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Blueprint For Prostate Cancer In Blacks Seeks Consistent Message On Screening

The American Cancer Society Jan. 13 announced a "National Blueprint for Action" for combating prostate cancer in African Americans.

The document, which is based on findings of a conference in Houston Nov. 20-22, calls for additional research in prostate cancer as well as increased advocacy in Washington.

Under the best-case scenario, the document will unite patient groups, professional societies, government agencies, and African American voluntary organizations in a common agenda that includes advocacy, as well as basic and clinical research.

The Houston conference, which was funded by ACS, NCI, and the

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In Brief

Roth Honored; Jessup Leads UPCI Program In GI Cancer; Berger Wins ACS Grant

JACK ROTH will receive the Hamilton-Fairley Memorial Lectureship Award from the British Association for Cancer Research and the British Association for Surgical Oncology. Roth is chairman of the Department of Thoracic and Cardiovascular Surgery and professor of surgery and tumor biology at M.D. Anderson Cancer Center. He will receive the award in recognition of research in gene replacement therapies for lung cancer. . . . **JOHN JESSUP** will lead the University of Pittsburgh Cancer Institute Program in Gastrointestinal Cancer. Jessup, a professor in the department of surgery at the University of Pittsburgh School of Medicine, plans to investigate controlling colorectal polyps by vaccinating high risk patients, and to partner with Carnegie Mellon University to study GI tract cancers. . . . **SHELLEY BERGER** received a three-year, $315,000 grant from the American Cancer Society to support research into the role of GCN5 histone acetyltransferase in humans. Berger is a laboratory head in the Molecular Genetics Program at the Wistar Institute. . . . ***M.D.* ANDERSON CANCER CENTER** researchers received 10 grants totaling $1.45 million from the Advanced Technology Program and the Advanced Research Program administered by the Texas Higher Education Coordinating Board. Researchers receiving the Advanced Technology Program grants include **Paul Chiao, Lawrence Lachman, Michele Mitchell, Waldemar Priebe, Tahir Rizvi, Alan Schroit, Peter Steck,** and **Hong-Ji Xu.** Researchers receiving the Advanced Research Program grants include **John McMurray,** and **Stephanie Watowich**. . .

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Blueprint Calls For Consistent Prostate Screening Guidelines

(Continued from page 1)

Centers for Disease Control and Prevention, brought together 260 participants, scientists, physicians, cancer survivors, as well as representatives of churches, civic and fraternal organizations.

The conference was developed by the three sponsoring agencies as well as the Intercultural Cancer Council, 100 Black Men of America, the National Prostate Cancer Coalition, and the National Black Leadership Initiative on Cancer. Altogether, 129 organizations were represented.

"Throughout prostate cancer, there is an enormous number of complicated questions that need to be answered," said Jay Hedlund, president and CEO of the National Prostate Cancer Coalition. "This fundamentally underlines the need for a strong, aggressive advocacy for more money for research; research that will give us better information, better answers about screening, treatment, prevention, and cures."

The excerpted text of the document appears on page 3.

Under the worst-case scenario, these immensely complicated scientific and policy issues will be lost in a debate over guidelines for screening of African Americans, several observers and participants said.

The coalition includes groups that advocate screening African American men for prostate cancer.

"We will be working to make sure that African American men will understand the importance of screening, and getting the necessary counseling as well as exams each year," Thomas Dortch Jr., president of 100 Black Men of America, said at the ACS press conference in Washington.

NCI has no data to support guidelines on prostate cancer screening. "We are agnostic about screening for prostate cancer," said Otis Brawley, director of the NCI Office of Special Populations Research. "We do not know whether it is net beneficial or net harmful to the public, and we are committed to finding out."

The issue of prostate cancer screening is very different from the issue of breast cancer screening. Last year, NCI reconsidered its position on breast cancer screening after reviewing the outcomes of at least eight randomized studies.

"There are no randomized clinical trials that have been completed in prostate cancer screening," Brawley said to **The Cancer Letter**.

An Interim Position?

The blueprint released by ACS earlier this week calls for adoption of consistent guidelines on prostate cancer in African Americans.

"The medical and scientific community must resolve the different messages on early detection and screening for the public," the document states. "Health care providers should discuss these issues with men in appropriate age groups."

In a telephone interview, Harmon Eyre, ACS executive vice president for research and cancer control, said that while evidence-based guidelines would remain the ultimate goal, the ACS guidelines can provide an interim solution.

