THE CANCER LETTER INTERACTIVE

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Did The Dog Eat It? NIH Fails To Turn In A Prostate Cancer Plan Assigned By Senate

Prostate cancer is more than an abstract policy issue for Sen. Ted Stevens (R-AK), chairman of the appropriations committee.

Last year, Stevens, a prostate cancer survivor, amended the Senate appropriations bill to insert a $175 million earmark for NIH research in prostate cancer. This was no small matter: no earmark exists even for NIH breast cancer programs, despite the fact that breast cancer research

(Continued to page 2)

In Brief:

Von Hoff To Direct Arizona Cancer Center; American Health Foundation Appoints Nixon

DANIEL VON HOFF has accepted the position of director of the Arizona Cancer Center, in Tucson, and will assume his new duties in mid-August. Von Hoff will succeed founding director **Sydney Salmon**, who will serve as director emeritus and continue as Regents Professor of medicine. Von Hoff is director of the Institute for Drug Development of the Cancer Therapy and Research Center. Arizona said it would provide Von Hoff with resources of $5 million a year for three years to build a new drug discovery program and recruit faculty. "I hope to continue the legacy that Dr. Salmon built and work toward making the center an even greater place to help patients with cancer," Von Hoff said. Salmon had announced last year that he would be stepping down. "I'm absolutely delighted that Dan Von Hoff has accepted the directorship of the Arizona Cancer Center," Salmon said to **The Cancer Letter**. "He was the Search Committee's first choice, and mine as well. I've known and interacted with Dan in various research activities for more than 20 years and am convinced that Dan's expertise in drug development and clinical oncology will enhance our already strong pharmacology program. His enthusiasm and leadership capabilities are precisely what is needed at this time for our center." **Ray Nagle**, professor of pathology and deputy director of the center, served as chairman of the search committee. **Charles Coltman Jr.**, CEO and president of CTRC, said, "I am pleased for Dan and his family as they undertake this exciting new challenge. We are very fortunate that we will continue to have an extremely strong team of researchers who are totally committed to continue the work developed at the IDD over the past seven years." Von Hoff is the current president of the American Association for Cancer Research. . . . **DANIEL NIXON** was named president of the American Health Foundation. Nixon, formerly

(Continued to page 8)

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NIH Provides No Explanation For Failure To Turn In Homework

(Continued from page 1)

has the most effective grassroots support in oncopolitics.

Though the senator's earmark was struck from the final conference bill, there was no reason to doubt that fiscal 1999 was going to be The Year of the Prostate. Last October, the Senate committee report mandated that NIH present a five-year plan for researching the disease.

The plan was due on Capitol Hill in April. Considering the clarity with which the exercise was described in the appropriations report, as well as the clout of the people who assigned it, it should have been difficult for NIH to lose sight of this piece of homework.

Expectations were high. For two weeks, the staff of the Senate Labor, HHS and Education Appropriations Subcommittee was preparing for an April 22 hearing during which NIH was to roll out its prostate plan.

Then, in the morning of April 20, two days before the hearing, NIH officials informed the subcommittee staff that the Institute-wide plan was not ready, and the NCI plan, which was ready, was yet to be cleared. NIH asked for an extension until June, sources said.

Celebrity witnesses, including former Presidential candidate Bob Dole and financier Michael Milken, had to be informed that their testimony would not be required. Urologist Andrew von Eschenbach, director of the M.D. Anderson Center for Genitourinary Cancers, and William Schwartz, vice chairman of the National Prostate Cancer Coalition, were told to turn back as well.

While NCI was ready to present a 40-plus-page plan for spending about $141.5 million for fiscal 1999, NIH apparently had not prepared a plan for the remaining $33.5 million that would have come from other Institutes, and had not cleared the NCI plan for release to Congress, sources said.

What went wrong?

Officials in Bethesda declined to comment. Capitol Hill was silent, too. Prostate cancer advocates, by contrast, were anything but mum. "I think it's a particularly weak showing, since NIH was put on notice in October to have this done in April," Jay Hedlund, NPCC president and chief executive officer, said to **The Cancer Letter**. "Failure to produce a plan that Congress said was a priority is a bit dumbfounding."

