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PO Box 9905 Washington DC 20016 Telephone 202-362-1809

# Cancer Incidence, Mortality Rates Trend Downward, NCI, ACS Say In "Report Card"

U.S. cancer incidence rates decreased on average 0.7 percent per year during 1990 to 1995, in contrast to a 1.2 percent per year increasing trend during 1973 to 1990, according to a study to be published in the March 15 issue of the journal Cancer.

*Cancer mortality rates* decreased on average 0.5 percent per year during 1990 to 1995, following increases of 0.4 percent per year, on average, for the earlier time period, the study says.

The study of cancer incidence and mortality data from the NCI

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*In Brief:*

## UICC Honors Center Director's Efforts To Improve Cancer Control In India

**PRAFULLA BHAGUBHAI DESAI** will receive the 1998 Mucio Athayde Cancer Prize presented by the Union Internationale Contre le Cancer. Desai is director, chief surgeon, educator, and researcher at the Tata Memorial Centre, Hospital and Cancer Research Institute in Mumbai, India. He will receive the award in recognition of his contributions to cancer control in India, including the development of a department of preventive oncology and cancer education, a department of professional education, a rehabilitation clinic for children in remission, and a hospital-based cancer registry at the Tata Memorial Centre. The UICC award includes a prize of $150,000. . . . **FDA** has scheduled a National Consumer *Forum, to be held March 20* at the Washington Plaza Hotel, in Washington, DC. The forum is designed to provide an opportunity for patients and consumers to meet FDA officials and express their views about regulatory and consumer issues. Contact Michael Anderson, FDA Office of Consumer Affairs, tel: 301/827-4417, fax: 301/443-9767, email: mandersl@oc.fda.gov. . . . **JULES HARRIS** was named to the newly established Judd and Marjorie Weinberg Presidential Professorship at Rush University. Harris is the Samuel Taylor Professor of Medicine and professor in the department of immunology/microbiology at Rush-Presbyterian-St. Luke's Medical Center, and a principal investigator on the NCI Prostate Cancer Prevention Trial. . . . **HANS-GEORG KLINGEMANN** was named the Coleman Foundation Inc., Professor of Medical Oncology and director of the Thomas Hazen Thorne Bone

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## Cancer Incidence, Mortality In Downward Trend, Study Says

(Continued from page 1)

Surveillance, Epidemiology and End Results program was a collaboration by researchers from NCI, the American Cancer Society, and the Centers for Disease Control and Prevention. The organizations said the study represented the first of what is planned as an annual "report card" on progress in cancer prevention and control.

The organizations planned to announce the results at a press conference in Washington on March 12. [Coverage of the event will be contained in next week's issue of **The Cancer Letter**.]

According to the study, the recent downward trend in incidence for all cancer sites combined was not statistically significant (P>0.05); however, the change in direction between the two time periods was significant.

Incidence rates peaked in 1992, and then began decreasing significantly by an average of 2.7 percent per year during 1992 to 1995, the study said.

For cancer mortality, the difference in trends between the two time periods and the change in direction for mortality were statistically significant (P<0.05), the study said.

In 1996, NCI, ACS, and CDC reported the first sustained decline in cancer mortality since the federal government began collecting data in the 1930s (**The Cancer Letter**, Nov. 22, 1996). That analysis did not address incidence rates.

The new report also includes cancer incidence and mortality rates analyzed by four populations: whites, blacks, Asians and Pacific Islanders, and Hispanics.

### Caveats: Age-Adjustment, Geographic Areas

The study was based on age-adjusted cancer incidence and mortality rates. Age-adjustment is a method widely used by researchers to compare data from different time periods, but the method has limitations. The method "may mask important variations in the deaths or incidence rates among specific age groups," the study said. "For cancer in particular, declining mortality at younger ages is offset by increases at older ages, resulting in a small net mortality decline for all ages and all sites combined, a pattern reflected in specific sites as well."

