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# NSABP Executive Committee Nominates Wolmark To Succeed Fisher As Chairman

The Executive Committee of the National Surgical Adjuvant Breast & Bowel Project last week nominated surgeon Norman Wolmark to replace his former mentor Bernard Fisher as chairman of the troubled cooperative group.

At the committee's meeting Oct. 14, Wolmark received 19 votes, with only three votes going to other candidates.

The group's constitution gives the Executive Committee the authority to appoint chairmen. Approval by the members is not required. Therefore, Wolmark would officially take his post after NCI determines whether the search process was conducted properly.

In an interview with **The Cancer Letter**, Wolmark said he intends to prepare a bid—or, if necessary, separate bids—for NCI grants that supportthe cooperative group's research.

That will mean competing for the NSABP headquarters grant, and,

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*In Brief*

## Komen Foundation Awards Honor Dingell, Osborne, Freeman; Tobacco Regulation Urged

**REP. JOHN DINGELL** and **Debbie Dingell** received the Betty Ford Award for their work on breast cancer health care issues from the Susan G. Komen Breast Cancer Foundation at its national awards luncheon Oct. 21 in Dallas. **C. Kent Osborne,** of Univ. of Texas Health Science Center, received the Komen Award of Scientific Distinction. Other awards: **Harold Freeman**, of Harlem Hospital, individual community service; **Tiffany & Co.** for corporate philanthropy; **Roger Hirl**, CEO of Occidental Chemical Corp., individual philanthropy; **Ladies Professional Golf Assn.**, corporate voluntarism; **Francie Larrieu Smith**, individual voluntarism; **New Balance Athletic Shoe Inc.**, corporate community service; **Good Housekeeping** magazine, and **Gary Collins**, media. . . . . **COALITION ON SMOKING OR Health** will circulate a petition urging FDA to regulate the way tobacco products are manufactured, sold, labeled and advertised, especially to children. The coalition, made up of the American Cancer Society, American Lung Assn. and American Heart Assn., will send the results to President Clinton and Congress. . . . **THOMAS MOON**, director of the Univ. of Arizona Disease Prevention Center, has been appointed, effective Dec. 1, professor of biomathematics and director of the Clinical Biostatistics Center at M.D. Anderson Cancer Center.

## Wolmark: Orderly Transition, NCI Support, Is First Task

(Continued from page 1)

if NCI decides to split off the funds for the biostatistical center, competing for that project as well. Also, Wolmark may find himself in a battle to keep the controversial Breast Cancer Prevention Trial within NSABP.

"Right now, the first task is to set up an orderly transition, where the new chairman will be given the support of NCI to carry out headquarters responsibilities and restore the integrity of the group," Wolmark said to **The Cancer Letter**.

"The other aspects will obviously be points of negotiations between the chairman and NCI—and we are anxious to proceed with those negotiations," Wolmark said.

Indeed, points of negotiations abound:

- It is unclear how the transition would proceed, how it would be financed, and by whom.
- It is also unclear what role the two institutional sponsors of Wolmark's bid—Allegheny General Hospital and Fox Chase Cancer Center—will play in the recompetition.
- Many observers say the future of NSABP will be determined by its success at regaining control of the Breast Cancer Prevention Trial. As it stands, the trial's 300 participating institutions have, in effect, become a separate network coordinated by Leslie Ford, Chief of the NCI Community Oncology and Rehabilitation Branch, sources said.
- For the next year-and-a-half, until the recompetition of the NSABP grants begins, Wolmark's position as chairman will remain separate from the position of principal investigator, held by Ronald Herberman, director of the Pittsburgh Cancer Institute, which is part of the Univ. of Pittsburgh. Both Wolmark and Herberman said to **The Cancer Letter** that they intend to cooperate. Now, the two will have to work together on short-term projects while preparing competing bids for NCI grants supporting the cooperative group's research.
- Finally, at this writing, the NSABP Executive Committee remains a plaintiff in an action initially brought by Fisher against the Univ. of Pittsburgh. Negotiations in the case, now going into its second month, are yet to yield a settlement.

