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NIH Review Division Considering Proposal For Clinical Oncology Study Section

The NIH Center for Scientific Review (formerly the Division of Research Grants) is considering an NCI proposal to route all investigator-initiated clinical cancer research grant applications to a single study section, Institute Director Richard Klausner said to the National Cancer Advisory Board at a recent meeting.

Klausner said he met with CSR Director Elvera Ehrenfeld to convey the NCI Executive Committee's proposal that the Experimental Therapeutics 2 study section review only patient-oriented oncology grant applications. ET2 currently reviews patient-oriented as well as laboratory

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In Brief

NIH AIDS Chief William Paul To Step Down; Aldige To Lead NCCR; Rimer Joins NCI

WILLIAM PAUL plans to step down as director of the NIH Office of AIDS Research, NIH said this week. Paul, the OAR director since 1994, said he will return to working full-time as head of the Laboratory of Immunology at the National Institute of Allergy and Infectious Diseases. Paul is credited with establishing priorities for NIH-funded AIDS research. A search committee is being established to find a new OAR director. In related news, NIAID has selected the first grant recipients for the INNOVATION Grant Program for Approaches in HIV Vaccine Research. The institute last week awarded 49 grants totaling $11.8 million. . . . **CAROLYN ALDIGÉ** was elected president of the National Coalition for Cancer Research. Aldigé is president of the Cancer Research Foundation of America. She succeeds Albert Owens, founding director of the Johns Hopkins Oncology Center. New members of the NCCR Board of Directors include: **Donald Coffey**, president, American Association for Cancer Research; **G. Denman Hammond**, president and CEO, National Childhood Cancer Foundation; **Marc Lippman**, director, Lombardi Cancer Center, Georgetown University; **Jerome Yates**, vice president for clinical affairs, Roswell Park Cancer Institute; **Lucille Adams-Campbell**, director, Howard University Cancer Center; **Anna Barker**, president and CEO, Oxis International Inc.; **Harmon Eyre**, executive vice president for research and cancer control, American Cancer Society; and **Kathi Mooney**, professor of parent-child and adult nursing, University of Utah College of Nursing. . . . **BARBARA RIMER** resigned

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NIH Review Division Working With NCI On Study Section

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research grant applications.

"We have reached about 90 percent agreement that we should move quickly toward working through the details, working together to do such an experiment, to try to create what has been requested for a least a decade or more: a clinical oncology study section," Klausner said at the NCAB meeting Sept. 24. "This would bring together cancer patient-oriented research that is scattered in multiple study sections."

Various studies have suggested that patient-oriented research grant applications do not fare well in direct competition for funding with laboratory research, Klausner said. A report last week by the NCI Clinical Trials Program Review Group also recommended the formation of a clinical oncology study section (**The Cancer Letter**, Oct. 3).

An article in a recent issue of the Journal of the American Medical Association concluded that patient-oriented applications fare worse than laboratory research when study sections do not review significant numbers of patient-oriented applications.

"We have tried in part to address this *post-hoc* with the Accelerated Executive Review, but there remains what many believe is a disincentive to apply, because of the sense that the system may be stacked against patient-oriented research," Klausner said to the NCAB.

Under the AER program, NCI provides funding by exception to certain grant applications that missed the payline.

"One example that we often see, and feel there is a problem, is in endocrine-related patient-oriented research, which goes to Endocrine Metabolism [study section]," Klausner said. "The review is often oriented much more toward the endocrine issues than the clinical cancer issues."

In 1991, NCI asked NIH to form a clinical oncology study section, or appoint more clinical scientists to ET2. The Division of Research Grants responded that few patient-oriented grant applications were being submitted to ET2, but if more came in, the request would be considered.

NCI appealed to clinical scientists to apply for R01 grants. Although the number of clinical applications submitted doubled in one year, the funding rate remained the same as in the previous year, 19 percent for clinical oncology versus 23 percent for biochemistry and pharmacology (**The Cancer Letter**, July 17, 1992).

