THE CANCER LETTER INTERACTIVE

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NCAB Says President's Budget Would "Seriously Damage" Cancer Program

The National Cancer Advisory Board said the budget proposed by the Clinton Administration would result in reductions in new programs and would "seriously damage the National Cancer Program."

"The burden of cancer in our population is increasing," said NCAB member Phillip Sharp, professor and head of the biology department at the Massachusetts Institute of Technology Center for Cancer Research. "A 2 percent increase is going to take the wheels off this machine and result in a decrease of the number of grants NCI can fund."

The board voted unanimously at its meeting Feb. 10 to send a letter

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In Brief:

Bristol To Drop Angiostatin; Protein Fails To Meet Criteria For Development, Firm Says

Bristol-Myers Squibb Co. (NYSE: BMY) of Princeton, NJ, and **EntreMed Inc**. (Nasdaq: ENMD) of Rockville, MD, earlier this week said they had modified their agreement aimed at development of the Angiostatin protein.

Robert Kramer, BMS vice president, oncology drug discovery, said the company decided to redirect its resources to other drug candidates. "Angiostatin protein in its present form does not meet our criteria for molecules that advance to clinical trials," Kramer said in a statement. "We continue, however, to view antiangiogenesis as an important and viable target in the spectrum of oncology research."

BMS officials described the Angiostatin pre-clinical research effort as the company's "largest oncology discovery program ever."

Though EntreMed has assumed responsibility for all future preclinical and clinical work on the Angiostatin molecule, BMS has retained the option to resume development and marketing rights for the protein "once clinical proof of principle has been demonstrated," the company said. NCI will continue to work with Angiostatin, Institute officials said. . . . **DONALD HOLT,** a senior editor of the Journal of the National Cancer Institute, was charged with first degree murder last week after police found the body of his wife, Nancy Holt, in her car parked at Baltimore-Washington International Airport. Papers filed in Frederick County District Court said Holt confessed to strangling his wife on Jan. 18, placing the body in the car, and driving it to the airport, The Washington Post reported. Nancy Holt worked for the Health Care Financing Administration.

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Shalala Takes Heat From House On NIH Budget Proposal

(Continued from page 1)

to the White House and Congress detailing its concerns about President Clinton's budget proposal, which was submitted to Congress on Feb. 1 (**The Cancer Letter**, Feb. 5).

On the same day, the Administration's proposal for funding biomedical research came under fire at the House Labor, HHS, and Education Appropriations Subcommittee. Presenting the budget request, HHS Secretary Donna Shalala seemed unable to muster much enthusiasm for the NIH funding level recommended by the Administration.

"Going up and down on the NIH budget is not, in my judgement as a former university chancellor, the way in which you make long-term commitments to biomedical research," Shalala said to the subcommittee.

Rep. John Porter (R-IL), chairman of the subcommittee, said the administration was in effect presenting a budget it could not enthusiastically defend.

"After Congress last year decided it was a very high priority for this country to double funding for biomedical research over a five-year term, to have the President come back with a budget that pegs NIH for 2.1 percent next year, is simply very, very cynical," he said. "It isn't fair to the budget process or to the committee to come in with a budget like that."

The abrupt shift in funding from the $375 million, 15 percent increase appropriated by Congress for fiscal 1999, to the $70 million, 2.4 percent increase President Clinton proposed for the year 2000, would discourage scientists and "not serve the public interest" at a time when the burden of cancer is increasing, the NCAB said in a draft of its letter.

According to NCI projections, the Institute would fund about 10 percent fewer research project grants under the Administration's proposal in fiscal year 2000 as compared to this year, Institute Director Richard Klausner said to the NCAB. About 80 percent of the $70 million proposed increase would fund commitments made to grantees in previous years, Klausner said.

The average length of a grant award is four years.

"We are given a budget one year at a time, but the vast majority of our commitments go up in all four years," Klausner said, presenting the projections to the board.

The proposed funding for NCI is included in the Administration's budget request for NIH of $15.9 billion, a 2.1 increase over the current year's appropriation.

