THE CANCER LETTER

Vol. 23 No. 34
Sept. 5, 1997

Price $265 Per Year US
$285 Per Year Elsewhere

Bernard Fisher Settles Suit For $2.75M, Retains Title; University Apologizes

Cancer researcher Bernard Fisher last week agreed to drop his suit against NCI, the University of Pittsburgh and the Washington law firm of Hogan & Hartson.

Under an agreement that settles the suit, Fisher will receive $2.75 million and retain his title of Distinguished Service Professor, but would collect no salary or employee benefits, legal documents state.

Pursuant to the agreement, the university issued an apology for

(Continued to page 2)

In Brief

Pelayo Correa Heads LSU Cancer Center; Foundation To Honor Feinstein, Mack

PELAYO CORREA was named director of the Stanley S. Scott Cancer Center at Louisiana State University Medical Center. Correa is the Boyd professor of pathology at the university. Correa will lead the center in its efforts to achieve NCI comprehensive cancer center designation, the university said. . . . **LOUIS HARRISON** was named chairman of the department of radiation oncology at Beth Israel Medical Center, and associate director of the Beth Israel Cancer Center. Harrison is the former chief of brachytherapy service and leader of the head and neck cancer disease management team at Memorial Sloan-Kettering Cancer Center. Beth Israel Medical Center also named **Joseph Wagner**, formerly of the NCI Surgery Branch, as physician-in-charge of urologic oncology. . . . **LYMPHOMA RESEARCH** Foundation of America will present the Paul Tsongas Memorial Award to Sens. **Dianne Feinstein** (D-CA) and **Connie Mack** (R-FL) in recognition of efforts to double NIH funding over the next five years. The award will be presented as part of National Lymphoma Awareness Week, Oct 12-18. . . . **INTERNATIONAL BONE MARROW TRANSPLANT REGISTRY** next week will mark its 25th anniversary with a symposium, "New Directions in Blood Cell and Bone Marrow Transplants." The registry, located at the Medical College of Wisconsin, Milwaukee, will also host a gala dinner to celebrate the event. . . . **ONCOLOGY NURSING SOCIETY** has established a new award to recognize an oncology nurse for excellence in pain management. The $4,000 award will be presented in 1998. For an application, contact ONS Customer Service, tel: 412/921-7373, fax: 412/921-6565.

URGENT: Please deliver this FAX edition to the person named on the cover sheet. For transmission problems or information, call 202-362-1809.

Fisher Settles Suit With NCI, Pitt, And Hogan & Hartson

(Continued from page 1)

"any harm and public embarrassment that Dr. Fisher sustained which was in any manner related to the activities of the University of Pittsburgh and/or its employees."

NCI, also a defendant in the civil action brought by Fisher, issued a statement that enumerated Fisher's contributions to the understanding and treatment of breast cancer.

"Through his role as the scientific leader of the National Surgical Adjuvant Breast and Bowel Project, [Fisher] has not only changed the way breast cancer is treated, but enlightened medical science to view breast cancer as not just a tumor confined to the breast, but as a systemic disease requiring more than surgical intervention," NCI said in a statement.

The Institute contributed $300,000 to the overall settlement, to cover a portion of Fisher's legal expenses, sources said.

The settlement was reached Aug. 27, six days before the case was scheduled to go to trial at the US District Court for the Western District of Pennsylvania.

Though all parties agreed not to discuss the terms of the settlement agreement, **The Cancer Letter** obtained a copy of the document under the Freedom of Information Act.

THE CANCER LETTER

An Independent Newsletter

Member, Newsletter Publishers Association

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Staff Writer: Catherine Fiore
Circulation: Rena Guseynova

P.O. Box 9905, Washington, DC 20016
Tel. (202) 362-1809 Fax: (202) 362-1681
Editorial e-mail: kirsten@www.cancerletter.com
Customer service: subscrib@www.cancerletter.com
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.

Founded Dec. 21, 1973 by Jerry D. Boyd

Tangled Controversy Concluded

"I am glad to be alive to see this vindication," Fisher said to **The Cancer Letter. "**I feel that I am still in a position to continue to make contributions, and I want to go forward in the best way I can: to write, and to complete data that needs to be put out."

