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More Than 450 Mammography Facilities Are Accredited By American College of Radiology

A year and a half after starting an ambitious program to accredit mammography providers, the American College of Radiology has awarded three year accreditation to more than 450 mammography facilities in the U.S. The ACR Mammography Accreditation Program was started in August 1987 to provide

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In Brief

Fleming New ACCC President, Jennifer Guy President Elect; Rauscher Joins UNIMED Board

IRVIN FLEMING last week became the first surgical oncologist to head the Assn. of Community Cancer Centers since John Nelson was president more than 10 years ago. Fleming, with Methodist Hospital of Memphis, succeeded **David King** of Phoenix. ACCC members elected **Jennifer File Guy** as president elect. She will be the first woman and the second non-MD to head the organization. Guy is administrative director of St. Anthony's Medical Center Cancer Program in Columbus, OH, and administrative director of the Columbus Community Clinical Oncology Program. Other officers elected during last week's annual meeting were **Lloyd** Everson, medical director of the regional cancer center of the Community Hospital of Indianapolis, ans secretary; and **Robert Clark**, chief executive officer of Memorial Medical Center, Springfield, IL, as treasurer. . . . **FRANK RAUSCHER**, former NCI director and currently executive director the Thermal Insulation Manufacturers Assn.'s Health Safety Group, has been elected to the board of directors of UNIMED Inc. UNIMED is a pharmaceutical company specializing in the acquisition, development and marketing of new cancer therapeutic agents. Rauscher left the American Cancer Society last year as senior vice president for research to join the New York based Thermal Manufacturers Assn. . . . **CHARLES FENTRISS**, former director of public information for the Assn. of American Medical Colleges, has joined the Wussow Consulting Group, a public relations firm representing health related organizations, based in Nashville. **Rolly Wussow** formerly was with NCI's Office of Cancer Communications. Fentriss heads the firm's Washington DC office. . . . **CORRECTION**: Wadie Elaimy, now executive director of the Louisiana Cancer Consortium in New Orleans, previously was executive director of the Idaho Cancer Coordinating Committee and was not a staff member of the Mountain States Tumor Institute (**The Cancer Letter**, Feb. 17).

ACR Program Accredits More Than 450 Mammography Facilities

(Continued from page 1)
radiologists with peer review and evaluation of their facility's equipment, staff qualifications and quality control.

The impetus for the program was the concern of radiologists, national medical and consumer organizations and the federal government that qualified personnel and dedicated mammographic equipment be used to ensure that women receive good quality examinations with the lowest possible risk.

The American Cancer Society provided seed money for the pilot project that preceeded introduction of the program.

ACR officials say they are pleased with the program's results and have begun work on materials to help mammography facilities get reaccredited after their three year certificates expire.

"This is the first time that radiology has been subjected to such a test, and it has had some benefits," Marie Zinninger, director of practice accreditation, told **The Cancer Letter.**

"Judging from the calls we get and articles in women's magazines, it seems consumers are looking for this kind of thing," she said. "Besides the consumer angle, the college is committed to the fact that mammography can save lives."

As of the end of March, 967 mammography facilities had applied for accreditation involving 1,120 mammography devices, or units. Since the accreditation is aimed at the quality of the imaging, the accreditation applies to the mammography equipment owned by the facilities, as well as the facilities themselves. Some facilities have more than one unit.

Of the facilities that applied, 456 passed the accreditation program, involving 526 mammography units. The remaining facilities have either failed accreditation on the first try or are still in the application process.

An average of 60 mammography facilities a month are applying to the Mammography Accreditation Program, and the numbers have been increasing, said Pam Wilcox, project coordinator for ACR.

"March was our best month, with 62 facilities applying, and still a few days to go," Wilcox said late last month.

Estimates of the number of mammography facilities in the U.S. are rough. ACR has estimated that there are about 6,000 mammography facilities now.

"I don't think anybody has a good idea how many are out there," Zinninger said. Since screening mammography is now reimbursable under Medicare, the number of mammographic facilities is expected to grow.

