THE CANCER LETTER

Vol. 23 No. 12
March 28, 1997

Price $265 Per Year US
$285 Per Year Elsewhere

In Turnaround, NCAB To Advise Screening Mammography For Women In Their Forties

The National Cancer Advisory Board is expected to release a statement recommending mammographic screening every one to two years for women in their forties, sources said.

The NCAB announcement, scheduled for March 27, marks a turnaround for the board, which was expected to recommend an educational strategy rather than a screening guideline.

As a result of the NCAB statement, HHS Secretary Donna Shalala is expected to announce that Medicare will cover mammographic

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In Brief

UICC Honors Dodd; Centers Recognize Nealon; Yale Expands Transplant Program

GERALD DODD will receive the Mucio Athayde Cancer Prize, awarded by the International Union Against Cancer, at the UICC's First Cancer Management Meeting, to be held June 28 in Vienna, Austria. Dodd is a former president of the American Cancer Society, and recently retired from M.D. Anderson Cancer Center. The award is in recognition of his contributions toward breast cancer diagnosis. . . . **ELEANOR NEALON** was recognized by the Public Affairs Network of NCI-Designated Cancer Centers, for her work in helping to develop PAN, which works to further public awareness of cancer research, prevention, detection, and treatment. Nealon is director of the NCI Office of Liaison Activities. . . . **BERNARD FORGET** was named director of the research component of the recently expanded stem cell transplantation program at Yale Cancer Center. Forget is a professor of internal medicine and section chief of Hematology. **DENNIS COOPER** was named clinical director of all clinical components of the transplantation program. He is an associate professor of Internal Medicine, Medical Oncology. . . . **BINGUI SHEN** was named assistant research scientist at City of Hope National Medical Center's Department of Cell and Tumor Biology. Shen is a former researcher for the Los Alamos National Laboratory's Life Sciences Division. . . . **V. CRAIG JORDAN** received the fifth annual Herbert J. Block Memorial Lectureship at the Arthur G. James Cancer Hospital and Research Institute's Comprehensive Cancer Center. Jordan received the award, in recognition for his work with tamoxifen, at an awards dinner on Feb. 26.

NCAB Statement To Come On Heels Of ACS Guideline

(Continued from page 1)

screening for women in their forties, sources said.

Shalala also is expected to ask the Centers for Disease Control and Prevention to incorporate screening for women 40-49 into the center's mammography demonstration projects, sources said.

Last month, NCAB Chairman Barbara Rimer said the board would not take a position on the issue of when mammographic screening should begin (**The Cancer Letter**, Feb. 28). Instead, the board would recommend a strategy on educating women about mammography, Rimer said at the time.

Rimer could not be reached for comment.

Return To Previous Guideline

The upcoming announcement is likely to conclude the latest round in the political and scientific controversy over mammographic screening for women in their forties.

The controversy began last January, after an NIH consensus panel met to consider new data on screening mammography.

The panel concluded that the data did not support a recommendation for screening all women 40-49 (**The Cancer Letter**, Jan. 31).

The NCAB, at its meeting last February, reviewed the data as well as the panel's statement. The board formed a subcommittee to study the controversy.

The subcommittee, co-chaired by Frederick Li, of Dana-Farber Cancer Institute, and Robert Day, of Fred Hutchinson Cancer Research Center, ultimately developed recommendations to the full board.

The statement scheduled to be presented March 27 has the endorsement of the NCAB, sources said.

Sources familiar with drafts of the statement said the NCAB recommended that women receive regular screening mammography every year or two beginning at age 40, and annual mammography after age 50.

The statement would, in effect, return NCI to its endorsement of pre-1993 “consensus guidelines” established by the American Cancer Society and other health organizations.

The upcoming statement from the NCAB could tip the scales in favor of screening in this age group among major cancer organizations, observers said.

Last week, two key players in the screening controversy released diametrically opposed recommendations:

- The American Cancer Society Board of Directors voted to recommend that women begin annual screening mammography at age 40. The recommendation also was endorsed by the American College of Radiology.
- An NIH Consensus Development Panel released the final version of its “consensus statement,” concluding that the evidence does not warrant a universal recommendation for screening all women in their forties. However, two members of the panel wrote a minority opinion, concluding that health professionals “should actively encourage” routine screening mammography for women in their forties.

