THE CANCER LETTER

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Senate Passes Non-Binding Resolution To Double NIH Budget Over Five Years

The Senate on May 21 unanimously passed a resolution to double the NIH budget over the next five years and increase the FY 1998 funding by $2 billion.

The resolution, introduced by Sen. Connie Mack (R-FL), was a non-binding measure aimed to influence this year's appropriations process.

Another advisory measure, an amendment to the Senate budget resolution, was expected to be introduced on May 22 by Sens. Arlen Specter (R-PA) and Tom Harkin (D-IA).

(Continued to page 2)

In Brief

Wynder Receives ACS Award At ASCO; Brinker To Be Honored For Public Service

ERNST WYNDER, president of the American Health Foundation, received the American Cancer Society Award, presented at the American Society of Clinical Oncology annual meeting in Denver earlier this week. Wynder's award lecture, titled "Nutrition as an Adjunct to Cancer Therapy--Lessons From Nature," focused on certain types of fat as promoters of breast cancer. Wynder is the coordinator of the Womens' Nutrition Intervention Study, supported by NCI. . . . **NANCY BRINKER** will receive the 1997 Jefferson Award, presented by the American Institute for Public Service. Brinker, founding chairman of the Susan G. Komen Breast Cancer Foundation, will receive the S. Roger Horchow Award for Greatest Public Service by a Private Citizen. . . . **ALBERT DE LA CHAPELLE** was named director of the human cancer genetics program at Ohio State University Comprehensive Cancer Center, and will lead the new Division of Human Cancer Genetics at the College of Medicine. De la Chapelle, recently elected to the National Academy of Sciences, is professor and chairman of medical genetics at the University of Helsinki. . . . **BEVERLY ZAKARIAN**, cofounder and executive director of CAN-ACT, a cancer patient activist organization which pressed for acceleration of FDA drug approvals, died of ovarian cancer on May 11. Zakarian was recently appointed by FDA as the first Oncology Fellow to represent cancer survivors in the cancer therapy review process. . . . **JAMES HOLLAND**, Distinguished Professor of Neoplastic Diseases at Mount Sinai School of Medicine, received an honorary doctorate in science from the State University of New York, Buffalo. His lecture was titled, "New Medicine for the Third Millenium."

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Senate's Words Need Backing With Deeds, Advocates Say

(Continued from page 1)

The Specter-Harkin amendment proposes adding $1.05 billion to discretionary health programs, an amount that would allow an increase of 7.5 percent for NIH. The increase would come out of a proposed $100 billion cut in non-defense discretionary administrative costs.

Earlier this year, Specter, chairman of the Labor, HHS and Education Appropriations Subcommittee, pledged to increase the NIH budget by 7.5 percent. Harkin is the ranking minority member on the subcommittee.

The President's budget proposal contains a 2.3 percent increase for NIH.

While the Mack resolution aims to established the overall "sense of the Senate" on the issue of increasing funding for biomedical research, the Specter-Harkin amendment aims to establish priorities—and influence—the allocation of funds that would ultimately be distributed by the subcommittees.

"The hard work of translating these initiatives into law lies ahead," said Dave Kohn, spokesman for Rep. John Porter (R-IL), chairman of the Labor, HHS and Education Appropriations Subcommittee.

"Symbolically, it's important that the Mack amendment passed 98-0," said Ellen Sigal, chairman of Friends of Cancer Research, a group formed to mark the 25th anniversary of the National Cancer Act. "The bottom line is that we have momentum. We have people feeling very good about NIH, and now our job is to translate these feelings into action."

Marguerite Donoghue, executive director of the National Coalition for Cancer Research, called on scientists and patient advocates to write to their members of Congress to maintain the momentum.

"The [Senate] budget resolution is the first step in an uphill fight to double the NIH and NCI budget," Donoghue said. "Now cancer advocates, researchers and community leaders must use the congressional recess period to ensure we are well positioned in the appropriations allocations. Everyone must make the phones ring to their elected officials to make sure that the allocation to the Labor, HHS appropriations subcommittee is adequate to cover increases in NIH and NCI funding as well as the priorities of the domestic discretionary programs."

