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NBCC Seeks $2.6 Billion For Breast Cancer By Year 2000, Begins Voter Registration Drive

The National Breast Cancer Coalition has added another weapon to its already formidable armamentarium:

The grassroots organization of survivors of the disease has begun a voter registration campaign aimed at making breast cancer a political issue

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In Brief

Lippman Leads M.D. Anderson Clinical Prevention; Baylin Named Ludwig Professor

SCOTT LIPPMAN was appointed first chairman of the new Department of Clinical Cancer Prevention at M.D. Anderson Cancer Center. The clinical program, under the Division of Cancer Prevention, will develop interdisciplinary approaches to prevention, with an emphasis on predisposition to cancer, said Lippman, an investigator at the center since 1988. The department also oversees the center's involvement in Breast Cancer Prevention Trial, as well as a Clinical Cancer Genetics Program, a clinical training program, and a cancer detection program. . . . **STEPHEN BAYLIN** was named first occupant of the Virginia and D.K. Ludwig Professorship in Cancer Research at Johns Hopkins Oncology Center. Baylin is associate director for basic research and chief of cancer biology. . . . **SAMUEL WILSON** was named deputy director, National Institute of Environmental Health Sciences, Institute Director **Kenneth Olden** said May 8. Wilson, an environmental toxicologist and director of the Sealy Center for Molecular Science, University of Texas Medical Branch at Galveston, spent 22 years at NCI as a scientist in the Laboratory of Biochemistry and was chief of the nucleic acid enzymology section prior to moving to Texas. . . . **DAVID KESSLER**, FDA commissioner, received the Progressive Leadership Award for Public Service from the National Kidney Cancer Association. The association cited Kessler for his persistence in combatting tobacco, for cancer initiatives to speed drug approval, and for improving FDA staffing. . . . **B.J. KENNEDY** was awarded Mastership in the American College of Physicians. Masters are distinguished physicians who have made significant contributions to medical science. Kennedy, Regent's Professor of Medicine and Masonic Professor of Oncology, Emeritus, University of Minnesota Medical School, pioneered efforts to establish medical oncology as a subspecialty of internal medicine. . . . **SARA PERKEL** was named chief operating officer, National Comprehensive Cancer Network. She succeeds **Catherine Harvey**, who became vice president, Axion Health Care Inc. Perkel has been business manager, Department of Surgery, Stanford University School of Medicine.

NBCC Seeks $2.6 Billion For Breast Cancer Research

(Continued from page 1)

on the local, state, and national level.

"We couldn't be in the political arena without doing the guts of politics, and the guts of politics is getting out the vote," said Patricia Barr, the group's board member.

Barr spoke at the NBCC advocacy conference that brought 500 activists to Capitol Hill to lobby for the group's new 10-point platform that demands that the federal government spend $2.6 billion on breast cancer research by the year 2000.

The conference, which included workshops on advocacy and science policy issues as well as a "Lobby Day," was held May 4-7.

"What we are asking you to do is to bring a platform to every single public official," Fran Visco, NBCC president, said to the coalition activists at the conference. "We are talking local. We are talking your city council. We are talking state legislators. We are talking appointed officials, and we are certainly talking federal officials, whether elected or appointed.

"We want breast cancer to be an issue that candidates run on, to be an issue that is on all of their lips, to be an issue in every debate, to be a part of everyone's platform," Visco said.

For next year alone, NBCC seeks $800 million for breast cancer. This would include $575 million in funds for NCI, about a 10 percent increase from the level recommended in last year's Bypass Budget.

The most recent Bypass Budget does not break down research opportunities by disease site. This year, NCI is expected to spend about $406 million on breast cancer research.

In addition to funding for NCI, NBCC seeks $150 million in the Department of Defense breast cancer research program and another $75 million for research to be conducted by the Veterans Administration and the Environmental Protection Agency.

"Don't let anyone flinch when you say that number, because it's a little number," said Joanne Howes, a Washington lobbyist for the coalition.

