THE CANCER LETTER

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Chabner Cautions Against Downsizing, Consolidation Of NCI Intramural Programs

NCI's intramural programs should not be consolidated to conform to the organizational model used in other NIH institutes, a senior NCI official said.

Addressing the Div. of Cancer Treatment Board of Scientific Counselors, division director Bruce Chabner, said he opposed several ideas under consideration by a committee reviewing NCI's intramural program:

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In Brief

Fischinger, SAIC Win $400 Million Contract For Frederick, Unseat Program Resources Inc.

A CONSORTIUM led by **Peter Fischinger**, of Medical Univ. of South Carolina, has won a $400 million operations and technical support contract for the Frederick Cancer Research and Development Center. NCI made the award Feb. 24 to Fischinger's group, which includes San Diego-based Science Applications International Corp., EG&G, based in Wellesley, MA, and MUSC, where Fischinger is chairman of experimental oncology and head of the Hollings Oncology Center. The award is for a one-year contract with two one-year extension options. The decision, by NCI Director Samuel Broder a few days prior to his leaving the Institute, unseats Program Resources Inc. PRI was awarded the Frederick contract in 1982, and won a renewal in 1987. PRI and its parent corporation, DynCorp Advanced Technology Services Inc., based in Reston, VA, filed suit against NCI to prevent the agency from making the award. A US Court of Federal Claims judge denied the request for a temporary restraining order on Feb. 16 (**The Cancer Letter**, Feb. 24). Fischinger directed FCRDC from 1981 until his appointment as HHS AIDS coordinator in 1987. He left the government in 1988. . . . **AMERICAN ASSOCIATION** for the Advancement of Science has formed the AAAS Center for Science, Technology and Congress, a nonpartisan source of information on scientific and technological issues for members of Congress and their staffs. The center operates under the auspices of a 10-member advisory board co-chaired by former US Representatives John Brademas (D-IN) and Bill Green (R-NY). The center grew out of a two-year grant from the Carnegie Corp. of New York. . . . **OTIS BRAWLEY**, of NCI's Div. of Cancer Prevention and Control, Community Oncology and Rehabilitation Branch, has been appointed to the Board of Directors of Theragenics Corp. Brawley is the NCI project officer for the Prostate Cancer Prevention Trial and

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NCI Intramural Programs Should Not Merge: Chabner

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- Consolidation of NCI intramural research including basic, clinical, and epidemiological research under a single intramural scientific director.
- Separation of the intramural and extramural responsibilities.
- Downsizing of intramural programs, particularly the programs not located on the Bethesda campus.

"I do not favor the creation of a single intramural program," Chabner said to the DCT board Feb. 27. "I believe the Institute director should be a scientist of sufficient knowledge and standing to be the ultimate decision-maker for intramural research, but that the day-to-day management of such a broad program of research will require expertise not found in any single individual."

Debate Over NCI Mission

The organizational issues are part of a larger debate at NIH over the mission of NCI, Chabner said.

"Is the mission of the Cancer Institute—to prevent and cure cancer—best accomplished by a substantially greater investment in basic research, at the expense of current targeted programs such as drug discovery and development, the cooperative groups, the cancer centers, and other 'translational research' programs?" Chabner said.

"This debate will surely proceed in the next few months, and the advisory boards should have a role in this discussion," he said.

Chabner is scheduled to leave NCI on April 1 for a position at Massachusetts General Hospital.

THE CANCER LETTER

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Consolidation Not Best Solution

The National Cancer Advisory Board's Ad Hoc Working Group on NCI Intramural Programs, co-chaired by Paul Calabresi and Michael Bishop, is considering organizational changes and is questioning the value of several programs, Chabner said.

"Major changes in the way NCI does business have been proposed and are under discussion by the Bishop-Calabresi committee," he said.

"These changes are proposed for a number of reasons. Consolidation would allow one person to represent and manage intramural cancer research, and this change would potentially allow for better prioritization and decision-making across the divisional barriers that currently exist," Chabner said.

