THE CANCER NEWSLETTER

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NEW COMMUNITY CENTER ASSN. DETERMINED TO IMPROVE QUALITY OF CARE "WITH OR WITHOUT" NCI ASSISTANCE

"The people need us, the doctors need us, and we can damn well meet those needs with or without NCI."

The Assn. of Community Cancer Centers completed its organizational tasks last week in Denver with that statement by one of the participants summarizing the members' view of the challenge they have accepted.

ACCC's membership includes for the most part physicians directly involved in the management of cancer patients, either through private

(Continued to page 2)

In Brief

TRAINING ACT REQUIRES 75% FOR INSTITUTIONAL GRANTS, REST FOR INDIVIDUAL FELLOWSHIPS

NATIONAL RESEARCH Service Act (*The Cancer Newsletter*, Sept. 20) authorizes $208 million annually for research training. No money has been appropriated yet for it (it will come in a supplemental appropriations bill,) probably considerably less than the amount authorized. The Act requires that 75% of any appropriations must go for institutional grants, the rest for individual fellowships. NCI's own clinical training programs will not be supported by funds authorized by the new Act but will come out of the institute's regular budget. . . . **ABSTRACTS** in NCI's International Cancer Research Data Bank currently are from literature only through 1972. John Schneider, director of the data bank program, hopes this can be improved with the help of the scientific journals, obtaining author's abstracts prior to publication. An NCI senior executive not involved in the program said ICRDB would be of significant help to investigators, but probably would not be used much by clinicians. . . . **NEW BUDGET** act signed into law earlier this year changing the fiscal year starting date from July 1 to Oct. 1 becomes effective in 1976. NIH Director Robert Stone said that various alternatives on how the transition will be applied to grant and contract awards are under consideration: 15-month awards with fiscal 1976 funds; 12-month awards plus supplemental three-month awards; 15-month awards with part financed under a continuing resolution. Grant review cycles and application deadlines may be affected. . . . **RHESUS MONKEY** shortage caused by India's reduction in monkey exports resulted in $289,000 contract award to Hazleton Labs, $191,000 contract to Litton Bionetics by the NIH Div. of Research Resources for stepped up production of the animal widely used in biomedical research. Hazleton will establish a breeding colony in Texas, Litton in South Carolina. . . . **NCI STILL** is looking for a permanent director of the Treatment Div. The job was offered to Emil T. (Tom) Frei III, director of the Sidney Farber Cancer Center in Boston, and to Vincent T. DeVita Jr., chief of the Treatment Div. Medicine Branch. Both turned it down.

COMMUNITY MDs PLAN WAYS TO IMPROVE CARE, INCLUDING CLINICAL STANDARDS

(Continued from page 1)

practice or affiliation with local and relatively small institutions. They admit that serious deficiencies exist at the community level; they feel that present knowledge and technology is not being utilized at that level; and they are concerned that research advances will be too long in filtering down to them. They look upon ACCC as the vehicle through which they can take positive action toward solving those problems.

The members are skeptical of NCI's willingness to help despite being told by Diane Fink, director of the Div. of Cancer Control & Rehabilitation, that she is working up some RFPs directed to community physicians and hospitals.

"What will our chances be of getting any of those contracts?" asked one member. "Slim and none?"

"These contracts will be directed at community activities. One hundred per cent of them will be awarded to community physicians and hospitals," Fink insisted.

Physicians at the community level rarely have occasion to respond to government RFPs, and some ACCC members seemed intimidated by the paperwork involved.

Fink invited the organization to encourage its members to serve on appropriate NCI reviewing groups and advisory committees. "We need your advice and we especially want to establish liaison with a group that is concerned with clinical standards," she said.

Ralph Clayton, medical director of the El Paso Cancer Treatment Center, said, "Those of us practicing medicine don't have time to come to Washington to sit on those groups. And we don't have the staff to help us respond to the RFPs."

One of the services that has been suggested the organization could perform would be to assist members with preparation of RFP responses and grant applications.

Members were disappointed that NCI has not offered ACCC much encouragement. When Fink was asked if NCI could assist with a planning grant or some other funding mechanism to help implement organization programs, she said only that it was "conceivable" but that ACCC first would have to "get its tasks organized."

The most ambitious and probably most difficult and controversial program ACCC intends to undertake is the development of clinical standards. Clayton chaired the workshop in which this task was outlined.