Donoghue said she was concerned about a recent memorandum issued by Speaker of the House Newt Gingrich (R-GA). The memorandum, titled "What the President Did Not Get From This Agreement," lists NIH among the President's "protected domestic discretionary priorities" that lost their protected status in the balanced budget agreement.

"The agreement substantially scales back the President's insatiable appetite for more government spending programs," the memorandum states. The document was released May 16.

"We are gravely concerned that the Speaker is on record supporting the notion that the NIH is not a `protected discretionary priority,'" Donoghue said to **The Cancer Letter**. "NCI and NIH have proven time and again that medical research is a sound human and economic investment.

"It certainly deserves to be a top priority," she said.

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Professional Societies

ASCO To Study Its Role As "The World's Oncology Society"

DENVER—Though "America" is in the title of the American Society of Clinical Oncology, the society has in recent years become international.

One in five ASCO members lives outside the U.S. and more than half of the 15,000 people who attended the ASCO annual meeting earlier this week

came from outside North America.

Considering the international character of the audience that gathered to hear his presidential address, James Armitage had to qualify his appeal for increasing federal funding for cancer research:

"For those of you who are American citizens, I urge you to contact your senators and congressmen to tell them to support and expand funding of NCI and investments in cancer research," Armitage said in his final address as the society's president.

International membership is the society's fastest-growing segment, Armitage said in his address. More than 50 percent of the submissions to the society's Journal of Clinical Oncology come from international investigators, indicating that it is not just sightseeing in the U.S. that these professionals are seeking.

"This has truly become the world's oncology society," said Armitage, professor and chairman of the Department of Internal Medicine, at the University of Nebraska Medical Center.

The rapid growth of international attendance and membership brings challenges, but exactly what to do is not clear, ASCO leaders said. The society plans to study its role internationally as part of a strategic plan, Armitage said.

ASCO should consider adding a position on its Board of Directors for an international member, Armitage said. In previous years, the society added slots on the board for community oncologists and other specialties.

According to Armitage, the society needs to balance its resources between its two major activities. "These are on the one hand, our scientific and educational mission, and on the other, protecting the interests of our patients and members," Armitage said. "I believe that if we intend to protect the interests of our physician members, we must always put first the interests of our patients, or we will fail."

In recent years, ASCO has moved toward greater inclusion of its international members, society officials said. At the meeting last week, the society staffed the international registration desk with interpreters who spoke the four most common languages identified in ASCO demographics reports: Spanish, French, Italian and Japanese.

A New Specialty

In the past 10 years, ASCO membership has more than doubled, to nearly 12,000. The society added 1,200 members in the past year.

In his address, Armitage provided an overview of ASCO's development and leadership since the society's founding in 1964. "Most of our members have joined ASCO in the last several years and don't know our history," Armitage said.

The excerpted text of his speech follows:

Oncology, as a distinct, clinical specialty, is fairly new. Beginning in the last century, surgeons provided the major therapeutic attack on cancer. The recognition that high energy radiation had an anticancer effect in the early part of this century lead to the development of a second therapeutic specialty in radiation oncology. Internists and pediatricians entered the game with the discovery of nitrogen mustard and folate antagonists in the 1940s and numerous other anticancer agents over the subsequent decades.

However, the value of chemotherapeutic agents in the management of cancer was hotly debated for some time. Although the cure of choriocarcinoma with drugs was demonstrated in the 1950s by Li and Hertz, and shortly thereafter Dennis Burkitt found long survivors using chemotherapy in patients with a lymphoma named after him, many physicians found the toxicity of these agents unacceptable for the contribution they provided. In 1964, a paper presented at the American Association of Cancer Research asked the question "Is toxicity necessary?" and a few years later a famous hematologist suggested that adults with acute leukemia should not be treated.

It was in this environment that a small group of physicians who were involved in the care of patients with cancer and trying to develop a scientific basis for their investigations decided to form a new society. Many, but not all, were members of the American Association of Cancer Research, but felt the need for a society that emphasized clinical cancer research. At that time it was very difficult to get a paper accepted for presentation at any meeting if the paper dealt with clinical cancer therapeutics. It is interesting to note that even in the early 1960's an objection raised to this project was that there were already too many meetings and it was difficult to attend them all.