"What ACS is saying is that in the interim, until we have the answers, we believe that our position is a reasonable one," Eyre said to **The Cancer Letter.**

Last year, ACS, joined by other advocates of breast cancer screening as well as their Congressional supporters, created a political climate that ultimately led NCI to adopt a breast cancer screening statement similar to the ACS guideline (**The Cancer Letter**, March 28, 1997).

The ACS prostate cancer guideline, adopted last June, states that prostate specific antigen and digital rectal examination should be offered annually to men over 50, though men who have a family history of prostate cancer as well as African Americans "may

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

P.O. Box 9905, Washington, DC 20016
Tel. (202) 362-1809 Fax: (202) 362-1681
E-mail: kirsten@cancerletter.com or paul@cancerletter.com
World Wide Web URL: http://www.cancerletter.com

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begin screening" at age 45 (**The Cancer Letter**, March 21, June 20).

The ACS guideline states that patients should be told about possible "risks and benefits of the intervention."

Eyre said the ACS guideline is reasonable because it is based on a consensus of scientists, clinicians, and patients who represented a broad spectrum of views.

Last September, the board of directors of the American Urological Association adopted a policy statement that endorses the ACS guideline.

The previous AUA policy said that African Americans and other men at high risk of prostate cancer "should be given information" about DRE and PSA, as well as "the option to participate" in *screening programs* starting at age 40.

The National Medical Association is considering a statement that calls for more aggressive screening for African American men than ACS recommends.

The members of the executive committee of the NMA urology section who attended the Houston conference last November met separately to update the NMA screening guideline.

According to the document they produced, African Americans "should have DRE and PSA starting at an earlier age than Caucasians (e.g. age 40)." The statement is scheduled to be presented to the NMA board.

The text of the ACS guidelines and a compilation of the guidelines of other organizations appears on page 5.

A Delicate Balance

Eyre said ACS will not allow the debate over *screening guidelines* to overshadow the broader goal of controlling prostate cancer in African Americans.

"What we are all trying to do is to de-emphasize the controversy over screening," Eyre said.

Charles McDonald, ACS president-elect and professor of medicine at Brown University, agreed that the broader goals of the coalition outweigh the importance of the screening issue.

"I will make sure that this single issue—to me it's almost a semantic issue—would not keep us from implementing this plan," McDonald said to **The Cancer Letter**. McDonald, whose term will begin in November, said prostate cancer in African Americans as well as pediatric cancer will be his two areas of emphasis.

The public desire for clear, simple answers on prostate cancer was evident at the ACS press conference.

"I still haven't seen in all these materials what we are supposed to tell black viewers," said one television reporter. "Should they schedule screening this week? Should we not waste our opportunity and go ahead and start this?"

"No, no, the document we are introducing today is a planning document," McDonald responded. "It is the outcome of a planning meeting."

"What you can tell your viewers is that this is a dreadful disease, that it's impacting great many Americans, and that it's impacting African Americans at an even more alarming rate," added John Kelly, vice chairman of the ACS National Board of Directors and a psychologist at the Navy Family Service Center of Gulf Port, MS.

"You also need to tell them that if they want to get involved, call ACS, call 100 Black Men of America," said Dortch. "We need to develop and recruit our army. If the press can do that, that would be a tremendous help to us."

NCI and CDC, agencies that provided funding for the Houston meeting, decided not to attend the Washington press conference. NCI and ACS officials said the Institute was absent because, as a government institution, it was precluded from discussing advocacy goals contained in the blueprint.

"Research recommendations in the blueprint will be considered by NCI's Prostate Cancer Progress Review Group, which is conducting an extensive evaluation of NCI's prostate cancer research program in order to create a national agenda for research," the Institute said in a statement that was distributed at the press conference.

The text of the NCI statement appears on page 6.

Blueprint Lists "Action Steps" For Prostate Cancer Research

Following is an edited text of the "action steps" contained in the National Blueprint for Action, developed during the Leadership Conference on Prostate Cancer in the African American Community.

Research: Basic and Behavioral Science

1. Increase research regarding the disproportionate incidence of and mortality from

prostate cancer in African-American men, and further clarify effective treatment and prevention modalities for the disease.

2. Increase research to identify risk factors associated with prostate cancer in African-American men.

3. Test new technologies for the early detection, diagnosis, and treatment of prostate cancer and apply them as soon as the technologies are proven effective.