"Separation of intramural and extramural programs would allow the scientific director to focus solely on intramural research and would eliminate the 'distractions' of extramural problems," he said.

"Consolidation and downsizing would allow the elimination of duplicative programs and a reduction in the perceived excessive intramural effort, which now commands close to 20 percent of NCI's budget."

However, NCI's clinical program is the largest among the institutes, Chabner said. "No other institute has a clinical program even 50 percent the size of ours," he said. "I believe a more reasonable solution is to organize basic research, population studies, and clinical investigations each under a separate scientific director."

NCI's current structure in which three research divisions incorporate intramural and extramural programs provides opportunities for intellectual exchange between staff, Chabner said. "This structure provides access to ongoing laboratory and clinical programs for the professionals who manage extramural grants and contracts," he said.

"A program such as our drug development effort requires the intellectual contribution of active laboratory investigators. Our effort to understand the cell line screen in molecular terms would have failed without the input of Susan Bates, John Weinstein, Pat Steeg, Yves Pommier, and others from intramural laboratories.

"Similarly, the professional staff of the Cancer Therapy Evaluation Program participate in intramural clinics and laboratories," he said. CTEP physicians maintain attending and other responsibilities in the intramural clinics, he said.

"Many of these people are recruited to extramural management positions with the promise that they will

be able to maintain their clinical skills through these ties," Chabner said. This allows NCI to attract an exceedingly capable and respected extramural staff in the face of significant economic disincentives to stay at NCI.

"If the intramural and extramural staffs are separated by divisional barriers, I doubt if the recruitment of future staff will be as successful," he said.

Role of Scientific Director, Mission of Institute

The role of the scientific director has changed in the 13 years since Chabner became the DCT director, he said. "Without question, it has lost authority and independence from Building 1 [the central NIH administration]," Chabner said.

Chabner said new challenges to the independence of the scientific director include:

- The scientific director's performance will be reviewed by the BSC and reported to the NIH deputy director for intramural research, Michael Gottesman.
- Tenure review is no longer conducted by the scientific directors, but by an independent committee selected by Gottesman.
- The Institute's AIDS research funds are now managed by the NIH Office of AIDS Research.
- Unoccupied space reverts to the office of the NIH director.
- Freezes on promotion and hiring.

"Some of these changes will undoubtedly elevate the quality of science at NIH, but at the same time they have reduced the flexibility and authority of the scientific director," Chabner said.

As authorities have become more centralized at NIH, "the role of the individual Institute and its particular mission to address a specific disease has been de-emphasized in favor of an increasing emphasis on molecular genetics and cell biology," he said.

"On this campus, clinicians have the sense that their research is less important than laboratory-based investigation," he said. "In the extramural arena, it has meant that the targeted programs of NCI such as drug development, clinical cooperative groups, Specialized Programs of Research Excellence and cancer centers may have an uncertain future.

"I strongly believe it is important, if not critical, that the institutes maintain their focus on specific disease entities and that NIH not become the 'National Institute of Genetics and Cellular Biology.'

"Our reason for being here is to prevent and cure cancer," Chabner said. "Without these targeted programs—centers, cooperative groups, drug development—NCI's research agenda would be indistinguishable from the National Institute for General Medical Sciences."

NCI Drug Development: "A Steady Player"

DCT's drug discovery and development programs of the Developmental Therapeutics Program and the Biological Response Modifiers Program particularly are under scrutiny, Chabner said.

"This effort has produced the most important new drugs—platinum and Taxol—of the past two decades, and has contributed significantly to the clinical evaluation of every other new cancer drug now in human hands," he said. "It has been the steady player on a field that has witnessed inconstant efforts by most of the major pharmaceutical companies, and has been an important partner with a number of smaller companies, particularly in the field of biologicals."

The program's work in natural products research, the use of a panel of cell lines, and in AIDS drug screening, are unique, Chabner said. The new director of DTP, Edward Sausville, "is a remarkably talented and capable scientist and physician," he said.

