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U.S. Preventive Services Task Force Recommends Mammograms For Over-40

The U.S. Preventive Services Task Force recommends screening mammography, with or without clinical breast examination, every one to two years for women ages 40 and over.

The new recommendation affirms the HHS and NCI position on the value of mammography, HHS Secretary Tommy Thompson said.

"When it comes to mammography, the federal government's recommendation remains very clear: women in their 40s and older should be screened every one to two years with mammography," Thompson said at a Feb. 21 press conference. "NCI also advises women to consult closely

(Continued to page 2)

In Brief:

Horvitz Wins BMS Award In Neuroscience; Group Room To Discuss Congressional Issues

H. ROBERT HORVITZ, known for his discovery of the genes responsible for apoptosis, received the 14th annual Bristol-Myers Squibb Award for distinguished achievement in neuroscience research on Jan. 17 in New York. He is a neurobiologist, developmental biologist and geneticist, David H. Koch Professor of Biology at the Massachusetts Institute of Technology and the McGovern Institute for Brain Research, neurobiologist and geneticist at Massachusetts General Hospital, and investigator of the Howard Hughes Medical Institute. The award carries a $50,000 cash award and a silver medallion. The ceremony was originally to have been held last Sept. 13. . . . **THE GROUP ROOM,** a nationally syndicated radio call-in cancer talk show that airs live every Sunday night, will discuss some of the issues before Congress affecting cancer patients on Feb. 24, from 4-6 p.m. ET (1-3 p.m. PT). During the second hour (5-6 p.m. ET), **Nancy Davenport-Ennis**, cancer survivor, CEO and founding executive director of the Patient Advocate Foundation and the National Patient Advocate Foundation, will call in about patient-related initiatives on Capitol Hill and to report on the Patient Congress III, a not-for-profit organization. Issues presented during visits to Congress include the Patient's Bill of Rights, the ombudsman program, Medicare prescription drugs, oral anti-cancer drugs, cancer care reimbursement, Medicare administration reform, and funding for NIH. The simulcast is available on the Internet at http://www.vitaloptions.org. Callers can enter discussions by dialing 1-800-GRP-ROOM (1-800-477-7666). . . . **UICC INTERNATIONAL CANCER CONGRESS**, which takes place every four years and is scheduled for

(Continued to page 8)

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Clear Message From HHS: Mammograms For 40+

(Continued from page 1)

with their physician about the issue of breast cancer and what course is best for them."

The HHS statement this week represents the strongest, clearest message about screening mammography for women in their 40s from the federal goverment since the early 1990s, unifying the recommendations of NCI and the task force.

The simple message is likely to please members of Congress, who in previous years berated NCI and HHS officials for seeming to provide more debate than guidance on the question of screening for ages 40-49.

The task force published two earlier breast cancer screening recommendations, in 1989 and 1996, that endorsed mammography for women over age 50. In the new report, the task force has extended that recommendation to women over age 40.

The task force grades its recommendations according to the strength of evidence and magnitude of benefit. It gave the recommendation a "B," meaning that the task force found "fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer."

The task force found that the strongest evidence of benefit and reduced mortality from breast cancer is among women ages 50-69. The recommendation acknowledges that there are some risks associated with mammography (false-positive results that lead to unnecessary biopsies or surgery), but that these risks lessen as women get older, the report said.

Thompson said he decided to make a statement about mammography because of public confusion over studies and rebuttal letters published in The Lancet starting last October, and coverage of the debate in the press.

"Over the past few months there has been renewed discussion and controversy about mammography and its impact on saving lives," Thompson said. "The debate must not detract from the recommendation that women be screened. Now it is affirmed."

Making a clear statement "was the right thing to do," Thompson said. "Women are confused."

In a statement released by HHS, NCI Director Andrew von Eschenbach said: "Early detection of cancer saves lives and we continue to recommend mammography for women in their 40s and older. While we seek improved methods of diagnosis and treatment of breast cancer, today mammography remains an important part of our effort to save lives through early detection."

Janet Allan, vice chairman of the task force and dean of the School of Nursing, University of Texas Health Science Center, San Antonio, said the task force began in 1999 to analyze eight randomized controlled trials of mammography (four of mammography alone and four of mammography plus clinical breast examination) that have reported results with 11 to 20 years of follow up. These studies have all been published since the previous task force report in 1996.

The task force also studied the controversial critique of the screening trials, written by the Nordic Cochrane Centre investigators Ole Olsen and Peter Gotzche and published in The Lancet last Oct. 20.

