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AACR President Coffey Urges Clinton To Support Doubling Of NIH, NCI Budgets

In a letter to President Clinton, Donald Coffey, president of the American Association for Cancer Research, called for the doubling of the budgets of the National Institutes of Health and the National Cancer Institute.

"We urge you to announce in your upcoming State of the Union Address that funding for medical and cancer research will be doubled during your Presidency, and to delineate for the American people where progress must be made to eradicate cancer," Coffey, a basic scientist at Johns Hopkins University, wrote in a letter dated Dec. 12.

So far, the administration has been aware of the intensified lobbying on behalf of cancer research, an effort that in the most recent

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In Brief

Pennsylvania Cancer Center Gets $100 Million; Watson, Weinberg Win National Science Medals

UNIVERSITY OF PENNSYLVANIA received $100 million from the Abramson Family Foundation to create the Leonard and Madlyn Abramson Family Cancer Research Institute at the University of Pennsylvania Cancer Center. The pledge is the largest single donation to cancer research given to an NCI-designated cancer center. The new institute will enhance current research and treatment programs, recruit scientists and physicians worldwide, and support leading-edge cancer research. **John Glick**, director of the Penn Cancer Center, will serve as director of the Abramson Family Institute. . . . **PRESIDENT CLINTON** awarded the 1997 National Medal of Science to **James Watson**, president of Cold Spring Harbor Laboratory, and **Robert Weinberg**, member of the Whitehead Institute for Biomedical Research and professor of biology at Massachusetts Institute of Technology. Watson received the award in recognition of scientific and intellectual leadership in molecular biology, and his advocacy for the Human Genome Project. Weinberg was recognized for discoveries that clarified the genetic basis of human cancer. . . . **PRESIDENT'S CANCER PANEL** plans to hold a series of meetings next year on quality issues in cancer. The panel plans to collect data to back up the testimony it hears at the meetings, Panel Chairman **Harold Freeman** said to the NCAB at its meeting Dec. 2. "The panel has been set up over the years to collect testimony and raise questions, but it is

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Coffey Invites Clinton To Lead Effort To Increase Funding

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appropriations cycle included the entertainment industry and some very wealthy political donors.

Yet, as the cancer issue has been gaining visibility, Congressional Republicans have been better poised to take the lead in the issue. Also, at appropriations, cancer has been in direct competition with education, the issue the President emphasized in last year's State of the Union Address.

Coffey's letter constitutes an invitation to the President to emerge as a leader (as opposed to a detached observer or even an opponent) of The March: Coming Together to Conquer Cancer, an event scheduled to take place in Washington on Sept. 26, 1998 (**The Cancer Letter**, Oct. 31).

"Mr. President, the American people are very frustrated that more cannot be done to find the answer to the cancer epidemic, and they will be organizing a national March next year to express their frustration and anger," Coffey wrote. "The willingness of millions of cancer survivors to work alongside the scientific community to create a 'top-of-mind' awareness about the value of cancer research is providing incredible momentum...

"We fervently hope that, as our national leader and as a person who knows all to well the pain of losing a loved one to cancer, you will make the eradication of cancer for all Americans a key goal of your Administration, and that you will support this action by calling for a doubling of the budgets of NIH and NCI by the end of your Presidency," Coffey wrote.

The research directions listed in Coffey's letter are consistent with the NCI Bypass Budget, a document in which the NCI Director outlines the scientific opportunities. (**The Cancer Letter**, Dec. 5). The funding targets are consistent with a nonbinding Senate resolution to double the NIH budget over the next five years. (**The Cancer Letter**, May 23). The resolution, which passed unanimously, was introduced by Sen. Connie Mack (R-FL).

Setting targets for appropriations for cancer research is something of a work in progress for AACR and other organizations involved in the upcoming March. That effort is being spearheaded by Friends of Cancer Research, an independent group that includes scientific societies, advocacy groups, business executives and the entertainment industry.