"The members of the National Cancer Advisory Board are writing to express our concern that the initial FY 2000 budget request for the National Cancer Institute will not serve the public interest, and over both the short and long term, will seriously damage the National Cancer Program," the board wrote in a draft of its letter. "In short, an abrupt shift in funding from the current 15 percent increase over FY 1998 funding levels, to a recommended increase of 2 percent for FY 2000, will result in a critical loss of momentum.

"This will be seen in a reduction of new programs, loss of ability to renew current programs of excellence, and an inability to rapidly translate new discoveries into applications for patients," the board wrote. "Investigators will become discouraged, and scientists in training will re-evaluate their decisions to begin careers that will provide the next generation of researchers….

"At current rates, it is estimated that cancer incidence will increase by 29 percent and mortality by 25 percent over the next 10 years due to changing demographics and aging of the population," the

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board's letter continued. "The economic burden of cancer by the year 2010 will be well over $200 billion per year. Investments in research today will provide dividends many times over in the future, in the more effective control of the burden of this disease….

"We implore the Administration and the Congress to take the long term perspective and make the budgetary commitments necessary to sustain the National Cancer Program in reaching its goals of reduced incidence and improved survival and, ultimately, prevention of disease," the letter concluded. "This will mandate an NCI budget that recognizes the magnitude of the burden and the priority that this country has assigned to the control of cancer."

Research Vs. Social Programs

At the appropriations hearing, Republican subcommittee members voiced their displeasure with the NIH budget proposal, while several Democrats said the increase for NIH was costly for education and social programs. HHS Secretary Donna Shalala defended the President's budget request, but said she agreed that sharp changes in funding were not an ideal way to support biomedical research.

In her prepared remarks, Shalala said the proposed increase for NIH, when added to this year's appropriation, would keep the Institutes on track for a 50 percent increase between fiscal year 1998 to fiscal year 2003.

In questioning Shalala, Rep. Dan Miller (R-FL), said that with inflation, the proposal would result in a budget cut for NIH. "It is extremely frustrating for those of us who are really strong supporters—as you are—of the crown jewel of our government, the NIH, and to sit here and say that you continue the President's commitment to continue on the path of a 50 percent increase, when really we're cutting NIH in your budget," he said.

"Last year, [Clinton] proposed an 8 percent increase, and we put it up to 15 percent," Miller said. "But when you start off with a 2 percent increase, it's hard to go very far. I don't know how we ever get to this 50 percent increase, if this year we only get a 2 percent increase. What did you originally ask for, and how did it get cut back so much?"

SHALALA: "My discussions with the President and the senior budget people normally are confidential. I think the way in which we get to 50 percent is adding up last year's percentage, this year's percentage, and what we intend to do over the next three years. The President is committed to getting to a 50 percent increase. He intends to do that over the five-year period where he had pledged to do that.

MILLER: "The roller-coaster, the word you used [at a Feb. 1 press conference], where you go up and down, is just bad planning and bad public policy."

On the other side of the aisle, Democrats said NIH had received a large increase at the expense of other programs.

Rep. David Obey (D-WI), the ranking minority member of the subcommittee, took issue with Porter's characterization of the NIH budget proposal as "cynical."

"I think what was cynical was that last year, when we knew that we were facing a bill that was totally inadequate, what was cynical was to pour a large amount of additional money into NIH when people knew that that bill could never survive until the cuts that were required in education and labor programs in order to finance it were corrected," Obey said. "In the end, we wound up correcting those, along with having a large increase in NIH. But we had to add about $6 billion over the amount that this bill contained when it was first brought to the House."

"The president has recognized in his NIH number is that, while all of us on this committee have a strong record of funding NIH increases, we can't fund NIH exclusively at the expense of other programs," Obey said.

Rep. Steny Hoyer (D-MD), questioned the ability to reach the 50-percent increase under current Congressional caps on discretionary spending. "Last year, NIH funding had a consequence. We zero-funded low-income energy assistance coming out of this subcommittee. We zero-funded summer jobs for youth…both of which I thought were inappropriate, but did allow us to fund NIH more generously," Hoyer said. "Frankly, can we meet the 50 percent target within the caps that now exist, responsibly?"

