

A Texas Radiation Center's Survival Move Draws M.D. Anderson Into PPM Competition

Forty years ago, when radiation treatment for cancer was new and equipment scarce, philanthropists in Fort Worth put together the funds to establish a not-for-profit radiation center.

The center, named after its benefactors William and Elizabeth Moncrief, was both an object of local pride and a valued medical resource that drew patients from 55 Texas counties.

The old radiation center is no longer a symbol of pride and cooperation. Instead, the center has become a case study in the volatility

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In Brief:

Ireland Cancer Center Named Comprehensive; UPCI Appoints Four Program Directors

IRELAND CANCER CENTER, at the University Hospitals of Cleveland and Case Western Reserve University, received NCI designation as a Comprehensive Cancer Center. **James Wilson**, professor of hematology and oncology at the Case Western Reserve School of Medicine, is director of the center. . . . **UNIVERSITY OF PITTSBURGH CANCER INSTITUTE** named **Andrew Baum** deputy director for cancer control and prevention. Baum is head of the Behavioral Medicine and Oncology Program, and professor of psychiatry and psychology at the University of Pittsburgh School of Medicine. **Roberta Ness** was named program leader for cancer epidemiology at UPCI. Ness is an assistant professor of epidemiology at the University's Graduate School of Public Health, and leader of the Epidemiology of Women's Health Program at the University. **Joel Weissfeld** was named program leader for cancer control and prevention. Weissfeld is an assistant professor of epidemiology at the University. **Brian Carr** was named director of the UPCI Liver Cancer Center. Carr is a professor in the departments of surgery and medicine at the School of Medicine. . . . **JOHN MENDELSON**, president of M.D. Anderson Cancer Center was elected to the board of directors of ImClone Systems Inc. (Nasdaq: IMCL) of New York. . . . **WILLIAM KLEIN** was named chairman of the department of biochemistry and molecular biology at M.D. Anderson Cancer Center. Klein has been interim chairman of the department since 1996. . . . **LOUIS WEINER** received a \$50,000 award from Janssen

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Gift Of Radiation Center Pulls M.D. Anderson Into PPM Wars

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of the Texas oncology market, and—some observers say—a harbinger of what's to come nationwide.

Driven by the need to generate revenues and the will to survive, the center's competitors embarked on an unusual building boom that saturated downtown Fort Worth and surrounding Tarrant County with redundant radiation facilities.

Then, in a shrewd maneuver, the Moncrief center's supporters gave the place to M.D. Anderson Cancer Center, ultimately pulling the academic institution into competition between physician practice groups vying for control over the Fort Worth and northern Texas market.

"If you think this story is an anomaly, think again," said Bettina Kurowski, a Los Angeles-based oncology consultant who was involved in attempts to solve the radiation center's problems. "Similar battles are going to erupt in community after community as PPMs and managed care companies continue to consolidate resources and establish links with academic cancer centers."

The Moncrief center may well survive these events. Its supporters are making plans to revitalize the facility through an affiliation with the M.D. Anderson Cancer Center in Houston and a

partnership with OnCare Inc., a San Francisco area PPM.

"In a short time, we are going to be at the center of an oncology network that will be selling cancer carve-out products to large payers in the Dallas-Fort Worth area," said Richard Larison, president of the M. D. Anderson Cancer Network-Tarrant County, an entity that controls the Moncrief. "We will have access to patients. We will have the best informatics in the industry. We will have cutting-edge protocols. And we will make these assets available to community physicians as well as to academic and not-for-profit providers in northern Texas."

Supporters of the Moncrief can afford to think big, partly because the object of their rescue has the backing of a \$40 million endowment. In addition to having access to capital, the institution's supporters pack political clout that extends all the way to the University of Texas Board of Regents, which runs all state academic institutions.

The center was given to M.D. Anderson in 1995. The endowment, now controlled by an independent board, will be given to the cancer center in 2005. This unusual transfer was engineered by William "Tex" Moncrief Jr., an independent oil and gas producer whose family has been the source of much of the center's cash and influence.