With the appointment of Ehrenfeld as the DRG director eight months ago, the opportunity for NCI to encourage the formation of a clinical oncology study section has never been greater. Ehrenfeld, a virologist from the University of California, Irvine, served on the Advisory Council to the National Institute of General Medical Sciences. She is married to Donald Summers, who was appointed NCI associate director for the Frederick Cancer Research & Development Center earlier this year. In remarks to the NCAB earlier this year, Ehrenfeld said the NIH peer review system needs reorganization.

"She has brought a whole new perspective, a sense of openness and change to DRG, which is not even called DRG anymore," Klausner said.

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FY97 Funding Statistics: Klausner provided the NCAB with the Institute's grant funding statistics and related commentary on fiscal year 1997, which ended Sept. 30:

—R01 payline ended the year at the 23rd percentile. "I continue to feel that the effect of the increased success rate for investigator-initiated research is not only incredibly important in terms of what it accomplishes, but has had a salutary effect on the optimism of the community," Klausner said.

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Founded Dec. 21, 1973 by Jerry D. Boyd

NCI funded 673 competing R01s in FY97, an increase of 167 grants, or 33 percent, since 1995. Of the competing R01s, 374 were new grants. NCI spent a total of $575 million to support 2,192 R01s, an increase of 14 percent from FY95.

—R29 or FIRST Award payline was at the 38th percentile. About 109 new awards were funded for $12 million. NCI funded a total of 450 R29s, a 17 percent increase from FY96.

—Program project grants (P01s) were funded through the priority score of 140, resulting in the award of 41 competing grants for $55 million. Overall, NCI provided $200 million to fund competing and renewal P01s, a 10 percent increase from FY96.

—Grant funding by exception: NCI spent $20 million, or 10 percent of the amount spent on all competing research project grants, to fund grants that fell below paylines, but were considered important. This includes the Accelerated Executive Review Process.

—Accelerated Executive Review, by the NCI Executive Committee, provided $7.3 million to fund R01s that fell below paylines (up to 10 percentile points for patient-oriented research and 4 percentile points for all others), an increase of $1.3 million from FY96. Of the applications submitted to the AER process, 54 percent were funded.

—Cancer Center Support Grants: Two centers received CCSGs for the first time in FY97. They are the Cancer Institute of New Jersey at the Robert Wood Johnson Medical School, center director William Hait; and Oregon Cancer Center at Oregon Health Sciences University in Portland, center director Grover Bagby Jr. Funding for CCSGs increased by 3.5 percent over FY96.

—Specialized Programs of Research Excellence funding increased by 17 percent to support the breast, lung and prostate SPOREs and to fund a new gastrointestinal SPORE, emphasizing pancreatic cancer, at the University of Nebraska Medical Center.

—Cooperative groups funding increased by 6 percent.

—Training: NCI plans to study its training programs in the coming year. "We have not had a single review that does not direct us to increase training or think about new training needs," Klausner said. "Clearly, we are going to have to take a hard look at what we are accomplishing with our training programs."

—Research and Development contracts: NCI funded about $180 million worth of these contracts, representing 7.5 percent of the Institute's budget.

—NCI intramural research program used $450 million, or 17 percent of the NCI budget, down from 18 percent in FY96.

—Research management and support was maintained at $100 million, a Congressional requirement. "This is an area that is rapidly becoming a real strain on the Institute, in terms of how much is spent to support a growing Institute, with a growing variety of programs," Klausner said.

—Office of Cancer Survivorship used $2 million to fund 20 grant supplements for research on long-term cancer survivors.

—The Small Business Innovation Research program, requiring that federal research agencies set aside 2.5 percent of their extramural funding to support research by small business, "represents a significant challenge to NIH," Klausner said.