Friends plans to formulate its research agenda concurrently with other activities of the March, said Ellen Sigal, chairman of Friends. The agenda will address cancer research exclusively, and will not address the needs and opportunities in other areas or biomedical research, Sigal said at a Dec. 9 briefing held by the organizers of the March.

Armed with an authoritative research agenda, the organizers of the March would be able to tell the government what needs to be done and how the task should be accomplished, Sigal said at the meeting.

While this work proceeds, AACR Executive Director Margaret Foti invited all cancer constituencies to sign on to Coffey's letter to the White House.

"Since its annual meeting last spring, AACR has been focused on the doubling of the NCI budget," Foti said to **The Cancer Letter**. "It is clear from the points in the letter to President Clinton that even calling for a doubling is an understatement of what is needed to accelerate our progress against cancer.

"Therefore, we hope that all cancer groups will join us both by signing on to our letter calling for the President to announce a major new initiative in his State of the Union address, and by making these priorities in cancer research the focus of activities in the year to come," Foti said.

The text of Coffey's letter follows:

Dear Mr. President:

The human suffering and death inflicted on our

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citizens by cancer is a national tragedy. Our national investment in research has failed to provide the resources required to eradicate cancer. Although the "War on Cancer" was declared with great resolve twenty-six years ago, it has never been a full-scale war—it has only been a skirmish. Now, you have an unprecedented opportunity in your upcoming budget request to launch a real war to eradicate cancer for all Americans. This could be your greatest legacy to the American people and indeed to the world. With our knowledge of cancer increasing rapidly, there have never been more compelling reasons to take thins courageous action, and we desperately need your Presidential leadership in this national effort. We implore you to support a full-scale war against cancer by calling for a doubling of the budgets of the NIH and NCI by the end of your Presidency.

A groundswell of support to mount a real war against cancer is spreading across our country. Now is the time to rally the American people behind you to wage and win this war. We urge you to announce in your upcoming State of the Union Address that funding for medical and cancer research will be doubled during your Presidency and to delineate for the American people the areas where progress must be made to eradicate cancer.

Cancer recognizes no racial, economic, or social boundaries. One out of every three Americans will get cancer in their lifetime, adversely affecting almost every American family. In 1998 alone, more than 1.4 million Americans will be diagnosed with cancer, and over 560,000 of our citizens will die from cancer. Cancer also wreaks economic devastation on its victims and on this Nation, with associated health care costs of well over $100 billion per year. The human suffering, death, and economic burden from cancer will become even more staggering as cancer rates rise due to the increase in America's elderly population, especially as members of the "Baby Boomer" generation enter their 50s.

Although cancer is an extraordinarily complex disease, our past investments in cancer research are paying off with cures for some cancers and considerable progress in understanding others. Recently, there has been an explosion of new information on the genetics and associated biology of cancer cells that can be translated into new strategies for detection, treatment, and prevention. The opportunities to accelerate progress against cancer have never been greater, but the resources required to conquer this tragic disease are grossly inadequate relative to the increasing severity of the problem.

Research is our most powerful weapon against cancer. Sadly, adequate funds have not been available to support promising research projects, even those which will be of particular benefit to cancer patients. Outstanding senior scientists and young cancer researchers alike are abandoning the fight because of the unavailability of research funding. New therapeutic and preventive agents that are successful in laboratory experiments are not yet available to cancer patients because of a lack of resources and limited adult participation in clinical trials. For the sake of all of the Americans who will be affected by cancer, we need to dramatically renew our national resolve to conquer this tragic disease.

The total budget of the NIH is $13.648 billion, and the NCI budget is $2.547 billion for FY 1998. Listed below are some important initiatives which would more than justify doubling the budgets of the NIH and NCI, as a first step in eradicating cancer.

•Ensure that a greater percentage of valuable research projects against cancer is funded. The funding rate of scientifically approved grants needs to increase from its abysmal level of 23% to at least the level achieved in the 1970s. A funding rate of 50% would require an expenditure increase of approximately $1.0 billion.

