulting firm, the Neaher Pape Company, represented the foundation in Washington until last year.

Since Pape's move to the foundation's board earlier this year, the foundation has been represented by Patton, Boggs & Blow, a Washington law firm with strong ties with the Democrats. Several observers said Patton, Boggs was a savvy choice for the 10-year-old foundation, which has been associated with the Republican Party.

Nancy Brinker, a breast cancer survivor who formed the foundation and named it after her sister who died of the disease, was appointed by George Bush to the National Cancer Advisory Board and the President's Cancer Panel.

For the past three years, the National Race for the Cure, the most visible of the races supported by the foundation, has had the same honorary chairmen: Marilyn and Dan Quayle.

Disease 'Makes No Distinction'

"Breast cancer makes no distinction between Republicans, Democrats or Independents," Greenberg said to **The Cancer Letter.** "From the start, Mrs. Brinker was going to be involved with anyone who could afford positive change for breast cancer patients. We hope to have the same kind of relationship with whomever is in the White House and the vice president's office."

Last month, the foundation was among the sponsors of a symposium on "Minorities, the Medically Underserved & Cancer." The biennial meeting, which was co-sponsored with M.D. Anderson Cancer Center, Baylor College of Medicine and the Methodist Hospital System, was devoted to the problems of access to mammography screening by African Americans, Hispanics, Native Americans, Asians and the Appalachian poor. Joycelyn Elders, the U.S. Surgeon General designee, was the keynote speaker.

On Capitol Hill, the foundation appears to have succeeded at amending the NIH reauthorization bill to instruct the NCI director to strengthen breast cancer control programs "including community based programs designed to assist women who are members of medically underserved populations, low income populations or minority groups."

Hill sources said the provision, introduced by Rep. John Bryant (D-TX), is likely to survive the House-Senate conference committee.

"We are going to be putting more emphasis on access to screening, and the logical place will be the Centers for Disease Control breast and cervical cancer screening program," said Kate Boyce, a partner at Patton Boggs, who represents Komen in Washington. "We'd like to see that program expanded from 16 to all 50 states."

The upcoming National Race for the Cure could well offer the most clear indication of the foundation's adaptability. This year's honorary cochairmen are Tipper and Al Gore. Virginia Kelley, the President's mother, is expected to walk a stretch of the race. She will be wearing a pink visor identifying her as a breast cancer survivor.

Capitol Notes

Clinton Budget Disappointing, 'Distorted,' AACR Testifies

The President's budget proposal requests a disappointingly low level of funding for NCI and NIH, Margaret Foti, executive director of the American Assn. for Cancer Research, said at a hearing of the Senate Labor, HHS and Education Appropriations Subcommittee.

"We are very disappointed with the Administration's budget request for NIH and NCI," Foti, who is also president-elect of National Assn. for Cancer Research, said at a hearing April 26.

Excerpts from Foti's statement follow:

"The President's request for $10.7 billion for NIH, an increase of 3.2 percent, is very distorted. In the absence of the Department of the Army transfer of funds for breast cancer, the overall NIH budget increase is only 1.1 percent.

"Under the Administration's request, nine of the Institutes would actually receive a decrease from their 1993 appropriation. For NCI, the Administration's budget request, excluding the Department of Defense transfer, is only $1.975 billion, or .15 percent below the 1993 appropration.

'Biomedical Research Not Top Priority'

"In the year in which health care access and its affordability are among the most pressing issues facing Congress and the Administration, it is ironic that the President has not made biomedical research a top priority.

"Biomedical research is a crucial link in the chain of improved health for all Americans, an investment that

saves lives and reduces untold suffering. Yet, the $10.36 billion appropriated to NIH for 1993 and the $10.67 billion requested for 1994 is less than 2 percent of our nation's $800 billion health care spending.

Foti repeated the AACR and NCCR request for the $3.2 billion bypass budget for NCI (**The Cancer Letter**, March 12). However, echoing the testimony of other NCCR members who testified at House appropriations hearings earlier, Foti said, "if there is not enough money to appropriate the bypass budget for 1994, we recommend, as a minimum incremental step to achieve the bypass funding level, an increase of $380 million to strengthen and maintain our nation's cancer program."