NCI assigned nearly $48 million to the program in FY97. "We need to work much harder to figure out how to attract the best proposals and applications," Klausner said. "All of us feel there is an enormous amount of terrific stuff that could be done, yet we end up paying through paylines that are significantly higher than those supported through the rest of the [research project grant] pool."

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Gene-Environment Interactions in Breast Cancer is the title of a large new study being developed by NCI with the Centers for Disease Control and Prevention and the National Institute of Environmental Health Sciences.

The study will use a one-time appropriation of $15 million to the Department of Health and Human Services that was attached to a flood relief measure. The funding was designated for study of the environmental causes of breast cancer.

The three agencies are developing a population-based, multicenter, case-control study that would include high and low-risk areas of the country, and would collect extensive questionnaire information, environmental monitoring data, and biologic specimens, Klausner said.

"We need a study that will allow us to look at multiple interacting factors—environmental, hormonal, and behavioral factors with multiple genetic polymorphisms," Klausner said. "This is very different in terms of study designs, analytic issues, that what we have done before, where we decide we are interested in one gene and we design a study to

look at one gene, or two genes, and we hope that we've made the right guess.

"It provides us an opportunity to study cohorts of individuals broadly, to develop matrices of interactions between environmental factors and genetic variations," Klausner said. "To do this right is going to require the ability to work with the individuals, to be able to go back to ask the questions we will realize are important next year and two years from now, and three years from now.

"If this approach is successful in breast cancer, we believe we will learn an enormous amount about how to do such studies, how we develop new technologies for environmental analysis, coupled with genetic and molecular analysis," Klausner said.

Reinventing NCI

Clinical Trials System Changes "Not Easy, Quick,"--Klausner

Following is an edited transcript of the discussion at the recent National Cancer Advisory Board meeting of the draft report of the Clinical Trials Program Review Group. The report was summarized in the Oct. 3 issue of ***The Cancer Letter****:*

NCI Director Richard Klausner: "This was a very difficult charge and a very tough problem, and I think this report will set us on a new tack, where I believe there is consensus that we need to improve this system. These recommendations are going to be extremely helpful. There are going to be difficult decisions to make.

"We have begun taking steps in a number of areas, including working with [the Office for Protection from Research Risks] on a number of these goals, and beginning discussions with FDA. It's not going to be easy and it's not going to be quick, not because it's politically difficult, although there may be some of that, but also it's conceptually difficult, and we don't want to, in changing things, throw the baby out with the bath water.

"We will immediately have a small implementation group deal with these recommendations and begin making the tough decisions you charge us with."

Deborah Collyar, president, Patient Advocates in Research, who served on the Clinical Trials Program Review Group: "I am in support of this report as far as it goes. What we have are tactics and a way to improve the existing clinical trials system. What we don't have in here, and the way I think we need to look at this report, is that it is a first step to improving the entire clinical trial process. The process itself needs to be looked at very closely and carefully to see how we can improve it to incorporate some of the new scientific discoveries, because the clinical trial process was based primarily on the chemotherapy model, and does not necessarily work well with other disciplines and in new therapy approaches that are coming up.

"If we waved a magic wand today, and we got more accrual to trials, are we prepared to handle the impact that would put on our clinical trial system? The answer basically is 'no.' Chuck [Coltman] had a good example of when SWOG did that and ran into problems [see below]. It's not just a funding issue, it's an infrastructure issue as well.

"The [Community Clinical Oncology Program] has worked very well, but a review of that process has to take place, and it needs to be expanded in ways that don't necessarily orient it toward a group approach, but more looking at it from the way people are treated in this country."

Charles Coltman, chairman of the Southwest Oncology Group and member of the clinical trials committee: "One cannot get uniformity of opinion from 29 individuals, but [the report] does represent consensus, and I don't think it's consensus to a low level, it's consensus to a high level.

"If we are going to benefit from improvements in basic science and translate that into humans, which by the way happens to be what we are all about, we are going to have to have a larger clinical trials program, and there are two ways. One is to throw more money at it, and that's not always the best solution, but the other is to increase the efficiency.