The NBCC demand for $2.6 billion is being backed with a petition drive aimed at collecting 2.6 million signatures.

Message in Party Platforms

Over its five-year history, NBCC has made breast cancer one of the most important political issues uniting women nationwide and has created a constituency of motivated, well-informed cancer patients.

In the 1996 election, the coalition expects to be courted by both political parties. According to recent polls, President Clinton and his expected Republican challenger Bob Dole are running about even among men. However, Clinton appears to be running ahead among women voters.

With this in mind, NBCC lobbyists are working to include the coalition's policy statements into the platforms of both parties, Visco said.

The coalition, which unites 350 organizations and 41,000 individuals, has not been swayed by the frequent objections by NCI and many prominent scientists to earmarking funds for breast cancer.

Therefore, it was no surprise that in his remarks to the conference, NCI Director Richard Klausner did not volunteer his opinion on earmarking funds for specific diseases.

It was even less of a surprise that the question on earmarking was raised by a member of the audience.

"We are not crazy about earmarking," Klausner replied. "Intellectually, I am not sure how to do it. I often don't know where research on breast cancer begins or ends.

"I think all cancer has been underfunded for decades. However, we need a clear set of approaches to what we should fund by thinking out clearly what

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we are doing in particular areas, how effective we are in those areas, and then determine the opportunities for funding."

Klausner said the Institute plans to form Progress Review Groups of clinicians and basic scientists as well as advocates and consumers. "We will ask them to come in to NCI," Klausner said. "We will open the books entirely. We will try to work with these groups to answer the questions I can't answer, which is how are we actually doing, and what does that mean?"

Guilt-Free Earmark

Klausner's preferences notwithstanding, insistence on earmarking for breast cancer research is the principal element of the coalition's platform.

"People are now saying on the Hill: This is just outrageous that people want these earmarks," said Rep. Pat Schroeder (D-CO), a long-time supporter of the NBCC agenda. "The very same person has no problem earmarking for B-2 bombers.

"All of this is done to attack your guilt," Schroeder said at the conference. "I am trying to create a guilt-free room. When you march on the Hill, do not let them do that."

Howes, too, prepared the audience for the anti-earmark atmosphere—or at least anti-earmark rhetoric—on Capitol Hill.

"The Director of NIH, Dr. Harold Varmus, doesn't want the money earmarked," Howes said. "[Rep. John] Porter (R-IL) [chairman of the Labor, HHS & Education Appropriations Subcommittee] doesn't want the money earmarked.

"What that means is that [NIH] just wants to get all the money, about $11 billion, and then decide how it's going to get spent. Because the people deciding are really the same people who used to decide that women aren't important, we can't allow that to happen.

"In your visits [to Congressional offices], it's very important to say that the money needs to be earmarked for breast cancer research. They will tell you all the reasons why it can't be, but you will just have to say that this is the only way this is going to work," Howes said.

In another philosophical difference with NIH, Howes said good science can expand to follow funding opportunities, rather than the other way around. This principle is demonstrated by the Department of Defense breast cancer research program, which was set up three years ago in response to NBCC lobbying, she said.

"As we know from the DOD program, if there is money available, good science will come," Howes said.

The 10-Point Platform

The text of the NBCC 10-point platform follows:

1. The US Congress must appropriate $2.6 billion for high quality, peer-reviewed breast cancer research by the year 2000.

2. The US Congress and the President must continue support for the Department of Defense peer-reviewed breast cancer research program, under the strategies recommended by the Institute of Medicine.

3. The US Congress and the President must commit to continued, increasing appropriations for biomedical research through the NIH and the NCI and implement or expand programs to fund quality, peer-reviewed breast cancer research through all appropriate agencies and departments, such as the Environmental Protection Agency and the Veterans Administration.