In addition, the trends in incidence and mortality may depend on what year is chosen as the population standard for age-adjustment. The study used the U.S. population in 1970 as the standard.

"Recommendations currently are being formulated for national and state agencies to adopt the year 2000 as a uniform new standard, which will better reflect the current (and older) age structure of the population," the study said.

Using the year 2000 would result in slightly lower reductions in cancer incidence and mortality, the study said.

Another limitation of the study is the use of SEER data, which are derived from selected geographic areas of the U.S., representing only 9.5 percent of the population, the study said. CDC has funded a project since 1994, called the National Program of Cancer Registries, to improve the completeness and timeliness of cancer incidence data, the study said.

"In the future, data regarding the occurrence of cancer will become available for most states and will improve our ability to monitor cancer incidence trends and guide cancer control efforts throughout the U.S.," the study said.

### Findings By Age, Site, Race, Ethnicity

All age groups showed declines or "nonsignificant increases" in cancer incidence during 1990 to 1995, the study said. The largest annual decreases in cancer incidence occurred in persons

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

**Editorial: 202-362-1809 Fax: 202-362-1681**
**PO Box 9905, Washington DC 20016**
E-mail: kirsten@cancerletter.com or paul@cancerletter.com

**Customer Service: 800-513-7042**
**PO Box 40724, Nashville TN 37204-0724**

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**Founded Dec. 21, 1973 by Jerry D. Boyd**

who were 35 to 44 years old and in those over age 75 at diagnosis, the study said.

In some highlights from the study:

—The four leading cancer incidence sites for all U.S. populations during 1990-1995 were lung and bronchus, prostate, breast, and colon/rectum. These cancers account for 54 percent of newly diagnosed cancers, and represent the top four causes of cancer death for all racial and ethnic groups.

—Lung cancer incidence declined in all groups with the exception of white females and Asian and Pacific Islander females.

—Some cancers appear in the 10 leading incidence sites for only a specific population. Melanoma and leukemia are in the top 10 only for whites; pancreatic and oral cancers are among the top 10 sites only in blacks; and liver cancer is among the top 10 sites only in Asians and Pacific Islanders. Uterine and stomach cancers are among the top 10 sites for all groups except whites.

—Black males did not experience a decline in overall cancer incidence, most likely due to the 3.9 percent per year average annual increase in prostate cancer incidence.

—Incidence rates for female breast cancer did not decrease in 1990-1995, but the rates were no longer increasing significantly.

—Incidence rates for non-Hodgkin's lymphoma and melanomas continue to increase, although the increase for NHL appears to be slowing.

—Incidence of uterine cancer decreased during 1973-1990, but increased from 1990-1995.

—Lung cancer incidence is decreasing in black females, providing an indication that mortality may decrease soon.

—Lung cancer mortality increased for both white and black females during 1990-1995.

—For the top four causes of cancer mortality, blacks had higher death rates than whites, with the exception of female lung cancer.

—The decline per year in cancer death rates for all sites combined was greater in males than in females. The average annual decrease in males was statistically significant.

—In Hispanics, prostate cancer mortality increased at 1.5 percent per year during 1990-1995.

—Mortality rates for all cancers combined in Asian and Pacific Islanders remained unchanged.

The report, "Cancer Incidence and Mortality, 1973-1995: A Report Card for the U.S.," is published in Cancer, March 15, Vol. 82 No. 6.

*Preclinical Models:*

## NCI Advisors OK Funding Plan For Mouse Models Consortium

Advisors to NCI last week approved the Institute's plan to provide $22.5 million in extramural grant funding over the next five years to support the development and validation of mouse models for human cancer.

The NCI Board of Scientific Advisors approved a proposal to award up to six cooperative agreement (U01) grants to form a consortium to develop mouse models. Grants would be funded for up to $500,000 in direct costs per year.

NCI has never provided systematic support for the development of animal models, their characterization, or the development of new technology to advance the field of animal models, Cheryl Marks, the Institute's program director for the proposed consortium, said to the BSA at its meeting March 3.