Fisher declined to describe his plans for the future. "My plans are in the process of being formulated," said Fisher, who is 78. "At this time, I am scientific director of the NSABP, and I would like to continue in that mode, and to make whatever contributions that I can to the organization as it now exists."

The scientific director's post can have a significant impact on generating interest in clinical trials and development of protocols, sources said.

The statements by NCI, the University of Pittsburgh, and Fisher appear on pages 3 and 4.

The settlement is likely to conclude the tangled controversy that began on March 13, 1994, when an article in the Chicago Tribune disclosed that Montreal surgeon Roger Poisson had contributed falsified data to NSABP clinical trials. Soon after the publication of the story, Fisher was removed from leadership of the cooperative group.

The oversight and investigations subcommittee of the House Committee on Commerce conducted hearings on the matter, and the HHS Office of Research Integrity was brought in to investigate possible misconduct by Fisher and two other officials at the cooperative group.

Ultimately, the subcommittee, then headed by Rep. John Dingell (D-MI), accepted the mea culpa from NCI and Pitt and bowed out. Earlier this year, the ORI completed its investigation, finding no misconduct by Fisher and other NSABP officials (**The Cancer Letter,** March 7).

In the just-settled suit, Fisher claimed that NCI officials had "unlawfully terminated" him as principal investigator of NSABP and "crafted multiple false accusations" against him.

"In an effort to keep millions of federal research dollars flowing to the University," Pitt officials assisted NCI in Fisher's firing, Fisher's attorneys stated in the most recent version of the complaint, filed in December 1995.

The suit also named Martin Michaelson, an attorney with Hogan and Hartson, who was hired by the university to handle the matter in its initial stages.

"Defendants Michaelson and Hogan & Hartson obtained Dr. Fisher's confidences by representing

that a privileged attorney-client relationship existed between them," but ultimately shared these privileged and confidential communications with the university, NCI, ORI, and the staff of the Subcommittee on Oversight and Investigations of the House Committee on Commerce, the complaint states.

Under the settlement agreement, Fisher is to receive a single check for $2.75 million, documents say. The check would be issued by the University of Pittsburgh "on behalf of all defense interests" within 45 days of the signing of the agreement

While the federal government will contribute $300,000 toward the settlement, it is unspecified how much of the remaining $2.450 million would come from Pitt and how much (if anything) would come from Hogan & Hartson.

Though Fisher will retain his title, he would collect neither a salary nor employee benefits. If he chooses to stay at the university, Fisher would be provided with office space, but no support staff. If he accepts a position elsewhere, he would receive no office space.

Regardless of whether he stays or goes, Fisher would continue to have unrestricted access to NSABP data kept at the university, the agreement states.

In the document, federal defendants stated that all investigations surrounding Fisher have been concluded and that all previously imposed sanctions have been lifted. The text of that section of the memorandum follows:

- "Dr. Fisher is not required to submit his manuscripts to the NCI prior to publication… [Any] requirement to that effect was rescinded April 10, 1995.
- "Dr. Fisher is not precluded from participation in any federally funded cancer research project;
- "A grant applicant, including any applicant for the Operations Center [based at Allegheny General Hospital in Pittsburgh] or Biostatistical Center [based at the University of Pittsburgh] NSABP grants, may list Dr. Fisher as a participant on an application, and any such application will be reviewed through the normal peer review process;
- "NCI will consider Dr. Fisher for a position on a top advisory committee at the NCI, taking into account his achievements and reputation;
- "After a thorough investigation, the Office of Research Integrity did not make a finding of scientific misconduct."

Pitt Apologizes To Fisher, Expresses Pride In His Work

The text of the joint statement by Fisher and the University of Pittsburgh:

The University of Pittsburgh and Dr. Bernard Fisher announce the withdrawal of the lawsuit initiated by Dr. Fisher following his removal as principal investigator and chairman of the National Cancer Institute's National Surgical Adjuvant Breast and Bowel Project in the spring of 1994.