4. The President and the US Congress must expand the federal commitment to eradicating breast cancer through in creased outreach and education programs and the regulation and provision of treatment and other services, in all agencies and departments, including the Environmental Protection Agency, the Center for Disease Control, the Health Care Financing Administration, the Department of Education, the Department of Defense and the Veterans Administration.

5. The President should continue support for a national action plan on breast cancer that is a public/private partnership, under the leadership of the National Breast Cancer Coalition.

6. The laws, regulations and policies of the US must mandate universal access to high quality health care.

7. All women of appropriate age should have access to high quality, screening mammography at appropriate intervals.

8. Discrimination in the provision of health insurance or employment based on pre-existing conditions or predisposition to disease must be eliminated.

9. Third party payment of all costs, including all medically necessary care, incurred by participation in approved clinical trials and investigational studies

must be mandated.

10. The laws and regulations of all federal and state agencies and departments that impact breast cancer must mandate the inclusion of representative consumers in all decision making.

Breast Cancer Death Rate Fell 6% For Whites, Rose 1% In Blacks, In Early 1990s

NCI said the breast cancer death rate in American women continued to decline through 1993, a finding that suggests improved breast cancer management from early detection to treatment is having a beneficial effect.

Breast cancer mortality trends for white women in the US have improved markedly in the 1990s compared with the 1980s, NCI said in a statement May 7.

For black women, increases in mortality persist, especially among older women, but the overall increase has slowed significantly.

During the most recent five-year period of available data, 1989 to 1993, the age-adjusted breast cancer mortality rates fell approximately 6 percent in white women and rose about 1 percent in black women.

By comparison, from 1980 to 1989, rates increased 3 percent in white women and 16 percent in black women, according to data from the National Center for Health Statistics.

"These findings are good news, but not good enough," HHS Secretary Donna Shalala said. "The Clinton Administration will keep pursuing every opportunity for prevention, early detection and treatment, and an effective research agenda to fight breast cancer."

Positive Trend Seen

"The data suggest the trend is starting to move in a positive direction for African American women as well as white women," NCI Director Richard Klausner said. "Rates have declined among younger black women, although they are still higher than those of white women and are improving more slowly."

The overall rate in US women has fallen about 5 percent in recent years, dropping from 27.5 per 100,000 women in 1989 to 25.9 in 1993.

This year, an estimated 44,300 women will die of the disease nationwide, but that estimate could be too high if the trend continues.

Improvements In Younger Age Groups

In both white and black women, the greatest improvements in mortality during the recent five-year period were seen in younger age groups, but the changes were more modest in blacks than in whites of all ages.

—Among white women, death rates declined for all decades of ages from 30 to 79 years.

—Among black women, rates were down for all decades from 30 to 69 years.

—For women aged 30 to 39 years, rates dropped about 13 percent in whites and 5 percent in blacks.

—For women aged 40 to 49 years, rates dropped 9 percent in whites and 2 percent in blacks.

—For women aged 50 to 59 years, rates declined 9 percent in whites and less than 1 percent in blacks.

—For women 60 to 69 years old, rates declined 6 percent in whites and less than 1 percent in blacks.

—For women 70 to 79 years old, rates increased 5 percent in blacks and decreased 3 percent in whites.

—For women 80 years and older, rates increased 5 percent in blacks and 2 percent in whites.

The median age at death for white breast cancer patients is 68 years and for black breast cancer patients 62 years.

Reasons Not Well Understood

The recent decline in breast cancer mortality could be partly a result of mammography screening, which rapidly increased in the US during the 1980s and resulted in a shift toward the detection of breast cancer at earlier, more curable stages, NCI said. However, screening cannot explain all of the decline.

"Such changes in mortality trends across a wide age range usually indicate improvements in medical interventions, and examination of stage-specific breast cancer incidence rates and survival rates suggests that both earlier detection and improved treatment are likely contributing to the recent declines in breast cancer mortality," said Robert Tarone, of the NCI Biostatistics Branch.