**Fisher's Heir-Apparent**

Colleagues described Wolmark as a solid investigator familiar with the science, the mechanics—and the politics—of running NSABP.

In fact, Wolmark's nomination last week is a second attempt by the Executive Committee to put the surgeon in charge of the group.

Last spring, the board, in an informal meeting, voted to name him chairman. However, the committee ultimately reversed itself, opting instead to name a chairman in a more orderly manner (**The Cancer Letter**, May 27).

"Norman has the requisite experience to run the group and make it work," Bruce Chabner, director of the NCI Div. of Cancer Treatment, said to **The Cancer Letter**. "We look forward to seeing their plans for transition."

Wolmark, 49, who first came to the Univ. of Pittsburgh as a resident in 1973, has long been seen as Fisher's heir-apparent. Over the years, he earned an endowed chair in surgery at Pitt and rose to associate director, medical affairs, at the cooperative group.

However, in 1993 Wolmark left the university as a result of a dispute that began when Presbyterian University Hospital took administrative control of the Montefiore Hospital, where Wolmark was chief of surgery. Both hospitals are affiliated with Pitt.

Moving across town, Wolmark became director of the cancer center and chief of surgical oncology at Allegheny General Hospital.

In an interview after his nomination, Wolmark pledged that his past disputes with the Pitt administration will not be a factor in his dealings with the university.

"My personal disputes are no longer the issue," he said to **The Cancer Letter**. "The issue is survival of the cooperative group."

Herberman, too, pledged to cooperate.

**THE CANCER LETTER**

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"Dr. Wolmark has been a long-term and highly active participant in the programs of NSABP, and I wish him the best of success in his new role," Herberman said to **The Cancer Letter**. "I hope that we can forge an effective partnership for the benefit of the participants of the trial and for the benefit of the research conducted by NSABP."

Herberman said that in the near future, the NSABP chairman could play a valuable role as the liaison with the investigators throughout the network. "That would he a useful, complementary role," Herberman said.

However, Herberman said NSABP's transition from the era where all the functions of the cooperative group were controlled by one scientist to an era where authorities will be codified and separated will not be an easy one.

"It's uncharted territory," Herberman said. "In the past, all of these jobs have been held by the same person, Dr. Fisher. Now, for the first time in history of the group, you have a separation of functions. And that has not been worked out yet."

Peter Deckers, head of the NSABP search committee said he, too, expected that Herberman and Wolmark would be able to work together in the short term.

"It would be in Dr. Herberman's interests to work with Dr. Wolmark, and it would be in Dr. Wolmark's interests to work with Dr. Herberman," said Deckers, chief of surgery at the Univ. of Connecticut School of Medicine.

Ultimately, Deckers said, the Executive Committee expected that the positions of chairman and principal investigator would be held by the same individual once again.

"We expect that Dr. Wolmark will become the principal investigator of the cooperative agreements, because we expect to win that recompetition on behalf of the NSABP investigators," Deckers said.

Deckers said the Executive Committee had deliberately steered away from the question of the role that Allegheny General and Fox Chase would play in running the cooperative group if the Wolmark bid wins the recompetition.

"We haven't talked about the details," Robert Young, president of Fox Chase Cancer Center, said to **The Cancer Letter**.

Young said Fox Chase is still interested in backing Wolmark's bid. However, Young said no specific plans have been made because of the continuation of the suit that involves Pitt and the NSABP Executive Committee, the very parties that are pledging to cooperate in the transition.

"Everyone is waiting because of the legal maneuvers," Young said. "The longer this political confusion goes on, the more likely it is that the group is going to die."

## NCI Audit Verifies Accuracy Of NSABP Lumpectomy Trial

The authenticity of data in the landmark study comparing lumpectomy to mastectomy in the treatment of breast cancer has been verified in an audit by NCI.

The Institute's audit of the B-06 trial conducted by the National Surgical Adjuvant Breast and Bowel Project verified 97 percent of NSABP's datapoints.