"We acknowledge that the trials are flawed, and we saw the same flaws they did, but we think the trials are still valid," Allan said at the press conference.

The task force also said there is insufficient evidence to recommend routine clinical breast examination alone as a screening tool for breast cancer, and insufficient evidence to recommend routinely teaching to women or asking women to perform routine breast self-examination. While these techniques detect some additional cancers, there were not enough data to determine whether they reduced deaths from breast cancer, the task force said.

Peter Greenwald, director of the NCI Division of Cancer Prevention, said that because

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mammography detects smaller tumors, it gives women more treatment options.

The Olsen and Gotzche critique "does not refute the evidence about mammography, thus a change in NCI's recommendations is not warranted," Greenwald said.

U.S. breast cancer incidence rates are declining for larger tumors and later-stage disease, while increasing for smaller tumors and earlier-stage disease and pre-invasive cancers, Greenwald said. "This shifting of cases to earlier tumors with a better prognosis predicted a decline in mortality during recent years, accounting for about one-quarter to one-third of the observed decline in breast cancer mortality since 1990. That is, roughly a quarter to a third of the decline in deaths were due to finding the tumors in an earlier stage."

The American Cancer Society released a statement saying it "welcomes the new mammography screening guidelines."

The task force is sponsored by the Agency for Healthcare Research and Quality. The breast cancer screening recommendation and materials are available at http://www.ahrq.gov/clinic/3rduspstf/breastcancer/ or by calling AHRQ at 800-358-9295.

A webcast of the HHS press conference is available at http://www.kaisernetwork.org/healthcast/hhs/21feb02.

The NCI statement on mammography is at http://www.cancer.gov.

Summary of Recommendations

—The U.S. Preventive Services Task Force recommends screening mammography, with or without clinical breast examination, every 1-2 years for women aged 40 and older. B recommendation.

The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women.

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk of breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70.

The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women aged 40-49.

—The U.S. Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against routine clinical breast examination (CBE) alone to screen for breast cancer. I recommendation [insufficient evidence].

No screening trial has examined the benefits of CBE alone (without accompanying mammography) compared to no screening, and design characteristics limit the generalizability of studies that have examined CBE. The USPSTF could not determine the benefits of CBE alone or the incremental benefit of adding CBE to mammography. The USPSTF therefore could not determine whether potential benefits of routine CBE outweigh the potential harms.

—The U.S. Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against teaching or performing routine breast self-examination (BSE). I recommendation.

The USPSTF found poor evidence to determine whether BSE reduces breast cancer mortality. The USPSTF found fair evidence that BSE is associated with an increased risk of false-positive results and biopsies. Due to design limitations of published and ongoing studies of BSE, the USPSTF could not determine the balance of benefits and potential harms of BSE.

Capitol Hill:

Sen. Feinstein To Introduce New National Cancer Act

Sen. Dianne Feinstein (D-CA) next week is expected to introduce a new version of the National Cancer Act.

The bill is a compendium of measures that include a restructuring of the cancer centers program, changes in coverage of cancer care, and FDA regulation of tobacco. The legislation also authorizes a nearly 50 percent increase in the NCI budget over five years, starting at $4.8 billion in fiscal 2003, and ending with $7.1 billion in fiscal 2007.

According to a letter from Feinstein to advocacy groups, the proposed National Cancer Act of 2002 is based on the recommendations of the controversial National Cancer Legislation Advisory Committee, which developed a "white paper" for the legislation.

The committee is an offshoot of the National Dialogue on Cancer, an effort funded by the American Cancer Society and aimed at creating an overarching cancer agenda.

The legislation committee was funded by ACS and headed by the society's chief executive John Seffrin and former NCI Director Vincent DeVita. The committee meetings and hearings were closed to the press and the public.

Close Resemblance To White Paper

The close resemblance between the draft bill and the NCLAC white paper comes as a surprise to observers, since last fall Feinstein publicly blasted the legislative committee for setting goals that were at once nebulous and unrealistic.

"It's such a big grab bag, that it's almost impossible to cope with it all at one time," Feinstein said to the committee at the Oct. 10, 2001, hearing sponsored by the Senate Cancer Coalition (**The Cancer Letter**, Oct. 19, 2001).

Unlike the white paper, the legislation contains cost estimates for the proposed programs. Feinstein's press office didn't respond to a reporter's questions about the bill.

