THE CANCER LETTER

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US Could Lose Leadership In Research If NIH Budget Is Cut, ASCO President Says

LOS ANGELES—Congress should not allow the US to lose its leadership in biomedical research by cutting the NIH budget, the president of the American Society of Clinical Oncology said at the society's annual meeting here May 22.

Karen Antman, chief of the Div. of Medical Oncology, Columbia Presbyterian Medical Center, warned that major cuts in research funding could push cancer research the way of the US automobile and computer chip industries.

"We have been the world leader for cancer research and treatment, but the US is losing its edge," Antman said in her final address as ASCO president.

(Continued to page 2)

In Brief

Glick, Armitage Lead ASCO; NCAB Approves Resolution Calling For Higher NIH Budget

JOHN GLICK became president of the American Society of Clinical Oncology at its annual meeting in Los Angeles late last month, succeeding **Karen Antman**. Glick is director of the Univ. of Pennsylvania Cancer Center. **James Armitage**, professor and chairman of the Dept. of Internal Medicine, Univ. of Nebraska Medical Center, was chosen president-elect of the society. New members of the ASCO Board of Directors are: **Paul Bunn**, Univ. of Colorado Cancer Center; **John Minna**, Univ. of Texas Southwestern Medical Center; **James Wade**, Decatur Memorial Hospital; and **William Wood**, Emory Univ. Hospital. . . . **RESOLUTION** approved by the **National Cancer Advisory Board** at its meeting May 17 called on the Administration and Congress to "give specific consideration to the future funding of the National Institutes of Health and their mission to reduce the suffering and deaths due to cancer, and its economic consequences." The budgets proposed for NIH by the Administration and Congress "will have a devastating impact on the national resources for biomedical research, and specifically for cancer research and care, that have been so carefully developed over the past three decades," the resolution said. . . . **IMMUNO-US INC.** has donated $1.5 million to St. Louis Univ. School of Medicine to establish an endowed chair in pediatric research. The university appointed **Mary Hendrix**, a professor in the Dept. of Pediatrics and an expert in gene regulation, to the chair. . . . **BENJAMIN CORN** has been named the vice chairman and associate professor of radiation oncology at Thomas Jefferson Univ. Corn previously was clinical director of radiation oncology at Medical College of Pennsylvania.

Cut Of NIH Budget Threatens US Leadership, Antman Says

(Continued from page 1)

"We applaud the globalization of biomedical research, and Americans will certainly benefit from medical advances made elsewhere. But Congress should be mindful of losing the US leadership position in biomedical industries, as it has been in automobile manufacturing and in computer chips."

US spending on health care is $1 trillion a year, or about 14 percent of the GNP, while federal and pharmaceutical funding for research last year was $30 billion, or about 3 percent of the total health care spending, Antman said.

"The Congressional agenda centers on cutting spending, cutting taxes, and cutting the deficit, and every item of discretionary funding is vulnerable," Antman said. "For the first time since the founding of the NIH, biomedical research funding is a major target for substantial reductions."

Antman urged ASCO members to contact their Congressional representatives to encourage support of NIH as the appropriations bills are finalized over the summer.

"ASCO will continue to argue that the investment in research makes sound economic sense," Antman said. "Every dollar spent by NIH creates about $13 in the overall economy."

Misconceptions About Clinical Research

Appropriations to NIH should fund a balanced program of laboratory and clinical research, Antman said. However, two studies recently found that or patient-oriented research does not receive adequate support from NIH, she said.

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Both a report by the Institute of Medicine and a committee commissioned by the NIH Div. of Research Grants concluded that clinical research has a lower than appropriate funding level. The DRG committee also found that an insufficient number of clinical investigators to review clinical studies currently serve on NIH study sections. The committee recommended the formation of a clinical research study section.

"NIH funding by statute is intended to support research that will impact on the health of the American public," Antman said. "Pure science is funded by the National Science Foundation. Clinical research has the best possible track record and deserves adequate funding."