A unique aspect of NCI's intramural clinical research is the access to new drugs and biologicals that come out of the drug development program, Chabner said. "Having the drug development program on this campus at NCI has made possible the rapid movement of new monoclonals, vaccines, and AIDS drugs from laboratory to clinical trial," he said. "If the disbanding of the drug development effort becomes a serious possibility, I do hope that an expert extramural panel will be convened to address this question before a hasty decision is made."

The NCI intramural program is a great asset to cancer research, and it expensive, but it should remain its present size, Chabner said. DCT spends nearly $100 million annually on salaries, services and supplies for its intramural research, he said.

"There is no better place on this earth to do cancer research, and to bring it to clinical trial," he said. "To keep it productive, it needs resources, intelligent leadership, a pool of talented trainees to replenish its rank, and patients.

"The growth in resources for cancer research has been virtually non-existent in absolute dollars over the past 11 years," he said. "There are areas that could and should be cut, but overall it contains a remarkable group of innovative people who want to cure cancer."

Chabner said the intramural program must become more competitive in attracting clinical trainees, and improve the recruitment of patients to the NIH Clinical Center.

NCI this year experienced a 20 percent decrease in inpatient and outpatient activity as a result of cutbacks in travel funds and decreased patient referrals.

The General Accounting Office, in a recent study, recommended that NIH consider charging for routine patient care. That would require determining what is experimental and what is routine, and might require the Clinical Center to be managed by a contractor, Chabner said. "I view this as an exceedingly complex and potentially disastrous alternative to the present situation," he said. "It would discourage access for uninsured patients. Research would not come first.

"What is needed, in my view, is efficient management of the Clinical Center and an aggressive recruitment of patients for interesting protocols," he said.

The new Clinical Center director, John Gallin, has been cooperative with NCI, Chabner said. Gallin has promised not to increase NCI's share of the center's management fund for the next three years, and to assume some patient care costs now paid for by DCT, he said.

Comments on DCT Components

Chabner made the following parting comments to the board on specific programs within DCT:

Clinical Oncology Program: "There are excellent research efforts in adult and pediatric AIDS, and infectious diseases in immune-compromised hosts, in melanoma vaccines, in ras vaccines, in clinical pharmacology, in ovarian and GI cancers, and in gene therapy. The radiotherapy effort is manned by young people, has only a modest clinical research program defined at present, and will need your oversight and guidance."

NCI-Navy Medical Oncology Program: "Vital to the fellowship in medical oncology and doing excellent laboratory and clinical work. It interacts well on vaccine therapy with [the Div. of Cancer Biology, Diagnosis and Centers] and has initiated a very exciting new effort in clinical genetics with the Genome Center and Bert Vogelstein. It deserves to be protected and maintained as a high priority.

Medicine Branch: "Bob Wittes has made a heroic effort to improve the fellowship program and has an outstanding group of senior staff scientists. Its efforts in lymphoma therapy, gene therapy, and drug resistance are outstanding. Eddie Reed's clinical efforts in advanced ovarian cancer are very promising, with a high CR rate and good disease free survival for poor prognosis patients treated with Taxol, platinum and cytoxan. His laboratory work on DNA repair is likewise excellent."

Developmental Therapeutics Program: "Some great strengths, particularly the group working on DNA damage and cell cycle. The G-protein laboratory under Rick Kahn and the natural products group under Mike Boyd are leaders in their respective areas. I am impressed with the work of Terry Burke's group in the design of tyrosine kinase inhibitors and the projects on actin inhibitors in Ed Sausville's laboratory."

Cancer Therapy Evaluation Program: "It is essential to NCI, staffed by fine people, and doing its job. The staff, particularly Mike Friedman, Michaele Christian, Rick Ungerleider and Jeff Abrams, have been subjected to extraordinary pressures related to the NSABP affair, and have performed admirably. I strongly believe that they belong in DCT, close to the DTP and COP, and derive ideas and staff from the DCT intramural program.... They are perhaps the most essential of all of DCT's programs. In the great wisdom of the federal bureaucracy, they will not be eligible for the new bonuses offered to intramural physician-scientists."

