THE CANCER LETTER INTERACTIVE

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NCI To Support Chemoprevention Grants In Tobacco-Related Cancer, Ex-Smokers

Advisors to NCI approved the Institute's plan to set aside $7 million for the first year of funding for preclinical and clinical studies of chemoprevention for tobacco-related cancer in former smokers.

The two new grant programs would be administered by the NCI Division of Cancer Prevention and would fund up to 12 grants per year.

The NCI Board of Scientific Advisors unanimously approved the program concept statements at a March 5 meeting.

About half of the 164,000 new cases of lung cancer and half of the 54,000 new cases of bladder cancer diagnosed last year in the U.S. occurred

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In Brief:

Vanderbilt-Ingram Cancer Center Wins NCI's Comprehensive Designation

VANDERBILT-INGRAM Cancer Center, in Nashville, Tenn., was designated a Comprehensive Cancer Center, joining 38 other institutions in the highest recognition provided by NCI. **Sen. Bill Frist** (R-Tenn.) made the announcement March 9 at the center. "I'm proud that Vanderbilt has worked so hard to earn this distinction, and I'm pleased that NCI has awarded this prestigious designation in recognition of Vanderbilt's commitment to fight cancer," Frist said. **Harold Moses** is the center director. The center receives nearly $4.3 million each year for its Cancer Center Support Grant, scheduled for renewal in 2003. NCI and other funding sources provide nearly $75 million to support research and other programs at the center. Vanderbilt-Ingram was formed in 1993, and two years later, became the youngest cancer center in history to be designated by NCI as a Clinical Cancer Center. Since that time, the center enhanced its basic cancer research program, added programs in prevention and epidemiology, and began a cancer information, education and outreach office. The center is affiliated with Vanderbilt University and Medical Center. It includes the Henry-Joyce Cancer Clinic, inpatient facilities in Vanderbilt Hospital and Children's Hospital, the region's first comprehensive breast diagnostic center and its only Cancer Pain and Symptom Management Program and Family Cancer Risk Service. The center's Web site address: http://www.vicc.org. . . . **KAREN FIELDS** was promoted to chief of medicine at H. Lee Moffitt Cancer Center in Tampa, Fla. Fields is program leader of the Blood and Marrow Transplantation Unit and medical director of Affiliations and Referring Physicians. . . . **JOHN GREENE** was promoted to chairman of

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Advisors Approve $7 Million For Chemoprevention Grants

(Continued from page 1)

in former smokers, Vernon Steele, of DCP's Chemopreventive Agent Development Group, said to the board. Preventing lung, bladder, and other smoking-related cancers in former smokers is one of the research opportunities identified in NCI's budget proposal for FY2001.

In other action, the board appointed a committee to work with NCI staff to revise a concept statement submitted by the Radiation Oncology Sciences Program of the Division of Cancer Treatment and Diagnosis. The concept proposed a $19-million, five-year pilot program to establish radiation oncology partnerships for underserved medical institutions. A revised concept statement would be presented to the board at its June meeting.

Portions of the text of the approved concept statements follow:

[Concept statements represent NCI's plans for issuing future Requests for Applications or Requests for Proposals. Contact the program directors listed for further information on funding plans and grant application procedures.]

Chemoprevention of tobacco related concerns in former smokers: preclinical studies. Concept for a new RFA, five to six awards per year, length of award one to five years, first-year set-aside $3 million. Program director: Vernon Steele, NCI Division of Cancer Prevention, phone 301-594-0420, email vs1y@nih.gov.

The development of animal model protocols that can accelerate and improve the discovery and development of agents to take to the clinic to prevent or diminish the risk of cancer in former smokers represents an extraordinary opportunity to reduce cancer incidence and therefore subsequent morbidity and mortality. The purpose of this initiative is to invite investigator-initiated grant applications developing and evaluating chemoprevention strategies preclinically which are applicable to former smokers and would become immediately translated to clinical studies. The range activities supported by this RFA would include preclinical studies to: 1) develop modulatable biomarkers under former tobacco exposure protocols and reduce cancer risk which could be translated into a clinical setting. Such biomarkers would include: image analysis, gene or protein expression, or specific molecular changes, DNA mutations, etc., in specific preclinical models in which relevant cancer incidence and multiplicity are decreased by known effective agents, and 2) test and prioritize agents using former-smoker protocols in clinical animal models for tobacco related cancers, including lung, head and neck, bladder, kidney, esophagus, pancreas, and cervix.