According to a communication from the National Dialogue on Cancer to its members, the legislation is co-sponsored by Sens. Kay Bailey Hutchison (R-TX), Mary Landrieu (D-LA), Barbara Mikulski (D-MD), Barbara Boxer (D-CA), Blanche Lincoln (D-AR), Hillary Rodham Clinton (D-NY), Jean Carnahan (D-MO), and Maria Cantwell (D-WA).

According to a "discussion draft" obtained by **The Cancer Letter**, the legislation would establish a network of at least 20 "translational cancer research centers" that would be distributed evenly throughout the U.S.

The centers would be operated by "public or nonprofit private entities." Their mission would combine basic and clinical research, and transfer technologies to private companies that would assume development and commercialization of discoveries made at the centers.

Also, the centers would "develop and implement a plan expanding and disseminating the efficacious products of translational research to providers of cancer care in the region of the translational research center."

According to the document, the program would require $100 million a year. It is unclear how the translational centers would affect the NCI-designated cancer centers, cooperative groups, and other programs.

Other features of the bill include:

—Private insurers would be required to reimburse patient care costs associated with clinical trials.

—The application of Orphan Drug Act would be broadened in the case of cancer drugs. Now, the act applies to cancer types defined by primary site. Instead, the incentives should be extended based on targets and mechanisms of pathogenesis of diseases, the bill states. This provision of the bill is unlikely to have significant impact since many cancers meet eligibility of the current law: 200,000 patients per year.

—Authorize a $100-million-a-year Health Resources and Services Administration program to pay the tuition of health care professionals, primarily nurses, who commit to providing cancer care to the underserved.

—Require private and government insurers to pay for cancer screening, smoking cessation, genetic testing and nutritional counseling. The screening would be based on ACS guidelines.

—Direct the Institute of Medicine to conduct a study of the costs and benefits of providing Medicare coverage to cancer patients who lack other insurance.

—Develop standards of quality of cancer care. Under this provision, the Agency for Healthcare Research and Quality would convene a panel of experts who would develop and disseminate consensus protocols and practice guidelines for optimal cancer

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treatments.

—Authorize Medicare and Medicaid to pay a bonus to physicians who manage the care of cancer patients.

—Authorize $65 million for the Centers for Disease Control and Prevention to provide grants to the states to prepare a cancer plan. Altogether, 24 states have such plans. States would be able to use the CDC grants for linking cancer registries to environmental data bases, studying disparities in the access to appropriate care, and promoting cancer education and prevention.

—Give FDA the authority to regulate tobacco products. The bill doesn't call for creation of an oncology center at FDA. The center, which was recommended in the white paper, would consolidate the agency's handling of all oncology-related products.

NCI May Provide "Technical Support"

NCI Director Andrew von Eschenbach said he has discussed the draft legislation with Feinstein.

"Sen. Feinstein presented me with her outline draft of legislation that she is in the process of preparing that would basically revise the National Cancer Act," von Eschenbach said to the National Cancer Advisory Board Feb. 20.

"She is aware that in my new capacity, I cannot participate in the development of that legislation or be involved in any way, but certainly, she was reassured that the NCI will provide any technical support that would be appropriate and within the guidelines and parameters of our ethical considerations," von Eschenbach said.

"She very much is moving forward with that agenda, and I am certain that many of you in your other roles will be asked or will have the opportunity to comment on and contribute to that particular legislation," von Eschenbach said. "That is obviously going to be a very important part of the ongoing future agenda."

The draft legislation doesn't address oversight of the proposed program. Last year, NCLAC was split over DeVita's recommendation to create a White House Office of the Cancer Czar (**The Cancer Letter**, June 1). That recommendation was not included in the white paper (**The Cancer Letter**, Sept. 28).

Drug Development:

ImClone Offered C225 Deal To Seven Firms Prior To BMS

A Congressional committee investigating ImClone Systems Inc. and its development of C225 asked seven pharmaceutical companies to turn over records related to discussions of strategic partnerships with ImClone.

According to the letters dated Feb. 19, the seven companies had considered licensing C225, a monoclonal antibody also known as Erbitux, prior to ImClone's $2-billion deal with Bristol-Myers Squibb Co.

The letters were addressed to the chief executives of Pharmacia Corp., Merck & Co., Eli Lilly & Co., Johnson & Johnson, Chiron Corp., Amgen Inc. and Abbott Laboratories.