•Encourage young laboratory scientists and clinicians to enter and remain in all areas of basic and clinical cancer research. Our meager investments in training must increase 4- to 5-fold to recruit and retain the human resources required for this assault on cancer. Such an effort would require an investment of $0.5 billion.

•Implement a fully funded cancer prevention program. The current level of funding for prevention research is too low to achieve significant results. To begin to reduce the number of cancer cases would require an initial investment of at least $0.5 billion

Last Cancer Letter For 1997

This issue of **The Cancer Letter**, Vol. 23, No. 48, is the final issue for 1997.

The Cancer Letter editors and staff wish all subscribers a healthy holiday season and New Year. Stay with us in 1998 for **The Cancer Letter's** 24th year of publication.

The next issue, Vol. 24, No. 1, will be dated Jan. 9, 1998.

more per year than we are currently spending.

•Increase funding of early cancer detection programs. Such programs are required if we are to combat cancer at a point when intervention is still possible.

•Fund programs in "translational" research. This ensures that findings from basic science will be translated into new cancer therapies which are more effective and less toxic than current therapies. Although translational research offers tremendous opportunities to develop such therapies, it is difficult, expensive, and generally not a focus for funding through most current grant mechanisms.

•Increase the participation of adults in clinical trials. Fully enrolled clinical trials are essential to translate research advances into state-of-the-art patient care. Only 2% of adult cancer patients participate in NIH-approved clinical trials, delaying the development of promising therapies and relegating the vast majority of cancer patients to more painful and less effective treatments. Increasing the participation of adults in clinical trials could cost more than the current NCI budget of $2.5 billion.

•Provide resources to address the cancer problem among the medically underserved, minorities, and the poor. Although all Americans feel the devastating effects of cancer at some time in their lives, the incidence of certain cancers is higher in medically underserved, minority, and poor populations. Steps must be taken to improve access to quality cancer care, detection, and prevention for these groups. A full-scale war to eradicate cancer must include resources to ensure that the war can be won for all Americans.

•Reinvigorate existing cancer centers and establish new centers throughout the country. Such facilities would provide access to state-of-the-art cancer diagnosis, treatment, and prevention programs. Studies on specific cancers must receive additional emphasis through special funding mechanisms (SPORE grants).

•Reverse the decades-long decline in the US research infrastructure. New laboratories, academic medical centers, contemporary hospitals, and tools such as notional information systems and databases are required to accelerate progress against cancer.

The above list of important initiatives clearly demonstrates what is needed to make further progress against cancer. Implementing these programs would entail far more than simply doubling NCI's budget. We urge you to announce your commitment to these important cancer research initiatives in your State of the Union Address.

Mr. President, the American people are very frustrated that more cannot be done to find the answer to the cancer epidemic, and they will be organizing a national March next year to express their frustration and anger. The willingness of millions of cancer survivors to work alongside the scientific community to create a "top-of-mind" awareness about the value of cancer research is providing incredible momentum. Fighting a full-scale war to conquer cancer requires that the Nation unite. Winning will require that we dedicate, for the first time, the financial and human resources needed to conquer the disease that robs us of more citizens each year than all of the wars that we have ever fought. We fervently hope that, as our national leader and as a person who knows all to well the pain of losing a loved one to cancer, you will make the eradication of cancer for all Americans a key goal of your Administration, and that you will support this action by calling for a doubling of the budgets of NIH and NCI by the end of your Presidency. The cancer research community, cancer survivors and their families, and the American public stand beside you in this fight—together we will be victorious.

NCI Intramural Program:

Clinical Trials Infrastructure Needs Attention, Report Finds

The infrastructure that supports the NCI intramural clinical trials program fails to match the quality of the best clinical programs in the U.S., according to a report to the Institute by a group of external advisors.

Unless the organizational problems are corrected, they will continue to produce low patient accrual to trials, ineffective use of personnel, uneven quality of data, and below-standard protocol compliance, the report to the NCI Division of Clinical Sciences said.

