THE CANCER NEWSLETTER

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"OPTIMAL CRITERIA" FOR HOSPITALS TREATING CANCER PATIENTS DEVELOPED; NCI WON'T TRY FORCING CHANGES

NCI has no plans to attempt to enforce, either through awarding or withholding grants and contracts, adoption of guidelines developed by the Joint Commission on Accreditation of Hospitals for the optimal treatment of cancer patients. "Encourage" rather than "enforce" is the word NCI prefers, and one thrust of the Cancer Control Program is the effort to encourage the upgrading of hospital cancer treatment capabilities with demonstration projects.

JCAH has recently finished writing its "optimal criteria for care of patients with cancer" as part of its contract with Regional Medical Programs which also included development of criteria for treatment of heart disease, stroke and kidney disease. Proposed guidelines for cancer

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In Brief

ADMINISTRATION BACKS DOWN ON ATTEMPT TO KILL GENERAL RESEARCH SUPPORT, WILL TRY TO MODIFY IT

NIH IS LOOKING for a director for the new National Institute on Aging, established by Congress this year. The institute will be in operation by Dec. 1 with a budget of $14 million. . . . **NIH DIRECTOR** Robert Stone, in another "Dear Colleague" letter to scientists, said in effect that the Administration has abandoned its effort to kill the popular general research support program in the face of adamant congressional decrees but will continue attempts to modify it. The program was established to provide flexible funds which grantee institutions could use to help balance research programs, fund young investigators, support central research services and carry out other support of research projects and research training. Funds were awarded in proportion to the number and size of NIH grants institutions already held–the rich got richer. "In some instances the GRS grant has become incorporated into the regular operating budget of institutions, and the flexible or dynamic nature of the award has been diminished," Stone said. Comments on possible modifications of the program are welcome from the grantee community, Stone indicated. . . . **STUDY SECTION** summary statements and site visit reports on grant applications will not have to be released by NIH, the U.S. Court of Appeals has ruled, overturning a district court order. Research protocols in approved grants must be released on demand, the Appeals Court said, upholding the lower court's decision. The higher court did not rule on status of protocols prior to their approval. . . . **COPIES OF** *Science and Cancer*, 145-page paperback written at the high school science level explaining the nature of neoplastic disease and efforts to control it, are available free from NCI's Office of Cancer Communications. Multiple copies may be ordered from the U.S. GPO, Washington DC 20402, at $1.75 each. The book was written by Michael Shimkin, Univ. of California (San Diego). . . .

JCAH GUIDELINES LIST FOUR CATEGORIES FOR HOSPITALS TREATING CANCER PATIENTS

(Continued from Page 1)

treatment were published in the *Journal of the American Medical Assn.* Jan. 7, 1974, which generated substantial response in the form of criticism and suggestion. Much of that response was incorporated into the final draft, JCAH said.

If neither federal nor state governments are going to require hospitals to meet these standards, how will the JCAH recommendations be implemented?

"Through publicity," said Margaret Sloan, who had worked on the program as an RMP staff member and is now chief of the Liaison Branch in NCI's Div. of Cancer Control & Rehabilitation. She referred to an article in the *Los Angeles Times* last year which pointed out that only 19 of the 170 hospitals in Los Angeles County accepting cancer patients had been found by the American College of Surgeons to meet its qualifications for care of cancer patients. "That brought on a surge of applications for certification," Sloan said.

The guidelines recognize four hospital categories and list key criteria for each.

CATEGORY A–HOSPITALS PROVIDING BASIC SERVICES

These are small hospitals, admitting fewer than 100 new cancer patients per years (exclusive of those with squamous and basal cell cancer of the skin), capable of providing the more common tests for cancer detection and diagnosis. Most cancer cases will be referred for definitive diagnosis and treatment (including high-energy radiation therapy) to hospitals in categories B, C or S and then returned to the referring physician for continuing care which may include the services of the local category A hospital. Other criteria for category A hospitals include a medical staff consisting of board-certified (or equally qualified) specialists (full or part-time) in surgery, internal medicine and/or family practice, diagnostic radiology, and clinical pathology; basic life support services on a 24-hour basis, with arrangements for rapid transfer to category B, C or S hospitals; and arrangements within the community or region for rehabilitation services and continuing care.