The lack of funds "forces many of our investigators to cobble together sources of support for this purpose," Marks said. "Many of us who administer grants notice investigators sort of sneaking around with their R01 funds to do so, with the result that although we do get models developed, the progress is very slow and somewhat disconnected."

Many of the models are not completely validated or characterized with relevance to particular malignancies, Marks said. "With impediments to funding and review, the projects that receive funding are usually designed to ask very specific questions about the function of a particular gene or its mechanistic role in carcinogenesis and tumor progression," she said.

The development of preclinical models for human cancer has been included as the second of five "extraordinary opportunities" for new investment in cancer research outlined in NCI Bypass Budget proposals for the past two years.

Valid animal models would improve the testing of new cancer therapeutics and prevention strategies, aid in the identification of new genes and the understanding of tumor development, the Bypass documents said. Last year's Bypass Budget called for funding of $32.5 million in FY1999 to support the development and characterization of 1,000 new mouse models, funding for repositories and informatics, and training programs in pathology.

The current Bypass Budget, for FY1999, called for $11.8 million to develop technology and mouse models, validate and disseminate models, establish a mouse models database, conduct pilot projects to improve models, and support training in the use of mouse models. The document also requested $11 million to fund a proposed index of all mouse cancer-related genes, the Mouse Tumor Gene Index.

In 1996, NCI formed a Preclinical Models for Cancer Working Group, which in turn formed a Mouse Models for Human Cancer subcommittee to advise the Institute on reaching the Bypass Budget goals. The proposed consortium would implement one of the subcommittee's recommendations, Marks said.

"This is a clear example of the long process of priority-setting of the Bypass Budget," NCI Director Richard Klausner said to the BSA. "It was not just mouse modelers who were brought in, but clinicians, developers of prevention interventions, treatments—all of whom were telling us that we never had the opportunity to think about development of valid models.

"We don't have the mechanism to learn what it means to validate a model," Klausner said.

BSA member Tyler Jacks, associate professor in the Department of Biology, Massachusetts Institute of Technology and co-chairman of the Mouse Models subcommittee, said the consortium would provide the funding and outreach needed to bring together researchers with expertise in early model development as well as characterization and validation.

"We on the working group specifically did not advocate the development of a cash cow which would benefit select laboratories," Jacks said. "Instead, what we have is a mechanism, which is actually quite inclusive, that will involve many different laboratories in the cancer community with different expertise and skills."

The consortium should have "clear long-term goals and discernable intermediate endpoints," Jacks said.

"We don't know if the mouse will provide a good, accurate model for human cancer, but we can't know until we do it," Jacks said. "The feeling is, the time is now."

The BSA voted unanimously to approve the concept. Jacks abstained from the vote.

Edited portions of the concept statement, and further board discussion, follow:

*[Editor's note: Concept statements reflect NCI's plans for future grant or contract solicitations. Actual issuance Requests for Applications or Requests for Proposals, as well as funding levels, are not certain. For further information, contact the program director listed for each concept statement.]*

**Mouse Models for Human Cancers Consortium.** Concept for cooperative agreements (U01s), six awards, five years, $4.5 million set-aside for first year, total cost $22.5 million. Program director: Cheryl Marks, Office of the Deputy Director for Extramural Science, tel: 301-496-4291.

The mouse represents a powerful tool for developing cancer models. Despite the fact that transgenic and knockout technologies have been used successfully in mouse systems to study the function of specific genes in whole animals, there has been very little effective, concerted development and validation of mouse models that mimic the progression of human cancers. Nearly every group of basic, clinical, and population scientists focusing on a particular type of cancer has emphasized the need for improved animal models. In recognition of the fact that further progress in understanding cancer biology and in developing more effective preclinical strategies for therapy and prevention will depend upon the availability of better animal models than those that are currently available, NCI organized the Preclinical Models for Cancer Working Group in December 1996, which formed a Mouse Models for Human Cancer Subgroup along with two other subgroups.