The NCAB recommendation is expected to take a more cautious tone than the ACS statement, sources said. Sources said drafts of the the NCAB statement recommend screening every one to two years for women in their forties, while the ACS recommends annual screening.

Sources said the NCAB concluded that the evidence that screening women in their forties would save additional lives was uncertain. However, sources said, the board also concluded that screening would not cause harm.

NCI Said Pressed To Quantify "Lives Saved"

In a newspaper interview last week, NCI

THE CANCER LETTER

Founded 1974

Member, Newsletter Publishers Association

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World Wide Web URL: http://www.cancerletter.com

Subscription $265 per year US, $285 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter.

Director Richard Klausner acknowledged that the NCAB turnaround was likely and that the board's recommendation would be consistent with the latest ACS statement.

"I do not think the recommendation of the NCAB and the recommendation of the ACS will be significantly at odds," Klausner said to The Los Angeles Times March 24. "I think [the ACS and NCI recommendations] will be very compatible.

"I am looking forward to getting this settled and moving on," Klausner said.

Sources said in recent weeks, NCI has been under pressure from Congress and the Administration to resolve the mammography controversy.

According to sources, some advocates of mammography would like NCI to estimate how many lives would be saved if women in their forties were screened.

This pressure puts Klausner in an uncomfortable position for a director of a scientific institution, considering that the evidence for making such a statement is highly controversial among scientists and statisticians.

Klausner is on record describing the NIH consensus panel's draft recommendation as "defensible." However, from the outset, Klausner disagreed with the "tone" of that recommendation, and what he described as the report's failure to discuss evidence that could support the decision to screen younger women.

"Whatever guidance NCI provides must be based upon available evidence," Klausner said in Congressional testimony (**The Cancer Letter**, March 7). "Many of us want clear-cut, yes-or-no, black-and-white answers to difficult problems.

"We cannot and should not produce certainty or say that there is certainty where there is none," Klausner said.

ACS Urges "One Guideline"

The ACS Board of Directors voted on March 23 to accept the recommendation of a workshop held earlier this month to review the data from screening studies.

The workshop panel concluded that the new data warranted a recommendation for annual screening mammography for women beginning at age 40 (**The Cancer Letter**, March 14).

The society had previously recommended screening mammography every year or two for women 40-49, and annually after age 50.

"By beginning a program of annual mammography at age 40, women can give themselves the best chance of detecting cancer early, when there is a higher chance of long-term survival, and more treatment options," Myles Cunningham, ACS national president, said at a conference held March 24 in Reston, VA.

"In spite of its limitations, mammography is the most effective tool we currently have to detect breast cancers early, when a woman's chance for long-term survival and her treatment options are greatest," said Cunningham, a surgical oncologist in private practice in Evanston, IL.

"The society urges other health care organizations to examine the current data for themselves and join us creating one guideline to minimize confusion," Cunningham said.

Cunningham said ACS plans to develop materials that will provide women better information about breast cancer and mammography. The society should temper its past statements that women have a "1 in 8" lifetime risk of developing breast cancer, Cunningham said.

"It has the effect of raising a lot of awareness of breast cancer, but perhaps it exaggerated the risk to the majority of women," Cunningham said. "A risk of 1 in 8 is a lifetime risk, and it presumes that a woman lives to a ripe old age, perhaps to 100."

Women aged 40-50 have a risk of 1 in 66 of developing breast cancer, Cunningham said. "We have a job to do in diminishing the hysteria about the 1 in 8 business," he said.

The American College of Radiology, in a March 24 statement, said it had revised its screening guidelines to match the ACS recommendation.

"Although some breast cancers grow faster in women aged 40-49, annual screening can substantially increase the chance that these tumors can be detected earlier, at a more curable stage," said Stephen Feig, chairman of the ACR Breast Task Force.

NIH Consensus Statement

The NIH consensus statement was updated March 20 on the Consensus Development Program's site on the World Wide Web.

NIH made no announcement about the posting of the panel's final statement, now considered "in press."

The final statement is similar to the panel's earlier draft released last January. "The panel

concludes that the data currently available do not warrant a universal recommendation for mammography for all women in their forties," the statement said. "Each woman should decide for herself whether to undergo mammography.

"Her decision may be based not only on an objective analysis of the scientific evidence and consideration of her individual medical history, but also on how she perceives and weighs each potential risk and benefit, the values she places on each, and how she deals with uncertainty," the statement said.