CATEGORY B–HOSPITALS PROVIDING BASIC AND SOME HIGHLY SPECIALIZED SERVICES

These are community hospitals admitting 100 to 300 new cancer patients per year. They are capable of providing excellent diagnostic and therapeutic services for many types of cancer patients. The range of such services will vary and should depend on qualifications and experience of the medical staff and on the availability of qualified supporting staff and specialized equipment. The medical staff will consist of board-certified specialists in the management of cancer patients, surgery, internal medicine, diagnostic radiology, anatomic and clinical pathology, gynecology, urology, and thoracic acid and orthopedic surgery, with other specialists readily available as needed.

Radiation therapy with cobalt or other high-energy sources must be available, along with a 24-hour emergency room, some specialized rehabilitation services for cancer patients, and an outreach program providing consultation and education in cancer to community physicians and nurses and a cancer information program for the public.

CATEGORY C–GENERAL HOSPITALS PROVIDING COMPREHENSIVE SPECIALIZED SERVICES

These are large community or medical school teaching hospitals admitting more than 300 cancer patients a year with highly trained personnel and excellent facilities for the diagnosis and treatment of cancer of all or most anatomical sites. They will provide significant opportunities for basic and clinical research and for advanced specialty training. The medical staff, in addition to those required for category B hospitals, will include specialists in therapeutic radiology, anesthesiology, and all pertinent subspecialties required for diagnosis and treatment of cancer patients, plus persons with special competence in nuclear medicine, hematology, chemotherapy, hormonal therapy and immunotherapy. These hospitals also will have the full range of rehabilitation services, continuing education and outreach programs.

CATEGORY S–Hospitals providing comprehensive specialized services for cancer patients only, for special types of cancer, or for special population groups

These generally are designated as cancer institutes, with facilities and personnel similar to those for category C.

IMMUNOLOGY RFPs STIR BIG RESPONSE; DETAILS AVAILABLE ON 1974 CONTRACTS

It is NIH management, not NCI as some members of the scientific community have charged, that is discouraging efforts to reach greater numbers of potential investigators with information on cancer contract programs. This is true at least for the tumor immunology contract program which NIH has said is too small for the amount of interest generated by NCI's aggressive advertising of RFPs. There are too many proposals from unqualified persons, NIH feels.

"My feeling is that we should advertise as broadly as possible," William Terry, NCI Immunology Branch chief, told the Board of Scientific Counselors. "One of the criticisms we have faced is that contracts are closed operations."

The branch has sent out as many as 300 copies of an RFP, never getting more than a small fraction of that number back in proposals.

"It's harder to get a contract from this program than a grant," Terry told the Scientific Counselors. The Board, which is the advisory group to the Div. of

Cancer Biology & Diagnosis, heard a review of the immunology contract program.

NIH objections notwithstanding, NCI will continue to use a variety of publications to reach the scientific community with RFP notices deemed worthy of broad exposure. (Summaries of all NCI RFPs, of course, appear in *The Cancer Newsletter.* See list of new immunology RFPs elsewhere in this issue.)

The presentation to the Board of Scientific Counselors included detailed reports from each of the immunology programs--immunobiology, immunodiagnosis, and immunotherapy. The reports included lists of contractors and the amount of each contract, the number of responses and awards for each RFP released in fiscal 1974, and the RFPs announced so far for fiscal 1975.

Research summaries for contracts administered by the Div. of Biology & Diagnosis have been compiled by the division. Summaries include the project title, principal investigator, goal, approach, progress to date, relationship to the National Cancer Plan, project officer, and 1974 funding. Examples:

--Facility for supplying immune-related cell lines, Melvin Cohn (Salk Institute). Goal--To establish a library of lymphoma and myeloma tumor cell lines and make these available to investigators. Approach--Catalog available cell lines and characterize them as regards their lymphoma and myeloma characteristics; either frozen cell lines or mice carrying the appropriate tumors will be made available to investigators on demand. Progress--New items were developed to bring the catalog to the required 100 items, particularly immune related cells other than plasmacytomas; over 180 catalogs were distributed and 159 shipments of cell lines and mice were sent out. Funding--$83,153.