Applicants are especially encouraged to apply a number of newly identified molecular targets for tobacco related cancers to validate these markers in response to chemoprevention therapy in relevant preclinical models. Such preclinical validation efforts for the development of surrogate endpoints would be synergistic with NCI's Early Detection Research Network. Biomarkers relevant to target organs and tobacco use identified by EDRN could then be applied to former smoker preclinical models to validate their potential use in future clinical trials. Studies would be encourage specifically employing biomarkers which could be accessed easily and modulated by chemoprevention agents in smoke-related target organs (e.g., bronchus, bladder, and pancreas).

The studies funded under this RFA would be encouraged to collaborate and take advantage of animal models for human cancer, developed in collaboration with scientists involved in the Mouse Models for Human Cancer Consortium, for use with former smoker protocols. Transgenic animal models for lung cancer are already under development and might be used under a former smoker protocol with the application of drug development for such purposes.

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Likewise, newly developed imaging techniques that are being evaluated as part of the MMHCC activities could be incorporated. The MMHCC would also serve as a focal point for a meeting in the spring of 2001 to gather the larger community animal model developers to develop models in other tobacco related target organs such as bladder, head and neck, esophagus, pancreas, cervix, and kidney.

Examples of preclinical studies that would be appropriate for funding under this RFA include 1) studies developing cancer preventive agents using animal models for lung, bladder, head and neck, and cervix, employing protocols similar in designed to proposed clinical models in the former-smoker trials, and 2) validation of modulatable surrogate biomarkers in animal models specifically relevant to former smokers using molecular and morphological endpoints that could be applied to such clinical trials. The agents to be employed in such biomarker studies should have been shown to decrease cancer incidence and/or multiplicity in the smoke-related organ site of interest.

Applications will be accepted for R01, R21/23, and competitive supplements to existing awards in this area.

Chemoprevention of tobacco related concerns in former smokers: clinical studies. Concept for a new RFA, five to six awards per year, length of award one to five years, first-year set-aside $4 million. Program director: Eva Szabo, Division of Cancer Prevention, phone 301-435-2456, email es99v@nih.gov.

The purpose of this initiative is to invite investigator initiated grant applications for clinical trials developing effective chemoprevention strategies in former smokers. The range activities supported by this RFA would include: 1) Pilot clinical trials (phase I/II or phase II) evaluating the efficacy of chemoprevention agents in specified cohorts of former smokers. Such studies should incorporate the evaluation of biomarkers and surrogate endpoints into the clinical study design. 2) Translational studies performed on specimens (tissue, blood, urine, etc.) derived from ongoing or previously completed chemoprevention studies targeting former smokers. These studies should be aimed at identifying molecular signatures that may be used to recognize and predict the effectiveness of chemoprevention agents in targeted populations of former smokers.

Applicants are encouraged to apply a number of newly identified molecular targets for tobacco related cancers to validate these markers clinically. Applicants are also encouraged to interact with and take advantage of the resources available through NCI supported research infrastructures such as the Early Detection Research Network and Specialized Programs in Research Excellence.

Examples of clinical studies that would be appropriate for funding under this RFA include: 1) Pilot clinical trials that could be performed in populations of ex-smokers at high risk for cancer to examine the capacity of chemopreventive agents to regress dysplastic lesions in the lung, head and neck, or esophagus. 2) Pilot trials that would attempt to inhibit the recurrence of bladder tumors in ex-smokers who have undergone resection and remain at high risk. Such studies could examine gene/environment interactions of high risk to occupations such as the dye, pesticide, or asbestos industries, or other environmental exposures (radon or asbestos), which amplify the cancer risk of smoking, to define especially high risk cohorts.

Applications for the U01 mechanism will be sought for most clinical trials, while applications for the R01 mechanism will be sought for translational studies.

In board discussion of the clinical studies concept, BSA member Caryn Lerman said NCI should encourage grant applicants to incorporate in the clinical studies proven strategies to reduce attrition caused by smoking relapse among study participants. Lerman said the act of taking a potential chemoprevention agent may induce some former smokers to relapse.