SHALALA: "I think it would very tight to try to do that. You can see one of the problems … the President had as he was putting together the budget, is because of the limitations and his commitment to the balanced budget, he couldn't get everything in. I think that the Administration is prepared to work with Congress in a bipartisan manner to see how we accommodate everything we need to accommodate, but keeping it in the context of a balanced budget."

HOYER: "I agree with keeping it in the context

of a balanced budget, but I think I read your answer as 'No.'"

SHALALA: "I can't commit the Administration to the raising of the caps."

Porter Criticizes Last Year's Budget Process

Porter called last year's Labor-HHS-Education appropriations process a "disaster," and vowed that this year would be different. "When you can't get a bill to the floor, you have a disaster on your hands," he said. "Members of the subcommittee were not able to debate it on the floor, they were not able to come to conference, there was no democracy and no participation in the process. I am going to do everything I possibly can to make certain that that does not happen this year.

"Also, we lost in that process the bipartisanship that this committee has always had," he said. "Our approach has always been to work together with members of the majority and minority, and I think, again, it was a disaster that we simply cannot allow to happen again.

"The bill has been loaded with legislative riders," he said. "We are going to do our very best to minimize those riders, and I hope members will take the matters that concern them that are legislative in nature to the authorizing committees where they belong, and not attempt to use this appropriations bill as an authorizing vehicle."

Biology Societies Recommend 15% Funding Increase For NIH

The Federation of American Societies for Experimental Biology recommended a 15 percent funding increase for NIH in the fiscal year 2000. The increase, which would amount to $2.3 billion, would be consistent with the goal of doubling the NIH budget between fiscal years 1999 and 2003.

The goal of doubling of the NIH budget has broad support on Capitol Hill and among professional societies that represent scientists.

In addition to establishing a funding target for NIH, FASEB recommendations state:

—FASEB supports the continued reliance on scientific opportunity as the principal determinant of NIH research and training programs.

—FASEB also supports efforts of the NIH priority-setting process that includes consideration of disease burden and the inclusion of input from a broad spectrum of constituencies, including the general public and relevant patient, scientific, and medical communities.

—FASEB encourages NIH to more effectively communicate its planning activities to Congress, the media, and the public.

—FASEB encourages NIH to move forward with its planning efforts that relate to crosscutting issues. Specifically, NIH should address matters that are interdisciplinary and inter-institute in nature, and that span extramural and intramural programs of the agency. Examples include training, infrastructure, and the adequacy of current funding mechanisms.

—FASEB recommends increased support for high-quality, hypothesis-driven, patient-oriented research through conventional R01 and other investigator-initiated awards, and urges the appropriate involvement of physician-scientists in the review and selection process.

—FASEB recommends that NIH establish the Institutional Infrastructure Support Grant, funded at the level of 2 percent of the total Research Project Grants at a given institution. These funds should be used for shared equipment, infrastructure, bridge funds, and one-year pilot projects. This program should be administered locally with appropriate NIH oversight. All such funds should be distributed according to a rigorous, local scientific merit review mechanism.

—FASEB recommends that funding for the shared biomedical technology resource program (P41) be increased from the current level of $67 million to $167 million in FY 2000.

—FASEB supports NIH's ongoing study of ways to reduce the unnecessary burden that federal regulators impose on researchers.

Clinical Trials:

Data Manager Falsified NSABP Records On 3 Patients, ORI Says

The Office of Research Integrity has reported findings of scientific misconduct on the part of a data manager who worked at hospitals involved in clinical trials conducted by the National Surgical Adjuvant Breast and Bowel Project.

The ORI notice published in the Federal Register Feb. 4 identified the data manager as Thomas Philpot, of Rush-Presbyterian-St. Luke's Medical Center and Northwestern University. ORI found that Philpot fabricated or falsified data for three patients enrolled in three clinical trials.

ORI said Philpot had "falsified and/or

fabricated" telephone contacts and information, including the patients' survival status. Philpot's duties involved maintaining contact with patients as part of the follow-up phase of the studies.

Norman Wolmark, chairman of the NSABP, said the discrepancies were found through the cooperative group's auditing procedures.