--Evaluation of assays for circulating tumor associated antigens, Theodore Hersh (Emory). Goal--To determine whether the CEA assay is a useful adjunct in the diagnosis of gastrointestinal cancer. Approach--Patients who have signs and symptoms suggestive of gastrointestinal cancer will have complete clinical and laboratory evaluation, and in addition CEA values will be determined; correlation of elevated CEA levels with initial diagnosis of gastrointestinal cancer or development of cancer on subsequent followup will be evaluated. Progress--New contract. Funding--$47,965.

--Neuraminidase effectiveness in tumor immunotherapy and mechanism of its effect, Gabriel J. Gasic (Univ. of Pennsylvania). Goal--To evaluate neuraminidase-treated tumor cells in immunotherapy by establishing several animal tumor models and then examining the variables of dose, route of injection, etc., in these models; to examine the capacity of neuraminidase treatment in therapy of postsurgical metastatic cancer. Approach--Test effectiveness of neuraminidase-treated tumor cells as immunotherapy in two spontaneous and three methylcholanthrene-induced mouse tumors; use of model systems in which the neuraminidase treatment is effective, evaluating dose of treated tumor cells, number of successive subcutaneous injections, route of treatment, and time of administration after tumor grafting; evaluation of effectiveness of neuraminidase-treated tumor cells in immunotherapy of metastatic tumor using metastatic tumor cells; examination of effectiveness of neuraminidase modified cells in relation to the natural immunogenicity of certain target tumors. Progress--new contract. Funding--$51,500.

Contract summaries also are available for other programs administered by the division--breast cancer diagnosis, breast cancer task force, breast cancer epidemiology, breast cancer experimental biology, breast cancer treatment, diagnosis, cytology automation, and cancer control (funded by the Div. of Cancer Control & Rehabilitation but administered by DB&D --breast cancer screening programs).

Litton-Bionetics has a number of major immunology projects (although commercial firms hold only nine of the 117 existing immunology contracts, they receive 24% of the money being spent).

Clement Darrow of L-B is conducting bone marrow transplantation studies using Rhesus monkeys, $243,730 for fiscal 1974. David Lavrin is studying the immune responses of mice and rats to tumor associated antigens, $165,351. Edward Matthews is conducting in vitro tests for tumor specific antigens, antibodies and immune cells with animal and human serum cells, $382,761. James McCoy is conducting immunologic studies of murine RNA oncogenic viruses and their induced tumors, $183,481. McCoy also is measuring immunological reactivity to human cancer, $460,000. Kyle Sibinovic is studying induction, transplantation and preservation of plasma cell tumors in mice, $196,479.

Roy Woods of Meloy Laboratories is doing immunodiagnostic testing, antibody measurement and fractionation of serum and urine, $340,223. R.J. Trapani of Microbiological Associates is operating a human histocompatibility typing center, $196,000.

Publications: *Contract Research Program, Fiscal Year 1974, Div. of Cancer Biology & Diagnosis.*
Annual Reports: Committee on Cancer Immunobiology, Committee on Cancer Immunodiagnosis, Committee on Cancer Immunotherapy.
Write to the Office of Cancer Communications, NCI, Bethesda, Md. 20014.

BONE CANCER PROGRESS CALLED PROVING GROUND FOR INTEGRATED THERAPY

The multidisciplinary approach to the treatment of primary bone cancer "has been a proving ground for what integrated therapy can do," said Jerome M. Vaeth, director of the West Coast Cancer Foundation,

following the two-day symposium in San Francisco sponsored by the Foundation.

More than 200 cancer specialists heard reports on progress in the diagnosis and treatment of bone cancer from researchers and NCI staff members working in that field. Among them were:

Gerald Rosen, Sloan-Kettering, who described successes in treating osteogenic sarcoma with drugs following surgery.