NCI Programs:

NCI Sends Letter To Grantees To Explain Tighter Funding

NCI Director Richard Klausner sent a letter to grantees explaining the Institute's funding policies for fiscal 2001.

"It may seem paradoxical that at a time when the NCI budget has increased, we are instituting more stringent fiscal policies," Klausner wrote in the letter, dated March 1. However, research costs "have been escalating at an even more rapid rate than our increases, generous as they have been," he wrote.

The funding policies were set in consultation with a subcommittee of the National Cancer Advisory Board, Klausner wrote.

Klausner presented the policies to the NCAB last

month (**The Cancer Letter**, Vol. 27 No. 8, Feb. 23).

The letter was posted on the NCI Web site at http://www.cancer.gov/scienceresources/announcements/2001_funding_policy.htm.

Edited text of the letter follows:

The fiscal year 2001 appropriation awarded NCI a budget of $3,757,242,000, a 13.5% increase over last year's budget. The RPG portion of the total NCI budget constitutes nearly half of the total allocation. Over $1.6 billion of the total NCI budget has been made available for investigator-initiated research. This year, NCI will support the largest number of research grants in its 63-year existence. We estimate that the success rate for competing grant applications will be 29%, compared with 28% last year. We also expect that 4,485 grants will be awarded, an increase of 265 from last year.

Our ability to achieve these goals is based on the policies detailed below. Some of these policies are new, and may affect the way your funding level is determined. If you have specific comments or questions after reviewing these policies, please contact your NCI Program Director or the Grants Management Specialist assigned to your grant.

Non-Competing Research Project Grants

We will meet our commitments to previously awarded non-competing (Type 5) Research Project Grants at the level committed on the previous notice of grant award. To do this requires allocating 25%, or $110 million, of the increase in the budget to these awards, before any new or competing awards are made.

Competing R01s

The first step in the determination of NCI paylines is the scientific prioritization of applications by the peer review system. Then, based on increases in both number and cost of R01 applications and the available budget, a payline for new and competing continuation R01 grants is established. For FY 2001, the payline is the 22nd percentile. Although this payline is unchanged from last year, it reflects an increase of 55 competing awards from last year, bringing the total to 779 grants. Although the number of grants has only increased by 8%, the funds set aside for competing R01s have increased by 17% due to the increased costs of research.

This has been reflected in a large change in funding requests in this year's R01 grant applications. Among the 3,200 applications received in the first two rounds, an average increase in funding of close to 10% was requested. For those awards within the payline, the average increase requested by R01 investigators was 15% more than last year. This is in sharp contrast to our experience in previous years, which led us to expect average cost increases between 3% and 4%. In addition, the number of R01 applications approved for higher costs is increasing steadily. For example, projections are that 154 fundable applications will have a direct cost of $250,000 (10 modules), compared with 90 for last year. Last year, NCI funded only a single R01 that had a total cost in excess of $1 million. For the first two rounds this year, 7 applications, each costing in excess of $1 million, fall within the fundable payline. Clearly, this has a dramatic impact on both the total funds needed and the average cost per grant funded. With this continuing shift to more expensive grants, we recognized a need to revise the initial FY 2001 funding policy. Smaller R01 grants (defined as 7 modules or fewer) will be reduced 7% less than those R01 grants of greater than 7 modules. However, any cost reductions will vary by individual grant and be determined on a case-by-case basis.

Request for Applications

Grants received in response to Request for Applications will be paid from funds in the competing pool set aside for this purpose. In FY 2000, NCI allocated 6.3% (over $24 million) of competing dollars to support RFA applications. To increase support for unsolicited R01 awards in FY 2001, we have reduced the RFA pool to 5% ($20 million) of competing dollars.

Peer Review Recommended Levels

We have also had to make some administrative changes in determining the actual cost of an award. Starting with this year's competing applications, the NIH Center for Scientific Review has changed the process its study sections use in reporting budget levels for approved grants. The Summary Statement face page now contains only the applicant's requested budget. CSR no longer provides the study section's recommended award level on the summary statement. Instead, after review, NCI program and grant administrative staff will consider both the study section's funding recommendation and any other necessary cost adjustments in determining the final award level.