4. Work with agencies and organizations involved in funding research efforts to identify and address barriers such as education, trust, understanding, and communication, that are responsible for low minority participation in clinical research trials of early detection, and prevention initiatives.

5. Perform research on how African-American men seek medical information, medical attention, and follow-up on treatment recommendations.

6. Involve African-American scientists, institutions, and lay persons to a greater extent in prostate cancer research.

7. Increase minority professional and patient input into the development and implementation of clinical trials.

8. Develop creative new approaches to increase clinical trial participation and enhance trust on the part of African-Americans.

Health Promotion and Education Based on Science

1. Formulate and evaluate simple and concise educational messages about increased mortality from prostate cancer in the African-American community and the limitations and benefits of early detection methods.

2. Collaborate among the medical and lay leadership of the African-American community to develop creative and innovative public education programs and local and regional symposia on prostate cancer.

3. Promote effective communication between the medical and scientific community, the lay public and grass roots organizations, and survivor and spouse groups.

4. Improve professional and public awareness and understanding of the benefits of clinical trials.

5. Develop and implement strategies to reduce barriers to the delivery of early detection counseling by community physicians and other providers.

6. Increase consideration of interdisciplinary management of prostate cancer.

7. Educate health care providers and consumers on prostate cancer risk factors, including recommendations to reduce the percentage of fat in the diet of the American population to less than 30% of total calories.

8. Resolve the different messages on early detection and screening for the public.

Education and Support for Patients

1. Provide comprehensive education about prostate cancer for African-Americans in their communities, with emphasis on peer education.

2. Provide opportunities for men who have been diagnosed with prostate cancer to have ongoing personal follow-up and contact through education and support groups such as Man to Man or Us Too.

3. Explore and develop appropriate collaborations to reach target audience.

4. Reach out, educate, and invite appropriate national and local leaders and organizations to help spread messages and encourage facilitation of educational and support programs.

5. Empower patients in their relationships with their medical providers so they are comfortable asking questions and making decisions about their own health care.

Public Policy

1. Develop innovative strategies and approaches that eliminate barriers to participation by African-American men in clinical trials.

2. Advocate for significantly increased funding for basic clinical, psychosocial, and applications research programs to be supported by organizations including the Agency for Health Care Policy and Research, the American Cancer Society, the American Foundation for Urologic Disease, CaP CURE, the Centers for Disease Control and Prevention, the Department of Defense, the Department of Veterans Affairs, the Mathews Foundation, NCI, and the National Prostate Cancer Coalition.

3. Advocate for coverage by private and public insurers of the costs of prostate cancer early detection for men at highest risk for the disease, including men aged 50 and older and younger African-American men who are at high risk.

4. When possible, work in a coordinated fashion with other groups who have special health concerns such as breast cancer to effect more sweeping change in the health care system and avoid competition for

funds.

5. Ensure the availability of follow-up care and treatment for those men with positive screening findings after early detection.

6. Speak with one voice for African-American men and women when public policies are being formed and funding decisions are being made.

7. Strengthen the capacity of national grass roots organizations, particularly those representing African Americans, to engage in advocacy at every level of government, and to mobilize their constituencies in a coordinated manner on prostate cancer issues.

Prostate Cancer Screening Recommendations Are Varied

The following is a compilation of guidelines for screening for prostate cancer:

American Cancer Society last June adopted the following guideline:

"The annual screening of men for the detection of early prostate carcinoma should begin by age 50 years. However, men in high risk groups, such as men with a strong familial predisposition or African Americans may begin at a younger age (e.g. 45 years). More data on the precise age to start prostate carcinoma screening are needed for men at high risk.

"Screening for prostate carcinoma in asymptomatic men detects tumors at a more favorable stage. There has been a reduction in mortality for prostate carcinoma, but it has not been demonstrated that this is related to screening. An abnormal PSA test result has been defined as a value of above 4.0 ng/ml. Some elevations in PSA may be due to benign conditions of the prostate.

"DRE of the prostate should be performed by health care workers skilled in recognizing subtle prostate abnormalities, including those of symmetry and consistency, as well as the more classic findings of marked induration or nodules.

"DRE is less effective in detecting prostate carcinoma compared with PSA."

The earlier ACS guideline said screening "should be performed," rather than "offered." Also, the earlier guideline did not mention considering a man's age, life expectancy, and risk factors when deciding whether to screen.