Radiation Research Program: "It has a dedicated staff who know their business, but until the present, it has lacked sustained and permanent clinical leadership. A total of six individuals have headed RRP, either as permanent or acting directors, during the past 12 years." Carl Mansfield, of Thomas Jefferson Medical College, has been selected as the new director.

Biological Response Modifiers Program: "A fine laboratory program at Frederick and an important new capability to produce clinical grade biologicals on site, and a very efficient clinical operation." The Bishop-Calabresi committee is considering whether NCI needs the clinical program at the Frederick Cancer Research and Development Center, and Gallin has offered space at the NIH Clinical Center for the program.

Chabner said he has asked BRMP director Dan Longo and Clinical Oncology Program director Gregory Curt to consider consolidating their services at the Clinical Center. "My view is that the lymphoma patients and all protocols not exclusively devoted to

biologicals developed at FCRDC should move back to the Clinical Center," Chabner said. "However, I do view the unique confluence of laboratories, manufacturing facilities, and clinical leadership at Frederick to be worth preserving, and would urge that my successors give careful consideration to this issue before making a final decision.

"Is the Frederick BRMP program viable without a clinical unit on site?" Chabner asked. "It seems to me that if the BRMP clinic is closed and its protocols moved to the Clinical Center, then the program becomes a basic immunology effort not clearly distinct from DCBDC, its developmental capabilities could be attached to Developmental Therapeutics, and its laboratories could become a part of a larger NCI immunology program."

Consolidation may not accomplish cost savings because patient care at Frederick is less expensive than at the Clinical Center, Chabner said. The current cost of the BRMP clinic is $8 million per year, and patient care costs are partially offset by the collection of about 40 percent of charges from third-party carriers, he said.

Genes, Cells, Reveal Strategy For Cancer Cure, Bishop Says

In what could turn out to be the Capitol Hill equivalent of a screen test, molecular biologist Michael Bishop said advances in genetics and cellular biology have revealed the strategy that will lead to the cure of cancer.

Addressing the Labor, HHS & Education Subcommittee of the House Appropriations Committee, Bishop said knowledge gained through molecular biology in the past decade will revolutionize prevention, detection and treatment of cancer.

"For the first time in my 30 years as a biomedical scientist—I now believe that we will eventually conquer cancer," said Bishop, who is regarded as a contender for directorship of NCI. "It may take several generations more of hard work, but the strategies for conquest are clear."

Bishop, who won the Nobel Prize for research he conducted with Harold Varmus, now the NIH director, moderated a panel that included five other Nobel laureates. The panel, put together by the Joint Steering Committee, an advocacy group for biomedical research, appeared at the request of the subcommittee chairman, John Porter (R-IL).

Bishop, of the Univ. of California, San Francisco, is co-chairman of a committee reviewing the NCI intramural research program.

At the appropriations subcommittee hearing Feb. 28, Porter said that he opposed cutting taxes, but said the efforts to balance the budget would put a strain on all government programs.

"We know that in terms of delivering medical technology to the American people, the advances of technology have outstripped our resources and our ability to provide them to everyone," Porter said.

"And now we see the same thing with respect to biomedical research. We have moved so fast in such a relatively short time, and the possibilities are so great that we may be facing the possibility of not having the resources to fund all the exciting technology."

Responding to Porter's remark, Bishop said that in recent years the government has been able to fund programs that were far more costly than biomedical research.

"I have seen my government do some remarkable things," Bishop said.

"We have found more that $500 billion overnight to bail out a dubious fiscal industry. We have found $50 to $80 billion to help Mexico almost overnight. We found money to fight a totally unanticipated war in the Persian Gulf.

"And all of these are efforts on a magnitude far exceeding anything that's going to be required for a decisive solution to cardiovascular disease, or a decisive solution to cancer or Alzheimer's, or the Human Genome Project, etc.

"It's a matter of priorities, Mr. Chairman. And as a citizen and a scientist, I think I know what our priorities ought to be."