The panel urged that educational material be made available to help women and physicians make "difficult decisions regarding mammography."

Costs of screening mammograms for women in their forties who choose to have the exam should be covered by health insurance, the panel said.

In addition, the panel said, "A system should be established for ongoing monitoring and review of newly available information from research studies regarding benefits and risks of mammography for women in their forties. This will ensure timely formulation and implementation of any new policy recommendations that may become appropriate in the future."

Two Panel Members Break Ranks

Two members of the panel issued a minority statement in opposition to the statement by the other panel members.

It is only the third time in 103 NIH consensus statements over the past 20 years that a minority statement has been issued, according to John Ferguson, director of the NIH Office of Medical Applications of Research.

"We believe that the majority statement understates the benefits of mammography for women ages 40-49, and overstates the potential risks," wrote Daniel Sullivan, associate professor of radiology, University of Pennsylvania Medical Center, and Ruthann Zern, an obstetrician and gynecologist in Towson, MD.

"We believe the data show a statistically significant mortality reduction for women in their forties," the two panel members wrote.

"We further believe the survival benefit and diagnosis at an earlier stage outweigh the potential risks.

"There are no data to suggest that women are significantly harmed by having extra mammographic views or breast ultrasound. Furthermore, the false positive biopsy rate for mammography is not different from the false positive biopsy rate for clinical breast examination.

"Moreover, the false positive biopsy rate for women ages 40-49 is only slightly higher than for women ages 50-59," Sullivan and Zern wrote.

"Based on this, we make the same recommendation for screening all healthy women in their forties.

"If we believe a certain recommendation is right for a 45-year-old family member, we would (and do) make the same recommendation to 45-year-old patients who come for advice, and for 45-year-old women in general. We would alter that recommendation only if there were characteristics of the individual that were relevant," Sullivan and Zern wrote.

"We agree that women should know what data and value judgments we use to form our recommendations, and we support their right to disagree with or reject our advice.

"We believe that we should actively encourage routine screening mammography for women in their forties," Sullivan and Zern concluded.

Interpreting The Benefit

Key to the differing positions on screening mammography is how each group interprets the impact of the mortality benefit as measured in randomized, controlled trials, Cunningham said.

"It's a difference between seeing the glass half-full or half-empty," Cunningham said. "Other groups look at this and they balance the costs of mammography against the opportunity costs of putting the money into research, or advocacy, or other issues."

"Where there is a scientific difference—perhaps it's a policy difference—it is in measuring the impact of the benefit: Is it worth the cost?" Cunningham said. "We can have differences about the cost and benefit analysis and how else to spend dollars, but we cannot deny the fact that there is a benefit."

ACS took its position based on the most recent meta-analysis of clinical trials, results from the trials individually, surrogate measures, and evidence that breast cancers in young women may be faster growing than those in older women, Cunningham said.

In addition, the society wanted to make a clear, unequivocal statement, he said.

"When a group suggests that a woman must

make her own decision, a woman is lacking guidance," Cunningham said. "We feel very strongly that women need specific guidance in this respect, and that if there is a benefit, then we should say so."

ACS and the minority view of the consensus panel agree that there is a statistically significant mortality reduction, while the consensus panel's majority found no significant mortality reduction:

● According to the report of the ACS workshop on breast cancer detection guidelines, held earlier this month in Chicago:

"Results from the most recent meta-analysis of all eight randomized clinical trials yields an 18% (95% C.I., 0.71-0.95) mortality reduction among the 40-49 age group, and a 26% (95% C.I., 0.63-0.88) mortality reduction for the seven population-based randomized clinical trials.

"Results from two individuals trials in Sweden also reveal statistically significant reductions in mortality among women ages 40-49. After 12 years of follow-up, the Gothenburg trial has shown a 44% reduction in mortality (95% C.I., 0.32-0.98), and the Malmö trial has shown a 36% reduction in mortality (95% C.I., 0.45-0.89).

"Data for this age group now meet the same criteria of benefit that has been the basis for concluding that mammography was beneficial for women ages 50+ at randomization, i.e., that the observed mortality reduction achieves statistical significance at the 95% confidence level….

"[T]he observation that mortality reductions in the trials required longer periods of follow-up is best explained by 1) lower incidence and mortality in women in their 40s; 2) small numbers of women in their 40s in the existing randomized trials; 3) a greater proportion of diagnosis of ductal carcinoma in situ in the group invited to screening (the greater lead time achieved from a diagnosis at this stage requires a longer period of follow-up); and 4) the observation that screening intervals in excess of one year in the majority of the trials were comparatively less effective in detecting the more aggressive tumors at favorable stages."