There are 17 million women over age 65 in the U.S. who would receive Medicare benefits, and another 1 to 1.5 million under age 65 who receive Medicare due to a disability.

At least 14 states have passed legislation relating to payments for mammography. Several bills now pending in Congress would raise or eliminate the $50 Medicare cap on screening mammography.

The program is voluntary, but ACR hopes that as more facilities receive accreditation and as more women get mammograms, there will be peer pressure and perhaps legislative pressure on most facilities to get accredited.

"Some of us fear that those who get accredited are those who need quality assurance the least," said Robert McLelland, clinical professor of radiology at the Univ. of North Carolina School of Medicine. McLelland discussed aspects of the mammography screening program at a conference in Hilton Head, S.C., in February.

As part of the program, ACR sends a list of accredited facilities to every state chapter of the American Cancer Society once a month. Women who call ACS for information about mammography are referred to accredited facilies in their state.

About 25 percent of those applying have failed accreditation on the first try, Zinninger said.

One third of those fail because their unit's images do not meet the clinical image evaluation part of the test. Another third fail because they do not meet standards for the phantom image test, and the remaining third either exceed the maximum acceptable dose

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level or a combination of all three factors.

There is an appeals process if a facility disagrees with the reviewers, and facilities can reapply.

"Most do reapply after getting new equipment or remedying the problem," Zinninger said. "I think this has brought the level of awareness up among radiologists."

The director of one facility which did not pass on the first try "was appreciative after he found out that the equipment wasn't working properly." The facility bought a new unit and noticed that the clarity of the images had improved.

"This is supposed to be an educational process; it is not punitive," Zinninger said.

The cost of the accreditation is $500 for the first unit and $400 for each additional unit. The facility must also buy a phantom, a device that simulates the fibers and masses found in the breast, to use in testing the equipment. Those cost about $325.

Mobile van mammography units are subject to the same accreditation standards. In fact, the program suggests that each time the mobile van is moved, a test image should be made of the phantom.

The program is directed by the ACR Committee on Practice Accreditation of the Commission of Radiologic Practice. The ACR Task Force on Breast Cancer and the Physics Subcommittee assisted in developing the program.

The accreditation process starts with a questionnaire requesting information about the facility's practice, personnel, equipment and follow up.

"For some of these people, it's the first time they have put this information to paper," Zinninger said.

Each facility must be under the direction of a board certified radiologist, and the radiologic technologists must have certification from the American Registry of Radiologic Technology or an equivalent state license. Both should have had special training in mammography.

Other questions cover the mammography unit itself, when it was installed, the type of film and the processor used. The mammogram must be performed only on dedicated mammographic equipment or equipment adequately modified in the case of xerography, and have an adequate device for compression.

Information is also collected on the facility's quality control program. The radiologic physicist should calibrate the unit at installation and then at least once a year.

"With the number of women that we hope to be screening eventually, the idea is to standardize the mammography," Zinninger said.

Other questions are: What follow up procedures are there? Is a history and a physical done on site? Is the woman told she should have a physical exam? Are risk factors identified? Is the patient instructed in breast self exam?

"We're not saying this is what they have to do; we believe that mammography should be an educational process for the patient," Zinninger said.

The questionnaire asks what the mammography report includes and what mechanisms are in place for following up with the physician.

"We recommend that they have at least a phone conversation and a written follow up," Zinninger said.

Mammography facilities should make sure that patients who are self referred have a primary care physician.

The accreditation program also seeks information on whether the facilities are keeping track of patients after their mammograms, and the results of biopsies.

"We are asking them to start collecting outcome data, so that we can have a national data base," Zinninger said.

The facilities are asked about their film retention policy. The college recommends keeping films for five years.

Once the mammography facility finishes the questionnaire, it is sent a dosimeter and information on purchasing a breast phantom.

The program evaluates image quality, dose and half value layer in the phantom image. In one exposure, the equipment must image the phantom and expose the dosimeter. Those films are sent to ACR and reviewed independently by three radiologic physicists.