"As we look at the clinical trials system with all these different groups, each with different protocol guidelines, each with different protocol formats, each with different form sets—it's a tower of Babel. When you bring together groups into an intergroup setting, it's not a smooth, seamless transition. We tended not to recommend solely more money, but how we could improve the efficiency of the system."

[Coltman's SWOG accrual story:] "In 1990 and 1991, we had responded to the NCI admonition to enhance accrual to clinical trials by a variety of mechanisms. It was about March of 1991 when we identified that we were on a track by the end of the

year to have accrued something on the order of magnitude of 12,000 patients to clinical trials. That created a major financial burden in our operations office and statistical center, just managing that large amount of information.

"I went to [NCI] and asked if there was any opportunity for more money, because we were really in severe financial straits. The answer was 'no.' I ended up raising $270,000 from the pharmaceutical industry to bail us out, and delayed the activation of new protocols in an attempt to create a soft landing, so that we would get down to a level of accrual for which we had been funded, which was about 5,500 to 6,000 patients per annum. Money would have helped then."

Ellen Stovall, NCAB member and executive director, National Coalition for Cancer Survivorship: "I was struck when I looked at the witness list, and knowing that [NCAB member] Kay [Dickersin] only made it to two meetings, was it as conspicuous to you as it is to me that hearing from a lot of patients who have participated in clinical trials and hearing more from that community would not have been helpful in grappling with these issues? We did feel left out of this process."

James Armitage, chairman of the review group: "There was no attempt to turn people away, we were looking for people to share information."

Frederick Li, NCAB member, of Dana-Farber Cancer Institute: "Do you have any thoughts about targeted disease cooperative groups versus general groups? Is $90 million [budget for the cooperative groups program] appropriate, or should you have more, less, or is it about right?"

Armitage: "I have an opinion about how the groups should be organized, but there were 28 other opinions. I think there is merit for specific groups, but we would get very great differences of opinion about how to structure it. That's a decision someone is going to have to make.

"More money would get you more things, but doing the things we propose would get you more for the $90 million, and both would get you even more. We can't afford everything."

Richard Boxer, NCAB member, of Medical College of Wisconsin: "One thing you certainly can solve by throwing money at it is debt of the young physician who is thinking about going into academia or into clinical studies and is under the gun of $100,000 in debt. That is one place by throwing money you could make a significant impact."

Recommendation to Move CCOP

Pelayo Correa, NCAB member, of Louisiana State University Medical Center: "I am concerned about moving the chemoprevention trials to the therapy division. They could get diluted.

Armitage: "We should look upon these groups as—this is our lab to test ideas. If we build this extensive lab and only use it for therapeutic trials, and have to build another one for prevention trials, that's a silly and terrible mistake."

Robert Wittes, NCI deputy director for extramural science and director, Division of Cancer Treatment: "The motivation of the recommendation to move the CCOPs to the treatment division and to have one protocol review process for everything is clear, and correct. What we should do is reduce the ambiguity to a minimum—the ambiguity of who you have to deal with at NCI to get this work accomplished. We have not been organized very well over the last few years, in that we demand of clinical investigators multiple reports sometimes.

"I tend to feel that the CCOPs are philosophically more similar to the cancer centers or training than they are to the organizations that are devoted more clearly to one thing or another, and there might be some reason for moving them into a central core where they could be envisioned as a resource for the Cancer Institute and its grantees—not only for treatment, not only for prevention, but also for genetic susceptibility issues, imaging diagnostics, early detection, and the whole range of intervention things NCI cares about.

"What the prevention experience has shown brilliantly is that an oncology-centered operation can actually accrue in gangbuster style large numbers of subjects at risk but not yet diseased. That's a lesson that in reconfiguring clinical trials program and the prevention program we have to keep in front of our minds."