Just as importantly, the audit results were similar across all three of the trial's treatment groups, which, according to NCI, constitutes evidence that the results of the trial were not skewed by fraud.

"No evidence of fraud or systematic attempts to falsify or misrepresent data were detected," NCI's summary report dated Oct. 11 concluded.

A copy of the report was obtained by **The Cancer Letter**.

In a letter addressed to NSABP interim chairman Ronald Herberman, but circulated to a number of other individuals, NCI Director Samuel Broder urged the cooperative group to prepare a manuscript for "immediate submittal" to the New England Journal of Medicine.

NCI plans to make the audit results available independently, through publication in the Journal of the National Cancer Institute and electronically, Broder wrote.

The audit excluded the 354 patients accrued at St. Luc Hospital in Montreal.

The datapoints verified in the audit included:

- In 98 percent of patients, the number of positive nodes reported by NSABP matched the patient records and other documents obtained from institutions involved in the trial.
- Treatment reported by the cooperative group matched the patient records in 98 percent of patients.
- First events reported by the cooperative group was confirmed by the patient records in 94 percent of patients.
- Ipsilateral recurrence was confirmed in 97 percent of patients.
- Survival was confirmed in 98 percent of

patients.

•Eligibility for the trial was confirmed in 96 percent of the patients in whom it was assessed. One patient was judged ineligible.

"All data regarding number of positive nodes, treatment (date and type of surgical procedure) and outcome were completely verified in 1,421, or 92 percent, of the patients," the report said. "Auditors were unable to verify one or more of the data items in 66 patients (4 percent) and disagreed with at least one data item in 65 patients (4 percent) where discrepancies were noted....

"Overall, 7,544 (97 percent) of datapoints were verified, 150 datapoints (2 percent) could not be verified and the auditors disagreed with the database regarding 66 (0.9 percent)," the report said. "Verification rates were similar for all treatment groups: Total Mastectomy 97 percent, Lumpectomy 98 percent, and Lumpectomy + Radiation 98 percent."

The NCI audit began last March, following the revelation of fraud by one investigator involved in several NSABP studies, Roger Poisson of St. Luc Hospital in Montreal.

NSABP had discovered and reported the fraud to NCI in 1991. During the investigation of Poisson by the HHS Office of Research Integrity, NSABP conducted an analysis of the data that concluded that the results of the trial remained valid.

ORI found that Poisson falsified data regarding six patients entered on B-06, as well as 93 patients entered on other NSABP trials.

NSABP accrued 2,163 patients between 1976 and 1984 for the B-06 study, "A Protocol to Compare Segmental Mastectomy and Axillary Dissection With and Without Radiation of the Breast and Total Mastectomy and Axillary Dissection."

The NCI team that conducted the recent audit visited 37 of the 39 institutions involved in the trial. The auditors reviewed 1,553 patient charts, or 86 percent of the charts available for audit. Altogether, more than 30,000 data items were reviewed.

The audit team consisted of 36 physicians, eight nurses, eight pharmacists, two PhDs and 22 contract staff.

Early on, the NCI audit emphasized detection of fraud, but shifted to eligibility criteria that might influence the outcome of the study. A panel of three NCI physicians reviewed all cases with discrepant, unverified or ambiguous data.

According to the NCI report, the greatest number of discrepancies—40—was in the identification or date of first event, which included recurrence, second primaries, and death.

The NCI auditors attempted to verify the presence of positive margins in the surgical specimens of patients following lumpectomy. However, because NSABP had taken steps for hospitals to report this data uniformly, the NCI auditors could find no way to independently verify the findings.

The NCI auditors still are attempting to verify that all patients gave written or verbal informed consent. The report said the auditing of the informed consent process is complicated because the trial began prior to many regulations on consent.

Also complicating the picture are the varying international practices in obtaining informed consent, the trial's pre-randomization of patients, and the timing of consent, the report said.