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American Urological Association last September endorsed the ACS guideline for the screening of prostate cancer.

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The executive committee of the Urology Section of the **National Medical Association** last November approved a position statement that recommend that Africans Americans should be screened starting at age 40. The text of the statement follows:

"Since the mortality rate from prostate cancer between the ages of 45 and 70 is 2 to 3 times greater among African-Americans compared to Caucasians, we propose that African-Americans who have a life expectancy of at least 10 years should have DRE and PSA testing starting, at an earlier age than Caucasians (e.g., age 40). Testing should be accompanied by education about the benefits and risks of treatment."

NMA currently uses the old ACS guideline.

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American College of Physicians does not recommend that African-American men and men with a family history of prostate cancer begin screening before age 50.

—"Rather than screening all men for prostate cancer as a matter of routine, physicians should describe the potential benefits and known harms of screening, diagnosis, and treatment; listen to the patient's concerns; and then individualize the decision to screen.

—"The College strongly recommends that physicians help enroll eligible men in ongoing clinical studies."

ACP guidelines for the screening of prostate cancer were published in the March 15, 1997, issue of Annals of Internal Medicine.

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US Preventive Services Task Force does not recommend routine screening for prostate cancer with DRE, serum tumor markers, or TRUS.

"Patients who request screening should be given objective information about the potential benefits and harms of early detection and treatment. If screening is to be performed, the best-evaluated approach is to screen with the DRE and PSA and to limit screening to men with a life expectancy greater than 10 years. There is currently insufficient evidence to determine the need and optimal interval for repeat screening or whether PSA thresholds must be adjusted for density, velocity, or age."

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Centers for Disease Control and Prevention supports the US Preventive Services Task Force

recommendations.

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NCI has no guideline for prostate cancer screening.

NCI Review Group To Examine "National Blueprint For Action"

In a statement prepared for the Jan. 13 press conference, NCI said the "National Blueprint" would be considered by NCI's Prostate Cancer Progress Review Group, which is evaluating the Institute's prostate cancer research program.

The PCPRG will complete this work in the spring.

The NCI budget for prostate cancer has risen from $6.4 million in fiscal 1981 to about $84 million in the current year, the Institute said. The statement listed the following NCI research programs and clinical trials in prostate cancer:

—"NCI has begun the Cancer Genome Anatomy Project, the goals of which are to build an infrastructure of resources,information, and technologies that will create an index of all genes that are expressed in tumors. CGAP will also support development of new technologies that will allow rapid analysis of gene and protein expression as well as mutation detection of these tumor genes. The tumor type with the highest representation in the early stages of the CGAP effort is prostate cancer.

—"NCI is sponsoring 57 clinical trials in prostate cancer including 15 Phase III studies (clinical trials involving new interventions closest to approval). Ten trials in prostate cancer are underway at the NIH Clinical Center.

—"NCI is sponsoring two trials, including the Prostate Intervention Versus Observation Trial (PIVOT), in which "watchful waiting" is being compared in terms of outcome with surgical removal of the prostate and with radiation therapy. These trials are intended to determine if treatment of localized disease is effective.

—"The Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial is assessing the efficacy of prostate cancer screening. New PLCO sites are being added to enhance minority patient accrual.

—"The Prostate Cancer Prevention Trial involves 18,000 healthy men over the age of 55 to determine if the drug finasteride can prevent prostate cancer.

—"NCI clinical studies in prostate cancer have significant African-American participation. One NCI study shows that 14.7 percent of men enrolled onto NCI sponsored prostate cancer treatment trials are black while 10.3 percent of Americans diagnosed with prostate cancer are black.

—"NCI and the Department of Defense have collaborated in a study of treatment data and shown that equal treatment yields equal outcome within stage. This finding suggests that all NCI efforts to improve prevention, diagnosis and treatment of this disease benefit all patients equally.

"However, NCI staff analyzing SEER Program data have shown that there are tremendously differing patterns of care among black and white men with prostate cancer.

—"NCI has established the Urologic Oncology Branch within the Division of Clinical Sciences. One of the major areas of emphasis of this branch is prostate cancer.