● According to the NIH consensus statement: "On the basis of summary data from these [randomized, controlled trials], there is no statistically significant difference in breast cancer mortality within seven years after screening is initiated, between women randomized to receive or not receive screening.

"Summary data in five of eight RCTs show a trend towards reduced breast cancer mortality only after a follow-up of 10 or more years, with the decrease estimated at 16 percent (with confidence intervals from 2 percent to 28 percent). In the RCTs, many of the women began mammography while they were in their late forties, and continued to have mammography after age 50.

"Consequently, one cannot determine if the women who benefited from mammography in these studies showed this benefit because of breast cancer diagnosis following mammographic screening performed after age 50.

"Based on meta-analysis of the RCTs, regular screening of 10,000 women ages 40-49 would result in extension of the lives of 0-10 women. About 2,500 women would have to be screened regularly in order to extend one life. For those women whose survival is extended, the length of life extension is not known.

"[I]t is not necessarily valid to conclude that screening mammography results in fewer breast cancer deaths, because screening selectively identifies women with slow-growing cancers whose prognosis is better, regardless of treatment. Detection at an earlier stage is relevant only if it can be shown in a randomized study that fewer deaths occur in a screened population than in a comparable unscreened control population."

● According to the NIH panel's minority report: "Results from the eight randomized controlled trials indicate a statistically significant 17 percent mortality reduction (p=0.05) for women ages 40-49 at time of entry into the trials. Although this survival benefit is less, on a population basis, than the benefit for women in older decades, it is nevertheless substantial. Furthermore, the potential biases in the RCTs would act to underestimate this benefit.

"There are unequivocal data indicating that screening mammography in women ages 40-49 does result in earlier detection. This earlier detection is an important benefit apart from any survival benefit. Detection at an earlier stage allows women more choice in treatment options."

Where To Find The Statements

The ACS breast cancer workshop report is available on the society's Internet site at http://www.cancer.org.

The NIH consensus statement, which includes the minority statement, is available on the Consensus Development Program's website at http://consensus.nih.gov.

Americans Closer To Eating "5-A-Day," Food Survey Finds

The average American adult now eats about four and a half servings of fruits and vegetables a day, a step closer to the five or more servings a day recommended by NCI's National 5 A Day for Better Health program.

The data, from the Department of Agriculture's Continuing Surveys of Food Intakes by Individuals, are the most recent available on fruit and vegetable intake. Previous data showed that from 1989-91 the average adult ate approximately 3.9 daily servings of fruits and vegetables.

The new data show that by 1994, adults had increased their consumption to approximately 4.4 daily servings—just about a half a serving away from the recommended five or more.

"This increase in fruit and vegetable consumption is very significant to the 5 A Day program," said Peter Greenwald, director of the NCI Division of Cancer Prevention and Control. "We have made big strides to raise public awareness of the need to eat five or more servings of fruits and vegetables a day.

"The next critical—and often more difficult—step is to actually do it," Greenwald said. "The new CSFII consumption numbers show that behavior change is happening."

Increase In Consumer Awareness

Consumer awareness of the need to eat "5 A Day" has nearly quadrupled, from 8 to 35 percent, since NCI and the Produce for Better Health Foundation initiated the program in 1991. However, consumer behavior change happens more gradually.

The goal of the 5 A Day program is to increase the American public's consumption of fruits and vegetables to five or more servings a day by the year 2000.

"It's important to remember that five is the recommended minimum," said Gloria Stables, director of NCI 5 A Day for Better Health program. "Now that people are eating more fruits and vegetables, we're going to keep working to build all Americans' intake to five to nine daily servings."

Children Still Don't Eat Right

According to the survey, children still don't eat enough fruits and vegetables. The average consumption by children increased only from 3.1 servings per day between 1989-1991 to 3.4 in 1994.

"Adults need to be reminded of the importance of helping their children to develop sound eating habits early to last a lifetime—and encouraging them to enjoy fruits and vegetables is an easy way to do it," Stables said.

It is estimated that about 35 percent of all cancer-related deaths in the U.S. may be related to diet, Greenwald said.