The Clinical Trials Advisory Committee to the NCI Intramural Clinical Research Program submitted its final report to the division on Dec. 10. A copy of the report was provided to **The Cancer Letter**.

The NCI intramural clinical trials program enrolled about 1,600 patients on 200 protocols last year, the report said. Patients referred from around the country are offered treatment at government

expense at the NIH Clinical Center.

According to the report, the program needs to:

•Centralize protocol development, patient enrollment, and eligibility evaluation, and establish a central database.

•Consolidate clinical trial data management and analysis, and enhance statistical analysis.

•Enhance the resources and mandate of the Protocol Resource Office.

•Form diseased-based research groups that cut across the current branch structure of the division.

•Promote greater interaction between intramural and extramural researchers to move phase I and II results more quickly to phase III trials.

"These comments are not meant to reflect on the caliber of science within the division nor on the real efforts of NCI investigators to perform excellent clinical trials," the report said. "But it is apparent from our review and from the recent results of [independent] audits that standards for clinical trials data are not consistently being met.

"We believe that with the adoption of the recommendations found in this report, the division would be on par with the best clinical cancer research centers," the report said.

Elizabeth Eisenhauer, director of the Investigational New Drugs Program at the NCI of Canada Clinical Trials Group, served as chairman of the Clinical Trials Advisory Committee.

Other committee members were Donald Berry, professor, Institute of Statistics, Duke University; Alexandra Levine, chief, division of hematology, University of Southern California; Eleanor McFadden, director, Eastern Cooperative Oncology Group Coordinating Center; Mace Rothenberg, Department of Medical Oncology, University of Texas Health Science Center, San Antonio; and Samuel Wells, Bixby Professor of Surgery and chairman, Department of Surgery, Washington University School of Medicine.

The National Cancer Advisory Board discussed a draft version of the report at its meeting Dec. 2.

"If I got a report of my department that reads like this review, my toes would be shaking," said NCAB member Phillip Sharp, head of the Department of Biology, Center for Cancer Research, Massachusetts Institute of Technology. "[The report] needs to be read as a wake-up call of forceful magnitude."

Edison Liu, director of the Division of Clinical Sciences, said the division has organized three working groups to implement the report's recommendations.

"I can't understate what the impact is of this report," Liu said to the NCAB, in response to Sharp's comment. "Within a very short period of time we must turn around or there will be consequences.

"We are using this as a blueprint for change," Liu said. The advisory committee has been asked to return in a year to review the division's progress, he said.

According to the report, the division has made improvements recently. "The clinical trials infrastructure of the NCI intramural program has made progress in recent months, but still must implement several organizational changes to fully match the quality of the best clinical research centers in the country," the report said. "Areas where further change is recommended include centralization of some important functions which would help establish consistent and high standards of protocol development, setting of research and resource priorities, patient enrollment, eligibility evaluation, protocol compliance, data management and analysis."

The report complimented Liu on the progress made so far. "The committee would like to commend Dr. Liu for the initiatives he and his colleagues have already undertaken to enhance the clinical trials activities of DCS," the report said. "As he and his colleagues clearly recognize, a successful effort in clinical trials advancing knowledge in cancer research and treatment should be one of the chief goals of the NCI. We were impressed by the enthusiasm with which changes within the division were being greeted."

The excerpted text of the report's 20 recommendations follows:

Protocol Development and Initial Review

1. The time from generation of a study idea to trial activation should be prospectively monitored to assess the impact of the Protocol Review and Monitoring Committee. Ideally, four to six months should be sufficient to accomplish all levels of review.

2. The PRMC should develop a standardized one to two-page concept submission sheet including sections identifying the primary objective, laboratory correlates, design (with statistician signature), and feasibility based on previous accrual to similar studies. The PRMC should phase into reviewing all trial proposals in the concept stage.