## Burst Of Activity In DCPC: Board Ok's 7 New RFAs, 2 PAs

Advisors to the NCI Div. of Cancer Prevention and Control gave concept approval to seven new Requests for Applications, two new Program Announcements and the recompetition of two contracts at its meeting last week.

The DCPC Board of Scientific Counselors agreed to set aside a total of nearly $37 million over the next four to five years for the RFAs. The set-asides are possible through the increase in the prevention and control budget (**The Cancer Letter**, Oct. 14).

The board voted to table two RFAs and one PA, asking NCI staff for further information. They were: Molecular and Biochemical Mechanisms of Behavior Change for Dietary Modification of Cancer Prevention; Clinical Nutrition Research Units; and Cancer Prevention Research Units.

In addition to the concepts below, the board approved: $400,000 for an interim analysis of the United Kingdom's breast cancer screening trial; and $1 million for the Agency for Health Care Policy Research to develop a clinical practice guideline on breast cancer screening.

The concept statements follow:

**Human Metabolic Studies of Modification of Dietary Fatty Acid Intake for Prevention of Breast, Prostate, and Colon Cancer**. Concept for a new RFA, six to eight awards, review by ad hoc review group, $1.5 million per year for four years. Program Director: Diet and Cancer Branch, Susan Pilch.

This concept is intended to elucidate mechanisms

by which modification in amount and type of dietary fat/fatty acids consumed may reduce risk for human breast, prostate, or colon cancers. Research topics include human metabolic studies to clarify effects of reductions in the amount or modifications in the type of dietary fatty acids consumed on metabolic/physiologic parameters relevant to the prevention of breast, prostate, and/or colon cancer. These might include alterations in production and circulating levels of sex steroid hormones, metabolic activity and products of intestinal microflora, quantity and composition of adipose tissue, membrane permeability, prostaglandin synthesis, immune function, DNA damage and repair, or metabolism of chemical carcinogens.

**Nutritional/Dietary Modulation of Human Genomic Expression for Cancer Prevention**. Concept for a new Program Announcement, review by standing Initial Review Groups. Co-Program Directors: Susan Pilch, and Chemical and Physical Carcinogenesis Branch, Div. of Cancer Etiology, Carl Smith.

The investigator-initiated basic and clinical research encouraged in this concept will encompass the role of nutrients and other dietary constituents in human development, specifically, determining relationships between diet and genomic expression of predispositions to cancer, including nutritional/dietary modulation of gene expression relevant to human cancer prevention. Studies may involve manipulation of dietary patterns, individual nutrients, or non-nutritive dietary constituents; the relevance of the proposed studies to human cancer prevention must be clearly delineated. Illustrative examples of research areas include:

•Effects of dietary patterns, nutrients, and other dietary constituents on: •expression of oncogenes, including expression of genes for specific growth factors and nuclear receptors for ligand-inducible transcription factors, •expression of genes that encode for enzymes responsible for procarcinogen activation and carcinogen inactivation, •genomic imprinting; •ability of dietary patterns/constituents to modify expression of markers of known cancer predispositions.

**Assessment of Dietary Exposure to and Human Metabolism of Constituents of Plant Foods**. Concept for a new RFA for R01s, eight to 10 awards, peer review by an NCI ad hoc Special Review Group, $2 million a year, four years. Program Director: Diet and Cancer Branch, Susan Pilch.

The objectives of this concept are to assess dietary exposure to constituents of plant foods that may affect cancer risk and to assess their biological effects relative to cancer prevention in humans.

Research on food composition and dietary exposure to plant food constituents with potential effects on human cancer risk will be encouraged, as will studies of their biological activity, absorption, metabolism, and mechanisms of action and interactions for cancer prevention in humans. Although the major emphasis is on effects of foods and diet in human studies, animal studies may be considered provided they can demonstrate relevance to human cancer prevention. Proposed studies that include use of purified compounds should be designed to assess levels that can be obtained from foods in the diet, rather than nonphysiologic levels. Studies to develop improved analytical methods for the identification and quantification of plant food constituents and their metabolites and molecular epidemiologic studies may also be considered.