"In response to an inquiry from Committee staff, ImClone Systems provided a list of companies with whom ImClone Systems discussed a strategic partnership relating to Erbitux prior to the tender offer by BMS," said the letters signed by Energy and Commerce Committee Chairman Billy Tauzin (R-LA), Ranking Member John Dingell (D-MI), Oversight and Investigations Subcommittee Chairman James Greenwood (R-PA), and Subcommittee Ranking Member Peter Deutsch (D-FL).

"To assist our understanding in the ImClone matter, please provide the following by Feb, 28: all records including internal audits, investigations, and/or reports relating to ImClone Systems," the letters said.

Last September, Bristol-Myers Squibb paid $1 billion for a 20-percent stake in the company and $200 million in the first milestone payment for a 40-percent stake in C225. Bristol committed to pay another $800 million in milestone payments if the drug is approved.

This appears unlikely any time soon.

On Dec. 28, ImClone received a Refusal to File letter from FDA, stating that the application cannot be reviewed.

On Feb. 26, BMS and ImClone official are scheduled to meet with FDA to discuss the potential for salvaging the application.

Last week, **The Cancer Letter** published a review of ImClone's protocol for the pivotal phase II trial of C225 and CPT-11. After reviewing the protocol, three independent experts said that the trial cannot be expected to support approval of a new agent by FDA.

Consensus Conference:

NIH Panel Outlines Strategies To Manage Adrenal Tumors

A panel convened by NIH issued recommendations to help physicians evaluate a particular class of tumors of the adrenal glands and determine which should be removed and which should be left alone.

The tumors are known as "incidentalomas" because they are discovered by chance, as a result of testing for other conditions. Before the advent of sophisticated new imaging technologies, the tumors typically went undetected.

"Incidentalomas present a dilemma for physicians because while many of these masses are harmless, a few can progress into very serious conditions and cause a variety of complications," said panel chair Melvin Grumbach, the Edwin B. Shaw Professor of Pediatrics Emeritus at the University of California in San Francisco.

Noting that the prevalence of incidentalomas increases with age, Grumbach said that "the appropriate management of incidentalomas promises to be an increasingly common challenge for our aging society."

The adrenals are triangular glands that sit atop each kidney. They influence or regulate the body's metabolism, salt and water balance, response to stress, and other important functions by secreting a variety of hormones. Adrenal gland masses are among the most common tumors in humans, and although most cause no symptoms or health problems, a small proportion can lead to serious diseases, and approximately one out of every 4,000 adrenal masses is cancerous.

One type of adrenal tumor, known as a pheochromocytoma, releases hormones that can cause dangerously high blood pressure. Another type, known as an adrenal cortical cancer, has a high mortality rate. The panel recommends surgically removing both types when technically possible, regardless of size.

The panel members concurred with the prevailing view that incidentalomas should be surgically removed if they are greater than 6 cm, and that those under 4 cm, in some circumstances, may be followed to see if they grow or cause any symptoms. They regarded those tumors between 4 cm and 6 cm as falling into a gray zone. Decisions on whether to remove these tumors, the panel said, should be based on other factors, such as whether the tumor is producing abnormal levels of hormones.

The panel noted that minimally invasive laparoscopic surgery is an appropriate option for removing smaller, non-cancerous tumors. Open surgery involving a relatively long incision is usually appropriate for removing malignant tumors or large benign tumors.

Because managing incidentalomas may involve complex decisions, the panel recommended that patients be treated by a team of physicians with expertise in endocrinology, radiology, surgery, and pathology. Each member of the team can apply their unique expertise to dealing with a particular aspect of treatment.

The panel noted important gaps in knowledge about incidentalomas and therefore recommended that more research be conducted in several areas. Panel members said that studies should be conducted on the physical and mental health outcomes and quality of life of patients whose incidentalomas have not been surgically removed.

The panel said that potential therapies for managing these patients should first be tested in prospective clinical studies. The panel also called for studies to find markers that could be used to identify adrenocortical carcinoma.

The 12-member panel included representation from medicine, surgery, endocrinology, pathology, biostatistics, epidemiology, radiology, oncology, and the general public. The panel issued its statement at the conclusion of a two-and-a-half-day NIH State-of-the-Science Conference on Management of the Clinically Inapparent Adrenal Mass (Incidentaloma).

The panel reviewed an extensive collection of literature related to incidentaloma, including a systematic review of the available evidence prepared by the New England Medical Center, an Evidence-based Practice Center under the auspices of Agency for Healthcare Research and Quality.