—"NCI has established a fellowship program in urologic oncology that will also have as a major focus NCI's commitment to reduce the burden of prostate cancer in all segments of our society. NCI recently conducted a large interview-based study of prostate cancer in African Americans and whites. Analysis of the results have not thus far revealed any specific factor that could explain the racial differences in risk. However, further studies are under way, including an extensive evaluation of the role of different components of the diet.

—"NCI funded or co-funded 11 prostate cancer epidemiologic studies beginning in September 1995 with study durations of three to five years. Eight of the 11 studies include an assessment of risk factors among African-American men. Leads from this effort may help to clarify genetic and gene-environment interactions responsible for black-white differences in risk."

Cancer Policy:

Board Advocates $2 Increase In Price Of Cigarette Packs

The price of a pack of cigarettes must increase by $2 per pack to reduce the number of new smokers and encourage current smokers to quit, the National Cancer Policy Board said in a report released last week.

The price increase should be incorporated into the proposed settlement between state attorneys general and tobacco companies, because Congress

has never passed such a large increase in the federal excise tax on tobacco, the board said.

The report, "Taking Action to Reduce Tobacco Use," is the cancer policy board's first major policy statement since its formation last year by the Institute of Medicine and the National Research Council.

Revenues generated by a price increase should be used to support tobacco control programs, improve treatment for tobacco dependence, and for peer-reviewed research directed by NIH, the report said.

"The nation needs a strategy to reduce the death and disability caused by use of tobacco products," the report said.

"There are only three basic ways to reduce the death toll: to prevent the initiation of tobacco use, to get current users to quit, and to reduce exposure to tobacco toxins."

Proposed Settlement Not Large Enough

Under the proposed tobacco settlement between 40 state attorneys general and five tobacco companies, the companies would make payments of up to $368.5 billion over 25 years.

The Federal Trade Commission estimates that tobacco companies would increase prices by about 62 cents a pack as a result of the payments, but an industry analysis estimated a price increase of 82 cents, the board said.

According to the board, neither of the projected price increases would be enough to sufficiently reduce demand.

"The board cannot resolve the uncertainty over how much tobacco prices will increase, the effect of price increases on consumption, or the additive effect of price on other tobacco control measures," the report said. "The board believes, however, that the desired health goals should dictate tax rates or settlement payments, rather than the reverse.

"Fixing the tax rate or payment amount in advance, with no provisions for adjustments later in light of data about levels of consumption and the initiation of tobacco use among youths, invites failure to achieve public health goals," the board wrote. "If tobacco consumption and initiation do not recede, taxes on tobacco products should be increased to further reduce demand."

The increases should be indexed to inflation, and the settlement should include a system of public health monitoring, the report said. If goals for reducing tobacco use by youth are not met, financial penalties should be placed on manufacturers based on the brands used disproportionately by youth, the report said.

Tobacco use by youth has gone up in states with active tobacco control programs, though at rates lower than the national average, the board said. Those states, however, have not had large tax increases.

Strengthen FDA, Expand ASSIST

In addition to a price increase, federal regulation of tobacco must be strengthened by giving FDA the authority to regulate tobacco products, the board said.

In 1996, FDA enacted regulations on tobacco advertising and marketing to minors, but needs the broad authority to regulate the design and content of tobacco products, the board said. "Congressional action would avoid wasteful and unnecessary litigation and would establish a strong political and legal foundation for future regulatory initiatives," the report said. "Congress must also appropriate funding to FDA commensurate with its authority."

In its report, the board also advocated that the government:

—Expand the NCI ASSIST program, but transferring the program to the Centers for Disease Control, because CDC has a stronger public-health mandate, as opposed to NCI's research focus. States included in the ASSIST program have shown a 7 to 10 percent greater reduction in tobacco consumption than other states. "It is time to apply the lessons of ASSIST nationwide," the report said.

—Expand research by Public Health Service agencies on tobacco-related diseases.

—Fund of new research programs at FDA and NIH to improve future regulation, including the measurement of nicotine and tar, addiction, and tobacco additives.

—Adapt a community health improvement model described in a recent IOM report for use in measuring progress on tobacco reduction. More than one measure should be used to determine rates of teen smoking.

—Widely disseminate effective smoking cessation interventions. Insurers and government health programs should pay for these programs.

—Promote and fund evaluation and monitoring of international tobacco control.

—Refrain from implementing trade policies that undermine foreign tobacco control efforts.

The text of the policy board's report is available at the following web address: http://www2.nas.edu/cancerbd/.