"The NSABP has state-of-the-art procedures in place to monitor the women and men who participate in its clinical trials," Wolmark said in a statement. "The public should remain confident that these procedures work to protect them."

NCI and NSABP officials said the problems were discovered in 1996 with the help of the retrospective component that was recently added to the cooperative group's routine data auditing program. The new component used computer software to check various data points. After the audit revealed unexplainable discrepancies in the data, the cooperative group informed NCI, which in turn notified ORI.

ORI requested formal investigations at the institutions in which the data manager had worked: Rush-Presbyterian-St. Luke's Medical Center, Chicago, and MacNeal Cancer Center, then affiliated with Northwestern University, officials said.

Based on the evidence and findings by Rush-Presbyterian and Northwestern, ORI found that the data manager had intentionally falsified and/or fabricated data for the three patients. As a result of these findings, ORI has instituted administrative actions which limit the data manager's participation in research funded by the Public Health Service in the next three years, officials said.

The conclusions of the trials were not affected, said Richard Ungerleider, chief of the NCI Clinical Investigations Branch. "Each of these trials had a large number of patients and was conducted at many institutions," Ungerleider said in a statement. "The fabricated data, involving as it did just one patient on each trial, will not affect these trials' results."

Letter To The Editor:

IOM Panel Urges Greater Integration Of Research

To the Editor:

On behalf of the Institute of Medicine Committee on Cancer Research Among Minorities and the Medically Underserved, I wish to commend **The Cancer Letter** for its extensive coverage of the release of the committee's report. However, your series of articles on the IOM report contained a number of errors that should be corrected.

The IOM committee was asked by Congress to assess NIH's allocation of funds for the study of cancer among ethnic minority and medically underserved populations. This question has become conflated in your articles with the larger question of how much funding should be devoted to studies intended specifically to study minority and underserved populations, a question that can only be answered by an analysis of where research gaps exist, and by the development of criteria to determine under what circumstances should trials be designed to answer questions regarding population group differences.

The difference between our estimate and the NCI estimate of how much has been spent on research among these populations is largely due to a difference in the method of analysis, and an inability to reconcile the two methods. NCI and the IOM committee both agree that the appropriate accounting for allocation of resources is on the basis of the research question (i.e., whether studies pose one or more *a priori* research hypotheses that illuminate issues for minority and underserved groups). NCI, however, calculates expenditures on "minority-relevant" research by extrapolating costs based on the percentage of ethnic minorities enrolled as subjects in research programs. This methodology yielded a figure of $124 million for fiscal year 1997, according to NCI, which represented approximately 5.25 percent of the Institute's budget. By using the percentage of the minorities involved as a basis for allocation, however, the NCI accounting fails to give appropriate weight to the research question. We disagree with their approach and recommend that they account for resources to minorities and the underserved by a different method where the basis of allocation is more clearly defined in relation to the research question.

NCI reports a second figure for fiscal year 1997 of $43.9 million for research *specific to* "special populations"—that is, research targeted toward the cancer research needs of these groups. Despite Dr. Otis Brawley's statement in the Jan. 29 issue of **The Cancer Letter** that he was "troubled to find no reference to the $43.9 million in the report," this figure is reported in several places, including Table 3-4 and Figure 3-2. This figure, however, is also based on NCI's broad definition of "special

populations," which includes the elderly and blue-collar workers. These populations were beyond the purview of the IOM study. We therefore chose to do our analysis of spending on ethnic minority populations based on the list of research projects provided to the study committee by NCI. Our analysis yielded a figure of $24 million, a figure which has since been challenged by NCI officials and your report, who argue that the list was incomplete. As the data were provided by NCI, we had no reason to doubt its accuracy.

Even given the more liberal assessment of $124 million allocated to the study of cancer among minority and underserved groups, the amount would still be low with respect to three criteria for research priority-setting. These include the scientific opportunities inherent in the study of diverse populations, the burden of disease among ethnic minority and medically underserved populations, and the rapid proportional increase of ethnic minorities in the U. S. population.