The University of Pittsburgh wishes to take this opportunity to apologize to Dr. Fisher and express its sincere regret at any harm or public embarrassment that Dr. Fisher sustained which was in any manner related to the activities of the University of Pittsburgh, and/or its employees.

The University and Dr. Fisher wish to affirm that at no time was Dr. Fisher found to have engaged in any scientific or ethical misconduct concerning any of his work.

The University's acceding to the National Cancer Institute's decision in the spring of 1994 to remove Dr. Fisher as principal investigator of the NSABP and the subsequent developments in the now settled litigation reaffirms the necessity of the university's commitment to fully investigate any allegations against faculty members which leave the potential to impinge upon their First Amendment rights or the essential rights and freedoms of the academic community.

The university wishes to express its pride in the many accomplishments Dr. Fisher has had while associated with the university's Department of Surgery and wishes him success as he continues in the position of Distinguished Service Professor and Scientific Director of the NSABP.

Dr. Fisher will continue his efforts relative to the cause of women's health care, particularly as it relates to breast cancer research through his continuing role as Scientific Director of the NSABP.

NCI: Fisher A Dominant Force In Breast Cancer For 40 Years

The text of the NCI statement:

Bernard Fisher has been a dominant force in the study of breast cancer for the last 40 years.

Through his role as the scientific leader of NSABP, he has not only changed the way breast cancer is treated, but enlightened medical science to view breast cancer as not just a tumor confined to

the breast, but as a systemic disease requiring more than surgical intervention.

Among his contributions were:

● Showing that, for treatment of breast cancer, lumpectomy plus radiation provides the same surgical benefit as the radical, disfiguring Halsted mastectomy or modified radical mastectomy, while permitting conservation of the breast.

● Demonstrating that when used as an adjuvant therapy, tamoxifen, a hormonal treatment, improved survival of women with early stage breast cancer. Combined with his studies of adjuvant chemotherapy, this work led the NCI to state that all women with early stage breast cancer should consider adjuvant therapy (either hormones or chemotherapy) to improve their survival. His research on tamoxifen also showed that five years of tamoxifen therapy is as good as longer courses of treatment.

● Showing that neoadjuvant chemotherapy (chemotherapy before surgery) can safely permit some women with large breast tumors to choose lumpectomy plus radiation instead of mastectomy. He also showed that chemotherapy plus tamoxifen improves survival for early stage, node-positive breast cancer patients when it was compared to tamoxifen alone in both premenopausal and post-menopausal women.

● Initiating the Breast Cancer Prevention Trial, a study of tamoxifen in the prevention of breast cancer, which recently completed accrual of over 13,000 women.

● Convincing his medical colleagues of the importance of clinical research and that clinical studies could be carried out at the community level.

Fisher: "So Many People Don't Understand Clinical Trials"

Bernard Fisher's statement to ***The Cancer Letter****:*

I'm appreciative of the letter of apology that the university rendered. It's an important thing to recognize one's errors. This goes a long way to inform women that all that I did was correct.

The issue of integrity of the research is now completely put to rest. There wasn't anything that would have altered data or would have changed the results. There was a disruption of science that should never have taken place. That's very harmful.

I pursued this [litigation] to the end, because I honestly believe this was a bigger issue than me. It was about the scientific process. That's why I did this.

The greatest asset of this country is democracy as it is structured. This means you shouldn't be presumed guilty without due process. One has to have the ability to confront one's accusers in an environment that promotes exchange in a non-hostile manner.

That's not the way I got it. There was a rushed judgement in my case. I didn't get due process. A [Congressional] hearing that was adversarial and rigged is not the kind of an environment to let this take place.

The other thing I got out of this was a realization of the extent of misunderstanding and misinterpretation of randomized trials. It was so disappointing to me to learn that so many people did not understand—and to this day don't understand—the science, the process, and the mechanisms by which clinical trials are conducted.

Much of what happened was due to this lack of understanding at all levels—government, public, university. If something didn't seem to be logical to them, then it was wrong.