"I am hoping that M. D. Anderson would dispense its protocols around the state," Moncrief said to **The Cancer Letter**. "With the Moncrief radiation center and its nest egg, we can really do something in the Dallas-Fort Worth area."

Earlier this month, M.D. Anderson Cancer Network-Tarrant County and OnCare, a company that employs about half of the county's oncologists, announced an agreement to develop a network around the old radiation center and other underused hospital radiation equipment in the Fort Worth area.

The deal's single most important feature was an agreement by OnCare to use existing equipment instead of constructing its own facilities in the county, several participants said. The network would bill for the technical component of radiation treatment, a service that accounts for 66 percent of a typical radiation bill, while OnCare would bill for professional services.

The agreement not to build competing facilities will ensure the network's short-term survival. Long-term viability will be determined by the success of a plan to move accelerators to other areas of northern Texas, to build a referral network, and to use

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Founded Dec. 21, 1973 by Jerry D. Boyd

OnCare's informatics system to develop a capability to bid to assume the payers' cancer risk.

The Dallas-Fort Worth market for ambulatory oncology services is not exactly up for grabs.

Texas Oncology Professional Association, a unit of Dallas-based Physician Reliance Network Inc., controls about half of the ambulatory oncology market in Fort Worth and about 75 percent of the Dallas market.

While OnCare and the M.D. Anderson-Tarrant County are yet to sell their first oncology carve-out, PRN is at risk for 200,000 insured lives in the Dallas-Fort Worth Metroplex and is negotiating for 200,000 more, said Merrick Reese, vice chairman of PRN and president of TOPA.

PRN manages the practices of 340 physicians nationwide. About 100 of those physicians practice in northern Texas, the company said.

"The Dallas-Fort Worth market is no place for the meek," concedes Bill Jordan, a Fort Worth oncologist and chairman of the OnCare Texas unit. "If you are going to be a bear around here, you have to be a grizzly."

The View from Houston

The growls from Tarrant County are causing some discomfort down south, at the M.D. Anderson Houston headquarters.

The situation has challenged M.D. Anderson to sort out its policies and responsibilities. To begin with, the cancer center has been trying to stay out of battles between PPMs in the state. "My advice to all hospitals is to stay out of the physician wars, because you can't win," said Martin Raber, M.D. Anderson vice president for managed care. "Their battles are not our battles."

However, as the owner of the Moncrief radiation center and a participant in the Tarrant County network, M.D. Anderson had the responsibility to safeguard those assets. "Since M.D. Anderson is the owner of the Moncrief center, we had to do what's best for that center," Raber said. "Since M.D. Anderson is a board member of the Tarrant County network, we had to do what was best for the network."

The Tarrant County oncology market leaves no margin for error. Since TOPA is treating about half of its patients at its own facilities, OnCare doctors became the network's only hope.

"Our choice was either to do the deal with OnCare or to rethink whether the network is viable,"

said Raber who also serves on the 10-member board of M.D. Anderson Cancer Network-Tarrant County. "It was a good business deal in a very competitive market."

M.D. Anderson controls three seats on the board of directors of the Tarrant County outreach unit, as well as three of the six seats on the board that manages the endowment. "If I wanted to do something in Tarrant County tomorrow, I couldn't do it unilaterally," Raber said. "The Tarrant County network is a community-based alliance of hospitals that compete against each other in every other area, and used to compete in cancer."

The center has no plans for operating a statewide patient referral network, which means that the Tarrant County outpost is a means for carrying out M.D. Anderson's mandates in cancer control, cancer education, promotion of clinical trials, and assuring access to care.

While officials in Houston point to the cancer center's limited role in the venture, officials at OnCare and the Tarrant County network proudly unfurl the M.D. Anderson banner.

"As community-based oncologists and a community-based institution, we have the maneuverability and the knowledge of local terrain that large state institutions like M.D. Anderson cannot have," said OnCare's Jordan. "That's the strength of our partnership."