Brenda Edwards, director of the Institute's Cancer Control Research Program, said further study is required to determine the relative contribution of early detection and improved treatment, including the impact of adjuvant therapy.

Health authorities in the United Kingdom also

have reported a steep decline in the breast cancer death rate among women aged 55-69 during roughly the same period.

The mortality rate in this group dropped 12 percent from 1987 to 1994. This trend began at the same time as the introduction of the UK breast screening program, but researchers there have concluded that it occurred too soon to be entirely a result of screening. They attribute much of the decline to more effective treatment, particularly the adoption of tamoxifen therapy.

The continued increase in breast cancer mortality rates in older women extends a long-standing, increasing trend in breast cancer risk for women born from 1900 to 1920, Tarone said.

Researchers believe the increasing mortality rates in this group reflect changes in various risk factors such as delayed childbearing early in the century.

Less well understood is the declining mortality among women under age 40, who generally are not screened, NCI said.

The trend in this group appears to reflect a recent change in risk factors above and beyond improvements due to medical intervention.

HHS Campaign To Promote Mammography

HHS said its support for breast cancer research, prevention and treatment has increased from $271 million in 1993 to $476 million in 1996. Special programs include:

—NCI's effort to identify the genetic and biological basis of breast cancer, characterize patterns of risk in the population, and apply the knowledge gained through basic research to more effective prevention and treatment.

—The Centers for Disease Control's National Breast and Cervical Cancer Early Detection Program, which offers free or low-cost mammography to uninsured or low-income women.

—FDA's quality standards and inspection program for mammography services.

—Clinical practice guidelines on mammography issued by the Agency for Health Care Policy and Research.

—Health Care Financing Administration payments for mammography for Medicare beneficiaries. About 37 percent of women beneficiaries use the mammography coverage. An HHS campaign is aimed at increasing use of the benefit to at least 60 percent by the year 2000.

SEER Report Finds Black Men Have Highest Cancer Rate

Black men have the highest overall cancer incidence and mortality rates, largely due to excesses of prostate and lung cancer, according to a newly published study by the NCI Surveillance, Epidemiology and End Results Program.

The SEER monograph, "Racial/Ethnic Patterns of Cancer in the United States, 1988-1992," includes average annual age-adjusted cancer incidence rates for Alaska Native, American Indian, black, Chinese, Filipino, Hawaiian, Japanese, Korean, Vietnamese and white populations. Cancer mortality rates, compiled by NCI using data from the National Center for Health Statistics, are reported for each of the groups except Korean and Vietnamese, for whom data are unavailable.

The monograph is the most comprehensive report from NCI on patterns of cancer in a wide variety of US racial and ethnic groups, the Institute said. Individual states have published data on racial and ethnic cancer patterns, but no previous study has estimated national rates for so many different groups, NCI said.

"The data provide a basis for monitoring cancer rates in diverse populations, with unique cultures and lifestyles as well as possible unique genetic factors that may influence cancer risk," Benjamin Hankey, chief of the NCI Cancer Statistics Branch, said in a statement.

SEER consists of a network of cancer registries in five states and six metropolitan areas, covering about 14 percent of the US population. The program includes substantially larger percentages of minority populations in order to enable the calculation of cancer rates for these smaller populations.

NCI plans to use the data to select priorities for cancer control and research, the Institute said.

The Intercultural Cancer Council, an organization formed last year, said the SEER report should be a step in the development of a research plan that would help prevent cancer among different populations.

"Now that the data is on the table, it should be a major tool to diversify our national research agenda to deal with disproportionately higher cancer rates when they strike these groups," said Lovell Jones, of M.D. Anderson Cancer Center, and co-chairman of the ICC.

However, Jones said the SEER data, while the

most comprehensive to date, does not cover large portions of the US. ICC has asked Congress to fully fund the National Program of Cancer Registries, conducted by the Centers for Disease Control and Prevention.