3. To enhance the opportunity for statistical review

at the study concept level, an additional senior statistician should be added to the PRMC.

4. A process for review of phase I/II trials from the perspective of safety, efficacy, and accrual should be established. This might be accomplished by an expansion of the Data Safety and Monitoring Board mandate (which in general the committee favored), an expansion of the IRB mandate, or an independent process. The DSMB or a similar body should have the authority to recommend closure [of slow-accruing trials or trials showing excessive toxicity]. Membership of the DSMB might have to be altered.

Patient Registration

In the past year, the division established the Central Protocol Resource Office to conduct patient registration and randomization through a contract with the Orkand Corp., the report said. However, the committee found that in some DCS branches, 30 percent to 57 percent of the patients on studies had not been centrally registered.

5. All branches in DCS should prospectively register all trial participants at the time of consent with the Protocol Resource Office. The system for registration of emergency cases should be expanded to allow prospective fax or voice mail notification of the office.

6. The planned implementation of actual eligibility checks, rather than "yes/no" answers, should be put into place for all new protocols as they are activated and phased in over the next three to six months for all old, but still open, protocols.

Data Management

According to the report, NCI has 24 data managers and two information technology staff on site. Some of the staff are paid through the contract to Orkand, while others are paid through pharmaceutical funds awarded to Orkand for NCI projects. Each branch is assigned clinical research nurses, who are employees of the Clinical Center.

The report found that NCI tends to under-utilize the data managers. "In some branches, research nurses (or even PIs) may be doing data entry, depending on allocation of personnel within the branch," the report said.

"The findings of recent Theradex [a contract firm] audits indicated some branches were below standards for protocol compliance and response assessment," the report said. "The plan to implement prospective checking of eligibility criteria should reduce the ineligibility rates seen in some of these audits, and the use of computer accessed consent forms should remedy the problem of out-of-date forms, but issues of protocol compliance and response interpretation need to be addressed."

7. A review of the job descriptions of both nurses and data managers should be undertaken so that their roles can be defined to make better use of their training and expertise. For example, the role of data managers might be expanded to include trial management and simple report generation. They could also assist with mechanisms to ensure protocol compliance. Both data managers and nurses are part of the trial teams and all trial team members should be part of trial meetings with the PIs.

8. Training and procedures for all data managers (not just Orkand contract employees) should be centralized and standardized. This process should be supervised by an employee of DCS. This will be particularly important as DCS moves to a centralized computer database.

9. It is recommended that division-wide quality assurance standards be developed for protocol compliance and response evaluation. Eg: for responding patients, routine review of all films by a radiologist in the Clinical Center who is unaware of the protocol therapy should be required. This could be implemented for individual cases as responses are identified by research nurses and the data managers could be responsible for seeing this was done. In the database, reviewed and non-reviewed responses should be clearly distinguished.

10. A standardized approach to collecting laboratory and other data measured off-site [between patient visits to NCI] should be developed to ensure a complete and accurate database.

11. Resolution of the conflict between source of salary, job description, and accountability for research nurses should be achieved if at all possible.

12. Review of deployment of research personnel to the branches and within branches should be carried out annually by the DCS and every effort made to balance need (as assessed by accrual, workload, and scientific productivity) to appropriate levels of nurse and data manager support. There should be flexibility with the division to move personnel between branches.

Database and Computing

"Almost every branch has a different system for the entry, storage, and retrieval of clinical trials data," the report said. "There are at least four database systems in place. This makes it difficult to train data management staff and to transfer staff between branches."

The division has decided to move to a centralized database, the report said. The division's computing staff decided to use the Fourth Dimension software platform, currently in use in the Medicine and Pediatrics branches.

13. The committee wholeheartedly endorses the decision to move to a centralized database for all clinical trials carried out within the DCS. It should be noted that research projects addressing prevention or epidemiology questions have special needs that may not be addressed by a clinical trial database.

14. Fourth Dimension's capabilities to address the needs of the division should be continuously re-evaluated in the first months and years of use.