"The M.D. Anderson network has the commitment to improve cancer care in the state, and therefore is in this battle to provide the next-stage health care model," said Gabe Shapiro, an OnCare physician who practices at the Presbyterian Hospital, Dallas. "It's a great fit. You have M.D. Anderson's academic standing, combined with OnCare's information technology and high quality physicians."

"We view M.D. Anderson as a national treasure," said Michael Goldberg, CEO of OnCare. "It is an honor to play a role in advancing its mission. Our physicians are committed to building a stronger bridge between community practice and academic centers."

An affiliation with the M.D. Anderson network in Tarrant County provides several strategic opportunities for OnCare.

The association could enable the company to assemble a sufficient number of physicians, not-for-profit providers, and academic institutions under the name of the M.D. Anderson Cancer Network-Tarrant County, and to finance business development with

local capital.

TOPA president Reese said he is disappointed by the prospect that foundation money would be used to finance a business venture instead of meeting community needs that could include cancer prevention, screening, education, risk assessment, patient support, and clinical research.

"There are other sources of funds for building medical facilities," Reese said. "There are bank loans. There is Wall Street. We have the capitalist system to support that. But then there are all those needs that the capitalist system will not support, and those needs can only be met by the government or community philanthropic resources."

The competitor's use of the M.D. Anderson name is not a concern for TOPA, Reese said. "Patients seek physicians close to home, based on referrals and the physicians' reputation in the community," he said. "Patients who will seek care at M.D. Anderson will usually seek care in Houston, where M.D. Anderson's well-deserved reputation was built.

"You can't transfer the institutional mantle from Houston to a Metroplex suburb."

The Making of a Glut

Now, let us turn the clock back to 1958, when the radiation center first opened its doors in downtown Fort Worth.

The center's first X-ray generator was a 2-million-volt Van de Graaff. Only two of these machines were to be found in Texas, the Fort Worth Star-Telegram reported at the time. The second generator was at the Baylor University College of Medicine in Houston.

In 1959, Tex Moncrief's 7-year-old daughter, Monty Francene Moncrief, received treatment for childhood leukemia.

Treatment rooms at the center were drab. So, the girl's grandmother, Elizabeth Moncrief, had a generator painted a soft shade of pink and decorated several rooms with panels depicting tranquil beaches and scenes of plantation life.

Following Monty Francene's death in 1960, the Moncrief family continued to send Thanksgiving turkeys, Christmas trees, flower arrangements, and money to the center. In 1979, the center was named after Elizabeth Moncrief and her husband William Moncrief. To mark that occasion, the family pledged another \$1 million.

Later, Tex Moncrief endowed several

professorial chairs throughout the state, including three at the M.D. Anderson. From 1987 to 1993, he served on the Board of Regents, and, subsequently, on the board of M.D. Anderson Outreach Corp., a spinoff of the cancer center.

For years, the viability of the Moncrief radiation center was assured because it provided a service no other institution could provide. Later, the center's viability was reinforced by the certificate-of-need requirements that were used by the federal government to prevent construction of duplicative facilities. After the requirements were dropped, the radiation center was left unprotected.

The first threat to the Moncrief came from five blocks away. In 1993, Harris Methodist Hospital-Fort Worth began to develop plans to provide a complete array of cancer services, including prevention, outreach linkage to M.D. Anderson, clinical trials—and radiation therapy.

Harris officials were dissatisfied with having to ferry patients by ambulance to receive treatment at the Moncrief, located on the campus of All Saints Episcopal Hospital-Fort Worth.

Each round trip cost approximately \$1,300. Cook's Children's Hospital, an institution connected to Harris by a walkway, was similarly dissatisfied. Cook's incurred even higher transportation charges, since some of its patients had to be accompanied by anesthesia specialists during short ambulance rides.

Even then, the Moncrief center had more capacity than it needed. The center's six accelerators were capable of treating 320 patients per day, but were treating only 240.

In 1995, before the Harris center opened its doors, hospital officials were stunned to learn that they had been upstaged. The Moncrief center, along with its affiliate at Huguley Memorial Hospital and its foundation were given to M.D. Anderson.