The panel that testified before the appropriations subcommittee included James Watson, David Hubel, Michael Brown, Joseph Murray and Phillip Sharp. Varmus attended the hearing.

The excerpted text of Bishop's remarks follows.

"When I studied medicine 30 years ago, it seemed to me that we might never fully understand cancer, which takes so many forms and has so many different causes.

"Now all that has changed. Over the past two decades, we have found our way to a single explanation for all cancer, an explanation that promises a unified strategy for the conquest of that disease. The explanation is based on cells and genes.

"By now, we can point to at least one [proto-

oncogene] in almost every form of human cancer. We have no doubt that they are a universal feature of cancer."

"So, we have a powerful new view of cancer. The seemingly countless causes of cancer—cigarette smoke, sunlight, asbestos, chemicals, viruses, and many others—all these work in a single way, by playing on a genetic keyboard, by damaging a few of the genes in our DNA, by jamming the accelerators and removing the brakes of our cells. An enemy has been found, and we are beginning to understand its lines of attack.

"What does this new view promise for our ability to fight cancer? Simply put, it is going to change every aspect of our strategies against cancer:

- "It will eventually tell us new things about the causes of cancer, and thus open up new approaches to prevention;
- "It will allow earlier detection of cancer cells in our bodies, and earlier detection usually means a better chance for cure;
- "And it will allow us to refocus our therapeutic strategies in ways that we could not even have imagined 10 years ago...

"Can we muster the resources for the conquest?

"That is a question only you and your colleagues here on this hill can answer. But I want to close with a comment about one of those resources—the resource which I consider most vital—the next generation of scientists, just now taking form in our nation's schools and laboratories.

"These young people have heard the view that our nation is `insolvent' and may not be able to sustain medical research as it has in the past: the message has been sent to them in many different forms, not just through the musings of this committee.

"They can see only one sensible response: get out of science, find something else to do.

"I can think of few losses that would be more damaging."

Critics Question ORI Progress On Fisher Case; No Panel Yet

Last April, NCI requested a formal inquiry into possible scientific misconduct by Bernard Fisher.

More than 10 months later, the investigation appears to be nowhere near reaching a conclusion, and officials at the Institute say the HHS Office of Research Integrity is not proceeding with due speed.

"It should be a pretty simple and straightforward issue to deal with," said a senior NCI official familiar with the case.

"The delay is very unfortunate for Dr. Fisher and NSABP, and it certainly has made it more difficult to get on with the business of doing clinical trials," the official said.

Though originally the case against Fisher explored virtually every issue raised at hearings held by Rep. John Dingell (D-MI), all but one of the allegations have been dropped, Lyle Bivens, ORI director, confirmed.

Bivens said the only issue that remains before the investigators is whether Fisher had valid reasons for publishing data that he knew to be fraudulent and whether such submissions were intended to deceive.

"Our focus is on whether data that was known to be falsified or fabricated was knowingly included in manuscripts or publications without appropriate notification to the editors," Bivens said to **The Cancer Letter**.

Generally, ORI assembles panels of experts to advise the investigators. However, no panel has been formed in the Fisher case, Bivens said.

Bivens declined to say when or whether a panel would be formed. "We usually put together a panel," he said. "I wouldn't want to comment on when or what the makeup would be in this particular case."

The Fisher case is anything but straightforward, Bivens said.

"It's difficult in a sense that there are many, many publications involved, and the database underlying the publications is not crystal-clear," Bivens said. "It takes a lot of work for us to determine what patients are included in what publications. It's a complex and kind of tedious process."

Whatever the complexity of the case, ORI, always a controversial agency, is finding itself under attack from virtually all parties affected by the Fisher controversy.

"It is critical that ORI rapidly resolve this investigation in the interest of clinical research and in order that justice should be served," said Norman Wolmark, chairman of the National Surgical Adjuvant Breast & Bowel Project. "As it stands, the work of NSABP is being hindered."