A 5 A Day serving can come from fresh, canned, frozen, or dried varieties of fruits and vegetables. One serving is one medium fruit, 3/4 cup (6 oz.) of 100 percent fruit or vegetable juice, 1/2 cup cooked or canned vegetables or fruit, one cup of raw leafy vegetables, 1/2 cup dry peas or beans, or 1/4 cup dried fruit.

Funding Opportunities

NIAID Seeks Investigators, Risky Approaches, For Grants In HIV Vaccine Research

Acting on the recommendation of an expert advisory panel, the National Institute of Allergy and Infectious Diseases has unveiled a new grant program designed to speed the pace of AIDS vaccine discovery and development.

Called the INNOVATION Grant Program for Approaches in HIV Vaccine Research, the initiative will support research projects that may involve a high degree of innovation, risk and novelty, and that show clear promise for improving vaccine design or evaluation.

"This important initiative demonstrates our commitment to finding ways to prevent HIV infection and AIDS," said HHS Secretary Donna Shalala. "While recent advances in treatment show that we are making real progress against HIV/AIDS, a vaccine remains our best hope for stopping this epidemic."

New Investigators Sought

"This new grant program will enable us to rapidly exploit new scientific opportunities and broaden the base of scientific inquiry related to AIDS vaccine research," said NIAID Director Anthony Fauci.

Investigators with no HIV research experience are encouraged to apply for research support under

the INNOVATION program.

"INNOVATION will help bring creative ideas and new people into AIDS vaccine research," said David Baltimore, chairman of the AIDS Vaccine Research Committee, which endorsed the program at its first meeting on Feb. 17.

INNOVATION awards will be targeted at $150,000 per year in direct costs. The first phase of this pilot grant program encourages three areas of research:

- Understanding the structure and function of the HIV envelope protein (Env). This essential protein adopts a specific, but undefined structure for entry into cells. Defining this structure would provide important information for HIV vaccine design.
- Improved animal models for vaccine and pathogenesis studies. Current animal models for HIV do not fully reflect the spectrum of HIV disease as seen in humans, and few models can predict the effectiveness of vaccine candidates.
- Understanding the mechanisms of directing antigen processing in vivo to maximize the immune response. Scientists do not know the mechanism of action for many vaccine products. Determining where and how vaccines are processed within the body would allow researchers to direct and control the immune response and would greatly advance vaccine efforts against many diseases.

The program represents the AVRC's first action to help stimulate HIV vaccine research. The committee was created earlier this year after an external review panel called for improved coordination of NIH-supported AIDS vaccine activities.

The AVRC assists NIH in developing a comprehensive research program aimed at expediting the discovery and development of a safe and effective AIDS vaccine. It is also responsible for advising the HIV/AIDS vaccine research program at NIH about scientific opportunities, gaps in knowledge, and future directions of HIV/AIDS vaccine research.

In addition to Baltimore, a professor of molecular biology and immunology at the Massachusetts Institute of Technology, members of the committee include: Barry Bloom, Albert Einstein College of Medicine; Robert Couch, Baylor College of Medicine; Beatrice Hahn, University of Alabama at Birmingham; Peter Kim, Whitehead Institute; Norman Letvin, Harvard Medical School, Beth Israel Deaconess Medical Center; Daniel Littman, Skirball Institute of Biomolecular Medicine, New York University Medical Center; Neal Nathanson, University of Pennsylvania Medical Center; Douglas Richman, University of California at San Diego; William Snow, of San Francisco, CA; and Irving Weisman, Stanford University School of Medicine.

Applications will be due on or before May 23. For more information about the INNOVATION Grant Program contact Carole Heilman, associate director for scientific program development, Division of AIDS, NIAID.

NIAID materials are available on the Internet at http://www.niaid.nih.gov.

Army Breast Cancer Program Seeks Research Proposals

The U.S. Army Medical Research and Materiel Command (USAMRMC) will issue a Broad Agency Announcement (BAA) to solicit proposals for breast cancer research.

The 1997 Defense Appropriations Act provides $106 million to continue the Department of Defense Breast Cancer Research Program (BCRP).

The overall goal of this program is to promote research that will lead to the eradication of breast cancer. The objectives of the BCRP are to prevent breast cancer, cure breast cancer, and improve the quality of life for individuals living with breast cancer.