This was a maneuver worthy of a Texas oncopolitics insider. While Harris officials were offering to conduct *collaborative programs* with M.D. Anderson, Tex Moncrief was offering money, assets, and accelerators. Soon thereafter, key donors who funded construction by Harris directed the hospital to form a joint operating agreement with the Moncrief-M.D. Anderson alliance.

Still, Harris was able to complete construction of two accelerators. Now, eight machines were operating in Fort Worth's "hospital district," roughly a three-square-mile area of the downtown.

M.D. Anderson regarded the Moncrief center

as an important asset.

"At the time, we thought we were going to use it as part of a referral network that would provide care around the state," Raber said.

The Houston center was preparing for the worst-case scenario in managed care: plan managers and PPMs were in a position to cut off the patients' access to the cancer centers.

This threat led M.D. Anderson to explore (and ultimately discard) several strategies for ensuring that referrals would continue, sources said. At first, M.D. Anderson entered into negotiations with OnCare, but no deal was produced.

Subsequent plans to set up a collaboration with MedPartners Inc., a Birmingham, AL, PPM, was abandoned after running into opposition from the state's oncologists, the board of regents, and Tex Moncrief.

Meanwhile, the worst-case scenario did not materialize for M.D. Anderson.

PPMs and managed care plans continued to refer patients, the Texas state legislature passed laws that allowed Texans to refer themselves to the cancer center, eased M.D. Anderson's burden of caring for the indigent, and allowed the institution to streamline its purchasing and contracting.

While these events were playing out on the greater Texas scene, the fortunes of the Moncrief radiation center continued to decline.

Another challenge came from TOPA. The company bought a practice in the hospital district and wanted to negotiate a deal for the Moncrief center to provide the technical component for treating patients under capitated contracts.

Larison said the center tried to accommodate. However, the numbers were not working out, Reese said. "We were given a pricing mechanism that was far in excess of our cost of producing those same services in our facilities for our patients," Reese said.

After negotiations failed, PRN built two accelerators in Fort Worth, increasing the hospital district total to 10 machines.

The loss of a large portion of PRN referrals harmed the Moncrief and Harris centers now operated by the M.D. Anderson Cancer Network-Tarrant County.

Altogether, 21 medical oncologists and nine radiation oncologists practice in the county. For the most part, the Moncrief and Harris accelerators were being used by the nine medical oncologists and five radiation oncologists affiliated with OnCare.

TOPA physicians (11 medical oncologists and four radiation oncologists) generally treat about half of their patients at the company's office.

Patients are treated at the M.D. Anderson Tarrant County network when insurers designate these facilities as a preferred provider, or when a patient or a referring physician requests that follow-up treatment be provided there. TOPA business account for about 20 percent of the network's volume, Larison said.

These days, two of Moncrief center's six accelerators are not being used. *The remaining* accelerators at the center are treating 180 patients a day, working at about 60 percent of the center's capacity.

Proposal For Building A Network

While some observers regard the past three years as a learning curve, to Tex Moncrief it's time wasted. "I guess the gift hasn't worked out quite as I hoped it would, or as quick as I hoped it would," Moncrief said to **The Cancer Letter**.

M.D. Anderson Cancer Network-Tarrant County and OnCare are preparing a proposal for using some of the Moncrief center's endowment to build a cancer care network in northern Texas.

"I want to do something with that money that's helpful to this part of Texas, and helpful to M.D. Anderson," Moncrief said. "In other words, I don't want seven years to go by, and have that money just lost to the people in this locale."

The proposal the foundation will submit will include the following features, sources said:

The network will operate in 11 counties, including Tarrant, Dallas, Denton, Collin, Rockwall, Kaufman, Ellis, Johnson, Hood, Parker and Wise.

Larison said the objective will be to work with OnCare physicians, unaffiliated oncologists, academic institutions and not-for-profit providers. OnCare would either purchase practices or work with independent physicians.