The facility also must submit clinical films of a dense breast, generally from a woman aged 40 to 50 years old, and a fatty breast, typcially found in women over age 50. Those films are scored independently by three radiologic physicists.

Each set of images consists of two views of each breast for a total of four films for each type of breast. The committee set standards for the number of fibers, specks and masses that must be visualized on the phantom image, and determined the parameters that are scored on the clinical images.

The parameters are: positioning, compression, exposure level, resolution,

contrast, noise, exam identification and artifacts. The average glandular dose as determined by the dosimeter may not exceed 0.4 rads per view.

If the equipment gets passing scores on the phantom image, the clinical films and the dose parameter, as well as the overall information requested of the facility on the questionnaire, then accreditation is granted for three years. A certificate for each unit that passed is given to the facility.

Since the program began in August 1987, "it's been very educational for everybody," Zinninger said.

ACR is now beginning to work on the reaccreditation program. There will be more of an emphasis on quality control, Zinninger said. For example, the Practice Accreditation Committee might recommend that facilities image the phantom once a month for each piece of equipment.

The committee is working on a quality control manual.

"Once we did the accreditation, we realized that nowhere is it written down what quality control should be, who should do it and how it should be done," Zinninger said.

In addition, ACR is developing a home study course, which is getting support from ACS, for radiologists. ACR has also sent information on the program to other countries interested in establishing accreditation procedures.

Tearle Meyer of Columbus, OH, is chairman of the Practice Accreditation Committee. Edward Hendrick of Denver, CO, is chairman of the Physics Committee. Gerald Dodd, of Houston, TX, and chairman of ACR's Task Force on Breast Cancer, was also instrumental in the accreditation program's development.

Mammographic facilities interested in applying for accreditation may contact the American College of Radiology, 1891 Preston White Dr., Reston, VA 22091, phone 1-800-ACR-LINE (or 227-5463).

ASPO Hears Proposals For Economic Attacks Against Tobacco Industry

A twin pronged economic attack on cigarettes and the tobacco industry was suggested by presenters of two papers at the annual meeting last week of the American Society of Preventive Oncology.

One approach was a stepped up legal onslought recommended by R. A. Daynard of the Northeastern Univ. School of Law. The other was further increases in cigarette taxes at national, state and local levels, suggested by E.M. Lewit of the Univ. of Medicine & Dentistry of New Jersey Medical School.

Lewit's recommendation was based on a study which he said demonstrated the country could have both increased tax revenues from cigarette sales while at the same time reducing the number of cigarettes sold.

A summary of Daynard's presentation:

"Products liability litigation against tobacco manufacturers has the potential to reduce future tobacco consumption dramatically, along the model of asbestos litigation. Massive defense expenditures and harassment tactics have discouraged many potential plaintiffs and attorneys, requiring donated expert testimony and coordination by the nonprofit Tobacco Products Liability Project to keep the strategy viable.

"Additional successful cases would encourage sufficient attorney investment (to be recouped from awards against manufacturers) to make large scale litigation self sustaining. Thousands of successful cases, or even fewer with punitive damages, would shift billions of dollars of health and productivity costs from families and third party payers to tobacco manufacturers, forcing substantial price increases in tobacco products and consequent decreased consumption, especially among children and teenagers.

"Industry attorneys would insist that their clients stop their deceptive advertising, promotion, and public relations campaigns to reduce their punitive damage exposure.

"Even now, publicity about tobacco liability cases dramatizes the dangers of tobacco use, which the industry underlines by insisting that smokers knowingly and voluntarily assume these fatal risks. Furthermore, materials documenting the industry's disinformation campaign, discovered by plaintiffs' attorneys and the Tobacco Products Liability Project in the litigation process, have hindered industry lobbying efforts against other antismoking strategies."

Summary of Lewit's presentation:

"The federal government, all states and many localities levy excise taxes on cigarettes. Traditionally, these taxes were viewed either as revenue measures or as attempts to legislate morality by taxing 'sinful' behaviors. Increasingly, however, it has been recognized that by discouraging smoking, excise taxes can serve as potent instruments to improve public health.