ACS Asks NCI To 'Carefully Consider' Mammography Guidelines Decision

In a letter to NCI Director Samuel Broder, American Cancer Society President Reginald Ho has expressed the Society's concern about the report of NCI's workshop on breast cancer screening (**The Cancer Letter**, April 2).

The letter, dated April 27, in essence asks NCI to delay action on the report, by Suzanne Fletcher, until after a meeting of the International Union Against Cancer (UICC), scheduled for September.

The text of Ho's letter follows:

"ACS has reviewed recent reports from the International Workshop on Screening for Breast Cancer held February 24-25, 1993, sponsored by the NCI.

"I feel it is important that we confirm with you our concern over certain details of the report and of its potential impact on the public when it is released.

"Widespread adverse publicity associated with screening mammography has, in the past, resulted in unnecessary controversy and perhaps even hampered our collective health education and early detection efforts. The exaggeration of the dangers of radiation during the 1975/76 period is perhaps an example of this.

"From the inception of mammography there has been debate about the value of screening mammography in women ages 40-49. As well conducted as this conference was, that debate will still not go away. To quote from the report 'The meta analysis of Elwood showed a best estimate of no effect and a wide uncertainty in both directions--wide enough to include all derived results of trials, both positive and negative.'

"As the recent report of [Daniel] Kopans [Massachusetts General Hospital] in **The Cancer Letter** (April 16, 1993) indicates, in the age group 40-49, it is not entirely correct that women detected in various reports with screening mammography do not have a benefit in reduction of mortality. In fact they do. Moreover, we are also aware of various meta-analyses. However, there is a need to extend these observations beyond seven years to include at least a 10 to 12 year followup when possible. The improvements in mammography and the changes in periodicity of testing have also contributed to advances which older trials with smaller numbers, and other inherent defects, will not rectify.

"Moreoever, as you know, we now have the 14 year results from our combined ACS/NCI BCDDP program. I would be happy to share these with you. This report will be published shortly in 'Cancer.' The results indicate the same degree of benefit and reduction in mortality for women in the 50 and above group, as in the 40-49 group. While this is not a randomized trial, it is probably the largest group of women afforded an opportunity for physical exam and mammography in the U.S.

"The hazard exists that women will hear once again that the scientific community is divided and confused about the value of a procedure, and this may result in cessation of active participation in good health programs such as pap smears, mammography, and other self-help methods, including breast self-examination. We urge you to consider the message that is released with this report and that it be a positive message.

"Our collaboration, particularly in the 40-49 area, is important to maintain. As you know, UICC will also be holding a meeting with wider participation than our own, or yours, permitted, in September of this year in Geneva.

"We hope with further dialogue and communication that these issues, as they are not resolved now, will be better resolved then. Release of your report, with emphasis on some areas of disagreement or at least unsettled materials, may not contribute to the overall benefit of the American public.

"I trust you will carefully consider the content and emphasis of the report of your conference in light of my comments."

FDA No Longer To Exclude Women From Early Drug Studies

A new FDA guideline will encourage drug manufacturers to include women in reasonable numbers in studies and provide the agency information about any significant differences found between men and women in their responses to drugs.

The new guideline changes a policy in effect since 1977 that has resulted in the exclusion of most women capable of becoming pregnant from participating in the earliest phases of clinical trials.

The policy has not excluded women capable of becoming pregnant from trials of drugs for life-threatening diseases such as cancer and AIDS.

Based on several surveys of new drug applications, FDA found that women have generally participated in substantial numbers in clinical trials, usually reflecting the gender prevalence of the disease for which the drugs were being studied. However, women capable of becoming pregnant have been excluded in many cases from phase I trials, the earliest studies in humans intended to give a preliminary assessment of how well the drug is tolerated, and from early phase II trials, the first controlled studies of drug efficacy.

Results of animal reproduction studies have been required before women could be included in trials. This policy was intended to protect a fetus from any possibility of unnecessary exposure to potentially toxic agents.

The new guidelines call for precautions such as pre-enrollment pregnancy testing; use of contraception and behavioral measures that minimize the possibility of pregnancy; and providing women with appropriate information about potential risks. FDA also is planning to address the issue of the participation of pregnant women in clinical trials.

American Cancer Society Encourages Research Applications In Pain Control

The American Cancer Society is encouraging investigation in the area of pain control at all levels from basic to applied research.