Paul Chan, Southern California Permanente Group, who reported on the role of early diagnosis and radiation therapy in the management of Ewing's sarcoma. Multiple drug treatment and radiotherapy has been successful with 75% of patients treated, compared with the previous 95% fatality rate.

Steven Hajdu, Sloan-Kettering, who described development of needle biopsy for detection of bone tumors.

Miriam Finkel, Argonne National Laboratory, who in a discussion of the viral etiology of bone cancer stated flatly that viruses are involved in the etiology of all cancers.

Hugh Fudenberg, Univ. of California (San Francisco), who in his presentation on the role of immunology in bone cancer reported he had noted members of a household in which there had been one bone cancer patient had developed immune responses to the disease.

The proceedings of the symposium will be published in "Frontiers of Radiation Therapy and Oncology." The American Cancer Society provided financial assistance to the West Coast Cancer Foundation for the symposium.

SOLE SOURCE

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

Title: Analysis of cell proliferation in familial polyposis
Contractor: Memorial Hospital, New York.

Title: Potential prescreens for chemical carcinogens
Contractor: Stanford Research Institute.

CONTRACT AWARDS

Title: Breast cancer detection demonstration project
Contractor: Univ. of Arizona, $185,000.

Title: Brain tumor chemotherapy studies
Contractors: Univ. of Connecticut, $37,800; Bowman Gray School of Medicine of Wake Forest Univ., $21,763.

Title: Quantitative evaluation of protected environments
Contractor: Childrens Hospital of Los Angeles, $399,980.

Title: Continuation of the development and operation of a lymphoma treatment center and a solid tumor treatment center
Contractor: Makerere Univ. College Council, Kampala, Uganda, East Africa, $251,681.

Title: Oncology nursing programs in cancer centers
Contractor: Boston Univ., $403,693.

Title: Molecular hybridization studies with RNA of high specific activity
Contractor: Sloan-Kettering, $153,787.

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.

The following RFPs have been announced by NCI's Div. of Biology & Diagnosis. The RFPs themselves were not available by press time; they will be reported in more detail in a following issue.

RFP NCI-CB-53893-31

Title: *Detection of circulating antigen-antibody complexes in cancer*
Deadline: *Jan. 7, 1975*

RFP NCI-CB-53894-31

Title: *Role of antibody-dependent cell-mediated cytotoxicity in tumor immunity*
Deadline: *Jan. 7, 1975*

RFP NCI-CB-53895-31

Title: *Measurement of antigens in tissue sections of human tumors*
Deadline: *Jan. 7, 1975*

RFP NCI-CB-53896-31

Title: *Antibodies to human organ or tissue associated antigens*
Deadline: *Jan. 7, 1975*

RFP NCI-CB-53897-31

Title: *Development of practical techniques for the separation and isolation of human tumor cells and/or fetal cells*
Deadline: *Jan. 7, 1975*

RFP NCI-CB-53898-31

Title: *Search for new human tumor associated antigens in carcinoma of the bladder and prostate*
Deadline: *Jan. 9, 1975*

RFP NCI-CB-53899-31

Title: *Purification of human tumor associated antigens*
Deadline: *Jan. 9, 1975*

RFP NCI-CB-53900-31

Title: *Isolation and characterization of human peripheral blood monocytes*
Deadline: *Jan. 9, 1975*

RFP NCI-CB-53901-31

Title: *Development and evaluation of macrophage electrophoretic mobility assay for malignant disease*
Deadline: *Jan. 9, 1975*
Contracting Officer: Harold P. Simpson
Biology & Diagnosis
301-496-5565

RFP NCI-CN-55172-05

Title: *History of cancer control*
Deadline: *Dec. 9, 1974 (This RFP appeared Sept. 13 in The Cancer Newsletter under another RFP number and with an earlier deadline. The new number and deadline now apply)*

Primarily for ready reference by planning, programming and evaluation staffs, the Div. of Cancer Control & Rehabilitation requires a history of U.S. cancer control activities in the public and private sectors for the 26-year period from 1946 through 1971. The purpose of this procurement is to obtain such a history, which is objective, data-based and concise, with structuring and indexing and aimed toward aiding judgments by staff as to which past programs were or were not effective.