The IOM report found that in all of the biomedical sciences, most clinical investigators are over the age of 40, Antman said. "We have already lost a generation of clinical investigators," Antman said. "Lack of funding and protected time, as well as the difficulty obtaining promotions at universities that value NIH-funded research are major quality of life issues."

Prominent scientists and decision-makers often have misconceptions about clinical research, Antman said. She listed some comments about clinical research she had heard in the past year:

- Misconception: "Clinical research quality can't compete. The major successes have been in the lab, not the clinic."

Reality: Clinical research led to the knowledge that mammography for women over age 50 saves lives, and that the breast cancer survival rates for mastectomy and lumpectomy with radiation are equivalent, Antman said.

"As William Wood, chairman of surgery at Emory, said to the President's Commission on Breast Cancer, 'Everything we do to treat breast cancer, we learned from clinical trials,' " Antman said. "Funding review committees value hypothesis-driven mechanistic research, and reject such derivative studies. But ask any oncologist or for that matter, any cancer patient, how important these studies have been."

- Misconception: "Clinical research should be funded by the pharmaceutical industry."

Reality: "Pharmaceutical companies are unlikely to fund comparisons of mastectomy and lumpectomy, or those designed specifically to decrease the amount of drug use," Antman said. "Nor should they, since their predominant responsibility is to their stockholders."

● Misconception: "Advances proceed only from bench to bedside."

Reality: "Examples of translations from the clinic to the laboratory are at least as common as from lab to clinic," Antman said. "The clinical observation that all-trans-retinoic acid produced remissions in APL proceeded by several years the report in Science that the retinoic acid receptor is transposed in the characteristic 15-17 translocation of APL."

● Misconception: "Independence is essential to promotion."

Reality: Clinical investigators are at a disadvantage in obtaining promotions at universities that insist on independence. "Few projects in clinical medicine can be completed without a multimodality team approach, yet only one investigator can be credited with the advance," Antman said.

● Misconception: "We're not getting very far with clinical trials. A three percent increase in response rate isn't worth the cost."

Reality: "This excuse for not looking seriously at clinical research is particularly insidious because a three percent increase in response rate probably isn't worth the cost," Antman said. "However, the premise is incorrect. We have made substantial progress with clinical trials."

Basic and clinical research should complement—rather than compete with—each other, Antman said.

"Certainly the pace of laboratory research in cancer has been impressive, improving our understanding of the multi-step process of carcinogenesis," Antman said. "However, this body of knowledge is only beginning to be applied to clinical therapeutics. Clinical research is essential if only because all of the hypotheses produced by laboratory investigation will eventually need to be evaluated in patients."

Health Insurance Reform And Specialization

As health care undergoes a transformation, ASCO must adapt to meet the changing needs, Antman said. "We are probably the best qualified organization to craft a vision for the optimal care of patients with cancer, and we must take an active role in shaping the future of practice and research," she said.

ASCO's priorities in health insurance reform are: legislation that guarantees access to approved clinical trials, cancer centers and cancer specialists; eliminates exclusions for pre-existing conditions; and ensures that health insurance for cancer patients will be portable.

Some health care reformers have suggested that overspecialization has led to the high cost of health care in the US, and that fewer physicians should be allowed to specialize, Antman said.

"Too few specialists also can have a detrimental impact on public health," Antman said. "The five year survival for patients with breast cancer is 80 percent in the US and 60 percent in the UK. While there are many potential explanations for this difference, Dr. Kenneth Cowman, the director of the British Dept. of Health, has attributed the UK's higher mortality to too few oncologists."

To assess the US need for oncologists, ASCO last year formed an Oncology Workforce Committee, chaired by Robert Mayer, of Dana-Farber Cancer Institute (see related story, page x).

The committee found that the US currently has about the right number of oncologists, and may need more as the "baby boom generation" reaches their 50s and is at a higher risk of cancer, Antman said.