A group of seven oncologists, including Fred Ansfield, Harry Bisel, Herman Freckman, Arnoldus Goudsmit, Robert Tallry, William Wilson, and Jane Wright, drafted a letter over the name of Jane Wright, who served as secretary pro tem, inviting interested oncologists to an organizing meeting of the American Society of Clinical Oncology. The organizers originally met on June 19, 1964, at the Hilton Hotel in San Francisco and the formal organizing meeting was on November 5, 1964, at 7:30 p.m. at the Lake Shore Hotel in Chicago. There was one presentation at the meeting

by Dr. Kenneth Endicott, then director of the National Cancer Institute.

I am informed by those involved in the founding of ASCO that, although he never became president, Dr. Arnoldus Goudsmit was the force behind founding the society. Dr. Goudsmit is retired, but resides in Minneapolis.

The first scientific meeting of the American Society of Clinical Oncology took place at the Bellevue Hotel in Philadelphia on April 9, 1965, in association with the AACR. This meeting was a far cry from the giant undertaking of today. The meeting took place between 8 and 10 p.m., and the scientific which took up the first one and one-half hours of the meeting, was made up of three presentations.

The first elected president was Dr. Harry Bisel from the Mayo Clinic. Approximately 70 members and guests attended the meeting.

The second meeting of ASCO in the spring of 1966, took place in Denver. This meeting was presided over by the second president, Dr. Michael Brennan, from the Michigan Cancer Foundation. The meeting had increased rapidly in size and 176 people registered.

The third and fourth ASCO meetings took place, respectively, in Chicago and Atlantic City. The third president of ASCO was Dr. Fred Ansfield, originally a general practitioner from Wisconsin who went on to an important career at the McCardle Cancer Center in Wisconsin, and the fourth president was [the late] Dr. George Escher from Albert Einstein College of Medicine.

The fifth president of ASCO was Dr. Emil Frei, who currently is at the Dana Farber Cancer Institute. During Dr. Frei's presidency, ASCO was working towards board recognition for medical oncologists. One of the major topics at the annual meeting that year was recognition that Adriamycin, a newly available antitumor antibiotic had activity in breast cancer and ovarian cancer. Dr. Frei was followed in the presidency by Dr. Paul Calabresi, now from Brown University. Dr. Calabresi later served as chairman of the subspecialty board for medical oncology. With the annual meeting chaired by Dr. Calabresi, the meeting attendance passed 500.

The seventh president of ASCO was Dr. Jesse Steinfeld from the Medical College of Virginia. During the annual meeting in 1971, the first Karnofsky lectureship was presented by Sir

Alexander Haddow. Dr. Steinfeld was followed in the presidency by Dr. Kenneth Olson, from New Smyrna Beach, FL. It was during Dr. Olson's presidency that the medical oncology subspecialty board came into being, and the National Cancer Act was passed.

The ninth and 10th presidents were Dr. Paul Carbone, recently director of the Wisconsin Clinical Cancer Center, and Dr. Bayard Clarkson from Memorial Sloan Kettering in New York. These two important leaders of medical oncology presided over ASCO during a time of rapid therapeutic advances based on the use of chemotherapeutic drugs in combination, and during a time of rapid expansion of research infrastructure due to an infusion of research money. It might make some of you now jealous to know that they told me that grants then were so easy to get that all you had to do was apply.

The 11th and 12th presidents were Dr. Rose Ruth Ellison, from Englewood, NJ, and Dr. Joe Bertino, currently at Memorial Sloan Kettering. By this time meeting attendance had increased sufficiently that it was becoming very difficult to manage the Society. The meeting organizing company SLACK was hired and organized membership management was begun. At the 1976 meeting, the first joint session between AACR and ASCO was held and more than 1,000 members attended the ASCO meeting. It is interesting to note that a paper at that meeting showed that cisplatin, vinblastine, and bleomycin could cure a high proportion of patients with disseminated testicular cancer.