NCI will begin to report reductions in the average cost awarded as an adjustment from the requested

budget level, rather than from the recommended level. Past NCI funding typically awarded competing investigator-initiated R01 grants at 85-90% of the study section's recommended funding level. Normally, the study section's recommended level represented about 95% of the grantee's request. Hence, the awards averaged about 80-85% of the grantee's original requested budget. Consequently, any comparison with reductions from previous years (which were stated in terms as "from recommended") should be viewed carefully since they may not be comparable.

Competing Program Project Grants (P01s)

A priority score payline for Program Projects has not been established. Funding of P01 applications will be determined by the NCI Executive Committee on a case-by-case basis. Since NCI has capped requests for budget increases on competing renewal (type 2) Program Project applications, budget negotiations will be different for new (Type 1) applications than competing renewal applications. New P01 grants will be reduced an average of 15% from recommended levels while competing renewal P01s will be reduced 6% from recommended levels. (Note: NCI performs the review for P01 applications and is continuing to calculate the recommended level.) The net effect on type 2 awards will still provide an average growth of 15% over the current level of funding. In part, the increased cost for P01 awards reflects a changing mix of basic, clinical and population-based applications and the growing complexity of translational and clinical research.

Exception Funding

Over $42 million has been set aside by the NCI to support those grants that fall outside the established paylines yet have been approved as exceptions to the payline. The NCI Executive Committee or its individual Division Director members, with program staff input, decide which applications to fund as exceptions to the payline. Included are applications deemed eligible for Accelerated Executive Review (AER), a mechanism the NCI uses to turn a strict payline selection process into one that provides funding flexibility for those applications within a gray zone. The standard AER eligibility criteria for basic science R01 applications will be those scored in the range from the 22.1 percentile to the 27.0 percentile, and for Patient Oriented Research from the 22.1 percentile to the 32.0 percentile. It is anticipated that between 40-45 AER awards will be made.

Science Policy:

IOM: Mammograms Still Best For Breast Cancer Detection

Although several new technologies on the horizon show promise for improved capability to detect breast cancer, none have yet proved superior to traditional, X-ray film mammography in screening for breast cancer, according to a report from the Institute of Medicine and National Research Council of the National Academies.

More evaluation and development of new imaging tools and of promising molecular biological techniques is required, the report said.

"With all of its limitations, film mammography remains the gold standard against which new imaging technologies will be measured," said Joyce Lashof, chairman of the committee that wrote the report and professor emerita, School of Public Health, University of California, Berkeley. "To date, no quantum leap has been made in this area. At the same time, many of the newer tools offer certain advantages and deserve to be studied further."

No single imaging technology is capable of accurately detecting all breast abnormalities, the report said. Ultimately, the best detection may come from using several different tools. For example, ultrasound and magnetic resonance imaging have shown potential as adjuncts to mammography in diagnosis and screening, especially in getting a clearer picture of dense breast tissue in certain women.

In addition to evaluating scientific evidence on the new technologies, the committee examined the process by which newer screening technologies work their way through the pipeline from testing to routine clinical usage. The report raises a concern that technologies approved for diagnosis could be prematurely adopted for screening. Diagnostic tools help determine the nature of a breast abnormality first detected through screening and may not be appropriate for both purposes, the report said.

In evaluating a new technology's appropriateness for screening, FDA and the Health Care Financing Administration should base approval and coverage decisions on results of clinical trials that prove screening effectiveness, the committee said.

To accomplish this goal, a more systematic approach is needed for the assessment of screening tools, the committee said. Such an approach must involve clinical trials that are coordinated and designed with support from relevant federal agencies and breast-

cancer advocacy organizations. Private insurers should cover the costs of screening tests for women who participate in clinical trials but are not eligible for Medicare or Medicaid.

Because detection technologies and treatments are continually evolving, NCI should sponsor clinical trials every 10 to 15 years to reassess the effectiveness of established screening tools, the report said.

Also, NCI should collaborate with other organizations in sponsoring further studies to assess the benefits and risk of mammography in women over age 70, the report said.

While imaging technologies indicate structural differences or changes in the breast, some of the latest molecular biological technologies can provide information about the cellular characteristics of these abnormalities. The committee examined a number of tools such as growing breast cancer cells in the lab and identifying the genetic changes in particular kinds of tumors. NCI should expand breast cancer specimen banks, both in number and resources, the committee said.