The committee surveyed the 4,239 ASCO members who identified themselves as either medical oncologists or hematologists/oncologists. A preliminary analysis of the study indicated that oncologists presently see about 180 different patients per month, of whom about 80 percent are under active treatment for malignant or hematologic conditions, Antman said.

Oncologists reported an average of 72 percent of their time spent in patient care activities, and 11 percent of their time devoted to teaching and research.

Oncologists in private practice and HMOs spent three to four percent of their time in teaching and research, compared with 14 percent of those practicing in community hospitals and 29 percent for those in academia.

One goal of the workforce study was to obtain specific data on the extent of primary care services routinely delivered by oncologists, Antman said. The surveyed oncologists said that primary care services comprise only a small minority of their professional time, she said. If managed care required increased patient volume, medical oncologists preferred to increase the number of oncology patients, and would decrease time spent in primary care, teaching and research, the survey found.

"Certainly, one way to decrease costs is to eliminate teaching and research, and participation in clinical trials," Antman said. "However, this is neither true costs savings or even appropriate cost savings."

New EVP Position

Antman introduced ASCO's new executive vice president, John Durant, formerly vice president for health sciences at Univ. of Alabama at Birmingham. Durant, a former ASCO president, became the society's first executive officially on April 1.

Durant is planning to expand the ASCO Washington office, and move the office to Alexandria, VA. The office has hired a specialist to answer member's billing and coding questions.

ASCO Statistics

ASCO added 568 new members at the meeting in Los Angeles, bringing total membership to 10,110.

Meeting registration was more than 12,000, including more than 10,000 physicians. In addition, 51 percent of the meeting registrants were from outside the US.

ASCO membership by specialty: 57 percent hematology/medical oncology; 14 percent radiation; 5 percent pediatrics; 10 percent surgical subspecialties, 1 percent nursing, social services, biostatistics and others.

Forty-three percent of ASCO members work in private practice, 34 percent are in universities, 5 percent in HMOs, 4 percent in government, and about 2 percent in industry. Only 34 percent of members are primarily academic, but almost two-thirds of the members hold academic rank.

Oncology Seeks To Determine Impact Of Health Care Changes

LOS ANGELES—After Congress and the Administration abandoned their plans for a top-to-bottom makeover of the American health care delivery system, the change has been left entirely to market forces.

And with regulators getting out of the picture, the market is likely to determine how many oncologists will be able to find work, how much time these physicians will be able to devote to clinical research, and how patients will be able to gain access to state of the art care.

At its annual meeting, the American Society of Clinical Oncology attempted to examine the upcoming change from several perspectives by assembling a panel that included a medical educator, a patient advocate, a clinical researcher and an official of an insurance company.

Excerpted statements of these speakers follow:

Oncology Workforce: Glut in the Making?

Robert Dickler, vice president, clinical services, of the Association of American Medical Colleges.

"The current predictions for the year 2000 would argue that we would have an excess ranging from 24,000 to 143,000 physicians. While there is a continuing debate on whether we need more generalists, I think almost everybody has concluded that we need fewer specialists.

"Hematology/oncology seems to be better off than most specialties. [There is] about one oncologist per 50,000 [people], it looks about right. However, you have doubled the number of residents you are training since 1988/1989.

"At the same time we are having a debate regarding the size of the workforce, we are going to have rapidly diminishing resources to support that workforce. We have supported graduate medical education through patient care dollars, either through higher rates at teaching hospitals or through explicit payments from Medicare. Both of those are in real jeopardy.

"With these dramatic changes, we are going to have to ask some hard and serious questions. And I would propose that they include the following for both undergraduate and graduate medical education:

"We will need to rethink how we teach. We will need to rethink how we meld delivery and education. We will need to rethink the physician/hospital paradigm.

"It is no longer possible to keep pointing the finger at each other and say, That's your responsibility. In the integrated delivery system of tomorrow, it's going to be our joint responsibility."

A Patient's Nightmare

Amy Langer, executive director of the National Alliance of Breast Cancer Organizations.

"Let me catalogue for you cancer patients' fears in the environment where cost concerns dictate the level and extent of oncology care.