Hours after learning about the cancellation of the Senate hearing, Hedlund and Richard Atkins, president of CaPCURE Government Research Initiatives Group, a unit of the Santa Monica, CA, based organization founded by Milken, sent letters of protest to NIH Director Harold Varmus.

"The history of prostate cancer research at NIH has been characterized by too much neglect and indifference," Hedlund wrote in the letter dated April 20. "Your failure to be prepared suggests a continued indifference to making prostate cancer a priority at NIH... Your delay seriously undermines our confidence that NIH is committed to waging an effective fight against prostate cancer."

CaPCURE official Atkins similarly accused Varmus of "precipitously" canceling the hearing. "On behalf of the millions of men an family members in America whose lived have been devastated by this disease, we find NIH's need to postpone the hearing appalling," Atkins wrote. "It is appalling because—once again—it relegates this disease to lesser consideration and concern by the federal agency that should be responsible for fostering its cure."

The "cc" lists on the two letters could constitute their most damaging feature: copies went to House and Senate members who are in a position to inflict pain on NIH.

Capitol Hill hearings are often delayed.

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However, even a casual observer would have known that this hearing was not one to delay. The NIH issue at stake was nothing less than "Disease Olympics," or earmarking of funds for specific diseases in response to pressure from advocacy groups.

The specter of Disease Olympics has brought about a curious dynamic on Capitol Hill. Appropriators fear that, if played to the logical extreme, Disease Olympics would lead to the apportioning of all biomedical research funds based on the clout of advocacy groups, thereby making scientific opportunity irrelevant. Advocacy groups, by contrast, have learned that pressing for earmarks for specific diseases may not get the earmarks, but it is guaranteed to get the attention of the appropriators.

This is why the stakes were so high last fall, when Stevens introduced a $175 million earmark for prostate cancer programs at NIH. The last-minute amendment was a typical strategy for prostate cancer groups, which reserve their key plays for the final weeks of the appropriations process.

In this case, the amendment was the result of a long collaboration between Stevens and the prostate groups, sources said.

Stevens has a different perspective on earmarks than the majority of House and Senate appropriators who have been resisting Disease Olympics at NIH. The Defense appropriations subcommittee, which Stevens chairs, earmarks DOD funds for research in breast, prostate and ovarian cancers. Being no fan of these earmarks, Stevens may have seized the opportunity to accomplish two goals: (1) to move the cancer earmarks to NIH, and (2) to increase the government's commitment to prostate cancer research.

Ultimately, Stevens lost the battle with Sen. Arlen Specter (R-PA), chairman of the Labor, HHS subcommittee, and John Porter (R-IL), chairman of the House Labor, HHS subcommittee (**The Cancer Letter**, Oct. 30, 1998).

In the House-Senate conference report, the earmark was replaced by the following language:

"The conference agreement deletes without prejudice the Senate bill language specifying $175 million for prostate cancer research at NIH. The House bill contained no similar provision. It is agreed that spending for prostate cancer research over the years has not kept sufficient pace with the scientific opportunities and the proportion of the male population who are afflicted with this disease. This has resulted in significant gaps in scientific and clinical knowledge that contribute to the ongoing morbidity and mortality directly attributable to prostate cancer.

"To address this shortcoming, NIH is strongly urged to make prostate cancer a top priority in allocating funding increases. The agency is expected to accelerate spending on prostate cancer, taking into account the recommendation contained in the Senate report and bill.

"It is further expected that NIH will consult closely with the research community, clinicians, patient advocacy groups, and the Congress to identify promising new avenues of basic and clinical research. The agency is directed to develop a report to be presented to the House and Senate committees on appropriations within six months outlining the professional judgment for prostate cancer research within five years.

"The [HHS] Secretary and the [NIH] Director should also be prepared to discuss actions taken in planning, funding, and implementing the agency's prostate cancer research portfolio for fiscal years 1999 and 2000."