Greater public access to current technologies is needed, particularly for women who lack health insurance, the report said. Congress should expand the Centers for Disease Control and Prevention breast-cancer screening program to reach more women—from the current 15 percent to 70 percent—and state legislatures should provide Medicaid funds for treatment of women with breast cancer identified through this screening program. HCFA and a panel of independent experts should analyze the current Medicare and Medicaid reimbursement rates for mammography and comparable radiologic techniques to determine whether the cost is adequately covered. Federal agencies and professional organizations should evaluate the current and future numbers of radiologic specialists and take measures to ensure an adequate supply of these experts, the report said.

The committee evaluated film mammography and 17 other technologies. These included ones with FDA approval, such as full-field digital mammography, ultrasound, computer-aided detection systems, and magnetic resonance imaging, as well as those not yet approved, such as optical imaging. No studies have shown a new technology to be a replacement for film mammography, for either screening or diagnosis, the report said. For instance, while digital mammography has been lauded as a major technical advance—facilitating storage, retrieval, transmission and image adjustment for mammograms—it has not shown greater accuracy than its nondigital counterpart.

Film mammography does not detect all cancers, particularly among younger women, who often have denser breast tissue that is more difficult to view with X-ray technology, the report said. Film mammography also may not detect fast-growing malignancies early enough to effect a cure. Routine screening in clinical trials resulted in only a 25 percent to 30 percent decrease in breast-cancer mortality among women between the ages of 50 and 70, and a lesser benefit was seen among women aged 40 to 49.

Of all breast lesions that are biopsied following suspicious findings on a mammogram, 75 percent turn out to be benign. Current screening methods also can lead to overdiagnosis and overtreatment of some women, the report said. Earlier identification of breast-tissue abnormalities will remain problematic until a deeper understanding of the biology and genetics of such abnormalities makes it possible to distinguish those that are non-threatening from those that may become invasive and progress to full-blown, metastatic breast cancer, the report said.

The study was sponsored by the Breast Cancer Research Foundation, the Carl J. Herzog Foundation, John Castle, the Jewish Healthcare Foundation, the Josiah Macy Jr. Foundation, the Kansas Health Foundation, and the New York Community Trust.

Copies of the report, "Mammography and Beyond: Developing Technologies for the Early Detection of Breast Cancer," are available from the National Academy Press, tel: 202-334-3313 or 1-800-624-6242, or see http://books.nap.edu/catalog/10030.html.

Besides Lashof, members of the Committee on Technologies for the Early Detection of Breast Cancer were Craig Henderson (vice chairman), University of California, San Francisco; D. Craig Allred, Baylor College of Medicine; Derek Van Amerongen, Humana Choice Care, Cincinnati; Wade Aubry, The Lewin Group; Janet Baum, Harvard Medical School; Suzanne Fletcher, Harvard Medical School; Marthe Gold, City University of New York Medical School; Leon Gordis, Johns Hopkins University; Daniel Hayes, Georgetown University; M. Carolina Hinestrosa, Nueva Vida, Support Network for Latinas with Cancer; Jean Latimer, Magee-Women's Research Institute, University of Pittsburgh; Richard Nelson, Columbia University; Kenneth Offit, Memorial Sloan-Kettering Cancer Center; Faina Shtern, Harvard Medical School; and Michael Vannier, University of Iowa College of Medicine.

Funding Opportunities:

RFAs Available

RFA GM-01-004: Large-Scale Collaborative Project Awards

Phase I Application Receipt Date: June 18, 2001
Phase II Application Receipt Date: Jan. 16, 2002

National Institute of General Medical Sciences announces a program for independently funded scientists to form research teams to investigate the major problems in biomedical research beyond the means of any one research group. Biomedical science has entered a new era where these collaborations are becoming critical to rapid progress and which increasingly must be solved through the application of a multitude of approaches. These include the involvement of fields, such as physics, engineering, mathematics, and computer science with the ability to attack large projects that involve considerable data collection and technology development require the collaboration of many groups and laboratories. For phase I applications, the RFA will use the NIH R24 grant mechanism; phase II applications will use the NIH specialized center cooperative agreements mechanism, U54.