"Frustration" In Clinical Research

Philip Schein, NCAB member, chairman and CEO, U.S. Bioscience Inc.: "A theme that came through the document was the frustration that clinicians have about the length of time it takes from the conception of an idea to the completion of a statistical report. It takes a decade. There should be greater sense of urgency. We have to think about ways of truncating the process in getting to an answer much quicker, and that includes very heavy

involvement of FDA in this process. So that [we don't have] the gross inefficiencies that there have been in the past if the designs do not ultimately satisfy the requirements of FDA.

"We're hearing a plethora of new, exciting ideas. We are going to have a logjam. They need to be translated very quickly and validated as to whether or not they will produce a result that is worthy of the several years of commitment. I wonder if the cooperative groups are ideally suited to take this on, or whether we need an entirely new mechanism? Do we have the resources in place in our program? Do we have the people to conduct the amount of work that needs to be done?"

Armitage: "You are right about the frustration. To be fair, there's frustration among the people in NCI dealing with investigators. We have a system that is dysfunctional in some ways. We have good people trying to do the best they can with the same goals, and both get mad. There are things we could fix. Groups are not the place you develop translational research. The groups will test the ideas. They are not the place that brings together basic and clinical science. That's done to a great degree in the cancer centers or universities."

Kay Dickersin, NCAB member, of University of Maryland School of Medicine: "Even though I was unable to make meetings beyond the first two, I want to confirm that Jim [Armitage] did an admirable job of guiding the group evenhandedly. I did express concern then, and I still have it, about the group with the vested interest predominating the table. When I raised this issue, I was told again that this is our laboratory for research, and I think that's a valid point of view. My concern remains that there is ownership of cancer clinical trials by a single group of individuals. I am concerned about infusion of new ideas, being able to turn on dime when there's something happening, that it's always this same group, and a very large group, indeed.

"There was a suggestion to register all trials, though perhaps not industry trials. NCI is working with FDA now as part of the National Action Plan [on Breast Cancer] to see that industry trials are registered, too. Maybe that could be modified in the report. We don't want to go backwards.

"I like the idea of large, simple trials. The trouble is, we may miss outcomes that are very important to patients. Let's not just focus on mortality and disease-free survival.

"The idea of similar data collection forms and outcomes is appealing in some sense, we can combine data. But there's also benefit to differences. There's not just one way to do something. We may learn something by asking a question a different way."

Alfred Goldson, NCAB member, of Howard University Hospital: "This is a very refreshing and well-thought-out report. I've always felt that the only thing that should be convoluted and difficult in research is research itself. Not the process of writing the grant or reporting it.

"I also believe that if you make it simplified to the point that the clinician in his or her office can participate in trials, it answers the point Kay brought up, that usually it is large groups that direct things. That is because they have the resources to do the data management. If we make it user-friendly, then more people can participate. If we do that, it will do something that I've always felt was my goal on the NCAB. In African-Americans, the survival rate is 15 percent less than the majority population. If we could just get them on the existing protocols without any new magic bullet, just get a 15 percent improvement, that's a lot of lives saved."

Report Emphasizes Physician Barriers

Fran Visco, member of the President's Cancer Panel and president of the National Breast Cancer Coalition: "I'm concerned about our talking about the clinical trials program in the country if the revisions are going to facilitate unimportant questions and poorly designed trials, regardless of whether they are funded by NCI or not. Not that I think that this report does that, but I am very concerned about the discussion about vested interests that participated in the report.

"I'm concerned about wanting to get answers more quickly if the answers we are getting are not answers we can rely on. I don't want us to get answers more quickly at the expense of good science and well-designed trials.

"I want to echo what Ellen Stovall said. We did have a very strong patient advocate on the committee, but I think we need to hear more of the perspective of patients themselves. If you had a group that consisted of 25 percent patient advocates, the report would have been different. It may have been a bit longer. Perhaps the barriers to access to trials would have focused more on patient barriers than on physician barriers, which is what I read a great deal of in the report. Physician barriers are extremely

important and we need to address those, but perhaps now we need a supplemental report that addresses patient barriers to access to trials."