Workshop members agreed that, while clinical standards are needed, it is not possible now to define them in every area of cancer care, but that a beginning can be made in finding those areas where standards are possible. More approved tumor registries are needed, and Clayton suggested that ACCC could help establish them.

The standards workshop also suggested that ACCC should work to define mandatory pretreatment review through a planning conference setup that would be active in making decisions leading to treatment.

Comments made by various members during the day-long meeting included:

Clayton–"We told the people of El Paso that there was something going on in Houston that we didn't have in El Paso in the management of cancer patients. We told them that if they would put up the money and help us recruit, they could have it, too. Now we have it. Our radiotherapy in El Paso is as good as there is anywhere and better than a great many. . . . We (the medical profession) have encountered a void in defining what is quality cancer treatment. We haven't belled the cat. The data is in the literature but it has not been collated or disseminated. The best methods and the best technology for the treatment of cancer is lying around in libraries not being used. There's no reason why someone can't gather this all together and write a set of guidelines. . . . It is especially important that a multidisciplinary workup following well-defined procedures be done on the patient before the initial treatment. The first treatment is where we have the best chance of success."

Robert Frelick, Wilmington, Del., Medical Center–"NCI has not been understanding of community problems. We have a planning grant for breast cancer screening and a contract for breast cancer management. But most cancer contract RFPs are designed for large population centers."

David Plotkin, Culver City, Calif.–"We need something other than the standard tumor registry. We should jazz it up. This is the ideal group to do it."

A member who asked not to be identified–"Our efforts to recruit a first class medical oncologist failed. They are hard to find."

Another member who preferred to remain anonymous–"We need a guide for the public, to help cancer patients recognize which facilities offer first class treatment and which have a nihilistic attitude."

Still another–"Existing organizations–AMA, ACS, and others–are too broad, too diffuse, too ponderous to take advantage of what is in the literature today."

Jerome Vaeth, director of the West Coast Cancer Foundation, San Francisco–"Community centers don't have enough money. They need help in finding out how to get it, how to raise money in the community without taking anything away from the ACS campaigns. We need more radiotherapists and medical oncologists. We have to convince the government it has to help meet these manpower needs without worrying about how much money they will make, that we aren't all getting wealthy. . . On the bright side, we have found there are people who trust each other, and will work together to improve cancer care."

ACCC ADOPTS OBJECTIVES, DEFINITION OF A COMMUNITY CANCER CENTER

Members of the Assn. of Community Cancer Centers unanimously approved a statement of the organization's purpose, philosophy and objectives that might have led to weeks of debate in some professional groups. ACCC spent less than an hour deciding that:

–"The purpose and philosophy of the ACCC is to effect improved cancer care at a community level by applying present knowledge and technology to the greatest number of cancer patients possible and to develop mechanisms for the translation of new knowledge into effective cancer care."

–Objectives will be:

"1. To promote the development of a defined system of cancer care to include cancer prevention, detection, diagnosis, staging, treatment, follow-up, continuing care and rehabilitation in communities through the development of acceptable clinical standards and medical audit, and the linkage of community cancer programs to PSRO and demonstration projects.

"2. To increase the utilization of existing community resources and develop new community resources where required to carry out effective cancer programs.

"3. To promote the development of effective cancer programs and actively recruit the participation in this association of the largest possible number of communities in the nation.

"4. To promote a means to identify and translate appropriate proven clinical knowledge and technology into cancer care delivery at the community level.

"5. To promote the development and application of effective methods of program evaluation to assure effectiveness of patient management systems and to maximize the impact of cancer programs at all levels of the community in order to reach the largest proportion of cancer patients and health professionals.

"6. To promote the development of effective communications and cooperative efforts between community health personnel, cancer centers, national and local organizations or agencies, and educational institutions concerned with the cancer problem.

"7. To provide an effective resource to the National Cancer Institute and other government agencies, the Congress and state and local governments.

"8. To provide an effective technical and consultative resource to participating organizations, comprehensive centers and community cancer programs."

Among the tasks suggested for ACC were:

–Catalog existing information regarding the establishment and operation of community cancer programs.

–Catalog clinical cancer management practices.

–Link or relate the catalog of clinical cancer management practices to PSROs.

–Identify potential community cancer centers and programs.

–Provide technical assistance for potential or existing community cancer programs (for example, requirements analysis).

–Identify existing and new knowledge and technology related to cancer care in order to apply these clinically through local community education programs.

–Develop evaluation systems for programs at a community and national level.