"Patients fear that the oncologist would be deemed to be too expensive to function as a gatekeeper for their general health. That they will be unable to be reimbursed for the care they are told they need, or that non-optimal regimens will be substituted. That quality of life care will be seen as somehow dispensable in the cost-rationing environment.

"If this nightmare scenario comes to pass, the impact on people with cancer will clearly be of

immense proportions. What, in turn, will be the effect on the oncology workforce and on clinical research?

"Simply put, cancer will become harder to research and harder to treat, so fewer will want to try. The ability of health care professionals to feel that they have an edge against this disease will be undermined.

"In my field, breast cancer, we have made significant progress in two areas: early detection and the patients' ability to be partners in managing their disease. For the first time in four decades, the breast cancer [mortality] rate has declined, although—sadly—only for white women. This progress is largely attributable to increased compliance with screening and more effective treatment options.

"If we cannot continue to offer screening and treatment advances to women and be sure they are paid for, what will be women's incentive to detect their disease?

"Now patients are empowered to seek the best, and their empowerment helps them survive. I genuinely hope that the nightmare scenario becomes that of tolerable adjustments that permit progress to continue. If not, advocacy organizations will intervene to secure needed research and treatment for people with cancer. A system designed with excessive constraints, little flexibility and no heart should expect a challenge at every turn."

Needed: Innovative Means of Funding

Robert Mayer, chairman of the ASCO Workforce Committee and clinical director, Dept. of Medicine, Dana-Farber Cancer Institute.

"Insurers are in a controlling situation. There is decreased grant support that's monumental. There are decreased referrals of patients for clinical trials. There are decreased jobs for trainees, and those trainees going out into the workforce are finding remuneration far less favorable than it was four or five years ago, particularly in California, and also particularly in cardiology, gastroenterology, and, undoubtedly, soon in this field as well.

"[In a survey conducted by the ASCO Workforce Committee] ASCO members expressed little interest in providing primary care. Even if they were asked to increase their patient volume, they do not view themselves as primary care physicians, but rather as the true subspecialists.

"What is it that we need? What is it that we can hope for?

"Innovative new means of funding. We need increased partnerships with the pharmaceutical industry and philanthropy to support clinical trials. And we need to compromise among ourselves about how to reduce fellowship number. We require patient advocacy—more now than ever—to provide us support. We need to guarantee access for cancer patients to the oncology community.

"And, most importantly, we need open, constructive dialogues."

Aetna Official: Better Technology Assessment

William McGivney, medical director, Aetna Health Plan.

"To provide you perspective on my thinking and the thinking of the industry, let me make nine quick points, and then a quick proposal.

"1. We support the technological [innovation] in medicine.

"2. Whether you are a patient, a physician or payer, you want to know whether there are data to support the safety and effectiveness of the treatment you are about to undergo, prescribe, or pay for.

"3. We recognize that clinical and coverage decisionmaking, especially in the area of cancer, constitutes a risk-benefit analysis. The more severe a particular illness, the less degree of certitude about effectiveness and the greater risk of harm that a patient, physician and payer should be willing to accept.

"4. We believe it's the responsibility of the proponent of a particular treatment to prove that a particular treatment indeed is safe and effective for the indication.

"5. Managed care is outcomes-based decision-making.

"6. Managed care companies tend to have very sophisticated technology assessment programs that evaluate the safety and effectiveness of the various treatments, procedures, drugs, devices that we are looking at to provide coverage for.

"7. This has resulted in a stricter adherence to provisions about exclusion of investigational technologies.

"8. I think the whole bone marrow transplant epic has been a disaster for this country. It has highlighted significant problems with existing mechanisms for the study and diffusion of significant new technologies.

"9. Most major managed care companies are more willing than ever to join a cooperative relationship with academic medical centers on major national research issues. *(See related story on page 6).*

"We need to set up what could be a national advisory group that would identify very significant new technologies, [such as] the bone marrow transplant in breast cancer issue when it comes along, and basically say, We will look at this particular technology in 40, 50, 60, or however many centers need to participate to ensure access across the country, and that payers would be willing to pay the patient care costs in these identified outcome studies.