Alison Martin, FDA representative to the NCAB: "It was refreshing not to see every slide directed at the FDA. We are concerned at the agency in facilitating new and easier ways to find better treatments. There are a number of discussions ongoing and sparked by this report. As with all large institutions, there is an institutional history as to why we have multiple advisory committees, and it may not be obvious why some drugs are directed toward one and not another. We've heard from some communities about this. We have not heard from all communities about this, and it's a good time for those who have an opinion to let it be heard, because we are listening.

"In terms of standardizing requirements, that's a win-win situation for everyone, patients, physicians, NCI and anyone else. We are very interested in doing that and have started discussions with CTEP and others, including the International Harmonization effort. We are open to opinions, data, and working relationships."

Klausner: "I want to make clear that in describing [the report] as a good start, I do not want to belittle it. If we don't have good starts, we're not going to get anywhere. This is a very important report and the changes that are going to be made in this institution will be traced very much to what we received from this report. The Institute feels this is a very critical report."

Armitage: "Calling it a good start would not hurt our feelings. In fact, that's what we want it to be. Most of the specific things we proposed clearly are tactics, not strategy.

"This wasn't the forum for resolving strategic questions, at least without bloodshed. We are going to have to do it in a different way and it's very important that we get on with it."

NCI Grants And Contracts

Historically Black Institutions Learn About Funding Process

For the purpose of obtaining government grants and contracts, administrators of historically black colleges and universities should remember that their institutions are considered disadvantaged small businesses, an NCI official told college representatives last week.

Joseph Bowe, small business manager for research contracts at NCI, gave representatives from historically black colleges and universities a step-by-step guide to the complexities of federal grant procedures as part of a roundtable sponsored by the Institute.

The event was part of National Historically Black Colleges and Universities Week, responding to a 1993 Executive Order by President Clinton to federal agencies to provide HBCUs with the assistance and information needed to obtain federal grant and contracts.

Bowe urged representatives to maintain contact with the small business managers at federal agencies for help in obtaining funding. HBCUs qualify as disadvantaged small businesses.

Verl Zanders, director of the HHS Office of Small and Disadvantaged Business Utilization, advised participants to focus on obtaining contracts over grants. "[Grant] money is living a very tenuous existence," Zanders said. "Grants are dwindling, but contracts will live."

HHS funded $158 million in grants and contracts to HBCUs last year, Zanders said. Overall, the department channeled $9 billion to institutes of higher education last year, he said.

Bowe and Zanders warned representatives that entering the world of NCI contracting would be difficult. Bethesda has its own language, not easily deciphered, they said.

HBCU representatives were told understanding the process would come from tracking the Commerce Business Daily, contacting prime contractors, and not being afraid to ask questions.

"You have not, because you ask not," said Laverne Morrow Carter, president of Emprise Designs, the meeting facilitator. "All of this can be learned—this is not magic."

The seminar ended with a session titled "What's in it for your institution?" Representatives were told to look beyond the obvious monetary benefits to obtaining research grants for their institutions. Obtaining NCI grants and contracts will increase the number of graduates with degrees in medical research, speakers said.

"Your main vision has historically been to produce good black students with degrees," Wilma Barnett Smith, professor at the University of Pittsburgh, told representatives.

"How willing are you to expand that vision?" she said.