–Develop communication systems for the ready transmission of knowledge and programs to a community level.

Members approved guidelines for community cancer centers. They should have:

1. Organized multidisciplinary cancer programs with required activites including promotion of the multidisciplinary approach for cancer patients, effective follow-up, continuing education, and staging. Desirable activities (but not required) include tumor registry, medical audit, detection, and continuing care.

2. Adequate support services to accomplish multidisciplinary programs within the community or by referral, with required activites including blood, surgery, sub-specialties, radiotherapy, chemotherapy and emergency services. Rehabilitation programs are desirable but not required.

3. Data base for evaluation of programmatic activities, desirable.

4. Relationships with ACS, health agencies, and community hospitals (clinical) are required. Relationships with PSRO, ACCC, medical societies, and comprehensive cancer centers are desirable but not required.

5. A program coordinator or director is desirable but not required.

6. Program critique and review for consultation and assistance by peers is required.

7. Status as a legal entity is required.

8. Support for planning or demonstration programs through NCI, ACS, state and local government, and private organizations is desirable but not required.

Gale Katterhagen, who chaired a workshop that discussed ACCC's potential impact, reported that the group determined ACCC should "provide the widest possible representation among community based physicians and groups whose interests and goals are better cancer care direction in their communities."

Potential benefits available to members, the group reported, should be that ACCC serve as an information exchange on management techniques and delivery procedures; it will help bring awareness of national and regional problems to appropriate federal agencies, Congress, and others; it act as a receptive clearinghouse on members' problems and needs; and

it help inform members of programs which are available and potentially useful.

James Donovan, director of the Kern Radiation Oncology Center in Bakersfield, Calif., was elected president of the organization. James Luce, medical director of the Mountain States Tumor Institute in Boise, Idaho, was elected vice president; and Simeon Cantril, deputy director of the West Coast Cancer Foundation in San Francisco, was elected secretary-treasurer.

At-large members of the board of trustees elected were Robert Frelick, Wilmington, Del.; Ralph Clayton, El Paso; Charles Cobau, Toledo; and Katterhagen.

SENATE ADDS $35 MILLION TO CANCER BILL FOR TOTAL OF $755 MILLION

Sen. Hubert Humphrey, after first offering an amendment that would have given NCI the full amount authorized for fiscal 1975—$800 million—succeeded in adding $35 million to the $720 million recommended by the Appropriations Committee when the Senate passed the HEW appropriations bill last week.

Humphrey pointed out that the full authorization was based on the 1970 recommendation of the Yarborough Panel and that subsequent inflation should be considered. He backed down when Sen. Warren Magnuson, chairman of the HEW Appropriations Subcommittee, pointed out that NCI had submitted a budget request of only $755 million to the Office of Management & Budget.

"The largest increase today in inflation is in medical costs and medical research," Humphrey said. "So that even though we appropriate more this year than last year, we do not get any more for it because of the increased cost of equipment, personnel, laboratory, and all that goes into it. This battle has to maintain its momentum."

Humphrey frankly admitted that he was pushing for the extra money so that, when Senate and House conferees meet on the bill, the split-it-down-the-middle practice on items in disagreement would add a few more million for cancer. The House voted $660 million for NCI.

"If I thought for a minute that we could get the Senate figure of $720 million, I would say halleluja three times out loud and spring up and do three handsprings," Humphrey said. "I know that the Senate cannot get that amount. When we come to the conference with the House we are lucky if we can come out with an even split."

Humphrey contended that spending more money on the cancer program would reduce inflationary pressures on the economy. "If we increase the appropriation for NCI by a modest amount, we can continue our cancer research without disruption and thereby make a sharp drop in private expenditures on cancer. We will have struck another blow against inflation." He said the cost of cancer care and cancer deaths is between $6 and $8 billion a year.

Humphrey singled out cancer control as one program needing more money. "This is getting only about $50 million," he said. "Cancer control must have enough funds to operate effectively. It will cut costs for patients by communicating to doctors and hospitals the best method of treatment and referral for each cancer victim."

NCI AWARDS $10 MILLION TO 12 STATES FOR CERVIX SCREENING PROGRAMS

NCI has awarded almost $10 million to 12 state health departments for a three-year program to screen low-income women for cancer of the uterine cervix.

With this support from the Cancer Control program, the health departments will make 1,194,000 screenings during the three years at an average cost per screening of $9. About 306,800 screenings will be made the first year.