Unfortunately, our recommendation that the accounting be done on the basis of the research question has been interpreted by NCI as a recommendation for segregation of research on minorities from the mainstream of cancer research. Nowhere in the IOM report does the committee recommend such action. Far from seeking to encourage segregation of research by ethnic group, the committee clearly urges greater use of studies across and within diverse ethnic groups—that is, greater *integration* of research questions pertaining to all ethnic groups within general research.

The accounting issue is an important public policy matter, but there are 21 other recommendations in the report on which there is substantial agreement. We are confident that additional discussions with the NCI will result in a way of accounting for this allocation based on the research question rather than on the number of minorities in the study.

M. Alfred Haynes
Chairman

The Cancer Letter responds: Dr. Haynes restates the points he has made in public statements since the release of the IOM report. We believe these points were accurately reflected in the extensive coverage **The Cancer Letter** has given the report in the issues of Jan. 22, 29, and Feb. 5. Failing to find the alleged "errors" in our coverage, we stand by our stories.

Funding Opportunities:

NCI Accepts Applications For Cooperative Group Awards

PA-99-058: DCTD Clinical Trials Cooperative Groups

NCI is reannouncing its willingness to accept applications from institutions interested in conducting multi-institutional clinical trials in a Cooperative Group setting. Awards will continue to be made using the cooperative agreement mechanism (U10). Potential applicants are encouraged to contact the Cancer Therapy Evaluation Program staff to discuss and/or clarify any issues or questions regarding this announcement.

The Clinical Trials Cooperative Group Program Guidelines and the Cooperative Group Terms and Conditions of Award are available from the NCI Program Director upon request.

The documents also are available at http://ctep.info.nih.gov/CGroupGuide/GuidelinesContents.htm

The NCI Clinical Trials Cooperative Groups were conceived in 1955 when Congress appropriated funds to the National Cancer Institute to establish the Chemotherapy National Service Center. By 1958, 17 Groups were organized that operated under research grants from NCI; their main thrust was the testing of new anticancer agents from the NCI drug development program. Over the intervening years the Group Program has evolved into one that places major emphasis on definitive studies of combined modality approaches to the treatment of cancer, and on the developmental efforts preparatory to such trials. Most recently, increasing attention has been give to translational research, correlating biologic insights gained from the laboratory with disease behavior and treatment outcome.

In 1980-81, the mechanism of support for the Clinical Trials Cooperative Group Program was converted from the grant to the cooperative agreement. The purpose of this change was to define the involvement of NCI program staff in the coordination of Group activities.

There are currently 12 NCI-funded Groups; approximately 20,000 new patients are accrued into their treatment studies each year, and many times that number are in follow-up. Thousands of individual investigators participate in Cooperative Group protocols. Currently, over $100 million is awarded annually by NCI in support of Group research.

The Groups consist of researchers at institutions affiliated with the Groups, who jointly develop and conduct cancer treatment clinical trials in multi-institutional settings. They are a major component of the extramural research effort of the Division of Cancer Treatment and Diagnosis. The Groups have been instrumental in the development of new standards of cancer patient management and in the development of sophisticated clinical investigation techniques.

The essential feature of the Clinical Trials Cooperative Group Program is the support of organizations that continually generate and conduct new clinical trials consistent with national priorities for cancer treatment research. Emphasis is placed on definitive, randomized Phase III studies and the developmental efforts preliminary to them. While a wide variety of investigational efforts are therefore appropriate, this Program specifically does not overlap with or replace funding mechanisms for more narrowly focused, Research Project Grant activities (e.g., R01, P01, U01, U19).

The Cooperative Groups are heterogeneous in their research objectives and their structures. These Groups presently are of four major types: (1) Groups that are specifically disease oriented (e.g., gynecologic oncology); (2) Groups that are designed to deal primarily with high technology, single modality studies (e.g., radiotherapy); (3) Groups in which the investigators have a particular expertise (e.g., pediatricians); and (4) multimodality Groups. The common thread, however, is the development and conduct of large-scale trials in a multi-institutional setting.

The goals of the Groups are:

1. Improvement of Therapy: Therapeutic research aimed at improving the survival and quality of life for persons with cancer is of highest priority.