In Brief:

Rimer Ends NCAB Service; Board Honors Ellen Sigal

(Continued from page 1)

as chairman of the National Cancer Advisory Board following the board's Sept. 24-25 meeting, to begin work as director of the new Division of Cancer Control and Population Science at NCI. Rimer will be commuting between Bethesda, MD, and Durham, NC, for the next two months while she phases out of her position as professor and director of the Duke University Cancer Prevention, Detection, and Control Research Program. The NCAB gave Rimer a plaque recognizing her "exemplary leadership of the NCAB from 1994 to 1997," and a live plant, a large Bromiliad. "People have asked me why I'm going to work for the government," Rimer said to the board. "I came to believe that I would have more impact on cancer control by giving up a seat at this table and joining colleagues around the room.". . . **ELLEN SIGAL**, an NCAB member, was honored at the board's meeting last June with a citation in recognition of her work in forming the Friends of Cancer Research, a coalition that has held events around the U.S. to increase public awareness of cancer research. "Thanks to her extraordinary leadership, there is unprecedented cooperation within the cancer community in emphasizing the critical role of research in conquering cancer," the citation said. . . . **E. DONNALL THOMAS**, of Fred Hutchinson Cancer Center in Seattle, received the Leukemia Society of America's Return of the Child Award for his research in bone marrow transplantation. Thomas won the Nobel Prize in 1990 for his discovery that bone marrow could be safely infused into a patient. . . . **HELEN COLEY NAUTS** will receive the National Institute of Social Sciences Gold Medal for Distinguished Service to Humanity. Nauts is the founder of the Cancer Research Institute, New York. The award will be presented Nov. 19. . . . **JOHNS HOPKINS ONCOLOGY CENTER** broke ground last week on a new cancer research building for basic science. The building will house programs in cancer biology, hematological malignancies, urological oncology, gastrointestinal cancer, solid tumor research, and cancer prevention and control. . . . **GEORGE CANELLOS**, William Rosenberg Professor of Medicine at Harvard Medical School and Dana-Farber Cancer Institute, received an honorary degree from the University of Athens Medical School, Greece. Canellos is a Fellow in the Royal Colleges of Physicians of Great Britain and Scotland. . . . **JAMES COX**, head of the Division of Radiation Oncology at M.D. Anderson Cancer Center, received a Gold Medal from the American College of Radiology. Cox will also receive the Medaille Antoine Beclere for his contributions to the field of radiation oncology and his efforts to create links between American and French specialists in the field. . . . **MICHAEL KASTAN** was named hematology-oncology chair at St. Jude Children's Research Hospital. Kastan is an associate professor of oncology and pediatrics at Johns Hopkins University School of Medicine and director of the experimental therapeutics division at Johns Hopkins Cancer Center. **Ching-Hon Pui** will serve as acting chair of hematology-oncology at St. Jude until Kastan moves to the hospital next spring. . . . **MICHAEL UNGER** was named director of the pulmonary cancer detection and prevention program at Fox Chase Cancer Center. Unger is the former director of laser research and development for medical diseases, and director of pulmonary endoscopy at Pennsylvania Hospital. . . . **MITCHELL MORRIS** was named vice president for information services and healthcare systems at M.D. Anderson Cancer Center. Morris is an associate professor of gynecologic oncology and director of graduate education in the Department of Gynecologic Oncology at the University of Texas. . . . **HELENA CHANG** was named director of the Revlon/UCLA Breast Center at UCLA's Jonsson Cancer Center. Chang is a former associate professor of surgery and pathobiology at Brown University. . . . **NUCLEAR REGULATORY COMMISSION** report summarizing a multi-agency investigation into the P-32 contamination of NIH researcher Wenli Ma (**The Cancer Letter**, Sept. 26) was posted on **The Cancer Letter** web site. The text of the report is available for online viewing or FTP download at www.cancerletter.com/html/documents.html.

NCI Contract Awards

Title: Development and Production of Parenteral Dosage Forms. Contractor: Ben Venue Laboratories, Bedford, OH, $9,211,720.

Title: Pathology and Veterinary Support Services. Contractor: Pathology Associates International, Frederick, MD, $930,881.

Title: Customized Disease Management. Contractor: Advanced Medical Systems Consultants, Fairfax, VA, $37,856.