Eight additional state health departments have one-year contracts, totaling $240,303, to plan cervical cancer screening programs. The health departments of all states and U.S. territories may apply for NCI funding to plan or implement cervical cancer screening programs.

Women participating in the screening programs will be advised if their Pap test results are suspicious or positive for cancer and urged to return for retesting and definitive diagnosis. Biopsy, dilation and curettage of the uterus, and other diagnostic procedures will be used.

When a definitive diagnosis of cancer is made, the state health departments contracting with NCI must see that treatment and continuing care are available.

State health departments are implementing this program in various ways. In Michigan materials to recruit women for screening are being prepared in Spanish and English. Mobile testing units are being used in Connecticut. The Migrant Health Dept. is cooperating in Nebraska. In a number of states, the program is being subcontracted to county health departments, private medical foundations, medical schools or hospitals with manpower and facilities.

The screening programs contracts were awarded to Connecticut, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, New York, Ohio, Oklahoma, South Carolina, Tennessee and Texas.

Planning contracts were awarded to Arizona, California, Maine, Minnesota, Missouri, Nevada, Washington and Wyoming.

CONTRACT AWARDS

Title: Hematology supportive care
Contractor: Microbiological Associates, $82,250

Title: Acquisition of chemicals and drugs for evaluation in cancer chemotherapy
Contractor: Starks C.P. Inc., $1,125,090

Title: Prototype network demonstration project in breast cancer
Contractor: Georgia Cancer Management Network, Atlanta, $149,742

Title: Phase 1 development of cancer data systems for comprehensive cancer centers
Contractor: Assn. of American Cancer Institutes, $38,530

Title: Search for new human tumor associated antigens for the GI tract
Contractor: Robert B. Brigham Hospital, Boston, $46,161

Title: Subcellular fractions and immunotherapy
Contractor: Rush-Presbyterian-St. Luke's Medical Center, $91,285

Title: Chemical characterization of purified thumic products or other agents promoting lymphocyte differentiation
Contractor: NYU Medical Center, $98,422

Title: , Isolation and characterization of human peripheral blood mononuclear cells
Contractor: Children's Cancer Research Foundation, Boston, $73,985

Title: Search for new human tumor associated antigens in carcinoma of the lung
Contractor: West Virginia Univ., $103,895

Title: Development and utilization of rehabilitation and/or continuing care resources and services
Contractor: Hospice, Inc., New Haven, Conn., $331,762

Title: Thermography technologist training program
Contractor: Univ. of Oklahoma, $46,000

SOLE SOURCE

Proposals listed here are for information purposes only. RFPs are not available.

Title: Continuation of pharmacology study of antileukemic and other anti-cancer drugs
Contractor: Southern Research Institute

Title: Comprehensive cancer centers communications network
Contractors: Illinois Cancer Council, Colorado Regional Cancer Center, Mayo Foundation, Children's Cancer Research Foundation, Boston, Fred Hutchinson Cancer Center, Seattle, Roswell Park Memorial Institute, and Memorial Sloan-Kettering Cancer Center.

Title: Activation of oncogenic viruses and induction of cancer by immunologic and non-immunologic methods
Contractor: Massachusetts General Hospital

Title: Isolation and tissue culture of human tumor cells
Contractor: Sloan-Kettering Institute for Cancer Research

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute, unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP. Some listings will show the phone number of the Contract Specialist, who will respond to questions about the RFP. Contract Sections for the Cause & Prevention and Biology and Diagnosis Divisions are located at: NCI, Landow Bldg. NIH, Bethesda, Md. 20014; for the Treatment and Control Divisions at NCI, Blair Bldg., 8300 Colesville Rd., Silver Spring, Md. 20910. All requests for copies of RFPs should cite the RFP number. The deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CN-55175-03

Title: *Industrial stewardship with regard to cancer risk from chemical manufacture*
Deadline: *Probably mid-December*

The Div. of Cancer Control & Rehabilitation is soliciting proposals for a project to establish a series of seminars to stimulate industrial stewardship and responsibility for reducing carcinogenic and potential carcinogenic risks associated with the manufacture, distribution, and disposal of chemicals and related products.

Contracting Officer: Hugh E. Mahanes Jr.
Cancer Control
301-427-7984

RFP NCI-CN-55176-03

Title: *A survey of exposure to chemical carcinogens and recommended control and intervention programs*
Deadline: *Probably mid-December*

The Div. of Cancer Control & Rehabilitation is soliciting proposals for a project to survey exposure to carcinogens and to identify several key carcinogens which warrant particular control activity and recommend a practical cancer control and prevention program. Expertise in public health, industrial technology, and control and prevention of cancer will be required.