Between October and April, Stevens did not lose sight of the issue. Sources said Stevens brought it up repeatedly in meetings and telephone conversations with top NCI and NIH officials. In public, too, the senator expressed disappointment about the level of funding for prostate cancer by NIH as well as his regret about having lost the battle over the earmark (**The Cancer Letter**, Feb. 26).

"Last year, I had a little battle with Sen. Specter, and he won, about earmarking funds for prostate cancer research," said Stevens at a hearing Feb. 24. "I am alarmed at the rate of allocation base for prostate cancer research, as compared to other cancers. It does seem to me that this is a growing problem. American men are suddenly waking up to the fact that they have been sort of the last pigeon hole, more or less, in the cancer research base."

It appears that Congressional directives (and Congressional reminders) were lost on Varmus, but not on NCI Director Richard Klausner.

Several weeks before the report language was adopted by the House-Senate conferees, NCI completed a report of a Progress Review Group of 22 scientists and advocates who analyzed the entire NCI portfolio of prostate cancer research. The report is available on the NCI website: http://www.nci.nih.gov/prostate.html.

Using that document as a foundation, the Institute developed a plan to spend about $141.5

million on prostate cancer in fiscal 1999, a 63 percent increase over fiscal 1998, ramping up the spending to $340 million in the year 2003, sources said. The plan assumes that the Institute's budget would double over the same interval.

The report that was prepared for the April 22 hearing includes the NCI plans for basic, clinical and translational research, as well as epidemiology and survivorship issues, sources said.

On April 16, NIH appears to have made a last-minute effort to produce a comprehensive plan. Sources said that in a communication sent out that day, institute directors were given five days to come up with their five-year plans for prostate cancer research.

In Congress:

Medicare Coverage Sought For Cancer Clinical Trials

Sens. Connie Mack (R-FL) and Jay Rockefeller (D-WV) last week introduced the Medicare Cancer Clinical Trials Coverage Act of 1999 (S. 784), which would provide coverage of routine patient care costs for Medicare patients enrolled in cancer clinical trials.

The House version of the bill, H.R. 1388, was introduced by Reps. Nancy Johnson (R-CT) and Benjamin Cardin (D-MD).

This is the third time Rockefeller and Mack introduced the legislation which would set up a five-year "demonstration project" partly aimed at determining the difference in costs of standard care and the care in clinical trials.

The bill covers a broader range of trials than the Administration seeks to cover in its budget proposal for the fiscal year 2000. While the Administration proposes coverage only for trials sponsored by NIH, the Rockefeller-Mack measure also applies to trials conducted under an Investigational New Drug license from FDA, as well as trials conducted under the purview of the Department of Veterans Affairs, the Department of Defense, and organizations which are approved by the NIH, such as the American Cancer Society.

"The President's proposal fails to meet the needs of Medicare beneficiaries and the health care professionals who treat them," Mack said. "Limiting coverage to certain government-sponsored clinical trials shuts these patients out of some of the most promising therapies being studied by the private sector."

Cancer Control:

Cancer Incidence, Death Rates Continue Downward Trend

The rate of new cancer cases and deaths for all cancers combined as well as for most of the top 10 cancer sites declined between 1990 and 1996 in the U.S., according to a report released April 20 by the American Cancer Society, NCI, and the Centers for Disease Control and Prevention.

However, unless the increase in adolescent smoking can be reversed, declining lung cancer rates are likely to start increasing again, according to the report.

The "Annual Report to the Nation on the Status of Cancer, 1973-1996, With a Special Section on Lung Cancer and Tobacco Smoking," is published in the April 21 issue of the Journal of the National Cancer Institute.

Clinton Administration officials said the report demonstrates that progress continues to be made in reducing cancer incidence and mortality. "We are turning the corner in the war against cancer," Vice President Al Gore said in a statement. Gore called for efforts to prevent children from smoking.

"These findings underscore the remarkable progress we've made against cancer, but it also reminds us that our battle is far from over," said HHS Secretary Donna Shalala. "We must keep fighting this disease with everything we've got."

Shalala said Congress should support the Administration's proposal to pay patient care costs for Medicare patients to participate in cancer clinical trials. "Along with additional research dollars for the National Institutes of Health, this proposal would help bring effective, new cancer treatments into the mainstream of American medicine," she said.