Funding is available through Research and Clinical Investigation Grants as well as Grants in Support of Personnel for Research.

Applications for these investigator-initiated grants will compete for funding through peer review by the Society's Scientific Advisory Committees and the Council for Research and Clinical Investigation Awards.

The deadlines for receipt of applications for Research and Clinical Investigations Grants are April 1 and Oct. 15.

The deadlines for receipt of applications for Grants in Support of Personnel for Research are March 1 and Oct. 1.

Applications may be submitted to or futher information may be received from: ACS, Research Dept., 1599 Clifton Rd. NE, Atlanta, GA 30329, Tel. 404/329-7558.

RFA Available

RFA CA-93-013

Title: **Breast cancer surveillance research**

Letter of Intent Receipt Date: May 13

Meeting of Interested Applicants: May 26

Application Receipt Date: July 27

The Surveillance Program (SP) of NCI's Div. of Cancer Prevention & Control invites applications for cooperative agreements from domestic institutions to design and conduct breast cancer surveillance research. New applicants and applicants currently funded under SP initiatives are invited to respond to this RFA issued to examine the operational aspects of breast cancer screening practices in the US.

Awardees are to conduct analytic research designed to assess the effectiveness, efficiency, and cost of screening programs as they relate to the reduction of breast cancer mortality. This may include studies of medical decision models for workup of women with positive screening tests, studies of utilization of emerging new technologies in breast cancer screening and diagnosis, and studies of biological differences among cancers related to detection methods. This initiative also encourages interdisciplinary approaches to this research and requires linkage to data from quality controlled population-based tumor registry programs.

The intent of the RFA is to stimulate collaborative research among clinical practice, basic research in breast cancer screening, and population-based cancer registration. These collaborations will facilitate adequate sample sizes for outcome measures.

Each applicant may submit more than one research plan within a single application, and each research plan, depending upon the nature of the proposed study, may or may not be a collaborative study. However, the potential for extension to a multi-institutional setting should be addressed.

Applications may be submitted by domestic for-profit and non-profit organizations. Applications from minority and women investigators are encouraged.

It is essential that an applicant show evidence of the ability to access and organize data collection from at least three different facilities which include: mammography facilities, pathology laboratories, and a quality-controlled, population-based cancer registry. If this expertise does not reside within one institution, an applicant may put together a group with the necessary expertise, that may involve the use of several institutions and/or organizations. Each applicant must have access to a resource unit that supports research data management and statistical analyses locally.

Support will be through the NIH Cooperative Agreement mechanism (U01). The anticipated average amount of the direct cost will be $233,000. The total project period may not exceed five years. Anticipated date of award is April 1994. Approximately $5,242,000 in total costs for five years will be committed to fund applications. It is anticipated that at least three awards will be made to applicants who successfully demonstrate that they can develop a "multi-institutional group" with the ability to access mammography and pathology facilities, and a cancer registry. Awards will be made to applicants who demonstrate their ability to work with other awardees in the formation of a Consortium to establish a centralized database and then use that data to conduct scientifically sound breast cancer research. First year costs

include development of computer systems dedicated to this research, if needed.

The objectives of this RFA are to foster research collaborations and interactions among basic researchers, clinical investigators, and applied researchers affiliated with quality-controlled population-based tumor registries. The focus of these collaborations is to advance research in breast cancer screening methods, technology, clinical work-up of women with abnormal screening tests, and differentials in the biology and immunobiology of breast cancers in relationship to detection methods.

Specifically, the objectives of the Breast Cancer Surveillance Research Project are to conduct analytic research on breast cancer screening in order to assess the operation (including cost) of screening programs and policies in the US, and associated decision models for workup of women with positive screening tests. The research must be amenable to extending implementation in a multi-group setting using comparable data. Secondary objectives extend the operational focus of breast cancer screening programs to incorporate basic and clinical research on emerging technologies in breast cancer detection and on biological differences of tumors associated with detection modality.

A meeting will be held in Bethesda, Maryland, on May 26 for interested applicants.

Inquiries may be directed to: Dr. Brenda Edwards, Surveillance Program, NCI, Executive Plaza North Rm 343, Bethesda, MD 20892; Tel. 301/496-8506, fax 301/402-0816.