Examples of relevant research areas are as follows:

•Determining the amounts of non-nutritive constituents in plant foods and the amounts consumed in typical diets; •Elucidating molecular and cellular mechanisms of actions for the anticarcinogenic effects of plant food constituents; •Examining the impact of interactions among various plant food constituents on their role(s) in cancer prevention; •Defining dose-response relationships for nutrient and nonnutrient plant food constituents on molecular and cellular events and alterations in metabolic pathways; •Identifying biochemical markers as quantitative measures of plant food intake, digestion, absorption, metabolic breakdown of specific nutrient and/or non-nutrient constituents; •Determining the bioavailability of nutrient and nonnutrient plant food constituents at various intakes and from different food sources; and •Determining the relation between dietary intake of environmental carcinogens consumed in plant foods and cancer risk.

**Nutrient Modulation of Cell Integrity and Repair Mechanisms**. Concept for a new RFA for R01s and R29s, four to five supported by NCI, review by a special initial review group, Div. of Research Grants, NIH; $1 million per year, five years. Program Director: Diet and Cancer Branch, Carolyn Clifford.

This concept seeks approval for DCPC to participate in funding grant applications that are received in response to a trans-NIH initiative, RFA DK-94-023, "Nutrient Modulation of Cell Integrity and Repair Mechanisms."

This initiative is designed to encourage research grant applications focusing on mechanisms (primarily molecular and genetic) that underlie nutrient modulation of cellular repair processes and maintenance of cellular integrity. Research will be aimed at the normal processes involved in the effects of specific nutrients or their metabolites on cellular, genetic, and metabolic functions, as well as elucidation of defective mechanisms. The major objective is to encourage application of the basic sciences and new technologies, e.g., molecular biology, nuclear magnetic resonance (NMR), electron spin resonance (ESR), positron emission tomography (PET), to nutrition questions.

Applications should clearly identify the nature in which a dietary nutrient or functional component is a study parameter. Collaborative interactions between nutritional sciences investigators and those in other disciplines are encouraged to promote utilization of newer technologies, especially technologies not traditionally used for nutrition research. Interactions between basic and clinical sciences are encouraged. Examples of research topics that could be considered for support by the NCI include, but are not limited to:

•The use of new technologies (e.g., ESR, NMR, PET) to investigate mechanisms of nutrient and nutrient metabolite interactions and functions in vivo;

•Antioxidant or other nutrient-mediated protection against genetic damage;

•Nutritional interactions associated with molecular regulation/control of carcinogen activation, inhibition, or potentiation;

•Nutritional control of cell differentiation, proliferation, and cellular/malignant transformation;

•Nutrient influence on DNA repair;

•Nutrient modulation of cell receptor expression and functions, including consequences from exposure to environmental agents;

•Role of nutritional factors in the regulation of genes that control immune system function.

**Early Detection Research Network**. Concept for recompetition of a master agreement, five to six awards, $2 million per year for five years, ad hoc review group. Project Officers: Sudhir Srivastava, John Gohagan, Early Detection Branch.

The objectives are to:

•establish a network of institutions with the facilities, resources, personnel and interest to undertake biomarker research in early cancer detection;

•advance the understanding of the molecular basis of tumorigenesis in relation to screening and early detection, and risk assessment;

•identify potential biomarkers that can be used as outcome measures or as intermediate endpoints for early detection or primary prevention clinical trials;

•respond to late-breaking developments in the field of biomarkers in a timely fashion.

Given the short history of the EDRN, established in 1991, it has already been very successful in accomplishing its mission. For example, it is only through the resources provided by the EDRN that studies are beginning to focus on the lesion, prostatic intraepithelial neoplasia. This mechanism has allowed cutting edge technology to be tested for the transition from the laboratory to clinically useful projects focused on biomarkers of early detection, diagnosis, and prognosis.