"Even as we celebrate progress today, it's no time for complacency," Barbara Rimer, director of the NCI Division of Cancer Control and Population Sciences, said in a press conference announcing the report. "It must be a call to work even harder to advance fundamental knowledge and to improve interventions to reduce the burden of cancer. We cannot be satisfied until the reductions in cancer incidence and mortality are shared by all segments of society."

John Seffrin, chief executive officer of ACS, said the inability of Congress to pass tobacco control legislation last year "will tragically lead to extraordinary excess deaths" from tobacco-related

cancers among the estimated 3,000 children who begin smoking each day in the U.S. "A true national emergency exists," Seffrin said.

Incidence Rates Peaked In 1992

The report shows that the incidence rate—defined as the number of new cancer cases per 100,000 persons—for all cancers combined declined on average 0.9 percent per year between 1990 and 1996. The greatest decrease occurred after 1992, the year in which incidence rates peaked. This trend reversed a pattern of increasing incidence rates from 1973 to 1990, and continued the downward trend first documented in a report last year by the same researchers (**The Cancer Letter**, March 13, 1998).

From 1990 to 1996, cancer death rates have been falling on average 0.6 percent per year, the report said.

The decline in the cancer incidence rate was greater for men than for women, the report said. The largest decrease in men occurred among those who were 25 to 44 years old and 75 years and older. The largest incidence trends for women were a decrease among those 35 to 44 years old and 85 and older.

The report analyzed data for white, black, Asian/Pacific Islander, American Indian/Alaska Natives and Hispanic populations and noted large differences in cancer incidence by race and ethnicity. Incidence rates are highest for African-Americans for all the major cancer sites except for breast cancer, the report said.

Decreases in the death rate occurred in men of all ages except those 85 years and older. The drop in the rate for men influenced the overall decline. Decreases in female death rates occurred for those younger than age 65. Death rates were highest for the black population for cancer overall and for the major cancer sites.

From 1990 to 1996, four cancer sites—lung, prostate, breast and colon and rectum—accounted for more than half of all new cancer cases and were also the leading causes of cancer deaths, the report said.

Prostate cancer incidence and mortality rates are decreasing, the report said. Breast cancer incidence rates have shown little change in the 1990s, while breast cancer death rates have been declining about 2 percent per year since 1990. Colorectal cancer incidence and death rates continued to decline for both men and women.

For two of the top cancer sites, the pattern is different. Incidence and death rates for non-Hodgkin's lymphoma are continuing to increase, although more slowly in the 1990s than the past decade. Incidence rates of melanoma have risen about 3 percent annually, but death rates have remained constant, the report said.

Lung Cancer: "Scourge Of The 20th Century"

The report includes a special section on lung cancer and tobacco, and presents state data for lung cancer deaths and prevalence of smoking in adults and youth. Lung cancer causes more deaths than any other cancer, accounting for 28 percent of all cancer deaths each year. Lung cancer also represents 14 percent of new cancer cases, and continues to be a key factor driving overall cancer trends, the report said.

During the 1990s, lung cancer incidence and death rates declined among males of all racial and ethnic groups except American Indians/Alaska Natives. During 1990 to 1996, male lung cancer incidence rates decreased on average 2.6 percent per year. Male lung cancer death rates decreased about 1.6 percent per year. These declines reflect the large decreases over the past several decades in active smoking and exposure to environmental tobacco smoke that together cause about 90 percent of lung cancer, the report said.

In contrast, lung cancer incidence and death rates increased among women, although the rate of increase has slowed in recent years. Among females during the 1990s, the average annual percent increase was 0.1 percent per year for incidence and 1.4 percent for mortality. Because the prevalence of smoking in women lagged behind men, the impact of decreased smoking on female lung cancer rates over all ages and racial groups combined has not yet been observed, the report said.

"As we turn to the new century, there is more good news in the decrease in male deaths from lung cancer," Rimer said. "There is a potential that this scourge of the 20th century may not also become a demon of the 21st, at least for men.