The Mouse Models for Human Cancer Subgroup noted that there were a number of barriers to model development. NCI has developed no systematic, reliable way of providing stable support for the early phases of model building and characterization or the development of associated novel technologies for advancing the state-of-the-art. Because there is no funding mechanism or review system in place suitable for animal model development, investigators are forced to piece together various sources of traditional research support for this purpose. The result has been the slow, disconnected development of mouse animal models, most of which are never adequately validated and characterized with respect to human cancer. This lack of a scientific fabric for model development has impeded the exchange of technical information between different scientific groups and the dissemination of adequate training to those who wish to employ the newest technologies in their research.

The purpose of this initiative is to create a consortium of scientific laboratories/teams of scientists dedicated to the development, validation and characterization of mouse models for human cancers. The objectives of the consortium would be (1) to enable each individual laboratory the flexibility to explore innovative, new technologies while developing and/or validating

mouse animal models important for the study of human cancer; (2) to promote scientific interactions and information exchange between the participating laboratories in the consortium, as well as with NCI and with key research communities and networks supported by NCI; and (3) to develop strategies and priorities that focus on the most critical areas of animal development and validation; that establish and maintain linkages to the basic, clinical and prevention and control research communities; that lay the groundwork for the development of key data bases; and that consider the best ways to provide access of animal models to the cancer research community.

The general strategy would be to identify the best scientific laboratories/scientific teams through the peer review process and then bring these laboratories together into a functional consortium that, through an Oversight Group (OG), effectively enhances information sharing and the development of interactions between the laboratories and with NCI and the cancer research community; decides on key research priorities and directions as they relate to animal model development; and advises NCI on strategies for providing access to animal models and maximizing their scientific exploitation. The OG would have considerable flexibility to achieve its objectives through regular meetings, specialized workshops etc. Administrative logistics for all travel, hotel arrangements, meeting facilities etc. for the OG's activities would be supported directly by NCI in order to maximize the time that scientists work together and minimize the time that they spend organizing.

Each laboratory would have capabilities in three areas:

1. Fundamental infrastructure needed to develop mouse animal models for cancers. These would be the fixed activities and facilities needed such as animal costs, key expertise (e.g. pathology, histology), supplies, travel, consultants etc.

2. Scientific expertise needed to develop the standards for and establish the key scientific collaborations needed to validate and characterize a model. This would involve considerable scientific flexibility and judgement and in many instances would involve the initial exploitation of the model in establishing its most promising possibilities for broader scientific use.

3. Scientific innovativeness to develop new technologies for advancing the field of mouse animal model development. This would involve new scientific approaches of the individual laboratory, the progress for which would be shared with the consortium.

Peer reviewers would evaluate each laboratory based on its merits in the following areas:

a. The adequacy of the facilities to accommodate a dedicated animal model development operation in accordance with national standards.

b. The qualifications of the principal investigator to head the operation and the qualifications of key personnel (e.g., technical, pathology) to conduct fundamental core activities.

c. The quality and adequacy of the laboratory's standards and plans for scientifically validating and characterizing the proposed model(s) as a model applicable to human cancer. Nature and quality of the proposed collaborations and/or consultations.

d. The innovativeness of the laboratory in exploring new approaches and technologies potentially important to advancing the field of animal model development and the nature and quality of the proposed collaborations and/or consultations.

e. Potential of the laboratory over the five-year grant period to develop models in areas other than those specifically proposed in the application.

f. How the proposed distribution of the budget between fundamental infrastructure, validation and characterization, and new approaches and technologies provide confidence that the laboratory understands how to manage an operation of this size in order to maximize and achieve its objectives.

The Oversight Group would consist of a chairman who would be a principal investigator of one of the participating laboratories in the consortium, an Executive Secretary, who would be the key NCI professional staff person responsible for facilitating and sustaining the activities of the Consortium, selected members from each participating laboratory, representatives from each extramural Division, and ad hoc scientists from the NIH intramural and extramural research community as needed.