ICC has urged NCI to take several steps to increase attention to populations with disproportionately high cancer rates, including a review of NCI research funds devoted to these populations, larger enrollments of minorities in cancer clinical trials, and programs to attract and develop more scientists from minority populations, said Armin Weinberg, co-chairman of the ICC and director of the Center for Cancer Control, Baylor College of Medicine.

Areas of Similarity, Differences

The report includes estimates of the number of newly diagnosed cancer and cancer deaths in the US, by cancer site, for each racial/ethnic group in 1990. The report does not describe trends in cancer incidence and mortality.

The racial/ethnic groups were found to be broadly similar on some measures of cancer. Men have higher overall cancer rates than women in all groups. The ratio of male to female incidence rates range from 1.1:1 in Alaska Natives to 1.7:1 in blacks. But in all groups, women ages 30 to 54 years have higher rates than men of the same age range, due to the higher incidence of female breast and gynecologic cancers.

Among women, cancer is most common in non-Hispanic whites, while the cancer death rate is highest in Alaska Natives.

One chapter of the report cites the five most frequently diagnosed cancers and the five most common causes of cancer death for each racial/ethnic group. Breast cancer incidence ranks first in all groups of women except Vietnamese, who have a higher rate of cervical cancer.

However, breast cancer incidence rates vary fourfold, from 28.5 per 100,000 Korean women to 115.7 per 100,000 non-Hispanic white women.

In mortality, lung cancer ranks first in most groups of women, and is in either first or second place in all groups except American Indians.

Breast cancer mortality ranks in the top two sites for all groups of women except Alaska Natives, in whom it ranks third.

Among men, either prostate or lung cancer ranks first in each racial/ethnic group for both incidence and mortality. Prostate cancer incidence varies more than sevenfold, from 24.2 per 100,000 Koreans, to 180.6 per 100,000 blacks. Colorectal cancer incidence rates also vary substantially: The Alaska Native rates are more than four times as high as the American Indian rates for both men and women.

A few generally rare cancers appear in the top five sites for specific groups. Cancer of the gallbladder ranks fourth in American Indian women in New Mexico, for instance, while thyroid cancer is fourth in Filipino women. Nasopharyngeal cancer, which is common in China and Southeast Asia, occurs much more frequently in Chinese and Vietnamese American men than in blacks, whites, and other groups.

Copies of the SEER monograph are available from NCI Office of Cancer Communications, tel: 301/496-6641.

As part of National Minority Cancer Awareness Week, April 21-27, NCI recognized 166 community groups in the US for their efforts to reach minority populations with cancer information.

AACR Honors Scientists; Establishes Web Site

American Association for Cancer Research honored six leading cancer investigators at its annual meeting in Washington, D.C.

Robert Weinberg received the 35th annual G.H.A. Clowes Award for his research accomplishments in molecular biology. Weinberg is a member of the Whitehead Institute for Biomedical Research and professor of biology at the Massachusetts Institute of Technology.

Samuel Wells Jr. received the first Joseph H. Burchenal AACR Clinical Research Award for clinical excellence as an oncologist and oncologic surgeon and for his promotion of clinical care and research. Wells is the Bixby Professor and chairman of the Department of Surgery, Washington University, and surgeon-in-chief, Barnes Hospital, St. Louis. His is also president of the American Surgical Association, and a former member of the National Cancer Advisory Board.

James Armitage received the 20th annual Richard and Hinda Rosenthal Foundation Award in recognition of outstanding research leading to improved clinical cancer care. Armitage is professor

of medicine and chairman of the Department of Medicine, University of Nebraska in Omaha. His is also president-elect of the American Society of Clinical Oncology.

Kurt Kohn received the Bruce Cain Memorial Award for his leadership in the field of the molecular pharmacology of cancer. Kohn is chief of the Laboratory of Molecular Pharmacology in the NCI Division of Basic Sciences. Kohn developed techniques used in the study of molecular mechanisms of DNA alkylation. He also developed the concept of DNA topoisomerases as targets of anticancer drugs.