"Studies of the price elasticity of demand for cigarettes suggest that excise tax increases can both raise revenue and curtail smoking. In particular, it appears that the overall adult price elasticity of demand for cigarettes is approximately -0.4. This means that an increase in the price of cigarettes of 10 percent should produce, on average and other things equal, a decrease in quantity of cigarettes demanded of 4 percent. Since prices or taxes rise more than quantity falls, total revenues increase despite the fall in the quantity of cigarettes consumed. Our results further suggest that the decline in actual cigarette consumption will result principally from a decline in the prevalence of smoking. That is, the price (tax) increase will act to encourage marginal smokers to quit or discourage nonsmokers from starting.

"In addition, it appears that cigarette consumption by teenagers and young adults is more responsive to changes in the price of cigarettes than is the smoking behavior of older more established smokers. For example, a 10 percent increase in the price of cigarettes would result in a 14 percent decrease in the quantity of cigarettes demanded by teens and a 12 percent decline in the number of teenage smokers.

"The doubling of the federal cigarette excise tax in 1983 provided an opportunity to validate these elasticity estimates. During the period between Nov. 1, 1981, and Nov. 1, 1984, the price of cigarettes adjusted for inflation rose by 26 percent because of increases in the federal tax, state taxes and the wholesale price of cigarettes. During the same period, U.S. per capita consumption of cigarettes fell by 11-12 percent, an amount consistent with a projected decline of 12 percent based on price elasticity estimates.

"Several authorities have derived crude estimates of some of the potential health effects of this decline in smoking. For example, it has been estimated that an additional 100,000 persons will live to reach age 65 as a result of the price changes induced by the federal tax increase and that the difference between letting the federal excise tax fall back to eight cents per pack from 16 cents and doubling it to 32 cents is a swing of 1,350,000 teenage smokers (500,000 from the decline; 850,000 from the increment).

"To the extent that the primary effects of excise tax increases impact on teenage smoking, mortality reductions will not be realized for decades. On the other hand, although no estimates of the impact of the tax increase on other health measures have been published, reductions in smoking induced morbidity and disability should raise aggregate health levels long before the projected mortality reductions are fully realized."

Thomas Moon, Univ. of Arizona, summarized the status of retinoids as cancer prevention agents:

"Retinoids and the family of natural and synthetic vitamin A compounds have received broad interest and controversy among the nutrients associated with cancer risk. Vitamin A is recognized in the control of cell differentiation and proliferation. Extensive laboratory research provides encouraging but inconsistent results, with tumor inhibition differing by which retinoid, carcinogen, animal and tumor site was selected.

"Human studies have provided mixed indications that retinoids have anticarcinogenic effect. Their interpretation have been complicated by the diverse sources of vitamin A and methodologic problems of quantifying vitamin A. The limitations of diet intake measures have been reported and are likely further complicated by lack of consideration of absorption, metabolism and tissue distribution.

"Use of blood retinol concentrations as a marker of vitamin A has been generally negative, largely due to low correlation with diet intake measures. The correlation was 0.11 between diet retinol and plasma retinol for subjects receiving placebo on our ongoing randomized double blind skin cancer prevention by retinoids trials.

"The unpublished relationship between baseline plasma retinol and its fatty acid ester, retinyl palmitate, among subjects on our retinoid cancer prevention trials indicate a significant ($p=0.02$) increase in plasma retinyl palmitate after one to six months of 25,000 IU retinol supplementation. A number of preneoplastic lesions have shown substantial responses to retinoids, including actinic keratosis, basal cell carcinoma, dysplastic nevi, leukoplakia, bronchio metaplasia, laryngeal papillomatosis, and cervical dysplasia.

"Further evaluation of retinoids alone or in combination in humans is needed. The challenge is to obtain a balance between dosage, safety nd effectiveness. These will be partially addressed by ongoing analytic and experimental epidemiology studies."

Richard Love, Univ. of Wisconsin Clinical

Cancer Center, discussed considerations regarding tamoxifen chemoprevention of breast cancer:

"Considerations of the possibility of giving the antiestrogen tamoxifen to healthy women in order to suppress appearance of clinically evident breast cancer fall into three groups.