It is envisioned that initially the individual laboratories will function independently, but as the Consortium with its Oversight Group develops its interactive and communicative capability, there will be an evolution to a more interdependent, collaborative posture both within the consortium and with scientists and research groups outside the consortium.

The exploitation of these models, once developed, would be through R01s, P01s etc.

The direct cost buying power of an award would be maintained so that indirect costs on subcontracting activities of a laboratory to another site outside the parent institution would be restored on an as needed basis. Thus, an award could exceed $500,000 direct costs in any given year depending on nature and extent of the outside institutional collaborations needed to achieve the scientific objectives of the individual laboratory.

All participating laboratories would be required to agree that any model developed would be immediately and freely available to the scientific community.

**BSA member Eric Fearon**, associate professor of internal medicine, molecular medicine and genetics at University of Michigan Medical Center, said the consortium should have a broad spectrum

of models for many organ sites, and should include specialists in human pathology. "One of the concerns I have is that the people who may be best at developing models and doing the work validating the endpoints in the mouse may not have access to human pathology," he said.

Jacks said he agreed. "This wouldn't focus exclusively on mouse types—that would be a huge mistake," he said. "What we are trying to do is validate these models as they relate to human cancer. To leave out human pathologists and oncologists would be very short-sighted."

NCI's Marks said applicants would not necessarily be required to list every participant in the grant from the beginning. "We envision flexible fund sections, one of which would describe the scientific and technical expertise that could be brought to bear through collaborations, consultants, etc., and another to deal with issues of technology," she said.

"We imagine that, over time, that members of the team and consortium overall would evolve to bring in the necessary expertise," Marks said. "We also envision that part of the Oversight Group's role would be to put together the annual meeting of this consortium and possibly have it at the same time as our SPOREs [Specialized Programs of Research Excellence] annual meeting, because that would put the clinical research community together with our models people and allow for the kinds of interactions that might really speed up progress."

*In Congress:*

## Varmus Defends Rationale For Cancer Research Increase

The chairman of the House Labor, HHS & Education Appropriations Subcommittee said revenues from the tobacco settlement would be unlikely to materialize during fiscal 1999, which would make it a challenge for Congress to find the money give NIH the increase promised by the Administration.

"The immediate difficulty is that the spending increase [for NIH] is supported by revenues that are unlikely, at least in my judgment, to materialize, at least in this fiscal year," said Rep. John Porter (R-IL), chairman of the subcommittee. "That will make some difficulty for us with respect to the (Labor, HHS) allocation, and in reaching the kinds of levels that we feel NIH deserves."

While the Administration has pledged that the increases for NIH would come through with or without a tobacco settlement, it is now up to Porter and his subcommittee to put together a plausible bill in the face of uncertainty.

At a hearing March 10, Porter asked NIH Director Harold Varmus to defend the rationale for the Administration's proposal to increase NIH funding by 50 percent over five years, and to provide what Porter described as "disproportional" increases for NCI. The hearing began a two-week stretch of testimony by NIH.

"While it may be good politics, it is very bad policy to earmark any disease as being politically important and take away from science the right to decide where scientific opportunity and progress lie," Porter said. "I am very skeptical of that earmark for cancer, but very supportive of providing all the funds we possibly can for cancer research and research in all the work that NIH does and funds."

The Administration has proposed an increase of 8.4 percent for NIH, boosting its budget to $14.797 billion in fiscal 1999. Over the following four years, NIH budget would increase by 50 percent, to $20.188 billion.

Under the proposal, cancer research, not limited to NCI, would increase by 10 percent in fiscal 1999. By the year 2003, cancer outlays by NIH would be increased by 65 percent.

Rep. David Obey (D-WI), the ranking member of the subcommittee, similarly asked Varmus to justify the dramatic increase.

"I frankly am skeptical about whether NIH has the capacity to absorb the kind of money we are talking about in the President's budget," Obey said. "Can you explain to me why I should believe that that kind of huge exopansion will be wisely spent without waste?"