The National Institute of Child Health and Human Development and the NIH Office of Medical Applications of Research sponsored the conference. Co-sponsors included NCI and the National Institute of Diabetes and Digestive and Kidney Diseases.

The text of the panel's statement is available at http://consensus.nih.gov. A summary of the evidence report by the New England Medical Center Evidence-based Practice Center is available at http://www.ahrq.gov/clinic/epcix.htm. Copies are also available from the AHRQ Publications Clearinghouse, by calling 1-800-358-9295.

Funding Opportunities:

RFAs Available

RFA-CA-03-004: Chemoprevention of Tobacco-Related Cancer in Former Smokers: Preclinical Studies

Letter of Intent Receipt Date: June 21, 2002

Application Receipt Date: July 26, 2002

NCI Division of Cancer Prevention invites applications for R01 and R21 grants and competitive supplements to existing grants to apply protocols which mimic the former smoker condition to preclinical animal models. Such research should be focused on (1) validating surrogate biomarkers for tobacco-related cancers in animal models under experimental protocols that mimic the high risk of former smokers and (2) identifying and prioritizing agents that prevent cancers in tobacco-susceptible organ systems using protocols which mimic the higher risk of former smokers at the time of intervention.

The RFA is designed to support research projects that examine agents for chemopreventive activity in cancers related to former smokers and address the development, validation and application of surrogate biomarkers for these agents. Prevention studies should employ late intervention protocols that mimic the risk and are applicable to former smokers. The target organs of interest include lung, head and neck, bladder, esophagus, pancreas, cervix, and colon. The goals of these studies are to provide agents and surrogate markers for future clinical trials to prevent cancers in former smokers.

The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-03-004.html.

Inquiries: Vernon Steele, Division of Cancer Prevention, NCI, 6130 Executive Blvd., Rm 2108, MSC-7322, Rockville, MD 20852 (express courier), Bethesda, MD 20892-732 (mail), phone 301-594-0420; fax 301-402-0553; e-mail vs1y@nih.gov

RFA-CA-03-003: Molecular Targets for Nutrients in Prostate Cancer Prevention

Letter of Intent Receipt Date: June 12, 2002

Application Receipt Date: July 17, 2002

NCI Division of Cancer Prevention invites applications for new R01 grants to promote investigations that will define molecular targets for nutrients and further, connect those targets with phenotypic outcome in prostate cancer prevention. Candidate targets for examination should not only be influenced by a nutrient but also be closely linked to a significant proportion of prostate tumors, be relatively specific for prostate cancer across various genetic backgrounds, and be related to changes in tumor risk and/or behavior when modified. Investigators are encouraged to use in vitro and in vivo studies with various levels of target expression and to address confounding factors that influence the overall physiological response to changes in a given molecular target. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-03-003.html.

Inquiries: Young Kim, Division of Cancer Prevention, NCI, Executive Blvd., Room 3156, Bethesda, MD 20892, phone 301-496-0126; fax 301-480-3925; e-mail yk47s@nih.gov

RFA-MD-02-002: Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (Project Export)

Letter of Intent Receipt Date: April 24, 2002

Application Receipt Date: May 24, 2002

The National Center on Minority Health and Health Disparities invites exploratory center applications P20s for a new program for centers of excellence. The purpose of the RFA is to solicit applications for EXPORT Center programs that would establish centers of excellence with a focus on community outreach, research on health disparities, and training. These centers may be established independently by eligible institutions, through partnerships between minority serving and other "designated" institutions, or between designated and non-designated institutions with substantial existing federal research support and/or research infrastructure as reflected in the report (http://thecenter.ufl.edu/research_data.html).

The objectives of Project EXPORT include but are not limited to: 1) promotion of the conduct of minority health and/or other health disparities research aimed at reducing disparities in health status, 2) building research capacity for health disparities research in minority serving and other institutions, and 3) promotion of the participation of health disparity groups in biomedical and behavioral research and prevention and intervention activities. The RFA will use NIH series P60 comprehensive center award mechanism. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-MD-02-002.htm.