"First, is there a well understood biological basis for this intervention? While competitive inhibition of estrogen action at the level of the estrogen receptor is believed to be the primary mechanism of action of tamoxifen, other mechanisms may be equally or more significant, particularly those involving growth factors. In rodent model systems, when the timing of the carcinogenic insult is fixed, continuous tamoxifen is effective in preventing over 90 percent of mammary cancers. In a large clinical trial of adjuvant tamoxifen in women with regionally limited breast cancer with no axillary node metastases and primary tumors with 'positive' levels of estrogen receptors (NSABP B-14), the early occurrence of second primary breast cancers was reduced by 50 percent, while the benefit of tamoxifen in reducing metastases was statistically significant but limited. These data suggest some uncertainty about the biological basis for and potential level of efficacy of tamoxifen as a chemosuppressive agent in healthy women.

"Second, are the nonbreast biological effects of tamoxifen well understood and nontoxic? In high doses, tamoxifen is apparently a promoter of hepatocellular cancers in rodents. While experience with oral contraceptives in humans suggests that this is not likely to be a numerically significant complication of low (usual) dose tamoxifen therapy in humans, the absence of long term data in humans prevents complete confidence that this is the case. Usual tamoxifen therapy may be estrogenic and tumor promoting for uterine endometrial malignancies. Effects of tamoxifen on cardiovascular disease risk factors and bone mineral density are unkown and under intense investigation at present.

Third, are the sympotamic effects of tamoxifen limited and acceptable to healthy women? While tamoxifen is acceptable therapy to more than 95 percent of women treated who have breast cancer, acceptability in healthy women is unkown.

Side effects which can significantly compromise 'quality of life'--hot flashes and vaginitis--accompany therapy in approximately one third of postmenopausal subjects. Depression occurs--severe in one percent and apparent in possibly another three to four percent of users.

"A clinical trial to test the hypothesis that tamoxifen could suppress preclinical breast cancers in 'high risk' postmenopausal women might require as many as 16,000 subjects, the overwhelming majority of whom would remain without breast cancer during the study and would be affected by any adverse biological and symptomatic effects."

Mary-Claire King, Univ. of California (Berkeley), reported on mapping genes for human breast cancer. A summary:

"Cancer is always genetic, in the sense that malignant transformation depends on alterations in critical DNA sequences in the target cell. Usually, these alterations are the result of somatic mutation in target tissues. However, in rare families at high risk of breast cancer, alterations in these critical sequences may be inherited. These high risk families can serve as models for breast cancer generally, so that mapping the genes responsible for breast cancer susceptibility in such families will also identify genes responsible for breast cancer in the population as a whole.

"This approach has already been applied to the localization of genes for retinoblastoma, multiple endocrine neoplasia, and colon cancer. We are working with extended families with at least four cases of breast cancer in three or more generations. Within these families, we test for coinheritance of breast cancer with candidate genes and candidate chromosomal regions.

"Candidate genes have included oncogenes HRAS, KRAS, NRAS, ERBA2, MTC, and MTB and a human homologue of the MMTV integra-integration site INT2, all of which have been excluded, and receptors for estrogen, progesterone, prolactin, and glucocorticoid, which are currently under study.

"Potentially interesting chromosomal regions which have been excluded include 3p (the site of VonHippel-Lindau disease); 11p (site of alterations in breast tumors); 13q (the site of the retinoblastoma gene and of alterations in breast tumors and cell lines); and 17p (another site of alterations in primary breast tumors."

W.C. Willett, Harvard Univ., presented an epidemiologic summary of micronutrients and breast cancer risk:

"Epidemiologic data relating micronutrient intake and risk of breast cancer are sparse. In several case control studies, total vitamin A

has been associated with a reduced risk of breast cancer. This protection was not clearly attributable to animal or vegetable sources of this vitamin.