"But the still-increasing, though slowing mortality from lung cancer for women is a major challenge for all of us," Rimer said. "This is not just a U.S. epidemic, this is a world-wide pandemic. There will be over 1 million new cases of lung cancer worldwide this year, and almost that many deaths.

"By the year 2025, there will be 10 million smoking-related deaths that year alone, unless we

act now on a global level."

The age-specific patterns of declines seen for males are beginning to occur in females, the report said. Lung cancer incidence and death rates declined among women ages 40 to 49 and 50 to 59, were approximately level among females 60 to 69, and were continuing to increase among older women.

"As we enter the new century, with the death rates from lung cancer in women continuing to rise, we must work to develop interventions and to educate society about this major cause of death," Rimer said. "Since about 1985, more women have been dying from lung cancer each year than from breast cancer. Lung cancer has become a women's disease, and women need to be concerned about lung cancer."

The prevalence of cigarette smoking among adults has declined over the past 25 years, but this trend has stalled during the past four to five years, the report said.

The number of high school students smoking cigarettes has continued to increase during the 1990s, and unless this trend can be reversed, the lung cancer rates that are currently declining may rise again, the report said.

"We need to understand more about how to prevent teenage girls from smoking and how to help women quit smoking," Rimer said. "To have a major impact on cancer mortality, we are going to have to reduce tobacco use further in our society."

NCI is about to begin several new initiatives in tobacco control, including grants for Transdisciplinary Tobacco Use Research Centers and state and community initiatives, Rimer said. Applicants for the center grants have been encouraged to study women and smoking, she said.

The report is based on incidence data from NCI's Surveillance, Epidemiology and End Results Program and mortality data from the CDC National Center for Health Statistics. Data on smoking behavior are collected by NCHS in nationwide household interviews and by CDC's National Center for Chronic Disease Prevention and Health Promotion from state departments of health and education in the Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System.

The authors the report are Phyllis Wingo (ACS), Lynn Ries (NCI), Gary Giovino (CDC), Daniel Miller (CDC), Harry Rosenberg (NCHS), Donald Shopland (NCI), Michael Thun (ACS), and Brenda Edwards (NCI).

Additional information is available on the following Web sites: SEER: http://www-seer.ims.nci.nih.gov; NCI: http://www.nci.nih.gov; ACS: http://www.cancer.org; CDC Division of Cancer Prevention and Control: http://www.cdc.gov/cancer; CDC National Center for Health Statistics: http://www.cdc.gov/nchswww/

Professional Societies:

AACR To Form Foundation To Support New Programs

PHILADELPHIA—The Board of Directors of the American Association for Cancer Research voted last week to establish a non-profit foundation that would have the goal of providing financial support for a variety of new programs, ranging from fellowships and scientific training to public education and outreach, AACR officials said.

The AACR Foundation, to be formed later this year, would be governed by a 25-member board composed of leaders in science, business, industry, and philanthropy, Margaret Foti, AACR executive director, said to **The Cancer Letter**. About a third of the seats would be reserved for AACR members.

"The raison d'être of the foundation would be to raise money in support of the mission of AACR," Foti said in an interview during the association's annual meeting. "That would include a number of programs, including funding for fellowships, training, and career development programs that the AACR wants to push forward."

Webster Cavenee, the immediate past president of AACR, said the foundation will provide a stronger and more stable basis of support than the association's "sustaining membership" program, in which corporations are encouraged to donate funds to the association.

"When we go ask for memberships or partnerships with companies, we do that individually as AACR members," said Cavenee, director of the Ludwig Institute for Cancer Research, San Diego, and professor of medicine, University of California, San Diego.

"To have a business-driven, savvy board of heavy-hitter type people, that's a whole different kettle of fish than anything we've done in the past," Cavenee said.

The foundation would be able to move more quickly to implement new programs than the association currently can, due to the requirement for full membership votes of approval for launching major

initiatives funded by member dues, Cavenee said. "It gives us much more flexibility," he said.

In the past three years, AACR has doubled its budget, from $7.6 million to $16 million this year, and the number of programs the association supports has tripled, Foti said.