The 13th and 14th presidents were Dr. James Holland from Mount Sinai School of Medicine and Dr. Vincent DeVita, now Director of the Cancer Center at Yale, but then of the National Cancer Institute. It was during this time that one of the most popular activities of ASCO was initiated, the Educational Symposia that still precede the Scientific Session of our meeting. The 1977 meeting again took place in Denver. One of the major issues that was dealt with the in the Scientific Session was the apparent breakthrough in the curability of melanoma with immunotherapy. Perhaps this particular memory should keep us all cautious and critical.

The 15th and 16th presidents were Dr. Al Owens of the Johns Hopkins Oncology Center and Dr. Charles Moertel from the Mayo Clinic. Dr. Moertel is the second president of ASCO to have passed away. He suffered from Hodgkin's disease. A fact that, sadly, should help those of us interested in lymphoma therapy to remember that Hodgkin's disease is still cancer.

The 17th and 18th presidents were Dr. Emil J. Freireich from M.D. Anderson and Dr. John Ultmann from the University of Chicago. During this time period, the society made a decision to develop its own journal. By 1982, more than 3,000 persons attended the annual meeting. In that year, Dr. Ultmann, in his

presidential address, suggested that we should consider decreasing the number of trainees so as not to saturate the field of medical oncology.

The 19th and 20th presidents were Dr. Saul Rosenberg from Stanford, and Dr. Phil Schein, currently with U.S. Bioscience Inc. In 1983, the first issue of the Journal of Clinical Oncology was published under the editorship of Dr. Joe Bertino. That year, ASCO held one of its first strategic planning efforts and determined that we needed to improve relationships with pharmaceutical companies and do a more effective job at supporting clinical research.

The 21st and 22nd presidents were Dr. Sydney Salmon at the University of Arizona College of Medicine, and Dr. John Durant, currently the executive vice president of ASCO, but then from Fox Chase Cancer Center. During their leadership, ASCO began its awards program, and the budget of the society passed $1.75 million annually. By 1986, more than 4,000 persons attended the annual meeting. Interestingly, Dr. Durant's presentation in 1986 focused on the coming impact of health care economics on the practice of medicine in general, and oncology specifically.

The 23rd and 24th presidents were Dr. Samuel Hellman, then at Memorial Sloan-Kettering Cancer Center, and Dr. B.J. Kennedy from the University of Minnesota. Dr. Hellman was the first radiation oncologist to be president. During Dr. Kennedy's year, ASCO was accepted as a member of the AMA House of Delegates.

The 25th and 26th presidents were Dr. Charles Coltman Jr. from the University of Texas at San Antonio, and Dr. Robert Young of Fox Chase Cancer Center. During their tenure, ASCO carried out a major strategic planning effort. Among the important outcomes was a determination to meet the needs of both academic and practicing members of the society. One of the results was the institution of a fall meeting to provide an educational experience for those that had to stay home and work during the annual meeting. In 1989, ASCO develop and published, in conjunction with the American Society of Hematology, guidelines for the performance of bone marrow transplantation that influenced policy makers and insurance companies. This was the first of our guidelines.

The 27th and 28th presidents were Dr. Harvey Golomb from the University of Chicago and Dr. Martin Abeloff from Johns Hopkins University. Dr. Golomb and Dr. Joseph Bailes, head of the clinical practice committee, visited oncologists throughout the country in an effort that eventually led to development of state societies. During these years, ASCO develop its first clinical research awards and for the first time hired professional public relations help. Also, ASCO began a major effort to influence reimbursement policy and health care regulation as regards oncology.

The 29th and 30th presidents were Dr. Bernard Fisher from the University of Pittsburgh and Dr. George Canellos from the Dana-Farber Cancer Institute. During these years, AACR decided to separate its annual meeting from ASCO. This was a sad event for many of our members.

The 31st and 32nd presidents were Dr. Karen Antman, now from Columbia University, and Dr. John Glick from the University of Pennsylvania. At this time, slightly over 40 percent of our members were in private practice and approximately 35 percent in academic medicine. Also during this time it was found that the mortality rate from breast cancer was falling in the U.S. During these years, we instituted the International Affairs Task Force, recognizing our growing international membership, hired our first executive vice president, and opened our Washington office.