NCI RFP Available

RFP N01-CP-81017-21

Subject: **Cohort And Nested Case-Control Study Of Aids-Related Non-Hodgkin's Lymphoma, Kaposi's Sarcoma And Other Malignancies**

Deadline: Approximately Feb. 25

The Viral Epidemiology Branch, Division of Cancer Epidemiology and Genetics, NCI, is seeking offerors for a new contract for an epidemiologic study of advanced HIV infection and associated malignancies. This contract will provide support for a new cohort and nested case-control study of AIDS-related non-Hodgkin's lymphoma (NHL), Kaposi's sarcoma (KS) and other malignancies. A pilot phase of this study has been recently implemented under a previous contract. This new contract will complement a number of other DCEG contracts in addition to a separate population-based study of non-AIDS NHL, but it will not overlap with any of them. The Contractor shall be responsible for the acquisition, maintenance and use of epidemiologic data bases; provision of support for collecting and handling biologic specimens; collecting epidemiologic, clinical and laboratory data; editing and collating data; creating necessary computer data records and conducting statistical analyses of these data; and responding quickly to requests involving certain priorities. This contract will NOT require the Contractor to perform laboratory assays nor be responsible for the costs of assays that are performed by various laboratories. The contractor will arrange for the collection and shipment of required specimens as well as interview, clinical and laboratory data for this cohort. The contractor shall obtain interview, medical record abstracts and blood specimens on a minimum of 5000 such subjects, which may include individuals currently under study at the NCI. It is anticipated that the proposed contract will be a cost-reimbursement, completion type contract for a five-year period of performance. All responsible sources capable of providing this support and meeting these criteria are encouraged to submit an offer and will be considered by the NCI.

Contracting officer: Barbara A. Shadrick, email: bs92y@nih.gov; fax: 301-480-0241. No collect calls will be accepted. The RFP may be accessed through the Research Contracts Branch Home Page by using the following Internet address: http://rcb.nci.nih.gov/rfp.htm. Street address: NCI, Research Contracts Branch, Cancer Etiology Contracts Section, Executive Plaza South, Rm 620, 6120 Executive Blvd., MSC 7224, Bethesda, MD 20892-7224.

Program Announcement

PAR-98-016

Title: **NCI/MARC Summer Training Supplement**

Application Deadline: March 1

The Comprehensive Minority Biomedical Section of the NCI Cancer Training Branch invites interested grantee institutions that have Minority Access to Research Careers grants to apply for CMBS support of MARC scholars in their junior/senior year who are interested in obtaining laboratory research experience at NCI.

NCI, through a co-funding arrangement with the MARC program of the National Institute of General Medical Sciences, provides support for research training to minority individuals and institutions and conference grant support to further address and enhance the mission of the National Cancer Program.

All domestic institutions with active MARC research training grants are eligible to apply.

The supplement will provide a subsistence of $300 per week ($3,000 for a maximum ten-week period), and round-trip transportation (from the MARC student's academic institution to NIH and return to the student's academic institution). Fiscal and Administrative costs may be awarded to the institution for up to a maximum of eight percent of the direct costs.

In lieu of submitting a form PHS 398, the applicant must submit a letter, countersigned by an authorized institutional official, requesting support for short term training at NCI. This letter shall constitute an application and must include or be accompanied by the title of the announcement, a statement from the student that describes his/her research interests and career objectives and a brief resume, two letters of recommendation, a current official college/university transcript, a copy of the face page of the active MARC grant including the grant number and period of award, and a description of the person to whom the student shall report his/her NCI laboratory experience.

Contact Bobby Rosenfeld, Office of Centers, Training, and Research Resources, NCI, 6130 Executive Boulevard, Suite 620, Bethesda, MD 20892-7405, tel: 301/496-7344, fax: 301/402-4551, email: rr63v@nih.gov.

In Brief:

Walter Enoch Heston, Retired NCI Lab Chief, Geneticist, 88

(Continued from page 1)

WALTER ENOCH HESTON, 88, a geneticist who retired from NCI in 1975 as chief of the laboratory of biology, died Jan. 10 at a hospital in Bradenton, FL. Heston worked at NIH from 1940 until his retirement. He was an editor of the Journal of the National Cancer Institute from 1953 to 1955. Heston was a former director of the American Association for Cancer Research, president of the American Genetic Association, and treasurer of the American Society of Human Genetics. He had lived in Bradenton since 1995.