2. Adjunct Studies: The database of patient information accumulated in the course of treatment research, including the possibilities for large-scale collection of tissue samples with subsequent correlation of biologic features with patient outcome, provide the Groups with unique opportunities to address scientific questions about genetics, etiology, epidemiology, pathology and other cancer-related topics. Such ancillary investigations can add considerable strength to a Group's total scientific program, and are strongly encouraged. While certain studies may be eligible for inclusion in a Group application for financial support, particularly when the laboratory efforts are integral to the clinical trials proposed, a variety of other funding mechanisms—including investigator-initiated grants (R01s, R03s, P01s) and cooperative agreements for discrete projects (U01s, U19s)—may also be appropriate.

3. Cancer Control: Groups supported by NCI's Division of Cancer Treatment and Diagnosis may serve as research bases for treatment and cancer control research performed by Community Clinical Oncology Program (CCOP) cooperative agreement awardees supported by the NCI's Division of Cancer Prevention. While this activity, when present, should be an integrated component of the Group's total research program, peer-review of the CCOP research program including cancer control research for the purposes of NCI financial support will be advisory to the Division of Cancer Prevention, and generally will be conducted separately from peer review advisory to the Division of Cancer Treatment and Diagnosis.

4. Clinical Trials Methodology: The Groups provide a unique framework for research in clinical trials methodology. While CTEP welcomes development of and experimentation with new study designs within the Group framework, purely statistical research is appropriately funded through other mechanisms.

Special Requirements: Each Cooperative Group should consist of three major operational components that collaborate to conduct the research agenda of the Group: the headquarters (including the Group Chair's office), the central statistical/data management office, and the participating investigators and institutions. Each component should have general responsibilities in meeting the goals and objective of the Cooperative Group or in completing tasks necessary to accomplish those goals. Each Group must be governed by a constitution and bylaws, which describe membership criteria, procedures for selecting group leadership and other details of governance. Each Group must be led by a chairperson who is ultimately responsible for the content and conduct of the Group's research program. Beyond these requirements, the structure and management of the individual Group is the responsibility of the Group itself to determine. The headquarters is the direct responsibility of the Group chairperson. It should provide executive leadership and day-to-day administrative management of the Group. Through this office the chairperson implements the Group's scientific and organizational policies. A Group's statistical and data management staff must be integral collaborators in all stages of study development, conduct, analysis, and reporting. It is anticipated that member institutions will be, for the most part, academic centers and their affiliated institutions, or large community practices supported through the CCOP programs. In addition to patient accrual, member institutions should provide scientific and administrative contributions to the Group. Each Group must establish its own specific criteria for membership and a formal process for application for Group membership.

Inquiries: Richard Ungerleider, Division of Cancer Treatment and Diagnosis, NCI, Executive Plaza North Suite 741, 6130 Executive Boulevard, Bethesda, MD 20892, Rockville, MD 20852 (if using express mail); phone 301-496-2522, fax 301-402-0557, email: ru4m@nih.gov

Program Announcements

PA-99-046: Clinical Cancer Therapy Research

NCI seeks grant applications to conduct clinical therapeutic studies/trials of neoplastic diseases in humans. Clinical research, by definition, involves a clinician/patient-subject interaction with a therapeutic intent. This PA encompasses a full range of therapeutic studies and clinical trials employing drugs, biologics, radiation, and surgery. The intent of the PA is to encourage clinical

researchers to translate insights in cancer biology and the development of new agents into innovative cancer therapeutic studies.

Inquiries: Roy Wu or Diane Bronzert, Division of Cancer Treatment, NCI, Executive Plaza North, Room 734, Bethesda, MD 20892, phone 301 496-8866, fax 301 480-4663, email: rw51j@nih.gov or db85g@nih.gov

PA-99-042: Models For HIV Disease And AIDS-Related Malignancies

This PA from NCI and the National Institute of Dental and Craniofacial Research encourages investigator-initiated grant applications for the development of useful and predictive biochemical, cellular, in vivo and mathematical models for the preclinical evaluation of new therapies against HIV and AIDS-related malignancies.