The programmatic strategy will be implemented by a call for proposals in four categories:

IDEA awards: The goal of this award is to stimulate and reward speculative but especially promising and creative ideas that may yield a high payoff. In accordance with this challenge to be innovative, the USAMRMC invites submission of proposals even if they lack pilot data. However, such proposals must nonetheless demonstrate solid scientific judgment.

Clinical Translational Research (CTR) awards: The intent of this category is to support research that applies highly promising and well-founded laboratory or other preclinical strategies to breast cancer patients. Successful proposals must demonstrate that initial clinical results will be obtained during the lifetime of the award. Applicants to this category will submit an initial pre-proposal which will be screened for conformity with category requirements. Highly rated applicants will then be

invited to submit a full proposal.

Computer-based Decision Support Systems (CDSS) awards: These awards are intended to fund projects that explore innovative approaches to the development of computer-based decision support systems that allow patients to better understand their diagnosis, treatment options, and risks associated with treatment.

Training and Recruitment awards: This category contains efforts in the form of Pre- and Post-doctoral Traineeships, Career Development Awards, and Sabbaticals. The USAMRMC particularly wants to submit participation by younger scientists, minorities, and scientists not previously involved in breast cancer search.

CTR pre-proposal deadline is June 11. Proposal deadline for all categories except CTR is June 25. Awards will be completed on Sept. 30, 1998.

For more information or to receive a copy of the BAA, download the document from the DOD World Wide Web address: http://mrmc.rad6.army.mil/documents.html. The document also may be requested by fax to 301/ 682-5521, or by calling 301/682-5517, ext. 101.

RFP Available

RFP N01-CP-71036-21

Title: Record Linkage Studies Utilizing Resources in Population-based Tumor Registries

Letter of Intent Recipt Date: May 9

The NCI Division of Cancer Epidemiology and Genetics, Radiation Epidemiology Branch, is seeking to expand the existing Master Agreement Pool for Record Linkage Studies. All MA holders already in the existing MA pool need not respond to this announcement. The MA pool currently includes: Iowa Cancer Registry; Finnish Cancer Registry; Connecticut Dept. of Public Health; Health Research, Inc.; Uppsala Universitet; Danish Cancer Registry; New Jersey State Dept. of Health; cancer Registry of Slovenia; and The Ontario Cancer Treatment and Research Foundation.

This acquisition is being advertised under a single umbrella title. An MA will be awarded under this title to each acceptable offeror. NCI wishes to contract with population-based tumor registries in the U.S. and other countries in order to collaborate in the conduct of record-linkage and subsequent analytical investigations. The duties required in support of the record-linkage studies include: develop a study plan which includes the evaluation of existing records that are potentially valuable for record-linkage, develop or apply the appropriate record-linkage procedures to link a "population file" with the cancer registry files, and provide results of the record-linkage study to the Project Officer either on computer tape or in tabulated form as requested.

After the record-linkage study has been completed, it may be desirable to consider additional analytical investigations that require data beyond that found on computer tapes. offerors should have cancer incidence data for all patients diagnosed within a defined geographic locale for at least five years during the previous decade, 1980-1989, and have the ability to ascertain all cancer cases within the registries' catchment area of women of all age groups and U.S. minority populations, as appropriate.

The offerors must have experience in the collection of cancer data from a variety of medical sources and multiple institutions, and must have legal authority to collect medical data within the given geographic area or be able to demonstrate the willingness of all medical facilities within that area to participate in data collection and patient follow-up activities. Master Agreements will be awarded to all respondents whose technical proposal is considered acceptable.

The initial Master Agreement award is non-monetary, and is exclusively for the purpose of expanding the existing pool of contractors who are qualified to perform services for epidemiologic studies of cancer utilizing the resources of population-based tumor registries. Each Master Agreement holder will be eligible to compete for contract awards to carry out specific record-linkage and subsequent analytical studies. Master Agreement holders receiving a contract award will be selected from among those with a Master Agreement who choose to compete for the contract awards to be solicited through this pool, based on technical merit and on budgetary considerations for the specified tasks involved. Master Agreements resulting from this annual resolicitation will be awarded for a period beginning with the effective date of the Master Agreement through March 14, 2000. Award is anticipated by June 30, 1997.

Inquires: Barbara Shadrick, NCI, Research Contracts Branch, Cancer Etiology Contracts Section, Executive Plaza South, Rm. 620, 6120 Executive Blvd., MSC 7224, Bethesda, MD 20892-7224, tel: 301/435-3787, fax: 301/480-0241.