Inquiries: Michael Rogers, Division of Pharmacology, Physiology and Biological Chemistry, National Institute of General Medical Sciences, 45 Center Drive, MSC 6200, Bethesda, MD 20892-6200, phone 301-594-3827; fax 301-480-2802; e-mail rogersm@nigms.nih.gov

RFA-ES-01-001: Transition to Independent Positions

Letter of Intent Receipt Date: June 7, 2001
Application Receipt Date: July 11, 2001

National Institute of Environmental Health Sciences TIP Program supports the transition from postdoctoral scientist to independent academic research positions relevant to the research priorities of NIEHS: the impact of environmental exposures on human health. The mechanism of support will be the NIH research scholar development award K22. Information about research topics is available on the NIEHS Web site: http://www.niehs.nih.gov/dert/programs/special/special.htm

Inquiries: Michael McClure, chief, Organs and Systems Toxicology Branch, Division of Extramural Research and Training, NIEHS, Box 12233, EC-23, 111 T.W. Alexander Dr, Research Triangle Park, NC 27709, phone 919-541-7825; fax 919-541-5064; e-mail mm461n@nih.gov

Program Announcements

PAR-01-061: Phased Application Awards in Cancer Prognosis and Prediction

Letter of Intent Date: May 9, 2001
Application Receipt Date: June 13, 2001

The Cancer Diagnosis Program of NCI invites applications for research projects, which will provide tools to improve clinical decision-making in the care of cancer patients. The program is intended to accelerate the translation of new discoveries into clinical practice by enabling investigators to apply new diagnostic strategies to clinical problems. The desired outcome will be studies with sufficient statistical power using efficient assay techniques that are conclusive enough to support the initiation of larger clinical trials designed to influence practice recommendations or to pursue FDA approval of a new device or analytic reagent. The first phase should demonstrate the technical feasibility of the study design proposed for the second phase, including the analytic performance of the assay or test system on samples comparable to those to be used in the second phase. The second phase should test whether application of the strategy will provide clinical benefit to a defined set of cancer patients. Support will be through the NIH exploratory/developmental research grant R21 and the exploratory/developmental research grant phase II R33.

Inquiries: Tracy Lugo, Cancer Diagnosis Program, Division of Cancer Treatment and Diagnosis, NCI, 6130 Executive Blvd, Rm 6042, Rockville, MD 20892, phone 301-496-1591; fax 301-402-7819; e-mail TL82S@nih.gov

PAR-01-062: Cancer Prognosis and Prediction: SBIR/STTR Initiative

Letter of Intent Date: May 9, 2001
Application Receipt Date: June 13, 2001

Support for this PAR is through the SBIR and STTR mechanisms, which are set-aside programs. Applications can be submitted for support as phase I STTR R41 or phase I SBIR R43 grants: phase II STTR R42 or phase II SBIR R44 grants; or under the SBIR/STTR Fast-Track option as described in the Omnibus Solicitation: (http://grants.nih.gov/grants/funding/sbirsttr1/PHS2001-2_Full_with_Topics.pdf).

Inquiries: See preceding PAR.

PAR-01-063: Review and Analysis of Tobacco Industry Documents

Letter of Intent Date: June 13, 2001; Jan. 8, 2002
Application Receipt Date: July 18, 2001; Feb. 12, 2002

Tobacco litigation brought by the State Attorneys General and others, Congressional inquiries, and the FDA investigation have resulted in the release of millions of previously inaccessible tobacco industry internal documents. The PAR will stimulate research on scientific, technical, marketing and tactical undertakings by the tobacco industry to provide a greater understanding of tobacco use and addiction and help researchers and public

health practitioners identify effective strategies to prevent and reduce its use.

Applications to analyze documents include, but are not limited to the following areas: nicotine pharmacology; nicotine addiction; health consequences of tobacco use, tobacco product additives, tobacco product design and manufacturing, advertising and promotion, youth initiation, tobacco use cessation, disruption of scientific research and public health programs; and policy research.

The most comprehensive collection of industry documents is at the State of Minnesota's document depository in Minneapolis and is now available at the following Web sites:

House of Representatives Commerce Committee http://www.house.gov/commerce/TobaccoDocs/documents.html

Tobacco Documents Online http://www.tobaccodocuments.org

University of California Library http://galen.library.ucsf.edu/tobacco

Tobacco Resolution (tobacco industry) http://www.tobaccoresolution.com

Tobacco Control Resource Center http://www.tobacco.neu.edu.