**Early Detection Research On Carcinoma Of The Pancreas**. Concept for a new Program Announcement. Program Director: Early Detection Branch, Donald Henson.

This Program Announcement calls for applied research on the early detection of pancreatic cancer at a curable stage or the identification of individuals who may be at high risk. Early detection should be based on blood tests or metabolic products excreted in the bile, pancreatic juice, stool, or urine. Tumor associated antigens, peptide hormases, and mutated oncogenes are areas of interest. Identification of high risk individuals would depend on: 1) potential carcinogenic products secreted in the pancreatic juice after absorption from the intestine, 2) the ability of the pancreas to activate drugs or other chemicals to carcinogenic and toxic agents that can be detected in the blood, stool or urine, and 3) genetic testing for the existence of metabolic pathways that activate procarcinogens. These individuals who are high risk may be candidates for dietary modification or chemoprevention. Genetic determinants of pancreatic metabolism may explain the black-white differences in incidence.

Specific hypothesis to be tested include:

•That plasma levels of specific peptide hormones, especially the diabetogenic factor, can be used to identify early cases of pancreatic cancer.

•That pancreatic cancer results from the absorption in the small intestine of carcinogenic agents generated in the stomach and secreted by the pancreas.

•That specific tumor related antigens may exist that can be found in blood h early stage pancreatic carcinoma.

•That procarcinogenic agents absorbed in the small intestine are activated by pancreatic acinar cells and secreted by the pancreas and can be detected in the pancreatic juice, blood, stool, or urine. Activation may be genetically determined and may explain black-white differences.

•That the ability to activate procarcinogens to carcinogens is genetically determined, and by genetic testing, it is possible to identify individuals at potential high risk.

**International Overview Analysis of Breast Screening Clinical Trials Data Pertinent to Screening Women 40-49**. Concept for a new RFP (Sole Source) Sweden, UK, Canada, Netherlands, Italy; five awards, $500,000 per year for two years. Project Officer: John Gohagan, Early Detection Branch.

NCI seeks to obtain as much information regarding this burning question from the world's clinical trials data as possible. To this end the Institute has established an international collaborating among the trialists on an overview analysis of relevant data from all eight trials.

NCI sponsored an International Workshop on Breast Cancer Screening in February 1993. Investigators from all eight randomized breast cancer screening trials under way or completed presented their data. A combined

analysis of all trial data has never been planned by the investigators. The proposed combined analysis of certain trial data is unique and important.

Two planning meetings have been held since the February 1993 workshop: 1) A meeting of the trial leaders and analysts in January 1994 at the NCI and 2) a smaller working group in July 1994 at Royal Marsden Hospital, London. The next meeting of the larger group is scheduled for Edinburgh in February 1995. A plan of analysis was developed at the second meeting; it is for this work that we seek funding.

Six primary research questions have been defined:

1. Do women who are first invited to breast cancer screening, including mammography, while aged under 50 years have reduced risk of breast cancer mortality compared with women who were randomized to the control group? If so what is the benefit?

2. If there is a benefit, what is the relative contribution of invitation to screening under and over the age of 50?

3. Same as 1, but for mammography only.

4. Same as for 2, but for mammography only.

5. Is there evidence that the mortality benefit achievable by invitation to mammographic screening (or to mammography plus physical examination) is less for women less than 50 years compared with women over 50 years.

6. How does the effect of invitation to screening vary with age at first invitation and length of follow-up?

Individual data records, not summary statistics will be the basis of the analyses. Data are available for analysis only through the trial directors. Each trial director will over see trial staff to develop the data formats needed for the combined analysis. A team of representatives selected by trial directors will develop the data formats needed for combined analyses, and will participate in the analysis and publication of results. NCI will maintain an active role in organizing meetings, setting agendas, focusing analyses, and publication of results.

**Surveillance Research: Breast Cancer Screening Performance, Diagnosis, Biological Characteristics, Treatment, and Outcome**. Concept for an RFA, cooperative agreements, two to three awards, NCI ad hoc review group, total $8 million over five years. Project Officers: Larry Kessler, Applied Research Branch, Surveillance Program; Benjamin Hankey, Cancer Statistics Branch.