We are certainly facing changes and challenges. For one thing, our annual meeting has grown to more than 15,000 attendees and does not appear to be leveling off. As much as I personally like Denver, it is quite clear that cities this size will not be able to host our meeting in the future. In fact, in the near future, the ASCO meeting will be restricted to only a few cities, including Los Angeles and Orlando, and they will be visited in rotation.

ASCO is expanding, and will continue to expand its education efforts. A very successful workshop on methods in clinical cancer research was held last year and will be continued annually in conjunction with AACR. Also in conjunction with AACR, focused educational meetings of specific topics or diseases was begun during the past year. The first of what will be regular ASCO/European Society for Medical Oncology symposiums was initiated this year at our annual meeting. Finally, ASCO is undertaking a major initiative in cancer genetics education.

I would like to draw your attention to what I believe is a very important relationship between the success of our profession as oncologists, the success of ASCO, and our country's investment in cancer research as reflected in the budget of the National Cancer Institute. There is a striking, direct relationship between NCI funding, research output as measured by abstract submission, and ASCO membership. I don't believe this relationship is incidental.

The recognition of oncology as a important subspeciality of medicine, surgery, pediatrics, radiation medicine, and surgical subspecialties came as a result

of scientific advances that allowed us new weapons to help our patients. As a group, we have pioneered the use of the scientific method to measure the effectiveness of clinical interventions.

Today, the rapid expansion in knowledge in biology, particularly molecular genetics, of normal and cancer cells promises continued exciting advances. However, this will not occur in the absence of a continued commitment to funding cancer investigation.

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Armitage invited ASCO members to stop by the society's headquarters in Alexandria, VA. "Those of you who haven't had the opportunity to meet the full-time staff of ASCO might not appreciate the extraordinary quality of people we have advancing our cause," he said.

Key staff include John Durant, the executive vice president; Ron Beller, vice president of administration; and department directors Michele Dinkel (science and education), Stacy Beckhardt (public policy), Deborah Whippen (publications), Saundra White (members and meetings), and Mark Somerfield (health services research).

ASCO has 37 employees and 11,156 square feet of office space.

Another ASCO location, albeit a virtual one, can be visited on the World Wide Web. "ASCO Online," the society's web site, is located at http://www.asco.org.

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Robert Mayer succeeded Armitage as ASCO president this week. Mayer is chief of the Division of Clinical Oncology at the Dana-Farber Cancer Institute, and professor of medicine, Harvard Medical School. He is recognized for his work in the treatment of leukemia and gastrointestinal cancers, as well as his work in the development of training programs for cancer researchers and clinicians.

Allen Lichter, professor and chairman of the Department of Radiation Oncology, University of Michigan, was chosen as president-elect.

Cancer Genetics

Cancer Risk From 3 Mutations Lower Than Expected, NCI Says

Results from a year-long study of cancer gene mutations in Ashkenazi Jews show the average risk of cancer to be much lower than originally projected, but still significantly higher than in the general population.

Three mutations in the BRCA1 and BRCA2 genes were tested in over 5,000 men and women of Eastern European Jewish heritage, and were found in one in 44 (2.3%) of those tested. The study was conducted in the Washington area.

The findings, published in the May 15 New England Journal of Medicine, show that for those carrying an alteration, the average risk of breast cancer by age 70 is estimated to be 56%. Results of a preliminary study, conducted last year on a smaller group with a strong family history of cancer, suggested a breast cancer risk of as much as 85%.

The latest study estimated the average risk for ovarian cancer for those with the alteration as 16%. The preliminary study estimate was 44%. According to the latest results, men who carry the gene alteration have a 16% chance of developing prostate cancer.

Unknown Variability

"Although this tells us a lot about the biology of how breast cancer develops, it still does not explain most common ordinary breast cancer," Margaret Tucker, chief of the NCI Genetic Epidemiology Branch, said at a press conference last week.

"We find that very important, because it tells us how tumors happen, but it really explains only a very small percent of [incidence of] breast cancer," Tucker said.

Jeffrey Struewing, co-author of the study, said the findings were preliminary. "Unfortunately, we don't know how much variability there may be in the cancer risk from one carrier to the next, nor what factors might modify that risk or might allow us to make better estimates about an individual carrier's risk," said Struewing, a senior research investigator in the NCI Genetic Epidemiology Branch.