I am glad to be alive to see this vindication. That, to me, is an emotional experience, because so many people have died, and then it was some time later for their vindication to appear. From that standpoint, I am very fortunate.

If I have made any contribution to the betterment of women with breast cancer, to society in general, then I'm happy for that. It's not for me to decide what contributions I made. That is to be decided by others. I'm too close to know what I really did.

I feel that I am still in a position to continue to make contributions, and I want to go forward in the best way I can: to write, and to complete data that needs to be put out.

My plans are in the process of being formulated. I am scientific director of the NSABP, and I would like to continue in that mode: to make whatever contributions I can to the organization as it now exists.

NCI Programs

NCI Tissue, Data Resources Available For Cancer Research

NCI announces the availability of the following NCI-supported tissue and data resources for cancer

research:

•**NCI Cooperative Human Tissue Network**: provides normal, benign, pre-cancerous and cancerous human tissue to the scientific community for biomedical research. Human tissue specimens are collected according to the investigator's individual protocol. Researchers may specify from among multiple preservation methods including fresh tissue (in any medium), fixed (in any fixative), and frozen (snap frozen or frozen in a tissue embedding media such as OCT). Requests for histological specimens (for blocks and slides) will also be considered. Information routinely provided with the specimens includes pathology reports and histological characterization. Specific additional information may be provided if requested in advance. The specimens are most useful for basic and developmental studies in many areas of cancer research, including molecular biology, immunology and genetics.

Further information is available from the CHTN website at http://wwwicic.nci.nih.gov/chtn/chtnmain.html, or Marianna Bledsoe, Resources Development Branch, Cancer Diagnosis Program, Division of Cancer Treatment, Diagnosis and Centers, NCI, tel: 301/496-7147; fax: 301/ 402-7819; e-mail: mb80s@nih.gov.

•**Gynecologic Oncology Group Tissue Bank**: provides malignant, benign, and normal ovarian, and cervical tissue. Primary tumor, metastatic tumor (when applicable) and normal adjacent tissue are available for most cases.

The bank includes snap frozen specimens, formalin fixed sections, OCT embedded primary tumor, touch imprint slides and patient serum collected prior to surgery. Clinical information provided with each case may include patient age and race in addition to the institutional pathology and operative reports. A limited number of tissue specimens are from patients entered into GOG clinical trial protocols. These specimens and the associated treatment, response and survival data may be available through collaboration with GOG investigators following review and approval by the GOG Ovarian Committee.

Contact the GOG Tissue Bank, Children's Hospital, J058, 700 Children's Drive, Columbus, OH 43205; tel: 614/722-2890; fax: 614/722-2897.

•**NCI Cooperative Breast Cancer Tissue Resource**: CBCTR can provide researchers with access to approximately 8,000 cases of formalin-fixed, paraffin-embedded primary breast cancer tissues, with associated pathology and clinical data. Tissue and data are available from patients treated locally in four diverse geographic areas of the U.S.

Tissue sections are prepared to meet the criteria of individual research protocols. All specimens are reviewed to verify the pathologic diagnosis. Clinical and outcome data include: diagnosis, demographic data, extent of disease, treatment, follow-up, recurrence, survival, and vital status. Cases are available for study, representing all stages of disease, including a large number of cases who received no adjuvant radiation or chemotherapy or were treated with conserving surgery and radiation but no chemotherapy. The collection is particularly well-suited for validation studies of diagnostic and prognostic markers. Researchers may search the database on the CBCTR World Wide Web site at http://www-cbctr.ims.nci.nih.gov to determine if tissues appropriate for their experiments exist within the Resource and apply to the Resource for the use of these tissues.

Contact Sherrill Long, Information Management Services Inc., 12501 Prosperity Dr. Suite 200, Silver Spring MD 20904; tel: 301/680-9770, fax: 301/680-8304; e-mail: sherrill@ssims.nci.nih.gov.