Varmus said the President's priorities coincided with the scientific opportunities outlined by NIH. Cancer is a logical area of emphasis at a time when discoveries in molecular biology are starting to find their way to the clinic, he said.

"The next dramatic transformation of medicine through genetics and molecular biology is likely to occur in the study of cancer," Varmus said.

"This is true, in part, because cancer is intrinsically a disease based on mutations, both inherited and acquired during life; because the genes implicated in many kinds of cancer were among those first isolated from the genomes of vertebrate animals;

and because the functions of many of the implicated genes and their encoded proteins have been relatively well characterized during the past two decades.

"As a result, it is already possible to predict an individual's genetic predisposition to several forms of cancer; to assess the genetic damage in certain types of cancers in order to gauge the likely course of the illness and select optimal therapies; to design novel means for destroying cancer cells—with drugs, toxic antibodies, immune cells, or gene therapies that address specific abnormalities in a patient's cancer; and to take advantage of new knowledge about blood vessel growth or the mechanisms of cell death to test entirely novel approaches to cancer therapy," Varmus said.

Varmus said NIH plans to make administrative changes in five areas:

—**Research Grants.** Next year, NIH will set two records, Varmus said. The number of research project grants will reach 30,000, and the number of new and competing awards will be close to 8,300. The size of average new and competing awards will increase by 10 percent.

—**Instrumentation.** New money would allow NIH to expand development of more powerful instruments, attract trainees from other sciences, foster sharing of instruments by research groups, and expand the use of computers.

—**Training.** "We will fund innovative research training programs that emphasize transdisciplinary work," Varmus said. "We propose to increase by 25 percent the stipends that we provide to graduate students and post-doctoral fellows, and we will create a research environment that offers improved stability and likelihood of research funding than was true in the early years of this decade."

—**Clinical Research.** NIH will initiate several categories of awards for training clinical investigators. These will include: (1) a program that will finance a supervised five-year apprenticeship for over 400 young investigators; (2) a program that will provide salary support for clinical research by 250 to 400 mid-career scientists who would be able to serve as mentors; (3) a training program that will bring organized educational programs in clinical research to over 20 institutions.

"We also plan to augment our clinical trials by developing comprehensive and accessible data bases, by enhancing recruitment...and by continuing recently-initiated discussions with industry, academia, and other agencies about improved design of clinical trials," Varmus said.

—**Administration.** The NIH Center for Scientific Review has begun restructuring of peer review panels, and has begun a study of the process used by NIH to identify priorities in research funding.

"In the meantime, we have sought more advice than usual from many of our professional and advocacy constituencies to plan the use of the enhanced resources requested for fiscal 1999," Varmus said.

**Unity of Politics And Policy?**

The following is an edited transcript of several key exchanges at the March 10 hearing:

**PORTER:** I've frequently expressed concern about politicization of science. I wonder if you had an opportunity during the formulation of the President's budget to raise the question of disease earmarking before the budget or the State of the Union message were offered?

**VARMUS:** Naturally, we have had discussions with the Administration about budget formulation, but the budget was put together in a traditional manner, that is in response to scientific opportunity and our sense of what's needed.

**PORTER:** Did the cancer initiative idea come from NIH or from the White House?

**VARMUS:** It's a chicken-and-an-egg problem, in a sense. The budget was formulated to support major increases in cancer-related activities, the remarkable opportunities that are available in cancer research, the fact that cancer is going to be a very major area in which breakthroughs in molecular and genetic technology are first applied.

There is the additional fact that many of the infrastructural issues in medical science—clinical trials development, training of clinical investigators—are going to be exercised there. So the budget for cancer was large.

The identification of cancer initiative that the President and the Vice President emphasized is the decision made by the Administration, but it's completely consistent with the budget numbers that we developed.