To make such collaborations possible, the company will make its proprietary informatics system available to participating physicians and institutions. Whenever necessary, OnCare would set up new oncology practices staffed by physicians who are being recruited through a national search, Jordan said.

Also, plans are being made to move some of Fort Worth's redundant radiation equipment to areas where it can be used.

In Washington:

No Immunity For Tobacco, Health Groups Urge Congress

Public distrust of the tobacco industry and increased support for tough tobacco legislation makes it necessary for Congress to enact legislation that does not protect tobacco companies from future law suits, said a coalition of public health organizations in a recent letter to Congress.

“With evidence of tobacco industry misdeeds and mendacity on hand and growing, with sound public health proposals on the table, with broad popular support for action, Congress has the *opportunity to make fundamental changes* in tobacco policy based solely and exclusively on what is good for the public’s health without making unnecessary concessions to the tobacco industry,” members of the Advisory Committee on Tobacco Policy and Public Health said in a letter addressed to House Speaker Newt Gingrich and Senate Majority Leader Trent Lott.

“This year may be the most important moment in the history of the tobacco wars, a moment when America chooses between a path toward social repair or one toward irrevocable public loss,” the letter said.

The committee, formed last year by former Surgeon General C. Everett Koop and former FDA Commissioner David Kessler, includes the American Cancer Society, the American Lung Association, the American Medical Association, and other national public health groups.

Under terms of the national settlement proposed last year, the tobacco industry would be protected from group lawsuits and from punitive damages. Civil suits brought by individuals and criminal suits would not be banned.

“We oppose granting the tobacco industry immunity against liability for past, present, or future misdeeds,” the letter said. “Congress should not alter the legal system in any way that would weaken its ability to protect the public health, or permit the tobacco industry or others to engage in any behavior that would otherwise be condemned.”

The letter outlines eight goals that the committee considers essential to any future tobacco legislation including:

—Granting full authority over tobacco products to FDA and increasing the agency budget to accommodate new regulatory and enforcement activities.

—Cutting youth smoking through education programs, increasing the price of cigarettes by \$1.50 per pack, banning advertising geared toward children, limiting the accessibility of tobacco products, and creating substantial penalties for underage smoking.

—Providing funds to integrate scientifically-established smoking cessation programs into health care financing systems.

—Expanding environmental tobacco smoke laws, and enforcing smoke-free public and work environments.

—Protecting the ability of those injured by tobacco products to seek compensation from the industry through law suits.

—Shielding state and local governments from federal preemption clauses, *making federal regulations* a base from which local governments can build on.

—Compensating tobacco farmers for lost income as demand for tobacco products declines.

—Implementing international trade policies that would apply US public health standards to tobacco products sold abroad.

. . .

President Clinton has proposed spending \$400 million in an effort to eliminate the health disparities between racial and ethnic groups in America.

“No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all,” Clinton said in his Feb. 21 radio address. “And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities.”

Clinton cited higher rates of prostate and breast cancers in African Americans, cervical cancer in Vietnamese women, and liver cancer in Chinese Americans.

The President said his goal is to close the gaps between white Americans and ethnic minorities in the areas of cancer screening and management, infant mortality, cardiovascular disease, diabetes, HIV/AIDS rates, and immunization levels by the year 2010.

The Administration’s budget proposal, submitted to Congress last month, proposes spending \$150 million to fund grants for up to 30 communities to create new strategies to improve minority health, and \$250 million to strengthen existing public health

programs and to fund community health centers in underserved communities.

In addition to the proposed funding, several new programs will be established to address the problem:

—An outreach campaign, led by newly appointed Surgeon General David Satcher, will focus on improving education and outreach through community-based programs geared toward minorities.

—A national conference sponsored by the Department of Health and Human Services and Grantmakers in Health, a coalition of over 136 philanthropic organizations, will coordinate research efforts, demonstrations, and evaluations on minority health.

—A task force, led by HHS Secretary Donna Shalala, will target existing programs within CDC and NIH to develop new ways to reduce health disparities between ethnic groups.