Lee Wattenberg received the fifth American Cancer Society Award for excellence in cancer epidemiology and prevention. Wattenberg's work laid the foundation for research in chemoprevention, according to the award citation. Wattenberg is special associate director for chemoprevention at the University of Minnesota Cancer Center and professor of laboratory medicine and pathology at University of Minnesota Medical School.

Carol Greider received the 17th annual Cornelius P. Rhoads Award in recognition of her contributions to the study of telomeres. Greider is senior staff scientist at Cold Spring Harbor Laboratory.

The association also honored two scientists with special awards and awarded two research fellowships.

Ann Marie Pendergast received the fourth Gertrude Elion Cancer Research Award, which is presented annually to one nontenured scientist. Pendergast received the award for her research proposal, "Signaling by ABL Tyrosine Kinases in Nromal and Transformed Cells." She is an assistant professor, Department of Pathology, Duke University Medical Center.

Gilbert Friedell received the 1996 Jack E. White/ LaSalle D. Leffall Jr. Award for Cancer Prevention and Control for his contributions to addressing cancer in medically underserved populations. Friedell is director of cancer control at the Lucille Parker Markey Center, University of Kentucky.

Two new research fellowships sponsored by AACR were awarded to **Michael Jensen**, a fellow in pediatric oncology, Unviersity of Washington, and **Jennifer Dowhanick**, a fellow in the Department of Pathology, Harvard Medical School.

AACR Information On Line

AACR has established a home page on the World Wide Web for on-line information about the association. It is available and the following URL address: http://www.aacr.org. The site contains information on membership, meetings, publications and other association activities.

NIH Policy On Applications Seeking $500,000 Updated

NIH will require any grant applicant seeking over $500,000 in direct costs per year to receive approval from the individual institute prior to submitting a grant application, the Institutes announced last week.

Following is the excerpted text of the updated policy, published in the May 3 NIH Guide to Grants and Contracts:

New Policy: An applicant planning to submit a new (Type 1) investigator-initiated grant application requesting $500,000 or more in direct costs for any year is advised that he or she must contact Institute or Center program staff before submitting the application, i.e, as plans for the study are being developed. Furthermore, the applicant must obtain agreement from Institute/Center staff that the Institute or Center will accept the application for consideration for award. Finally, the applicant must identify, in the cover letter that is sent with the application, the staff member and Institute or Center who agreed to accept assignment of the application.

Any application subject to this policy that does not contain the required information in the cover letter sent with the application will be returned to the applicant without review. Applicants who are uncertain regarding which Institute or Center to contact should call the Referral Office, Division of Research Grants.

Applicability: This policy applies to any unsolicited new (Type 1)research or research training grant application for any mechanism (e.g., R01, P01, R18, T32) that requests $500,000 or more in direct costs for any one year. This policy applies also to any group of unsolicited applications (e.g., clinical trial networks, epidemiologic studies) that requests $500,000 or more direct costs for any one year, even if none of the individual applications request that much.

This policy does not apply to applications submitted in response to RFAs. However, an application submitted in response to an RFA must be responsive to any budgetary limits specified in the RFA or will be returned to the applicant without review.

This policy does not apply to competing renewal (Type 2) applications. However, a Type 2 application must still comply to the budgetary limitations set by the awarding Institute or Center.

This policy does not apply to amended (revised, e.g.,

-01A1, -01A2) applications. An application received without indication of prior staff concurrence and identification of that contact will be returned to the applicant without review. The policy is effective June 1.

Inquiries: Referral Office, Division of Research Grants, NIH, tel: 301/435-0715, fax: 301/480-1987.