There are other diseases in the budget that received increases equal to or even greater than cancer, but in view of the magnitude of the cancer problem and the public's concern about cancer funding, and the medical advances we believe have come, it has been featured in the President's budget.

**PORTER:** In other words, you are saying that

the President did not necessarily vault cancer ahead of other diseases. He simply emphasized cancer and the increases that are being provided in any case, and he could have emphasized other diseases in the same way.

**VARMUS**: The budget proposal makes it clear, there is a very handsome increase for every disease area, and I don't believe that the modest increase in advance of the average for cancer research is discriminatory to other disease areas.

**PORTER:** We will treat it that way. Thank you.

**Why Not Double...**

**PORTER:** You've mentioned in a general way how you would use the increases that the President has proposed in his budget; a 50 percent increase over five years.

Many are proposing rather a 100 percent increase for NIH over five years. Can you tell us whether you could reasonably absorb an increase of 100 percent over five years, and how you might use funding at an increased rate of that magnitude?

**VARMUS:** I believe that what is going on in medical science at the moment is truly extraordinary. The capacity of our research community to make good use of funds is at an all-time high.

It's very difficult for me to calibrate exactly where the limit is reached, but we do know that there are many excellent grants that go unfunded, many investigators who are well-trained and able to do work who are currently not working at a peak capacity.

We know that there are areas of research that we have underexplored. We also know that as we make a transition from a molecular based science to a molecular based medical practice, there is going to be an expanded need for clinical trials, for general clinical research, both of which are more expensive than laboratory work.

I believe the opportunities are extraordinary, and even as much as twice our level of funding could be well used.

*Funding Opportunities:*

## RFP Available

**RFP N01-CN-85027-57**

Title: **Prostate, Lung, Colorectal And Ovarian Cancer Cancer Screening Trial Expansion**

Deadline: Approximately May 8

The NCI Division of Cancer Prevention, Early Detection Branch, is expanding the Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial and is interested in soliciting proposals from organizations for two new screening centers, each focusing on a different population group and each recruiting no less than 5,000 participants (2,500 subjects and 2,500 controls) to the Trial.

One screening center will target Hispanic communities and recruit at least 1,500 Hispanic Americans (or 30 percent of their total enrollment goal) and the other will target the general U.S. population. Female subjects will be screened for colorectal, lung, and ovarian cancers. Male subjects will be screened for colorectal, lung, and prostate cancer. Following the initial screen, screening will be performed annually for three years for prostate, lung, and ovarian cancers and only at the initial and third annual screen for colorectal cancer. Subjects and controls will be followed for at least ten years.

The RFP may be accessed at the following Internet address: http://rcb.nci.nih.gov/RFP.HTM.

Contact: Desiree Sylver-Foust, Contract Specialist, fax: 301-402-8579, tel: 301-435-3833, email: ds154o@nih.gov.

*In Brief:*

## ASCO Considering Change Of Pubishers For JCO

(Continued from page 1)

Marrow Transplant Center at Rush-Presbyterian-St. Luke's Medical Center. Klingemann is professor and senior attending physician in the department of internal medicine at the Medical Center. . . . **AMERICAN SOCIETY OF CLINICAL ONCOLOGY** is negotiating with Williams & Wilkins Periodical Publishing to publish the Journal of Clinical Oncology. Williams & Wilkins is a division of Waverly Inc. W. B. Saunders Co., a division of Harcourt Brace & Co., currently publishes the journal. . . . **SHINE CHANG** received the Cancer Research Foundation of America/American Society of Preventive Oncology Cancer Prevention Research Fellowship for her prostate cancer study, "Diet and Leptin: New Potential Targets for Cancer Prevention." Chang is a research associate in the department of epidemiology at M.D. Anderson Cancer Center. The fellowship includes an award of $34,982. . . . **DEADLINE** for abstracts for the Nov. 5-8 meeting of the American Association for Cancer Education is April 1. Abstract forms are available from AACE Secretary Virginia Krawiec, tel: 404/329-7612, email: gkrawiec@cancer.org.