Inquiries: Mary Wolpert, Division of Cancer Treatment and Diagnosis, NCI, 6130 Executive Boulevard Room 841 MSC 7456, Bethesda, MD 20892-7456, phone 301-496-8783, fax 301-402-5200, email: mw8u@nih.gov

Kenneth Cremer, Division of Cancer Biology, NCI, 6130 Executive Boulevard Room 540 MSC 7398, Bethesda, MD 20892-7398, phone: 301-496-6085, fax 301-496-2025, email: kc47i@nih.gov

PA-99-048: Technologies To Improve The Utility Of Animal Models

This PA encourages the small business community to develop technologies, reagents and equipment to improve the utility of animal models for biomedical research.

Inquiries: Director, Comparative Medicine, National Center for Research Resources, 6705 Rockledge Drive, Room 5158, Bethesda, MD 20892, phone 301-435-0744, fax 301-480-3819, email: johns@ncrr.nih.gov

Jo Anne Goodnight, Division of Cancer Biology, National Cancer Institute, Executive Plaza North, Room 500, Bethesda, MD 20892-7380, phone: 301-496-5307, fax 301-496-8656, email: jg128w@nih.gov

PA-99-055: Molecular Epidemiology Of Prostate Carcinogenesis

Letter of Intent Receipt Dates: March 18, Oct. 20

Application Receipt Dates: April 26, Nov. 19

NCI, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Institute of Environmental Health Sciences invite investigator-initiated research grant applications of molecular epidemiologic studies for understanding prostate cancer development and progression. Of special interest are studies of markers to elucidate multiethnic differences in prostate cancer susceptibility.

Inquiries: Kumiko Iwamoto, Division of Cancer Control and Population Sciences, NCI, Executive Plaza North Suite 535, Bethesda, MD 20892, phone 301-496-9600, fax 301-402-4279, email: ki6n@nih.gov

Leroy Nyberg, Urology Program, National Institute of Diabetes and Digestive and Kidney Diseases, Natcher Building Room 6AS-13G, Bethesda, MD 20892, phone 301-594-7717, fax 301-480-3510, email: nybergl@extra.niddk.nih.gov

Gwen Collman, Chemical Exposures and Molecular Biology Branch, National Institute of Environmental Health Sciences, PO Box 12233, Research Triangle Park, NC 27709, phone 919-541-4980, fax 919-541-4937, email: collman@niehs.nih.gov

RFA Available

RFA AI-99-001: Small Business Innovation Research: Animal Models Of HCV Infection

Letter of Intent Receipt Date: Feb. 12

Application Receipt Date: March 18

This is a multi-Institute solicitation targeting the development/identification of one or more small animal models of hepatitis C infection and disease progression including acute and chronic states, fibrosis/cirrhosis, and liver tumor development-not necessarily all in the same model. This RFA invites grant applications for SBIR projects with award duration and amounts greater than those routinely allowed under the SBIR program. It is expected that $4.2 million from the SBIR set-asides of the participating Institutes will be designated for 10-14 awards in FY1999/FY2000.

Inquiries: Leslye Johnson, Division of Microbiology and Infectious Diseases, National Institute of Allergy and Infectious Diseases, 6003 Executive Boulevard, Room 3A22, Bethesda, MD 20892-7630, phone 301-496-7051, fax 301-402-1456, email: lj7m@nih.gov

John Cole III, Division of Cancer Biology, National Cancer Institute, Executive Plaza North, Room 540, Bethesda, MD 20892-7209, phone 301-496-1718, fax 301-496-2025, email: jc121b@nih.gov

NCI "Challenge" Meeting Set

A pre-application informational meeting for those investigators considering submitting applications in response to RFA CA-98-027, "Director's Challenge: Toward A Molecular Classification of Tumors," is scheduled for Feb. 19, from 10 a.m. to 3 p.m. at the Natcher Building, NIH, Bethesda, MD in the Auditorium Balcony Room A.

Representatives from the Cancer Diagnosis 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.

Contact: James Jacobson, NCI Division of Cancer Treatment and Diagnosis, 6130 Executive Boulevard, Room 700, MSC 7388, Bethesda, MD 20892-7388, phone 301-402-4185, fax 301-402-7819, email: jj37d@nih.gov

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