"We are looking for financial stability," Foti said. "We are going to need a strong financial base to support all the new things we want to get into—electronic publishing of all four journals, the launch of a new journal, expanded public education, expanded science education and opportunities for associate members and women, and new categories of membership. We also want to work more in partnership with the survivorship organizations. All of this takes new funds."

AACR's major areas of income are the publications, primarily the journal Cancer Research, the annual meeting, member dues, and fundraising.

About 18 months ago, AACR created the position of director of development and hired Anthony Tremblay, a development and fundraising professional who was with Springfield College in Massachusetts.

Foti said the association wants to conduct more public outreach, particularly through the public forum it has put on at the annual meeting for the past three years, and during The March last year in Washington.

"We feel the strong need as an organization devoted to cancer research to get the message to the public about the value of cancer research and the importance of increased funding, but also of education about new advances," Foti said. "We are doing that every year at the annual meeting, but we anticipate expanding that to year-round events that will help the public learn about cancer."

New Membership Categories Approved

In other action at the annual meeting, the AACR board voted to establish two new categories of membership: affiliate and student.

Affiliate membership would be open to laboratory technicians, research associates, oncology nurses, health care professionals, and high school science teachers. More than 100 potential affiliate members attended the Philadelphia meeting under a pilot program.

Student membership would be open to high school and undergraduate students. About 400 high school students from the Philadelphia area attended the meeting.

Also, the board voted to combine the corresponding membership category, for scientists who live outside the U.S., with the active membership category. The change would allow international members to vote and hold offices. Under the change, three new seats would be added to the board.

The changes to the membership categories will go to a vote of the full membership later this year. "We believe the members will approve this, because it's something that they have been asking for," Foti said to **The Cancer Letter**.

AACR has more than 15,000 members. "The new categories will expand membership to what we think will be 23,000 or 25,000 in the next several years," Foti said.

The association has been considering a membership category for the public, but decided to evaluate the proposal further, Foti said. "We think that's not likely to be a membership category, but probably some kind of network that we would have of interested members of the public," Foti said. "We already have at least 1,000 people who have sent their names and addresses and want to be kept informed about progress in cancer research. We are looking at that as a possible new program."

Key leaders in survivor organizations with constituencies will be invited to become active members, while those who are survivor advocates but not at the helm of organizations will have the opportunity to apply for membership in the affiliate category, Foti said.

RFAs Available

RFA CA-99-002: Planning Grants: In Vivo Cellular And Molecular Imaging Centers (PRE-ICMICs)

Letter of Intent Receipt Date: June 17

Application Receipt Date: July 23

The Diagnostic Imaging Program, NCI Division of Cancer Diagnosis and Treatment invites applications for P20 planning grants that lead to the establishment of In Vivo Cellular and Molecular Imaging Centers. NCI anticipates making six three-year awards, and plans to set aside $2.4 million for the initial year's funding. Annual budgets in the range of $300,000 to $500,000 total costs are suggested.

Inquiries: Anne E. Menkens, Ph.D., Diagnostic Imaging Program, NCI, Executive Plaza North Suite 800, Bethesda, MD 20892, phone 301-496-9531, fax: 301-480-5785, e-mail: am187k@nih.gov

RFA CA-99-004: In Vivo Cellular And Molecular Imaging Centers (ICMICs)

Letter of Intent Receipt Date: June 17

Application Receipt Date: July 23

The Diagnostic Imaging Program, NCI Division of Cancer Diagnosis and Treatment invites applications for P50 Research Center Grants for the establishment of In Vivo Cellular and Molecular Imaging Centers (ICMICs). NCI anticipates that two to three 5-year awards will be made in FY 2000, and plans to set aside $4 million total for the initial year's funding.