Researchers took blood samples from 5,318 volunteers and tested for three specific alterations: 185delAG and 5382insC in the BRCA1 gene, and 6174delT in the BRCA2 gene. DNA analysis showed 120 of the volunteers carried one of the three targeted alterations, but none carried more than one.

No Testing Recommendations

Struewing said NCI was not making any screening or genetic testing recommendations. "The decision about testing is a very personal, very complex issue," Struewing said. "These are subjective things. It is not for us to say whether testing is right or wrong for a given individual."

Caryn Lerman, associate professor of medicine

and psychiatry at Georgetown University Medical Center said the findings do not warrant widespread genetic testing among the Ashkenazi Jewish population.

"I think the issue is not whether a Jewish person should be tested or not, but what information do we have to date that we can provide someone so that they can weigh the pros and cons and make a decision about whether they want to know," said Lerman.

"Some people may decide for themselves that they do not wish to know because there is too much uncertainty, and there are not enough proven prevention strategies. That is an individual decision that a man or a woman, Jewish or not Jewish, needs to make," she said.

A follow-up study is being developed in the Washington, DC, Jewish community to assess risk factors in addition to the BRCA alterations, and to give volunteers the option of knowing their results and receiving genetic counseling.

Clinton Backs Bill To Prevent Insurance Use Of Genetic Info

President Clinton urged Congress to pass legislation which would prohibit the use of genetic screening information for insurance discrimination.

In a commencement speech at Morgan State University earlier this week, the President said risk factors for certain diseases, based on an individual's genetic makeup, must not be used for determining insurance rates or eligibility.

"No insurer should be able to use genetic data to underwrite or discriminate against any American seeking health insurance. This should not simply be a matter of principle, but a matter of law, period," he said. "To that end, I urge the Congress to pass bipartisan legislation to prohibit insurance companies from using genetic screening information to determine the premium rates or eligibility of Americans for health insurance."

Rep. Louise Slaughter (D-NY), whose Genetic Information Nondiscrimination in Health Insurance Act has been referred to the House Committee on Commerce, said the President's support will get her bill passed.

The bill (H.R. 306) would prevent insurers from denying, canceling, refusing to renew, or changing the terms, premiums, or conditions of coverage for a policy based on genetic information. It would also prohibit insurance companies from requiring genetic testing as a condition of coverage.

A statement released by the White House endorsed Slaughter's bill, and said it "represents a strong foundation for this much needed reform."

In Congress

Bill To Mandate Payment Of Trial Costs Is Introduced

Reps. Nancy Johnson (R-CT) and Benjamin Cardin (D-MD) have introduce legislation to provide coverage for cancer patients participating in clinical trials.

The bill, (H.R. 1628) which mandates Medicare coverage of patient care costs for patients enrolled in clinical trials, was introduced May 15. The bill is the House version of a similar proposal (S.381) introduced by Sens. Connie Mack (R-FL) and John Rockefeller (D-WV).

"Medicare's refusal to cover clinical trials not only denies seniors hope of a cure, it denies us the chance to develop and evaluate treatments," Johnson said at a press conference last week.

The bill is endorsed by the American Cancer Society, the American Society of Clinical Oncology, and the Cancer Leadership Council.

Senate Defeats Bill To Cut Teen Smoking, Insure Children

The Senate this week defeated the Child Health Insurance and Lower Deficit (CHILD) Act, aimed at reducing teen smoking, providing coverage for uninsured children, and cutting the federal deficit.

The bill (S.525 and S.526) was introduced by Sen. Orrin Hatch (R-UT) and Sen. Edward Kennedy (D-MA) last week, and proposed a 43-cent increase in the tobacco excise tax. The bill was taken out of the budget resolution by a vote of 55 to 45.

In a statement released after the Senate vote, John Seffrin, CEO of the American Cancer Society, said the current budget resolution will leave over 5 million children uninsured. "Senate leaders have held this bill hostage all day to protect an industry that preys on destroying the lives of children with their deadly product," he said.

Supporters of the bill included the ACS, the Children's Defense Fund, and over 150 organizations that comprised the Campaign for CHILD Health Now.