Program Announcement: IRPGs

NIH has issued the following program announcement that extends the concept of Interactive Research Project Grants, developed and used first by NCI, to the programs of the entire NIH.

However, the IRPG no longer requires three applicants to submit concurrent applications; two concurrent and related applications are sufficient.

Following is the program announcement:

PA-93-078

Title: **Investigator-initiated interactive research project grants**

Application Receipt Dates: Feb. 15, June 15, Oct. 15

This Program Announcement provides for a new kind of formal interaction, based on the initiative of applicants, to enhance existing interactions with colleagues or to develop new collaborative relationships.

The Interactive Research Project Grant (IRPG) program encourages the coordinated submission of related research project grant (R01) and, to a limited extent, FIRST award (R29) applications from investigators who wish to collaborate on research, but do not require extensive shared physical resources. These applications must share a common theme and describe the objectives and scientific importance of the interchange of, e.g., ideas, data, and materials, among the collaborating investigators. A minimum of two independent investigators with related research objectives are encouraged to submit concurrent, collaborative, cross-referenced individual R01 or R29 applications. Applicants may be from one or several institutions. Applications will be reviewed independently for scientific merit. Applications judged to have significant and substantial merit will be considered for funding both as independent awards and in the context of the proposed IRPG collaboration.

Applications may be submitted by foreign and domestic, for-profit and non-profit organizations. Applications may be submitted from one institution or may include arrangements with several institutions if appropriate. Applications from or involving minority institutions, individuals, and women are encouraged. Applicants for IRPGs may not concurrently submit additional R01 or R29 applications (either investigator-initiated or in response to a Request for Applications) that represent significant duplication of the efforts described in the IRPG. Concurrent submission of program project (P01) or cooperative agreement (U01) applications that request support for essentially similar work is also prohibited.

Support will be through R01 grant and the FIRST (R29) award. The IRPG must consist of a minimum of two independent applications. An IRPG package may consist of a combination of R01s and R29s, or R01s only, but may not consist solely of R29 applications. Applications for both new (Type 1) and competing renewal (Type 2) awards may be submitted as IRPGs.

This announcement supersedes any previous announcement regarding IRPGs. Future IRPG applications must follow the instructions presented in this announcement.

NIH encourages qualified independent investigators to develop and submit coordinated R01 and R29 applications that address any research area supported by the Institutes and Centers. Applications submitted as part of an IRPG package must be tightly focused, and the interactions and benefits of the proposed linkages must be made explicit. The IRPG mechanism could be used constructively to support collaborative efforts designed to accelerate the development of fundamental knowledge and/or enhance the clinical application of that knowledge. The IRPG mechanism may fit well with clinical applications that propose limited, testable research questions or focused therapeutic and related correlative laboratory studies. However, the IRPG mechanism is not appropriate for large epidemiologic studies or for multi-institutional clinical trials using common protocols.

Historically, the NIH has relied on multi-component awards, such as program projects (P01), center grants (P30, P50), and cooperative agreements (U01) to encourage multidisciplinary collaboration in areas requiring integration and central direction of basic and clinical research components. In general, such awards include the provision of extensive core facilities/resources and appointment of a program director to manage the overall effort. However, for many research areas it may be appropriate to consider an intermediate level of collaboration that is beyond that practicable for single projects. For such scientifically originated collaborative efforts, the exchanges of data, materials, and ideas, rather than shared extensive physical resources or central oversight, are the primary requirement. The concept of the IRPG put forth in this announcement is meant to address and facilitate this class of research activity.

The IRPG offers a means of promoting collaborative efforts between or among projects with a common theme, while providing a record of independently acquired awards credited to each individually funded investigator and allowing retention of research autonomy by the named Principal Investigator (PI). Each grantee will have the ability to submit on his/her behalf

competing supplements as appropriate to incorporate promising new directions of research as they evolve. The freedom to establish collaborations on an equal footing at separate sites (including foreign locations) and the transferability of awards made to individual investigators are other benefits.