The goals of the President's initiative will be included in the Healthy People 2010 program, the agency said.

Funding Opportunities:

NCI To Meet With Applicants For Pediatric Brain Tumor RFA

NCI plans to hold a meeting for investigators interested in submitting applications in response to RFA CA-98-007 for cooperative agreements from institutions to participate in a Pediatric Brain Tumor Clinical Trials Consortium.

The meeting is scheduled for March 23, from 2-5 p.m., at the Holiday Inn O'Hare, in Chicago, IL.

Representatives from the Clinical Trials Evaluation Program, Radiation Research Program, Diagnostic Imaging Program, Grants Management Branch, and Special Review, Referral and Resources Branch will be available to provide information and to answer questions. Transcripts will be available upon request for investigators who are unable to attend, NCI said.

Investigators who plan to attend should contact the NCI staff member listed below by March 9.

Contact: Diane Bronzert Division of Cancer Treatment and Diagnosis, NCI, 6130 Executive Blvd Rm 736, MSC 7432 Bethesda, MD 20892 Rockville, MD 20852 (for express/courier service); tel: 301-496-8866, fax: 301-480-4663, email: bronzertd@ctep.nci.nih.gov.

RFA CA-98-007

Title: Pediatric Brain Tumor Clinical Trials Consortium

Letter of Intent Receipt Date: May 1

Application Receipt Date: July 10

The Cancer Therapy Evaluation Program of the NCI Division of Cancer Treatment and Diagnosis invites applications for cooperative agreements (U01) from institutions to participate in establishing a multidisciplinary network of highly specialized investigators to efficiently evaluate technically challenging and innovative treatment approaches for children with brain tumors. This *Pediatric Brain Tumor Clinical Trials Consortium (PBTCTC)* will conceive, develop, and conduct collaborative Pilot and Phase I and II clinical evaluations of promising new therapeutic agents or approaches for the treatment of primary central nervous system malignancies in pediatric patients. The Consortium will consist of up to 8 Participant Member Institutions selected by peer review for their documented ability to develop and conduct clinical trials of innovative treatment approaches and for their multidisciplinary expertise in supporting innovative brain tumor clinical research. The consortium is to have a single Operations, Statistics, and Data Management Center, also selected by peer review. The PBTCTC will be constituted from these separate funded awardees. Participant Member Institutions will be responsible jointly for proposing and conducting clinical evaluations of new treatment approaches, while the Operations, Statistics, and Data Management Center will be responsible for providing operational and data management/analysis support to implement Consortium protocols in a timely manner.

Eligible institutions may apply for either of the following types of awards: (1) *Participant Member Institutions*; and/or (2) *Operations, Statistics, and Data Management Center*. Participant Member Institution and Operations, Statistics, and Data Management Center applications must be submitted separately. Participant Member Institutions must document their multidisciplinary expertise in conducting innovative brain tumor clinical research and the ability to develop and conduct clinical trials of innovative treatment approaches (including the application of sophisticated imaging technologies for response and toxicity analysis). Operations, Statistics, and Data Management Center applicants must document their ability to coordinate multi-institutional clinical trials of children with cancer.

The total project period for each application may not exceed five years. The earliest anticipated award date is April 1, 1999. Approximately \$2 million in total costs per year for five years will be committed to fund applications. Approximately \$1 million total costs will be allocated for support of 8 anticipated Participant Member Institutions. One award for the Operations, Statistics, and Data Management Center will be made for

approximately \$1 million. In that award, it is expected that \$150,000 will be restricted for a Discretionary Fund for laboratory studies including pharmacokinetic evaluations and the shipping of patient specimens. It is also expected that approximately \$400,000 will be restricted for partial support of research procedures required to meet study objectives (e.g., specialized imaging studies), with these funds provided to the Operations, Statistics, and Data Management Center for distribution to Participant Member Institutions based on patient accrual.