"But again, the use of these new technologies under study would be restricted to those 60 or so centers. And when the outcomes data becomes available, this national advisory group would analyze it, and then make a determination as to whether or not this particular technology could defuse into general practice."

Cancer Centers, Insurance Cos. "Natural Allies," Aetna Says

Academic cancer centers and national insurance companies are "natural allies," an official of Aetna Health Plan said.

"I think there is a natural alliance, because of our orientation to outcomes-based decision making, between managed care companies and academic cancer centers," William McGivney, medical director of the Aetna Health Plan, said at the annual meeting of the American Association of Clinical Oncology.

McGivney said he supported the formation of a coalition of academic cancer centers. The new group, called National Comprehensive Cancer Network and formed earlier this year, has the immediate goal of enhancing the centers' position in competing for patients enrolled in managed care insurance plans. (**The Cancer Letter**, Jan. 27).

While academic cancer centers may not be the lowest-cost providers of cancer care, the care they provide is appropriate, McGivney said.

"Our problem with patient selection criteria is not with the academic institutions; it's with the community cancer centers out there, which are not keeping up with the data in certain areas," McGivney said.

McGivney said also that Aetna has a business involvement with a coalition of cardiac care academic centers, and has considered working through a similar network in cancer care.

"I think it's an excellent idea," McGivney said of NCCN. "We are doing a similar thing nationally with cardiac care. Whether we choose to do the same thing for cancer, I don't know. It's something we've thought about."

With the cancer center network still in its infancy, the questions asked by members of the panel exceeded the number of answers available:

- If new members are being accepted, which criteria will be used for institutions to join the new network?
- Will the practice guidelines currently under development by NCCN members be available outside the network?
- Will the research thrust of the member institutions be affected?
- Is a national marketing approach feasible in the area of cancer care?

Robert Mayer, clinical director of the department of Medicine at Dana-Farber Cancer Institute, said he hoped patients outside the network would be able to benefit from the practice guidelines being developed by NCCN.

"My concern, and I hope it won't be a real concern, is whether access will be at all influenced in a negative way by any of this," Mayer said. "I hope that access will be increased, and that the clinical practice guidelines that the NCCN membership is putting together will not only help patients treated there, but at other institutions as well."

Historically, health care has not been a national market in the US, said Robert Dickler, vice president, clinical services, at the Association of American Medical Colleges.

"It's still very unclear as to whether we are going to be successful in national care provider systems," said Dickler, "HMOs that have presence in multiple states, will tell you that this is still a local market phenomenon. They are dealing with local employers, local populations

"The other thing we have to be realistic about is that there are a lot of good providers outside of these 13 institutions, and one of the issues for the HMOs and the managed care organizations will be whether this is really a more cost-effective way to proceed than dealing with local providers.

"The research thrust of that system could be subverted because of those forces," Dickler said.

NCCN members are: Memorial Sloan-Kettering Cancer Center, Fox Chase Cancer Center, M.D. Anderson Cancer Center, Johns Hopkins Oncology Center, Fred Hutchinson Cancer Research Center, Dana-Farber Cancer Institute, City of Hope National Medical Center, St. Jude Children's Research Hospital, Stanford Univ. Medical Center,

Northwestern Univ. Lurie Cancer Center, Ohio State Univ. Comprehensive Cancer Center, the Univ. of Michigan Comprehensive Cancer Center, and the Univ. of Nebraska Medical Center.

Last month, Bruce Ross, former senior vice president of Bristol-Myers Squibb Co., was named NCCN chief executive officer.

OTA Finds Prostate Screening Not Yet Proven To Save Lives

The ability of prostate screening to extend lives is yet to be demonstrated, the congressional Office of Technology Assessment concluded in a study.

According to OTA, less is known about the efficacy of screening for prostate cancer than about screening for breast and cervical cancers.