15. Standardized coding schemes should be created as part of the centralized database development.

Statistics and Analysis

The report found that DCS has only two PhD statisticians and one masters level statistician to support its clinical statistical needs. While the division branch chiefs spoke highly about the level of statistical support they receive, the report said, the statisticians "may be somewhat isolated" physically from the rest of the division and, because of the workload, isolated from the statistical community.

According to the report, the committee could not find out when and by whom trials were analyzed. "It sometimes seemed only the PI had access to the trial results prior to the generation of the manuscript," the report said. The committee listed the guidelines in recommendation 18 to standardize this process.

16. Each protocol concept should be developed in collaboration with a statistician as outlined in recommendation 2. Further, all papers and abstracts should be read and approved by a statistician. Many will have no statistical content and will require only a cursory statistical review, but a statistician should be the judge of whether a paper or abstract has or should have statistical content.

17. Methods of increasing senior level statistical support should be examined. These might include one or more of the following: i) hiring a senior statistician with particular interest in methodology development, ii) adding fellowships, iii) adding MSc level biostatistical personnel for generation of basic study reports, and/or iv) consolidation of the biostatistical group in the division with others of similar interest on campus. This would help provide a "critical mass" of biostatisticians necessary for academic pursuits such as new trial designs.

18. The following guidelines are suggested for discussion in DCS:

I) Phase III trials: analysis of efficacy endpoints by arm should be carried out only as part of the annual review by the DSMB. The trial PI should not be privy to the data. Final analysis for publication should take place only at the times pre-specified in the protocol, unless the DSMB feels early closure is warranted for safety or extreme outcome reasons.

II) Phase II trials: phase II trials which have response or other surrogate measures of activity as their major endpoint usually have been designed to accrue patients in more than one stage. At the completion of the first stage, the statistician and PI should discuss the results. Trials which go to the second stage because of early evidence of activity should only do so if the internal response assessment procedures have been completed and protocol defined criteria for activity have been met or exceeded. The statistician should refer the study to the DSMB (or similar body) regarding the decision to continue accrual if excessive toxicity has been seen.

III) Phase I trials: toxicity data entered into the database should be available on request by the PI.

Accrual to Intramural Protocols

Low patient accrual threatens the viability of some of the division's programs, the report said.

"With approximately 1,600 patients entered into DCS trials last year and 200 active protocols, this means on average eight patients were accrued per protocol," the report said.

Last fall, DCS established a toll-free phone number for patients and health professionals to find out about protocols. The report said it was too early to assess whether the service had increased overall accrual.

"The committee noted, however, that the solution must go beyond ways of accessing greater patient numbers since the resources and infrastructure required to handle optimal accrual to 200 studies are not in place," the report said. "There must also be some attention paid to reducing the number of active protocols: identifying those of highest priority and closing those of lower priority in competition for the same population and/or those which are accruing so slowly that by the time they succeed in addressing question it will have become obsolete."

19. The committee recommends this problem be tackled from three perspectives:

a) Continue to work on creative means to increase patient referral.

b) Develop mechanisms to facilitate internal referral of patients within DCS. Investigators may not be aware that patients completing (or not eligible for) one trial may be eligible for another within DCS. It is also recommended that investigators in the Clinical Center increase collaboration wherever possible with colleagues in other branches in the DCS, at the Navy Medical Center and at Walter Reed Hospital.

c) Determine the realistic number of studies that can be open at any one time within DCS. DCS as a whole

needs to take an honest look at the number of patients available for study, avoid opening new trials which will be in competition for the same patient groups, develop mechanisms for closure of failing trials, or if failing trials are of high priority, develop means to shift referral of new patients in that direction.

Extramural Interaction

20. The committee recommends that Dr. Liu investigate mechanisms to promote interaction between intramural and extramural investigators. These might include: assignment of key intramural investigators to cooperative group experimental therapeutics committees, annual symposia involving intramural and extramural scientists, the development of "project teams" for investigational therapeutic areas of high priority within the division incorporating intramural and extramural membership.