"Vegetable intake itself was more strongly related to reduced risk of breast cancer than betacarotene intake in the several studies in which both have been examined. In a recent Italian case control study, neither carotenoid intake nor blood levels of betacarotine were related to risk of breast cancer, but serum retinol was associated with higher incidence.

"These data suggest that factors other than vitamin A precursors in vegetables, including either micronutrients or nonnutritive components, may favorably influence the development of this disease. In one small English study, vitamin E levels in prediagnostic sera exhibited a very strong inverse relation with breast cancer incidence; however, this was later found to be a methodological artifact.

"Animal and ecologic studies have suggested that higher consumption of selenium might be protective for human breast cancer. Although based on small numbers of cases, no significant associations have been seen between breast cancer risk and prediagnostic levels of selenium in serum or nails.

"Despite the plausibility of hypotheses relating micronutrients to risk of cancer in general, published data relating these to breast cancer are remarkably few. The limited literature suggests a possible protective effect of vegetables, but evidence does not support a role of any specific micronutrient."

ACS Plans Hearings Around The U.S. On Cancer Treatment In The Poor

The American Cancer Society plans to hold a series of hearings around the country this year on the incidence of cancer in the economically disadvantaged, ACS President Harold Freeman announced this week.

"The chance of getting cancer and of dying from it is disproportionately higher among poor Americans, regardless of race," Freeman said in an opening address to participants of the annual ACS Science Writer's Seminar in Irvine, CA, this week.

"The Society is acknowledging that the poor have not been a major program priority to date," Freeman said. "The time has come for us to address this situation and to evolve a comprehensive initiative toward reducing the disproportionate effect of cancer in the poor."

ACS plans to hold seven regional hearings in May, June and July. These will be held in Newark, NJ; St. Louis, MO; Atlanta, GA; Jackson, MS; El Paso, TX; Phoenix, AZ; and Sacramento, CA.

The process will culminate in a hearing in Washington on July 14 to report on the problem of cancer in the poor.

"We'll be soliciting the opinions and experiences of the people we hope to help, the poor, and the needs of those who are trying to help them," Freeman said.

"We hope to learn about the barriers to serving the poor and to hear if any of these barriers have been lifted in any localities, and perhaps find some good program models to replicate."

Participants will be asked about their experiences with cancer and where they go for treatment. Questions will be asked about attitudes and behaviors with regard to cancer prevention, early detection and treatment.

Issues of continuity of care, costs, coverage and the availability of detection, prevention and treatment services will be raised, Freeman said.

"Through this process we expect we can develop descriptions of immediate, medium range and long range needs which ACS can address in part through existing programs and future programs targeted to the poor," Freeman said.

The most valuable information ACS hopes to collect, Freeman said, will be examples of effective programs in some communities to change health behavior among the poor.

"There may be affordable, convenient and high quality screening programs to use as models throughout the country," he said.

At each hearing, speakers will be invited to make short presentations. A panel comprised of ACS volunteers, one representative each from NCI and the Centers for Disease Control, and one state or local policymaker, will question speakers.

ACS also will solicit written testimony from any interested parties.

"The gap in cancer survival between the poor and the more affluent must be bridged," Freeman said.

"We believe that we are in a unique position to influence national and local programs either through direct action or through programs of advocacy."

A 1986 report by the ACS Committee on Cancer in the Economically Disadvantaged found that nearly 34 million Americans below the poverty level--including 23 million whites,

9.5 million blacks and 1.2 million other races--have a relative survival rate of 10 to 15 percent below that of the average. Overall, the American survival rate is about 50 percent.

"It is not too difficult to explain why this is so," Freeman said. "The harsh realities of poverty create distinct barriers to the health care system."

The disadvantaged tend to use hospital emergency rooms, which are not geared to the early diagnosis of cancer, "as their entry to the health care system," Freeman said.

Risk factors related to some cancers, such as tobacco and alcohol use, poor diet and nutrition, and some occupational exposures also may contribute to the high incidence of cancer among the disadvantaged.

An estimated 37 million Americans lack health insurance, and nearly 11 million of these are below the poverty level, Freeman said.

When the disadvantaged do seek treatment, they are more often found to have late stage disease.