"Because scientific knowledge is limited, but the consequences of prostate cancer and its treatment are serious, an informed and reasonable patient could equally well decide to have screening or forgo it," OTA concluded in a recent 144-page report.

Nonetheless, OTA said it would be reasonable for Medicare to consider reimbursement for the screening test. "Reimbursement could be seen as ensuring that out of pocket screening expenses (however small) not impede well informed discussion and decision-making between physician and patient," the report stated.

One approach suggested by OTA is to offer the prostate screening benefit on a temporary basis, "subject to reconsideration as evidence from clinical trials about the effectiveness of screening and treatment becomes available.

While several randomized clinical trials of prostate cancer screening are being initiated, their results will be of no immediate use to Medicare, OTA said.

"Unfortunately, from the perspective of policymakers, the relatively indolent nature of many prostate cancers means that 10 to 15 years may be requires to see enough prostate cancer deaths among men in these studies to obtain adequate comparisons of the strategies being tested," the report said.

Commenting on the report, the American Urological Association, an advocate of screening and aggressive treatment for prostate cancer, disagreed with the statement that no conclusive comparative data exist on strategies for management of localized prostate cancer.

"While it is true that certain men of advanced age and poor health will not benefit from therapy for prostate cancer, younger men in good health, especially those with a family history of the disease, can be spared a premature death," AUA said in a statement.

"Concerns of the OTA regarding the value of treatment are based at least in part on medical literature reflecting the value of treatment before the availability of prostate-specific antigen testing.

"Patients in the older studies were primarily diagnosed by digital rectal examination alone, and had more advanced stage and extent of prostate cancer at the time of their diagnosis and treatment.

"Outcomes of the treatment, therefore cannot be expected to equal those being achieved now that prostate cancer—through PSA testing—can be diagnosed at an earlier, potentially curable stage," AUA said.

The report's title is "Costs and Effectiveness of Prostate Cancer Screening in Elderly Men." To obtain copies, send $9.50 to Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250-7974. Stock number 052-003-01414-9.

RFP Available

RFP NCI-CN-51001-32

Title: **Phase II Clinical Trials Of Potential Chemopreventive Agents**

Deadline: Approximately July 14

NCI is seeking contractors qualified to perform Phase II Clinical Trials that are small short-term, efficient studies of potential chemopreventive agents. This work includes small, short term, efficient studies to determine the dose of given chemopreventive agent that exhibits a pharmacodynamic effect on an intermediate endpoint. These studies will also require dose response studies to determine the minimum dose at which a biological effect is observed and confirmation of the maximum safe dose, and the performance of randomized blinded trials in small groups of subjects whose endpoints will be the measurable biological effect of the agent versus a placebo.

Contracting Officer: Richard Hartmann, tel: 301/496-8603; RCB Executive Plaza South Suite 635, Bethesda, MD 20892.

RFA Available

RFA CA-95-011

Title: **Cooperative Group For Breast And Colo-Rectal Cancer Clinical Trials**

Letter of Intent Receipt Date: June 23

Application Receipt Date: Aug. 25

The NCI Div. of Cancer Treatment invites applications for cooperative agreements to establish a

surgically oriented, Clinical Trials Cooperative Group that will perform multi-institutional clinical trials in adult patients with breast and colo-rectal cancer. The Group will be expected to conduct a broad spectrum of innovative therapeutic clinical trials which will advance the care of these patients. Approximately $9 million in total costs per year for five years will be committed to fund one Cooperative Group. Separate applications must be submitted for each of the following types of awards per Cooperative Group: Headquarters/Operations Office; Main Members; Statistical and Data Management Center.

Each Headquarters/Operations Office applicant must identify in both a cover letter and in the body of the application a single Statistical and Data Management Center with which it is proposing to collaborate. Each applicant for a Main Member award must identify in both a cover letter and in the body of the application the Headquarters/Operations Office with which the applicant is proposing to work. Each applicant for a Statistical and Data Management Center must identify both in a cover letter and in the body of the application the Headquarters/Operations Office with which the applicant is proposing to collaborate.