The PAR will use the NIH research project grant R01 award mechanism. NIH grants policies apply to these awards.

Inquiries: Michele Bloch, Division of Cancer Control and Population Sciences, NCI, Executive Plaza North, Rm 4032, MSC 7337, Bethesda, MD 20892-7337, phone 301-496-8584; fax 301-496-8675; e-mail blochm@mail.nih.gov

Administrative Supplements to Create Targeted Mouse Mutants

Receipt Date: June 1, 2001

The National Institute on Deafness and Other Communication Disorders, the National Institute of Mental Health and the National Institute of Environmental Health Sciences announce a program for administrative supplements to create mice carrying targeted mutations for currently-funded research project grants. The principal focus of the announcement is the creation of targeted mutations including knockouts, knock-ins, conditional mutants, and other specific mutations. Principal Investigators holding the following grant mechanisms are eligible to apply: NIDCD, R01, R29, P01, P50, K08, K23; NIMH, R01; NIEHS, R01, P01.

Inquiries: Jose Velazquez, scientific program administrator, Division of Extramural Research and Training, National Institute of Environmental Health Sciences, Box 12233, 111 Alexander Dr, MD EC-21 Research Triangle Park, North Carolina 27709, phone 919-541-4998; fax 919-316-4606; e-mail Velazqu1@niehs.nih.gov.

RFP Available

SOL N02-CP-11015-50: Interdisciplinary Studies of Occupational and Environmental Cancer

Deadline: Approximately April 26

The Occupational Epidemiology Branch, Division of Cancer Epidemiology and Genetics, NCI, is re-competing contract number N02-CP-71100 for support to interdisciplinary studies of occupational and environmental cancer, currently held by Westat Inc. The contract will establish a mechanism to provide all the services required to conduct a wide variety of domestic and international (case-control, cohort, cross-sectional, and pilot) studies related to occupational and environmental cancer. The projected level-of-effort for this contract is 10,000 direct labor hours per year for a total of 50,000 direct labor hours for the entire contract period. The scientific design and oversight of the activities are the responsibility of the OEB, DGEC, NCI professional staff.

The RFP may be accessed via the NCI Research Contracts Branch Web site: http://rcb.nci.nih.gov/ under "Current Request for Proposals."

Contact: Karen McFarlane, Contracting Officer, 301-435-3782, email km63K@nih.gov.

In Brief:

Thompson Tours Brown's Brain Science Center

(Continued from page 1)

the Interdisciplinary Oncology Program Education Committee at H. Lee Moffitt Cancer Center. Greene is an associate professor of oncology and medicine and section chief of the Division of Infectious and Tropical Diseases. . . . **HHS SECRETARY TOMMY THOMPSON** toured the brain science center at Brown University on March 9 to urge support of President Bush's proposal to increase funding for NIH by 13.7 percent (**The Cancer Letter**, Vol. 27, No. 9, March 2). The President's budget proposal would increase funding for NIH by $2.75 billion, or for a total of $23.1 billion. "Maintaining his commitment to doubling NIH's funding by 2003 is one of the most important initiatives in the President's budget," Thompson said. "This funding level will enable NIH to support the highest level of new and competing research project grants, and the highest level of total research project grants, in NIH history. Grants that will help Brown University and research and medical institutions across the country take on the challenges that will save lives and improve the quality of life for everyone."

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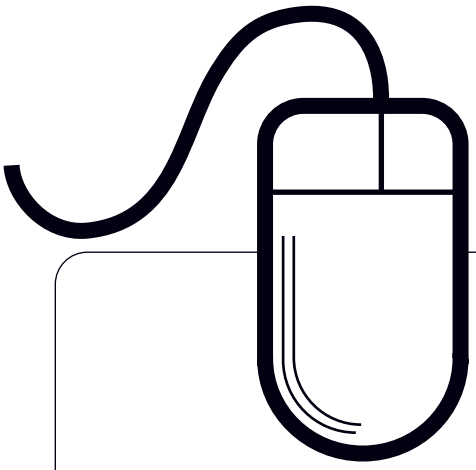

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