This RFA is being re-issued to add additional sites to the project with a focus on minority and rural populations not reached in substantial numbers in the current awards. Breast cancer screening is an important aspect of cancer control. The objectives of the Breast Cancer Surveillance Research Project are:

a) to conduct an observational study of screening in order to assess the operation of screening programs and policies in the US by utilizing comparable data on recommended screening policies, target groups for screening, rates of women screened, influence of screening on trends in breast cancer incidence and breast cancer mortality, quality assurance procedures, use of state-of-the-art technology;

b) to conduct analytic research on the operational aspects of screening to direct health policy and programmatic decisions and to generate health policy research particularly regarding: results of screening examinations, followup of screened women, and effect of screening on changes in breast cancer prognosis;

c) to track the utilization of state-of-the-art and emerging new technologies in breast cancer screening and diagnosis with outcome.

d) to facilitate investigator initiated studies of genetic alterations among women with breast cancer detected through screening and those with breast cancer which was non-screen detected.

It is not likely that a single institution can meet the wide ranging goals of this project. We propose that investigators with expertise in the establishment and management of the registry data, investigators from screening and treatment practices form a group within a geographical area to conduct the research proposed. There will be up to three groups funded in addition to the three funded in FY94. The groups will form one consortium. A system of data collecting and reporting on breast cancer screening by mammography and clinical breast exam, pathology of biopsied lesions, and outcome will need to be established by each of the areas of the consortium, i.e., geographical areas of the US which already have population-based cancer registries. These systems must be maintained for a minimum of five years.

**Support Contract for Cancer Control Science Program**. Concept for recompetition of a contract, one award, $600,000 per year for five years. Project Officer: Kathleen Barry.

Goals of this contract are to provide the CCSP with technical and logistical support services essential to the continuing development of existing interventions. The CCSP is responsible for developing effective, research-based strategies for cancer prevention and control and for transferring state-of-the-art applications of research findings to the public and health care providers.

**Therapeutic Efficacy of Pharmacotherapy and Adjuvant Behavioral Therapy on Nicotine Dependence**. Concept for a new RFA, three to five awards, NCI ad hoc review group, $1.2 million per year for four years. Project Officer: Thomas Glynn, Cancer Control Science Program.

Applicants will propose controlled, randomized trials to determine the most effective, generalizable, cost-efficient, and durable adjunctive behavioral therapies to

support the pharmacological treatment of nicotine dependence.

**Primary Care Provider Interventions to Improve the Eating Habits of Adult Low Literate Patients.** Concept for a new RFA, cooperative agreements, two to four awards, ad hoc review, $1 million per year for four years. Project Officers: Marc Manley and Regina el Arculli, Cancer Control Science Program.

NCI seeks applications to develop and evaluate training of primary care providers in providing nutrition counseling for low literate patients. Applicants should design studies that independently randomize primary care practices and yield valid results. They should also be willing to pool data for possible additional analyses. Applications should include the following elements: •baseline assessments of primary care provider and staff knowledge, attitudes, beliefs and practices regarding diet and cancer prevention; •practice environment organization; •plans for training of primary care providers in: (a) screening of patients' health risks, eating habits and readiness to change; (b) nutrition counseling of patients using the Low Literacy Materials; (c) primary care provider follow-up of patients for changes in eating behaviors; and •evaluation of barriers to primary care providers' implementation of nutrition counseling.

## Oncology Meetings Listed

**October**

**Society for Biological Therapy Annual Meeting**—Oct. 26-30, Napa, CA. Contact Richard Smalley, Tel. 608/276-6640.

**NCI Div. of Cancer Etiology Board of Scientific Counselors**—Oct. 27-28, NIH Bldg 31C Conference Rm 10, Bethesda, MD.

**Pediatric Oncology Group Semi-Annual Meeting**—Oct. 28-31, Chicago, IL. Contact POG Operations Office, Peg Persaud, Tel. 312/482-9944.