•**NCI-NAPBC Breast Cancer Specimen and Data Information System**: This database, which is available on the World Wide Web, (http://cancernet.nci.nih.gov/breastdata) contains a listing of institutions that are willing to provide breast cancer specimens and/or data to biomedical researchers. Collaborative relationships may be required by some institutions. For each resource listed in the database, information is provided on the number and types of specimens, the availability of associated clinical and outcome data, procedures for obtaining access to the specimens or data, costs, and limitations of use. The database may be searched for key words.

Contact Paul Hurwitz, Westat Inc., tel: 301/738 - 8313; e-mail: referral@westat.com.

•**NCI Cooperative Family Registry for Breast Cancer Studies and NCI Cooperative Family Registry for Colorectal Cancer Studies**: The Cooperative Family Registry for Breast Cancer Studies (CFRBCS) provides biological specimens from participants with a family history of breast cancer, breast/ovarian cancer, or Li-Fraumeni syndrome, and their relatives, as follows: tissue sections from paraffin embedded breast and ovarian

cancers; peripheral blood lymphocytes, serum, fresh frozen tissue (when available), and other biological fluids. The CFRBCS will provide related family history (pedigrees), clinical, demographic and epidemiologic data on risk factors exposures. The CFRBCS will also provide follow-up epidemiologic data as well as data on recurrence, new morbidity, and mortality in the participating families. Biological specimens and the clinical, family history, and epidemiologic data are available to the research community at large. The CFRBCS's repository and related databases are particularly suited to support interdisciplinary and translational breast cancer research.

Additional information is available from the CFRBCS site on the World Wide Web at http://www-dceg.ims.nci.nih.gov/cfrbcs or Daniela Seminara, Division of Cancer Epidemiology and Genetics, NCI, tel: 301/496-9600; fax: 301/402-4279; e-mail: seminard@epndce.nci.nih.gov.

A similar resource for colorectal cancer, the Cooperative Family Registry for Colorectal Cancer Studies, is expected to be available to the research community in early 1998. Contact Daniela Seminara, DCEG, NCI, tel: 301/496-9600; fax: 301/402-4279; e-mail: seminard@epndce.nci.nih.gov.

•**NCI AIDS Malignancy Bank**: The AMB is a collection of tissues and biological fluids with associated clinical and follow-up data from patients with HIV-related malignancies. The specimens and clinical data are available for research studies, particularly those that translate basic research findings to clinical application. AMB contains formalin-fixed paraffin embedded tissues, fresh frozen tissues, malignant cell suspensions, fine needle aspirates, and cell lines from patients with HIV-related malignancies. The bank also contains serum, plasma, urine, bone marrow, cervical and anal specimens, saliva, semen and multi-site autopsy tissues from patients with HIV-related malignancies including those who have participated in clinical trials. The bank has an associated database that contains prognostic, staging, outcome and treatment data on patients from whom tissues were obtained. The tissues are available to qualified investigators in the U.S. for research on HIV-related malignancies.

Additional information is available from the AMB site on the World Wide Web at http://wwwicic.nci.nih.gov/amb/amb.html, or Ellen Feigal, Cancer Therapy Evaluation Program, Division of Cancer Treatment, Diagnosis and Centers, NCI, tel: 301/496-2522; fax: 301/402-0557; e-mail: ef30d@nih.gov. Additional AIDS oncology information may be obtained on the web at http://ctep.info.nih.gov.

Other human tissue resources for cancer research may be available through collaborative arrangements. Contact Marianna Bledsoe, Resources Development Branch, Cancer Diagnosis Program, Division of Cancer Treatment, Diagnosis and Centers, NCI, tel: 301/496-7147; fax: 301/402-7819; e-mail: mb80s@nih.gov.

Funding Opportunities

AHCPR Seeks CRADA Partners For Health Care Research

The Agency for Health Care Policy and Research is seeking expressions of specific interest and general public comments regarding the Agency's intention to develop additional public-private partnerships for research to enhance quality and access in the nation's health care system.

AHCPR is encouraging new public-private partnerships for collaborative research projects, with groups representing every segment of the health care community.