Inquiries: Jean Flagg-Newton, deputy director, NCMHD, 6707 Democracy Blvd., Suite 800, MSC 5465, Bethesda, MD 20892-5465, phone 301-402-1366; fax 301-480-4049; e-mail Flaggnej@od.nih.gov

RFA-HG-02-002: Developing Robust Components for Model Organism Databases

Letter of Intent Receipt Date: April 17, 2002

Application Receipt Date: May 17, 2002

National Human Genome Research Institute and the National Institute of General Medical Sciences propose to improve model organism databases by supporting the development of robust software components, called modules. Each module will perform a particular database function, in a way that is well documented, robust,

potentially usable by more than one database, and compatible with standard data formats. These database modules will enhance existing model organism databases and will be useful for developing new ones. These shared modules will promote coordination and interoperability between databases. Eventually the modules could be used to create generic model organism databases that will be used by researchers to integrate genomic and genetic information for additional organisms.

The RFA is related to one or more of the priority areas including cancer, diabetes, immunization and infectious diseases, oral health, and maternal, infant, and child health. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-HG-02-002.htm.

Inquiries: Paul Wolfe, Division of Genetics and Developmental Biology, NIGMS, Bldg. 45, Rm 2AS25, Bethesda, MD 20892-6200, phone 301-594-0943; fax 301-480-2228; wolfep@nigms.nih.gov

RFA-DE-02-003: Research Infrastructure and Capacity Building for Minority Dental Institutions to Reduce Oral Health Disparities

Letter of Intent Receipt Date: March 15, 2002

Application Receipt Date: April 17, 2002

National Institute of Dental and Craniofacial Research and the National Center on Minority Health and Health Disparities invite applications from minority dental schools for the development of research infrastructure and capacity to carry out research aimed at reducing oral health disparities.

The purposes of the RFA are to augment and strengthen the institutional infrastructure and capacity for these institutions to conduct basic, clinical and behavioral research with the objective of reducing oral health disparities through support of assessment and planning activities as well as the development of collaborative research arrangements with other, research intensive, institutions.

The RFA will use the NIH U24 award mechanism. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-02-003.html.

Inquiries: Ruth Nowjack-Raymer, program director, Health Disparities and Health Promotion Research, Division of Population and Health Promotion Sciences, National Institute of Dental and Craniofacial Research, 45 Center Dr., Rm 3AN-44D, Bethesda, MD 20892-6402, phone 301-594-5394; fax 301-435-8254; e-mail Ruth.Nowjack-Raymer@nih.gov

NCI Contract Award:

Title: Multi-Disciplinary Investigations of Nutrition and Cancer (N02-CP-21004).

Contractor: Westat Inc. Rockville, MD.; amount: $3,094,929.

In Brief:

UICC Receives 1300 Abstracts For Congress In Oslo, Norway

(Continued from page 1)

June 30-July 5, in Oslo, Norway, will look at cancer as a global problem, as well as key factors such as rapid increase in the number of cancer patients worldwide and the variations of most prevalent types of cancer between countries. An objective is to define best standards of practice that may be implemented with affordable costs in most countries. According to UICC, 1300 abstracts have been submitted from 74 different countries, covering clinical oncology, basic research as well as epidemiology, prevention and early detection, although the congress emphasizes clinical oncology. About 300 abstracts will be accepted for oral presentation. In addition to the 300 invited speakers, this will total more than 600 speakers at the congress. For further information on the congress, see : http://www.oslo2002.org. . . . **NATIONAL COALITION** for Cancer Survivorship will not reschedule its annual Rays of Hope event at the National Mall in Washington, DC, this year, NCCS President **Ellen Stovall** said. Instead, the coalition encourages communities to host local Rays of Hope events to highlight the work of local peer support and cancer centers. The coalition is expanding its Web presence with Canceradvocacy.com, a site which helps users understand the Congressional debate over the Access to Cancer Therapies Act (H.R. 1624; S 913) and other legislative issues. The site address: http//:www.canceradvocacy.org. . . . **HEALTH & HUMAN SERVICES** approved plans by Oregon and Pennsylvania to extend Medicaid benefits to women with breast or cervical cancer. These are the most recent states to take advantage of the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, which allows states to expand coverage. . . . **NATIONAL** Human Genome Research Institute and the NIH Office of Rare Diseases have begun an information center that delivers free and immediate access to information specialists who can provide accurate, reliable information about genetic and rare diseases to patients and their families. Phone, M-F, 12-6 p.m., Eastern time: Voice 888-205-2311, TTY 888-205-3223; email gardinfo@nih.gov; fax: 202-966-5689; mail: The Genetic and Rare Disease Information Center, PO Box 8126, Gaithersburg, MD 20898-8126. The center is staffed by the Genetic Alliance, a coalition of 300 organizations and health professionals.

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