Joining the chorus of critics are two investigators who were involved in the Fisher case when they served on Dingell's staff.

"I would think they should have had a panel by now," said Peter Stockton, formerly an investigator with the Subcommittee on Oversight and

Investigations of the House Energy & Commerce Committee.

Stockton said Dingell's subcommittee staff never intended to have the matter go to ORI. Rather, the subcommittee would have preferred to see the continuation of the process begun by the Univ. of Pittsburgh last May.

Though Pitt appointed a three-member inquiry panel to determine whether an investigation would be warranted, the panel was suspended after Fisher sued the university and its outside counsel, Martin Michaelson. At that time, ORI took over the investigation (**The Cancer Letter**, July 22, 1994).

"Pitt was certainly motivated, and the inquiry panel was on the right track," Stockton said. "We had no interest in ORI taking it over. We thought the investigators were more competent at Pitt, and we were certainly gaining confidence in Michaelson."

Michaelson is an attorney with Hogan & Hartson, a Washington firm.

"If they are focusing narrowly on publications of data from St. Luc, I do believe they should be done by now," said Suzanne Hadley, formerly an investigator on Dingell's staff.

St. Luc, a Montreal hospital, was the institutional base of Roger Poisson, the surgeon who submitted fraudulent data to NSABP.

One member of the inquiry panel originally assembled by Pitt was surprised to learn that ORI has not completed its work.

"I am puzzled as to why it should take such a long time for ORI to determine what Dr. Fisher knew and when knew it," the panel member said to **The Cancer Letter**. "We expected to complete our work by September."

Fisher's attorney Robert Charrow said he is puzzled, too.

"Even at their glacial speed they should have had a panel at this time," he said to **The Cancer Letter**. "It's clear that at this point everyone at ORI is running for cover as quickly as they possibly can, and the shooting hasn't even started yet."

Charrow said ORI has not notified him of the progress in the investigation.

"It's hard for me to ascertain what is going on," he said.

One action ORI took was to identify and tag in NIH databases at least 88 publications that list Fisher among authors. The language of the tag, which included the words "scientific misconduct," was defamatory to Fisher, Charrow said.

Last week, Bivens requested that the words in question be removed from the Medline and Cancerlit databases (**The Cancer Letter**, Feb. 24).

However, as of Feb. 28, the words "scientific misconduct" remained in the databases.

In an interview, Bivens requested an opportunity to clarify a statement he made to **The Cancer Letter** last week, when he said that in the Fisher case ORI had flagged the databases "prior to any scientific misconduct finding."

"What I said [last week] implied that the flags were put on Medline notices because of the Fisher investigation," Bivens said. "If that is what the reporter heard, I misspoke or I made an error.

"It's really based on the Poisson confirmed findings of misconduct. It wasn't because of the Fisher investigation or anything we had concluded in the course of that investigation," Bivens said.

In another development, Ronald Herberman, principal investigator of the NSABP Biostatistical Center, disputed a statement by Bivens in last week's issue of **The Cancer Letter** that the cooperative group never provided ORI with a complete list of publications that contained data from St. Luc.

"I wish to correct some statements in the Feb. 24 article about the flagging of NSABP manuscripts, suggesting that the NSABP leadership failed to provide ORI with an appropriate, complete list of publications from NSABP," Herberman said in a statement.

"In fact, a list of publications that included data from St. Luc Hospital was included as an appendix to the NSABP's Plan for Corrective Actions, that was intially submitted to NCI in April 1994, and shortly therafter was transmitted in turn to ORI."

Asked by **The Cancer Letter** whether ORI has developed a list it considers complete, Bivens said:

"I couldn't speak for the investigators. I know it's a long list, and I don't think it's complete yet. I know that my investigators need to look at it more before they come to any conclusion."