RFPs Available

RFP NCI-CM-77249-30

Title: **Collection And Taxonomy Of Shallow Water Marine Organisms**

NCI Division of Cancer Treatment, Diagnosis and Centers, Developmental Therapeutics Program anticipates the award of one cost-reimbursement contract, for a base period of three years, with two one-year option years, beginning on or about Feb. 1, 1997. The objective of this project is to continue the exploration of marine organisms from the geographic areas of the globe in which biodiversity is thought to be the greatest; and to use these organisms as a source of pharmacophores that can be developed for the selective treatment of cancer and AIDS in humans. The successful offeror will be expected to provide qualified personnel, materials, and equipment for the collection, identification, storage and shipping of 700 frozen marine samples per year to an NCI designated extraction facility in the US. Collections will comprise approximately 1000 grams frozen, wet weight of each sample, collected by SCUBA divers at depths to 50 to 55 meters using suitable safeguards. Each sample will be identified as far as possible at the time of collection, and will subsequently be identified to species level. Properly prepared voucher specimens will be prepared at the time of collection for the purposes of later unambiguous identification, and for deposition at a minimum of two repositories identified by the NCI, together with complete documentation. The collection team should include qualified taxonomists, personnel experienced in scientific diving and collection by SCUBA techniques. The PI should be trained in marine biology or a related field and at least five years experience in marine organism collection and identification. Recollection of up to 50 marine samples per year in quantities to 50 kg may be required in the second and subsequent years. The number of smaller scale collections would be reduced in a suitable proportion. Collections will include examples from as wide a variety of phyla and families as possible. The collection will be heavily weighted towards invertebrates with allowance for a small percentage of marine plants, and with specific exclusion of vertebrates. This is a recompetition of a contract with Coral Reef Research Foundation.

Inquiries: Elsa Carlton, RCB, NCI, EPS Rm 603, 6120 Executive Blvd-MSC 7220, Bethesda, MD 20892-7220.

RFP N01-CM-77016-26

Title: **Operation and Support of the CTEP Protocol and Information Office**

Deadline: Approximately July 22

The Cancer Therapy Evaluation Program is responsible for the administration and coordination of the majority of the extramural clinical trials supported by the NCI Div. of Cancer Treatment, Diagnosis and Centers. It is also responsible for the development of over 200 investigational agents for which the division has filed INDs with FDA. The contractor shall assist the Protocol and Information Office in the various clinical research responsibilities pertaining to INDs and will provide general administrative support for IND sponsorship activities. The contractor shall operate and staff, on government site in Rockville, MD, the PIO which is responsible for 1) managing the protocol submission and review process, 2) maintaining the official records of all CTEP sponsored protocols, 3) protocol distribution, 4) managing and maintaining up-to-date information and records of all protocols in the CTEP Information Management System Database, 5) indexing and scanning of documents in the CTEP imaging system, 6) generating on line queries, providing standard/customized reports, and 7) tracking the progress of each protocol as well as clinical trial monitoring data. Competition is limited to eligible 8(a) concerns, SIC code 7375. One five-year incrementally funded level of effort contract is contemplated with an annual requirement of 12 FTEs totaling 60 FTEs over the five-year period.

Inquiries: Carolyn Swift, contracing officer, NCI RCB, TCS, 6120 Executive Blvd EPS Rm 603-MSC 7220, Bethesda, MD 20892-7220, tel: 301/496-8620, fax: 301/402-6699, e-mail: swiftc@rcb.nci.nih.gov

RFA Available

RFA CA-96-013

Title: **Translational Investigator Grants For Cancer Prevention And Control**

Letter of Intent Receipt Date: June 11

Application Receipt Date: Aug. 8

The NCI Division of Cancer Prevention and Control invites research project grant (R01) applications from new prevention and control investigators for the conduct of studies translating phase I (hypothesis development) and II (methods development) basic, epidemiological, and clinical research into new approaches for the prevention and control of cancer. Approximately $1.5 million, per year, in total costs for four years will be committed to fund new applications. It is anticipated that eight new individual awards will be made.

Inquiries: Helen Meissner, DCPC, NCI, Executive Plaza North Rm 232D, Rockville, MD 20852, tel: 301/496-8520, e-mail: meissneh@dcpceps.nci.nih.gov