AHCPR will permit CRADA partners to negotiate with the Agency for a patent license, or similar license, to use or market (and develop further) any inventions, intellectual property, or copyrightable material created or developed through the collaboration. Partners will be expected to provide resources to facilitate the collaboration, including funds to support the costs of the research.

The typical term of a CRADA will range from two to five years.

AHCPR is exploring new models for partnerships with other organizations. Areas for potential collaborations include, but are not limited to:

•How the structure and organization of health care markets and the evolving managed care systems impact on cost, quality, and access;

•Changes in the delivery of care such as clinical integration and new models of care, and how particular elements of managed care affect quality and outcomes;

•Changes in financing mechanisms for health care coverage, including the impact of employer coalitions and value-based purchasing efforts;

•Ways to use governmental and private sector

health care databases for applying advanced data-analysis techniques to improve health care delivery;

•Examining primary care delivery in terms of cost, quality, and patient outcomes;

•The use of consumer satisfaction initiatives in the design of improved health care systems;

•Development of syntheses of scientific evidence on specific clinical topics and technologies;

•Disseminating evidence-based practice information to the clinical community;

•Evaluating the relative impact (in terms of cost, quality, and outcomes) of new medical technologies, interventions, and innovations; and

•Expanding efforts to explore and evaluate outcomes and effectiveness of various treatments for the same condition.

The role of the private-sector partner in these research collaborations could include opportunities to:

•Support research design and study through the provision of funding or other valuable research resources (such as data, research personnel, equipment).

•Partner in the design, coordination, and conduct of research studies to evaluate the effectiveness and cost of health care delivery.

•Provide clinical or other technical support for studies.

•Improve consumer and practitioner access to research results through innovations in dissemination and evaluation.

Deadline is Sept. 23. Contact Larry Patton, Office of Policy Analysis, Agency for Health Care Policy and Research, 2101 E. Jefferson Street, Suite 603, Rockville, MD 20852, email: lpatton @ahcpr.gov.

High-Throughput Genotyping Offered By Genome Institute

The National Human Genome Research Institute announces the availability of resources and facilities for high throughput genotyping at the Center for Inherited Disease Research (CIDR).

CIDR has been established as a resource to provide, on a fee-for-service basis, high throughput genotyping services to research efforts that are attempting to identify genetic loci and allelic variants involved in multifactorial human disease. The mapping activities at CIDR will concentrate on the use of human populations and families but may involve analysis of pertinent animal models as well.

Access to CIDR will be determined on a competitive basis and is intended to be a resource for investigators who receive their primary research funding from NIH. CIDR will also be available on a competitive basis to NIH intramural scientists. Extramural investigators who have or are seeking NIH funding and who would like to use the services offered by CIDR, including those investigators submitting competing continuation (renewal) applications, and investigators submitting applications for competing supplements to add a genotyping component, are encouraged to request CIDR access prior to submitting their research grant applications to the NIH. Those already funded for genotyping can also request access to the facilities of CIDR.

Using samples provided by the principal investigators, CIDR will carry out genome-wide genotyping scans. A variety of different mapping approaches will be supported, including affected pedigree member methods, transmission disequilibrium testing, and linkage analysis in pedigrees. Consultation on study design and on statistical analysis are available, as additional services, to investigators. The data and analyses will remain the property of the principal investigators and once the studies at CIDR have been completed, will be returned to the principal investigators. At the outset CIDR will use automated fluorescent microsatellite analysis using standard marker sets (^10 cM average spacing) with an initial goal of 1-2 million genotypes (marker x DNA sample) per year. With this capacity, it is estimated that CIDR will initially be able to work on six to nine projects per year, although that number will obviously depend on the size of the projects.

Though focusing on genotyping services, CIDR scientists will also be engaged in research efforts across five main components: 1) statistical genetics, which applies the power of statistics to the hereditary patterns of genes to determine modes of inheritance from parents to their children; 2) genetic epidemiology, which applies genetic analysis gathered from disease-prone families to the general population to determine if the genetics patterns of the research families hold in large diverse populations; 3) medical informatics and database management, which uses computer programs to store, manipulate, and analyze the research data; 4) state-

of-the-art technology to rapidly scan whole genomes for multiple gene regions associated with a particular disorder; and 5) technology development, which continues to refine existing methods and generate new ways to perform high-capacity genotyping efficiently and cost effectively.