R01 grantees (and R29 awardees) previously unable or unwilling to join in P01s may wish to participate in an IRPG. One reason given by some grantees for reluctance to participate in P01s is the potential loss of autonomy. Such concerns are not pertinent with the IRPG because each investigator retains autonomy over his/her project. At the same time, each investigator may benefit because the IRPG mechanism establishes a larger framework of reference for the proposed work and facilitates formal collaborations tailored to achieving investigator-initiated research objectives.

If there is a question about the appropriateness of a set of applications for the IRPG mechanism, applicants are encouraged to discuss the issues with NIH staff contacts listed at the end of the announcement.

Any questions regarding the format for submission of an IRPG package may be directed to the Referral Office, Div. of Research Grants, Westwood Building, Room 248, Tel. 301/594-7250.

For further information regarding NCI, contact Dr. Marvin Kalt, Deputy Director, Div. of Extramural Activities, National Cancer Institute, Tel. 301/496-4218.

In Brief

NSABP Honors 10 BCPT Centers; Roentgen Ray Elects New Officers

(Continued from page 1)

. . . **TEN CENTERS** participating in the Breast Cancer Prevention Trial were honored by the National Surgical Adjuvant Breast & Bowel Project for high enrollment in the trial. Besides Fox Chase Cancer Center (reported in the April 23 **Cancer Letter**), the centers were: Michigan State Univ. Clinical Center, Univ. of Montreal BCPT Group, Southeast Cancer Control, Hoosier Oncology Group, Northwest/Virginia Mason CCOP, Illinois Cancer Center, Baptist Regional Cancer Center, M.D. Anderson Cancer Center, and Northeast Ohio BCPT Group. . . . **AMERICAN ROENTGEN** Ray Society installed new officers at its annual meeting last month in San Francisco. The new officers are: President, **Andrew Poznanski**; president-elect, **George Leopold**; first vice-president, **Ralph Alfidi**; 2nd vice-president, **Kay Vydareny**; secretary, **Joseph Ferrucci**; treasurer, **Beverly Wood.** The society honored two of its members for outstanding service. **Lee Rogers**, Northwestern Univ., and **J. Scott Dunbar**, Hospital for Sick Children, Ontario, Canada, received gold medals. . . . **"RECENT PROGRESS** in Early Detection and Treatment of Prostate Cancer" is the title of a meeting to be held May 29-30 in Quebec City, Canada. Contact Martin Godbout, Le Centre hospitalier de l'Universite Laval, phone 418/654-2296, fax 418/654-2735. . . . **ENDOCRINE SOCIETY** has recommended that the NIH budget increase to $11.6 billion in FY94, including $684 million for the National Institute for Child Health & Human Development and $835 million for the National Institute of Diabetes & Digestive & Kidney Diseases, society President **Wylie Vale** testified before the Senate Labor, HHS, Education Appropriations subcommittee. Those amounts are substantially above President Clinton's request. . . . **HOSPICE FOUNDATION** has opened an office in Washington, DC. The group, focusing on issues surrounding terminal illness, is based in Miami, FL. The purpose of the DC office is "to ensure that hospice care be made available under any new health care plan to all people, regardless of age or income," foundation President Jack Gordon said. The office is located at 1334 G. St. NW, Suite 605, Washington, DC, phone 202/638-5419. . . . **RADIOLOGY CENTENNIAL** Inc. has a budget of $3 million, with $2.5 million in hand or in pledges as of this month for its work to celebrate the centennial of radiology in 1995. **John Tampas** is president of non-profit corporation created to plan the anniversary activities sponsored by more than 45 national professional and scientific societies and 26 companies which supply products and services to radiologists.

NIH Seminar In Grants Administration Set For June 28-29, Augusta, GA

NIH has scheduled a regional conference on grants administration for June 28-29, at the Sheraton Hotel, Augusta, GA.

The seminar, hosted by the Medical College of Georgia, will be of interest to new and senior grant administrators and principal investigators, according to an NIH announcement.

Topics to be discussed include current issues affecting NIH funding and grant administration and the fundamentals of conducting business with NIH (application preparation, peer review, budget analysis, and award determination).

Featured speaker will be Geoffrey Grant, Director, Office of Policy for Extramural Research Administration, as well as Grants Policy Office staff.

Cost of the seminar is $125. Contact, by May 28, by fax that provides name, institution, address and phone number, Becky Jones, Physicians Practice Group, fax 706/724-1600, phone 706/828-6422.