Contracting Officer: Hugh E. Mahanes Jr.
Cancer Control
301-427-7984

RFP NO1-CM-53770

Title: *Primary and detailed in-vivo screening for anti-cancer activity*
Deadline: *Oct. 15, 1974*

The Drug Research & Development Div. of Cancer Treatment is conducting a large scale program for the

in-vivo screening of drugs for anti-cancer activity. It is anticipated that the program will be conducted at the level of 300,000 L-1210 tests or their equivalents per year. The contractor shall supply all necessary equipment, personnel, and facilities for the screening program.

Drug screening in vivo will include the evaluation of synthesis materials and materials derived from natural sources (plants, soil fermentation, animals) for therapeutic activity against tumors in rodents. Assay systems and test materials will be assigned and supplied by NCI and will be maintained in vivo as stock tumors by the contractor.

Specifically, the contractor shall perform the following:

–Maintenance of rodent colonies (largely mice), propagation and maintenance of tumor stock in vivo, preparation of materials for testing, administration of test materials to tumor-bearing animals, measurement of test materials activity using specified parameters of effects, collection and summarization of data as specified, determination of test material activity, and reporting of results to NCI or its agents in the manner and frequency to be specified, both for machine processing and for NCI staff use.

–Test materials will be evaluated in assigned assay systems and other procedures established by NCI. Materials will be supplied to the contractor with the assay system specified. Additional information (regarding solubility, stability, precautions in handling, potential hazards, known toxic levels which might indicate deviations from protocol prescribed dosages, etc.) will be supplied if such information is known to NCI and the contractor will be expected to modify testing procedures appropriately.

–Contractor will confirm observations of "activity" in his own laboratory. In addition, test materials found "active" in initial screening in another laboratory under contract to NCI or in other programs may be submitted to the contractor for "confirmation" testing. In the latter case, the contractor will select appropriate conditions for testing aimed at duplicating, as nearly as possible, the original conditions as reported on NCI computer generated summaries, or publications, or reports supplied by NCI.

–Upon specific request, the contractor will test new and older active drugs to determine the influence of factors which might modify "activity" such as the formulation for injection (vehicle, physical state, pH, etc.), the treatment schedule, the route of drug administration, the site of tumor implantation, etc. Such tests may require experimental procedures which deviate from those for routine screening and these will be specifically indicated by NCI. Drugs may be submitted for additional non-protocol testing related to the solution of specific questions arising during screening, toxicological examination, and/or clinical trial and may include tests for lathality in non-tumor-bearing rodents and combination chemotherapy. Such testing will be requested specifically by NCI.

The offeror shall submit proposals based on test levels of 25,000, 37,000, 50,000 and 62,000.

Contract Specialist: Thomas R. Hardy
Cancer Treatment
301-427-7470

SOURCES SOUGHT

The following synopsis involves a project of the National Institute of Allergy & Infectious Diseases of possible interest to some organizations engaged in cancer research.

Title: *Production of pure antibody to interferon*
Deadline: *Oct. 28, 1974*

Recent attemps to purify interferon have concentrated on the use of affinity chromatography. The degree of purification of the final interferon depends on (1) the degree of monospecificity of the antibody to interferon, and (2) the ability to absorb out impurities by using non-interferon antigens.

The limiting factor in the method has been that the interferon used to immunize the sheep or rabbit contains many antigens; therefore, the antibody is multivalent and many of the impurities of the interferon preparation are bound to the column. Even with the use of adjunct techniques, the antibody preparation is still multivalent.

Recently, there has been reported a method for the preparation of monospecific antibody. Separate clones of spleen cells from immunized animals are transformed by SV40 virus. The resulting clones each produce only one antibody type and can be maintained in continuous tissue culture.

NIAID proposes to support studies utilizing this principle to prepare monospecific antibody to human interferon. If such antibody becomes available, it should be possible to prepare completely pure interferon.

Interested laboratories possessing the capabilities of performing such a project should submit 10 copies of curricula vitae and a description of their facilities and current research in this area.

Contracting Officer: Merle J. Calahan
Contracts Management Branch
NIAID, NIH
Bldg 31 Rm 1B-40
Bethesda, Md. 20014

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