The novel treatment approaches studied by the Consortium will be selected by the Steering Committee based on research opportunities identified by Consortium investigators. These opportunities may have been *developed within institutions* participating in the PBTCTC, within the NCI, by other academic investigators, or by the pharmaceutical/ biotechnology sector. Laboratory studies to monitor patients (e.g., pharmacokinetics, pharmacodynamics) or to measure a particular biological response that may provide information relevant to the success or failure of the therapy administered are encouraged. It is anticipated that these studies will be included in the protocols to be created by the PBTCTC. Tissue specimens or biological fluids should be collected by the Participant Member Institutions for use in patient monitoring studies or donation to the PBTCTC Tumor and Tissue Repository for future correlative laboratory studies.

The Consortium will be expected to accrue 80-100 patients per year to 3-4 clinical trials evaluating innovative and technically challenging therapeutic strategies. Thus, each applicant to be a Participant Member Institution must demonstrate the ability to recruit a minimum of 10-12 patients per year with childhood brain tumors to the innovative treatment studies that will be sponsored by the Consortium. In addition, applicants should describe areas of clinical and laboratory expertise resident at their institution that could serve as a basis for the development of clinical protocols by the Consortium.

In the period immediately following the award of funds, NCI will sponsor a meeting at which the Principal Investigators of each awarded U01 (Participant Member Institutions and Operations, Statistics, and Data Management Center) and NCI staff will meet to discuss the operational features of the PBTCTC, including development of by-laws, organizational structure, and standard operating procedures (to be based on the proposed procedures and by-laws drafted by the Operations, Statistics, and Data Management Center). The ideas for clinical trials provided in the cooperative agreement applications as well as ideas generated after the formation of the Consortium will be presented, discussed and prioritized. Protocols will then be created, reviewed by the Steering Committee and submitted to the NCI for review and approval to ensure they are within

the scope of peer review and for safety considerations, as required by Federal regulations.

Inquiries: Diane Bronzert, NCI DCTD, 6130 Executive Blvd Rm 734-MS-C 7432, Bethesda MD 20892-7432, Rockville, MD 20852 (for express/courier service), tel: 301-496-8866, fax: 301-480-4663, email: bronzertd@ctep.nci.nih.gov.

Program Announcement

PA-98-022

Title: **Exploratory Studies in Cancer Diagnostics**

The Diagnostics Research Branch of the Cancer Diagnosis Program in the NCI Division of Cancer Treatment and Diagnosis invites research grant applications from interested investigators to conduct innovative studies in cancer diagnostics. The objective of this PA is to encourage applications from individuals testing novel ideas that are *scientifically sound and may advance progress in cancer diagnosis*.

This grant program provides limited funds (maximum of \$75,000 direct costs per year not including indirect costs of any collaborating institutions) for short-term (up to two years) research projects.

The goal is to promote the discovery of new molecular or cellular abnormalities in tumors that will be useful for cancer diagnosis. Investigators are encouraged to consider the broadest range of biological alterations in tumor cells and tissues, not simply conventional genetic or immunologic markers, and to explore the application of emerging new technologies. The emphasis in these applications should be on discovery, rather than incremental improvements in existing strategies.

Contact Tracy Lugo, DCTD, NCI, 6130 Executive Boulevard, Room 700, MSC 7388, Bethesda, MD 20892, tel: 301/496-1591, fax: 301/402-7819, email: tl82s@nih.gov.

In Brief:

Klein Heads MDA Biochemistry

(Continued from page 1)

Pharmaceutica Research Foundation in recognition of contributions to the field of receptor-targeted therapy. Weiner, chairman of medical oncology at Fox Chase Cancer Center, was granted the award to support his research on immunotherapy for cancer. . . **WILLIAM MIELER** is the first recipient of the Jack A. and Elaine D. Klieger Chair in Ophthalmology at the Medical College of Wisconsin Eye Institute. Mieler, professor of ophthalmology at the college, is a specialist in eye cancers and vitreoretinal surgery. The chair is one of two endowed chairs at the Medical College of Wisconsin established by a \$2 million gift from Elaine Klieger.