Investigators intending to seek NIH support for gene mapping projects and who wish to utilize the genotyping resources of CIDR are encouraged to request CIDR access prior to submitting a research grant application to the NIH. A short document (ideally 5-8 pages, single spaced) describing the project and justifying the need for such a resource is required. Investigators already funded for genotyping are also eligible to apply for CIDR access.

Factors that will be weighed in determining the suitability of a project for CIDR access include:

-size and scope of the project and the need for large capacity genotyping to complete the project.

-significance and complexity of the disorder/ trait.

-quality and completeness of the phenotyping carried out on the subjects.

-strength of the evidence for a genetic component to the disease phenotype.

-ability and preparedness of the investigator to manage the large amount of data that is generated by large genotyping projects.

-appropriateness of the study population for the specific disease mapping project.

-availability of adequate numbers of patient samples and the completeness of the patient sample set.

-appropriateness of proposed analytic methods and the ability of the investigators to carry out the methods.

-quality, availability and completeness of the DNA samples.

Contact Jerry Roberts, NHGRI, Building 38A, Room 609, 38 Library Drive, Bethesda, MD 20892-6050, tel: 301/402-0838, fax: 301/480-2770, email: robertsj@odder.nhgri.nih.gov.

RFAs Available

RFA TW-98-001

Title: **International Cooperative Biodiversity Groups**

Letter of Intent Deadline: Oct. 15.

Application Deadline: Jan. 22.

The National Science Foundation, NIH, and the Foreign Agricultural Service invite applications for the establishment or continuation of International Cooperative Biodiversity Groups to address the interdependent issues of biodiversity conservation, economic growth, and human health through discovery of therapeutic agents for diseases of importance to developed countries as well as those primarily important in developing countries.

Particularly relevant disease areas and health needs include cancer, HIV-AIDS and opportunistic infections, malaria, central nervous system disorders, contraception and sexually transmitted diseases, and cardiovascular and pulmonary diseases. Applications that propose, in addition to pharmaceutical drug discovery, research and training related to phytomedicine analysis and natural product-based crop protection or veterinary agents are also encouraged.

Participating NIH components are the Fogarty International Center, the National Cancer Institute, the National Institute of Allergy and Infectious Diseases, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Office of Alternative Medicine and the National Heart, Lung and Blood Institute.

Contact Joshua Rosenthal, Biodiversity Program, Fogarty International Center, 31 Center Drive MSC 2220, Bethesda, MD 20892-2220, tel: 301/496-2516, fax: 301/402-2056, email: joshua_rosenthal@nih.gov.

RFA No. CA-97-020

Title: **Cooperative Trials in Diagnostic Imaging**

Letter of Intent Deadline: Nov. 18.

Application Deadline: Feb. 18.

The NCI Division of Cancer Treatment, Diagnosis and Centers invites applications for cooperative agreements to establish a single national Network of investigators that will perform multi-institutional clinical trials in diagnostic imaging related to cancer. The Network will have the capability to conduct a broad spectrum of clinical trials in imaging. Similar to the treatment cooperative groups supported by DCTDC, this Network will generate new trials in areas of high scientific opportunity. Unlike most other major NIH cooperative trials efforts, the structure and funding of this Network will not be linked to specific clinical trials. Because the Network's apparatus for conducting trials will be continually in place, this mechanism has considerable flexibility for allocating resources quickly to the testing of promising new imaging devices or agents, both in limited-institution pilot studies and in large multi-center settings. The initial focus of the Network will be cancer; once the Network is functioning productively, consideration will be given to broadening the agenda to include additional areas of medicine with the support of other institutes of the NIH.

Contact Anne Menkens, Diagnostic Imaging Program, NCI, 6130 Executive Boulevard, Room 800, Bethesda, MD 20892, tel: 301/496-9531, fax: 301/480-5785, email: menkensa@dtpepn.nci.nih.gov.