Inquiries: Anne E. Menkens, Ph.D., Diagnostic Imaging Program, NCI, Executive Plaza North Suite 800, Bethesda, MD 20892, phone 301-496-9531, fax 301-480-5785, e-mail: am187k@nih.gov

RFA CA-99-009: Minority-Based Community Clinical Oncology Program

Letter of Intent Receipt Date: July 22

Application Receipt Date: Aug. 27

The Community Oncology and Rehabilitation Branch, NCI Division of Cancer Prevention, invites domestic institutions with the capability and intent to serve new cancer patients largely from minority populations to apply for cooperative agreements in response to this RFA. Up to $1.9 million in total costs per year for three years will be committed to fund applications. Up to seven awards will be made. The anticipated amount of the direct cost awards will range from $150,000 to $300,000 per year.

Inquiries: Worta McCaskill-Stevens, MD, Division of Cancer Prevention, NCI, 6130 Executive Blvd Room 305-D MSC-7340, Bethesda, MD 20892-7340, phone 301-496-8541, fax 301-496-8667, e-mail wm57h@nih.gov

RFA CA-99-010: National Cooperative Drug Discovery Groups

Letter of Intent Receipt Date: June 16

Application Receipt Date: July 14

The Developmental Therapeutics Program, NCI Division of Cancer Treatment and Diagnosis, invites applications for continuance of the NCDDG and National Cooperative Natural Products Drug Discovery Group Programs. NCI has budgeted $12 million total costs (direct plus facilities and administrative costs) for the first year of funding. It is expected that 12-14 awards will be made for periods up to five years.

Inquiries: George S. Johnson, Ph.D., Division of Cancer Treatment and Diagnosis, NCI, 6130 Executive Boulevard Suite 841 MSC 7456, Bethesda, MD 20892-7456, Rockville, MD 20852-7456 (for express/courier service), phone 301-496-8783, fax 301-402-5200, email: johnsong@exchange.nih.gov

RFA CA-99-011: The Early Detection Research Network: Data Management and Coordinating Center

Letter of Intent Receipt Date: June 11

Application Receipt Date: July 16

The NCI Division of Cancer Prevention invites applications for cooperative agreements to establish a national network that will have responsibility for the development, evaluation, and validation of biomarkers for earlier cancer detection and risk assessment. An estimated $400,000 will be available per year. One award will be made.

Inquiries: Sudhir Srivastava, Ph.D., M.P.H., Early Detection Branch, Division of Cancer Prevention, NCI, Executive Plaza North Room 330F, Bethesda, MD 20892, phone 301-496-3983, fax 301-402-0816, email: ss1a@nih.gov

RFA OH-99-003: Mechanistic-Based Cancer Risk Assessment Methods

Letter of Intent Receipt Date: May 26

Application Receipt Date: July 14

The Centers for Disease Control and Prevention, the Environmental Protection Agency, and NCI announce the availability of fiscal year 1999 funds for grant applications for research related to mechanistic-based cancer risk assessment methods. Approximately $1.55 million is available to fund the first budget year of five to six grants.

Inquiries: Roy M. Fleming, Sc.D., Director, Research Grants Program, NIOSH, 1600 Clifton Road NE, Bldg 1, Room 3053 MS D-30, Atlanta, GA 30333, phone 404-639-3343, fax: 404-639-4616, email: rmf2@cdc.gov

In Brief:

Ernst Wynder Retires At AHF, Daniel Nixon Named President

(Continued from page 1)

associate director of prevention at the Medical University of South Carolina, succeeds **Ernst Wynder**, who has retired. Wynder founded AHF in 1969. AHF is an NCI-designated cancer center devoted entirely to prevention, with offices in New York City and laboratories in Valhalla, NY. Nixon will retain a faculty appointment as the Hayne Folk Professor at MUSC. He previously was vice president for cancer detection at the American Cancer Society, and prior to that was an associate director in the NCI Division of Cancer Prevention and Control. . . . **NCI PLANS** to extend a contract with the Fred Hutchinson Cancer Research Center for another two years to evaluate transplanting human genes into yeast cells to develop a high-throughput screen for anticancer drugs. The project began in 1996 under a two-year contract with NCI. "The screening effort has shown interesting correlations between the compounds screened and various biochemical pathways in genetically engineered yeast," said an NCI notice published in Commerce Business Daily on April 1. "This two-year extension is required to continue the activities initiated under the basic contract and to pursue other interesting aspects of the screening program."

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