ACS said it will continue to campaign for the passage of the bill.

NCI Programs

Online Service Provides Info On Genetic Counseling

The NCI International Cancer Information Center has developed an online service to provide information on genetic counseling and testing resources.

CancerNet is a directory of genetic counselors, physicians, geneticists, and nurses with expertise in counseling on familial risk and genetic susceptibility testing. "The directory will help health care professionals who are increasingly in need of locating qualified cancer counseling and testing referral resources for their patients," said Susan Molloy Hubbard, director of the ICIC.

The Family Cancer Risk Counseling and Genetic Testing Directory is a database of over 200 health professionals, searchable by name, city, state, country, and type of cancer or cancer gene. The directory provides information on counselors' degrees, institutional affiliation, professional licenses, and certification.

Also provided are the specific gene or disease sites which counseling is provided for, context in which the service is provided, and fees involved.

To be eligible for listing, applicants must be in an oncology or genetics profession; licensed, certified or eligible for board certification; a member of a recognized health profession organization; and willing to accept referrals.

CancerNet can be accessed at http://cancernet.nci.nih.gov, tel: 800/4-CANCER, fax: 301/402-5874, email: cancernet@icicc.nci.nih.gov.

Funding Opportunities

RFPs Available

SOL N0: 2-CM-87014

Title: **Biochemical Genetic Monitoring of Rodents**

Deadline: Approximately July 25.

The NCI Biological Testing Program, Developmental Therapeutics Program , Division of Cancer Treatment, Diagnosis and Centers, is seeking organizations having the capability to provide a genetic monitoring resource for the BTP. Genetic monitoring for quality assurance will accompany efforts in microbiological quality, in order that each animal produced from rederived stock, under our production contracts, is as well defined as possible. Genetic monitoring will be accomplished by biochemical means. It is anticipated that one contract will be awarded for this effort, as a result of this RFP, for a period of 60 months. This RFP is a recompetition of the "Biochemical Genetic Monitoring of Rodents" project being performed by Texas A&M University.

Contact Patricia White, Contract Specialist, Frederick Cancer Research and Development Center, NCI, Building 427, Room 25, Frederick, Maryland 21702-1201, tel: 301/846-1113.

SOL N0: 2-CM-87015

Title: **Primary Rodent Production Center**

Deadline: Approximately August 1

The NCI Developmental Therapeutics Program is seeking organizations with the capability and facilities for producing large numbers of inbred rodents which are genetically sound and free of pathogenic organisms. To be considered for contract award, offerors should meet the following criteria: (1) the principal investigator and other key personnel must have experience and expertise in the production of the highest quality rodents free from pathogenic organisms; (2) the facility must be available at the time of contract award, capable of producing highest quality rodents at specified levels; (3) organizational experience in pertinent areas of quality rodent production including pedigreeing procedures, isolator production etc.; and (4) willingness to participate in grantee reimbursement collections. One contract award will be made. A five-year incrementally funded cost plus fixed fee completion type contract is anticipated. The contract will require the maintenance of approximately 23,275 mouse cage equivalents. A mouse cage equivalent refers to a shoe box type cage approximately 7 " x 11 " x 5 " high. A rat cage equivalent equals 2 mouse cage equivalents. All breeding stock will be supplied by the Government. The strains and stocks to be produced will be determined by the Government. The contract represents a recompetition of contract N02-CM-57218, Charles River Laboratories, Inc.

Contact Donald Harne, contract specialist, Frederick Cancer Research and Development Center, NCI, Rm. 25 Building 427, Frederick, MD 21702-1201. tel: 301/846-1113, email: harned@mail.ncifcrf.gov.

Funding Available For Trials Of Melanoma Immunotherapies

The Cancer Research Institute is funding Clinical Research Seed Grants to support phase I or phase I/II trials aimed at testing novel immunotherapies for the treatment of melanoma. Grants will be for $150,000 over two years.

Deadline for applications is Sept. 1.

Contact Lynne Harmer, director of grants administration, Cancer Research Institute, 681 Fifth Avenue, New York, NY 10022-4209, tel: 212/688-7515, fax: 212/832-9376, email: cancerres@aol.com.