**November**

**National Coalition for Cancer Survivorship Annual Assembly**—Nov. 2-6, Washington, DC. Contact NCCS, Tel: 301/650-8868.

**Oncology Nursing Society Fall Institute**—Nov. 4-6, Pittsburgh, PA. Contact ONS, Tel: 412/921-7373, FAX 412/921-6565.

**Modern Developments in Cancer Therapeutics**—Nov. 7-11, Taipei, Taiwan. Contact American Assn. for Cancer Research, Tel: 215/440-9300, FAX 215/440-9313.

**Chemotherapy Foundation Symposium**—Nov. 9-11, New York City. Contact Jaclyn Silverman, Div. of Neoplastic Diseases, Mount Sinai School of Medicine, Tel. 212/241-6772, Fax 212/996-5787.

**American Society of Clinical Oncology Fall Educational Conference**—Nov. 11-13, Atlanta, GA. Contact ASCO, Tel: 312/644-0828.

**NCI Workshop: An Appraisal of Clinical Research for the Treatment of Early Breast Cancer**--Nov. 15, Holiday Inn, Bethesda, MD. Contact Carmen Warren, Tel. 301/907-3844, FAX 301/907-9655.

**New Strategies in Colorectal Cancer: Alumni Society Meeting**—Nov. 17-18, New York City. Contact Jean Campbell, Memorial Sloan-Kettering Cancer Center, Tel. 212/639-3511, FAX 212/639-3535.

**American Assn. for Cancer Education Annual Meeting**—Nov. 17-20, Louisville, KY. Contact Dr. John Spratt, Tel. 502/852-5592, fax 502/852-7799.

**European Society for Medical Oncology 19th Congress**—Nov. 18-22, Lisbon, Portugal. Conference Secretariat, Tel. 41-93-63-2774, fax 41-93-63-2937.

**Translational Research in Cancer**—Nov. 29-Dec. 4, Asheville, NC. Contact American Assn. for Cancer Research, Tel: 215/440-9300, FAX 215/440-9313.

**December**

**American Endocurietherapy Society**—Dec. 7-10, Fort Myers, FL. Contact AES, Tel. 215/574-3158.

**Basic and Clinical Aspects of Prostate Cancer**—Dec. 8-12, Palm Springs, CA. Contact American Assn. for Cancer Research, Tel: 215/440-9300, FAX 215/440-9313.

**Future**

**Mechanism of Action of Retinoids, Vitamin D and Steroid Hormones**—Jan. 14-19, Whistler, British Columbia, Canada. Contact American Assn. for Cancer Research, Tel: 215/440-9300, FAX 215/440-9313.

**Renal Cancer: State of the Art Management**—Jan. 21, Cleveland, OH. Contact Cleveland Clinic Foundation, Tel. 800/762-8173 or 216/444-5695, FAX 216/445-9406.

**Molecular Biology of Cancer: Implications for Prevention and Therapy**—Feb. 13-18, Maui, HI. Contact American Assn. for Cancer Research, Tel: 215/440-9300, FAX 215/440-9313.

**American Association for Cancer Research Annual Meeting**—March 18-22, Toronto, Ontario, Canada. Contact AACR, Tel: 215/440-9300, FAX 215/440-9313.

**Nuclear Oncology**—March 8-10, Johns Hopkins Medical Institutions, Baltimore, MD. Contact Jeanne Ryan, Tel: 410/955-2959.

**UNC Lineberger Comprehensive Cancer Center Annual Symposium**—April 20-21, Chapel Hill, NC. Contact Sarah Rimmer, Tel: 919/966-3036.

**American Radium Society Annual Meeting**—April 29-May 3, Paris, France. Contact ARS, Tel: 215/574-3179.

**Marrow Transplantation in Children**—June 1-3, Hilton Head Island, SC. Contact Dr. Michael Trigg, Univ. of Iowa, Tel: 319/356-1608, FAX 319/356-7659.