"No matter how skilled the physician, or how advanced the technology, we cannot cure people with advanced, widely spread cancer," Freeman said.

New Publications

Rights To Story Of Susan Komen Is Sold To Simon & Schuster

The Susan G. Komen Foundation for Breast Cancer Research has announced that Simon & Schuster has purchased the rights to publish the story of Susan Komen by Nancy Brinker with Los Angeles writer Cathy McEvily Harris.

Nancy Goodman Brinker lost her sister, Susan, to breast cancer in 1981. In 1982, Nancy started the foundation. Four years later, Nancy was diagnosed with the disease. She is a member of the National Cancer Advisory Board.

"Reducing the Health Consequences of Smoking: 25 Years of Progress. Report of the Surgeon General," publication No. (CDC) 89-8411, Centers for Disease Control, Rockville, MD 20852.

RFAs Available

RFA 89-CA-10
Title: Avoidable mortality from cancer in native American populations
Letter of intent receipt date: May 1
Application receipt date: Aug. 3

NCI's Div. of Cancer Prevention & Control invites cooperative agreement applications for investigators to participate, with the assistance of NCI, in studies to determine the effectiveness of cancer control and prevention intervention strategies in native American populations. Subjects for the study will be native Hawaiians, Alaskan natives and American Indians. The research will involve studies which address the effectiveness and efficacy of cancer control and prevention intervention strategies to increase appropriate use of screening procedures to reduce cancer rates and/or risks among native Americans.

Interventions in avoidable mortality are characterized by methods which will circumvent or reduce barriers to cancer prevention and control services. Such barriers include but are not limited to (1) behavioral/cultural barriers, i.e., language differences, social psychological considerations, particular cultural believes which may affect accessing cancer control services, lack of knowledge and understanding of cancer prevention and control opportunities; (2) health system/structural barriers, i.e., availability of cancer control services, financial limitations, and transportation barriers.

The assistance mechanism used to support these studies will be the cooperative agreement, which is similar to the traditional NIH research grant but which differs principally in the extent and nature of NCI staff involvement with investigators.

Two elements are critical for obtaining support for a study. Respondents must demonstrate the ability to access and obtain the participation of the native American population in which the cancer intervention study will be conducted; and to develop and evaluate a culturally compatible intervention in the target population. Intervention studies will encompass the definition of a phyase three cancer control study: a controlled intervention study.

Approximately $1.2 million in total costs per year for five years will be committeed to specifically fund applications submitted in response to this RFA. Awards will not be made to foreign institutions.

Copies of the RFA and further information may be obtained from Gregory Christenson, PhD, Special Populations Studies Branch, DCPC, NCI, Executive Plaza North Rm 240, Bethesda, MD 20892, phone 301/496-8589.

RFA 89-CA-11
Title: Primary prevention: smoking and smokeless tobacco use and dietary change in native American populations.
Letter of intent receipt date: May 1
Application receipt date: Aug. 3

The Div. of Cancer Prevention & Control invites cooperative agreement applications for investigators to participate, with the assistance of NCI, in studies to determine the effectiveness of cancer control and prevention intervention strategies in native American populations. The subjects of the studies will be native Hawaiians, Alaskan natives and American Indians. The research will involve studies which address the effectiveness and efficacy of smoking and smokeless tobacco prevention and cessation or dietary change intervention strategies. The assistance mechanism will be the cooperative agreement.

Two elements are critical for obtaining support for a study. Respondents must demonstrate the ability to access and obtain the participation of the native American population in which the cancer intervention study will be conducted; and to develop and evaluate a culturally compatible intervention in the target population. It will be a phase 3, controlled intervention study.

Approximately $1.1 million in total costs per year for five years will be committed to specifically fund applications which are submitted in response to this RFA. Foreign institutions are not eligible for these awards.

Copies of the RFA and further information may be obtained from Gregory Christenson, PhD, Special Populations Studies Branch, DCPC, NCI, Executive Plaza North Rm 240, Bethesda, MD 20892, phone 301/496-8589.