In Brief

(Continued from page 1)

coordinator of the Minority Based Community Clinical Oncology Program. Theragenics manufactures TheraSeed (palladium-103), a radioactive source used in the treatment of localized prostate cancer. . . . **FOX CHASE** Cancer Center received a $200,000 one-year grant from NCI to complete the development of a com-

prehensive breast cancer research program. Principal investigator is Lori Goldstein. . . . **RONEN MARMORSTEIN** heads a new laboratory in protein crystallography at the Wistar Institute of Anatomy and Biology. The institute received a $300,000 grant from the Pew Charitable Trusts to fund the laboratory.

Letter to the Editor

Fund Seeks Support For Fisher

To the Editor:

We applaud you on your incisive and thorough expose of one of the most destructive and far-reaching scientific scandals of many years.

We were outraged when we learned that government officials had arbitrarily and wantonly labeled the publications of Dr. Bernard Fisher and other co-authors who are also members of the NSABP with the insulting notation "scientific misconduct" without regard for due process or consideration of the contents of those publications (**The Cancer Letter**, Feb. 24).

We are in support of Dr. Fisher's courageous fight to defend the principles of academic freedom, scientific investigation and clinical research. He is standing up on behalf of many scientists and clinical investigators to put an end to such misguided and defamatory actions.

As you can imagine, legal action is expensive. In order for Dr. Fisher to continue this battle to defend academic freedom, additional financial support is required for the legal crusade.

To assist Dr. Fisher, the Dr. Bernard Fisher and NSABP Legal Fund has been established. We encourage those who wish to aid in this most important non-tax deductible legal battle to contribute. The Fund's address is: Suite 201, 400 North 17th Street, Allentown, PA 18104.

David Prager
Peter Deckers
William Dugan
Fund Trustees

NCI Plans Phase-Out Of K04s

NCI plans to phase out and terminate its Research Career Development Awards Program (K04), the Institute announced last week.

The program, which was begun more than 20 years ago, no longer addresses the most critical research manpower objectives of the NCI, the Institute said in an announcement in the Feb. 17 NIH Guide to Grants and Contracts. The program is under review to determine whether it should be restructured or replaced with a new program that would be more relevant to contemporary research career development needs, the statement said.

The final application receipt dates for this program were as follows: Feb. 1 for new applications and March 1, for revised applications. Awards from this cycle will be for a full five-year project period and will represent the final awards. Applications will not be accepted for any future receipt dates. Any new awards made in FY 1995 or 1996, based on previously reviewed applications, will be for a full five-year project period.

Inquiries: Robert Adams, NCI Div. of Cancer Biology, Diagnosis, and Centers, Executive Plaza North Rm 520, Bethesda, MD 20892, Tel: 301/496-8580, FAX: 301/402-4472, email: ra30s@nih.gov.

RFA Available

Requests for Applications may be obtained electronically through the NIH Grant Line (data line 301-402-2221) and the NIH GOPHER (gopher.nih.gov) and by mail and E-mail from the program contacts listed under Inquiries.

RFA CA-95-009
Title: **AIDS-Associated Malignancies Clinical Trials Consortium**
Letter of Intent Receipt Date: April 4
Application Receipt Date: May 4

The Cancer Therapy Evaluation Program of the NCI Div. of Cancer Treatment invites applications from single institutions or consortia of institutions for cooperative agreements (U01) to design and develop clinical trials with novel agents or using innovative approaches in patients with AIDS-associated malignancies. NCI is seeking talented scientists from academic, non-profit and for-profit research organizations from the US and Canada who will interact with other members of the Consortium, and with CTEP to conceive, create, and evaluate new approaches to therapy of AIDS-associated malignancies. Eligible institutions may apply for either or both of the following types of awards: 1) Clinical Trials Member, 2) Operations, Statistical and Data Management Center. A separate application must be submitted for each type of award. The AIDS-associated Malignancies Clinical Trials Consortium will be developed out of the funded awardees. Clinical trials using conventional cytotoxic chemotherapy regimens alone would not be performed within the consortium. The potential exists for expanding to phase III studies. Approximately $2 million in total costs per year for four years will be committed. Eight to 10 awards for Clinical Trials Members will be made. There will be one Statistical, Operations, and Data Management Center award.

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