In Brief:

Finlay Directs Hassenfeld Center; Cohen Leads ASPHO

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clear we could be more effective if we collected real data," Freeman said. . . . **JONATHON FINLAY** was named director of the Stephen D. Hassenfeld Children's Center for Cancer and Blood Diseases and director of the division of pediatric oncology at NYU Medical Center. Finlay, former vice chairman of the department of pediatrics at Memorial Sloan-Kettering Cancer Center, was also named professor of pediatrics and interim associate director of clinical oncology at NYU's Kaplan Comprehensive Cancer Center. . . . **ALAN COHEN** was named president of the American Society of Pediatric Hematology/ Oncology. Cohen is chief of the division of hematology at the University of Pennsylvania School of Medicine. . . . **LAWRENCE WEISS** was named chairman of the division of pathology at City of Hope Cancer Center. Prior to his appointment as acting chairman of the division in January, Weiss was chairman of surgical pathology at City of Hope National Medical Center. . . . **AMERICAN-ITALIAN CANCER FOUNDATION** presented its 1997 Awards for Scientific Excellence in Medicine to **Carlo Croce**, professor and chairman of the department of microbiology and immunology and director of the Kimmel Cancer Institute and Kimmel Cancer Center at Jefferson Medical College, and **Bert Vogelstein**, professor in the departments of molecular biology and genetics at Johns Hopkins University School of Medicine. The awards were presented in recognition of contributions to cancer genetics research. . . . **ROBBIE NORVILLE** was elected president of the Association of Pediatric Oncology Nurses for 1997-98. Norville is a pediatric oncology nurse at St. Jude Children's Hospital. . . . **ENTERTAINMENT UPDATE: The Directors**, a band that has sprung from the basements of Bethesda, rocked the Great Hall of the National Academy of Sciences at its first and possibly last public performance Dec. 16. Guitarists and vocalists **Francis Collins, Richard Klausner**, and **Stephen Katz**, along with NIH scientists **John O'Shea** and **Tracey Rouault**, and postdoc **Chuck Allerson**, performed at the DC Science Writers Association holiday party. Collins, Klausner, and Katz have day jobs as the directors of the National Institute of Human Genome Research, NCI, and the National Institute of Arthritis and Musculoskeletal and Skin Diseases. Songs included: "Will Our Funding Go On Growing," "I'm A-Walking Through the Genes," and "Our Genome 'Tis of Thee," as well as unaltered campus favorites from the '60s. The light show was provided by an overhead projector displaying the lyrics. The Directors were the warm-up act for the **Wild Types**, a bluesy Baltimore band comprised of six Johns Hopkins University cancer researchers: **Bert Vogelstein**, **Kenneth Kinzler**, **Bob Casero**, **Chris Torrance**, **Pat Morin**, and **Ellie Carson**. The Wild Types will be performing at the American Association for Cancer Research annual meeting in New Orleans next spring, sources said to **The Cancer Letter**. An article about the Wild Types is posted on the Hopkins web site at http://hopkins.med.jhu.edu/ReadingRoom/jhmu/campusnews/cn_4.htm.

NCI RFA Available

RFA: CA-98-004

Title: **Full Coding Sequences of Genes To Facilitate Cancer Research**

Letter of Intent Deadline: Feb. 5

Application Deadline: March 12

The Technology Development Branch of the NCI Cancer Diagnosis Program, Division of Cancer Treatment and Diagnosis, invites applications proposing strategies for the cost-effective generation of full coding sequences of genes that may be useful for cancer research. A total of $2.5 million per year will be available to support approximately five awards.

Contact Jennifer Couch, DCTD, NCI, 6130 Executive Blvd, Rm 700-MSC 7388, Bethesda, MD 20892, tel: 301/402-4185, fax: 301/402-7819, email: jc332a@nih.gov.