It is the responsibility of potential applicants for the three components of the Group—Headquarters/Operations Office, Main Members and Statistical and Data Management Center—to identify themselves to each other and to establish affiliations. Main Member institutions can be members of other Cooperative Groups, but the research performed by the Main Member in other Groups can not overlap with the workscope of this RFA, and this should be made clear in the application. For this RFA, Main Member applicants can only affiliate with one Headquarters/Operations Office applicant.

Each applicant for a Headquarters/Operations Office Group must demonstrate the ability to recruit and support adequate membership to ensure the ability to mount multiple, concurrent large scale (sample size > 1000 patients) randomized clinical trials in different prognostic subsets in breast and colo-rectal cancer. Each Main Member applicant must demonstrate the capability to accrue a minimum of 30 new patients per year.

Inquiries: Richard Ungerleider, NCI DCT, Executive Plaza North Rm 741, 6130 Executive Blvd., Bethesda, MD 20892 (Rockville, MD 20852 if using express mail), tel: 301/496-6056, fax: 301/402-0557, Email: ungerler@dct.nci.nih.gov

Program Announcements

PAR-95-063

Title: **DCT Clinical Trials Cooperative Groups**

Application Receipt Dates: June 1, Oct. 1, and Feb. 1

NCI is reannouncing its willingness to accept applications from institutions interested in conducting multi-institutional clinical trials in a Cooperative Group setting. Awards will be made using the cooperative agreement mechanism (U10). Potential applicants are encouraged to contact Cancer Therapy Evaluation Program staff regarding this announcement. The Clinical Trials Cooperative Group Program Guidelines and the Cooperative Group Terms and Conditions of Award are available from the NCI Program Director upon request.

Inquiries: Richard Ungerleider, NCI DCT, Executive Plaza North Rm 741, 6130 Executive Blvd., Bethesda, MD 20892 (Rockville, MD 20852 if using express mail), tel: 301/496-6056, fax: 301/402-0557, Email: ungerler@dct.nci.nih.gov

PA-95-064

Title: **Immunologic Recognition and Control of Tumors**

The purpose of this initiative is to encourage applications that will provide for the continued expansion of a basic research foundation for ongoing efforts to develop cancer vaccines. Emerging concepts of antigen recognition and cellular effector mechanisms have led to the development of a new generation of candidate vaccines for cancer. The goal of this PA is to promote investigator-initiated research project grant (R01) and First Independent Research Support and Transition (FIRST) (R29) award applications to study the basic mechanisms of antigen recognition, cytotoxicity and immune regulation that are critical to the immunotherapy of cancer. To be responsive to the PA, studies must involve tumor cells or tumor antigens.

Inquiries: John Sogn, NCI Div. of Cancer Biology, Diagnosis, and Centers, Executive Plaza North Rm 501, 6130 Executive Boulevard, MSC 7381, Bethesda, MD 20892-7381, tel: 301/496-7815, fax: 301/496-8656, Email: js150X@NIH.gov

PA-95-065

Title: **Immunobiology Of AIDS Lymphomas**

The intent of this PA is to stimulate research on immunologic mechanisms involved in the development of lymphomas in AIDS patients. Specifically, this PA is intended to encourage development and testing of hypotheses about the mechanisms of lymphomagenesis in the unique immune environment induced by HIV infection. This environment is characterized by defects in immune regulation, loss of specific immune cell subsets, presence of abnormal cytokine levels, changes in the architecture of germinal centers and other lymphoid tissues and an apparent loss of immune surveillance. Grants will be awarded as investigator-initiated research project grants (R01) and FIRST (R29) awards.

Inquiries: John Finerty, NCI Div. of Cancer Biology, Diagnosis, and Centers, Executive Plaza North Rm 501, Bethesda, MD 20892-7381, tel: 301/496-7815, fax: 301/496-7815, Email: fin@nih.gov