Specific tasks to be performed are as follows:

—The design and presentation of a plan for the study, including a proposed outline of the final report, which identifies significant areas and programs important for this study for the years 1946 to 1971 inclusive, a proposed outline of the final documentation and bibiography, and an outline plan as to how the final documentation will be structured, indexed and corss-referenced to facilitate utilization by cancer control planners and programmers.

—The development of a schedule to cover reviews of pertinent cancer control literature, interviews with 50 to 100 past and present leaders of cancer control programs, interviews with between 10-20 more prominent federal and state public health leaders, compilation of an annotated bibiography on cancer control, 1946-1971 inclusive, and preparation of an executive summary of the history to accompany the final report.

Contract Specialist: Shelby Buford
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55173-06

Title: *A community-based cancer control program*
Deadline: *Phase I, Jan. 15, 1975; Phase II, Feb. 17, 1975 (A previous notice of this RFP appeared Sept. 20 in The Cancer Newsletter before the deadlines had been established)*

This procurement is directed toward developing a limited number of community-based cancer control systems, whereby all available cancer control capabilities in a community (i.e., leadership and resources) can be brought to bear on the cancer problem. However, it will be necessary to impose restrictions on responding communities, for during this embryonic period it will not be possible to be "all things to all people." Consequently, to be considered responsive to this procurement, an organization must clearly indicate in the proposal its abilities to:

—Provide convincing assurances that it can speak for, and act administratively in behalf of the community and all the organizations therein with acknowledged interests and capabilities relative to the control of cancer.

—Be legally constituted so that it can receive and manage federal and state contracts and grants, and to receive and manage local funds.

—Present convincing evidence that an organized population-based cancer reporting system is present and functioning in the community, or that one can be developed.

The goal of this procurement is the demonstration, promotion, and evaluation of comprehensive cancer control measures through a community-based system. To realize this goal the following objectives must be accomplished:

(1) Develop the administrative capacity of a community to provide leadership in cancer control, and coordinate and wisely use community resources, as well as all applicable (NCI and other) federal resources, in developing and maintaining a comprehensive cancer control effort.

(2) Mobilize the applicable resources (i.e., people, facilities, funds) of the community so that a comprehensive cancer control program can be initiated which eventually can become self-sustaining.

(3) Plan and put into effect a comprehensive cancer control scheme for the community by utilizing all tested and acceptable intervention procedures and methods in a program especially designed for the community and based on known epidemiologic characteristics of the disease and the demographic and socio-economic characteristics of that community.

(4) Establish an evaluation scheme whereby the community organization and NCI can monitor the progress of the program and assess the impact of intervention activities against selected cancers within the community.

An organization can respond to either Phase I:

planning or Phase II: implementation, but not to both. If a community is in the early stage of development, the responding organization representing that community should respond to Phase I. Completion of the work scope under that phase can lead directly into Phase II. If a community considers itself ready to start an action program, it should direct its proposal to Phase II. The judgment of whether a community should respond to Phase I or to Phase II rests with the community.

A conference will be held with prospective offerors for Phase I: Planning at 8:30 a.m. Nov. 22 in Bldg I, Wilson Hall, NIH, Bethesda, Md. A conference will be held with prospective offerors for Phase II: Implementation at 1:30 p.m. on the same day, same place. The purpose of each conference will be to provide information concerning the government's requirements which may be helpful in the preparation of proposals, and to answer any questions regarding this solicitation. Officers of the American Cancer Society are being invited to participate in the conference.

Contract Specialist: John P. Campbell Jr.
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55175-03

Title: *Industrial stewardship with regard to cancer risks from chemical manufacture*

Deadline: *Dec. 4, 1974 (A previous notice of this RFP appeared Sept. 27 in The Cancer Newsletter before a deadline had been established)*

The objective of this proposal is the establishment of a series of seminars for various industrial activities 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.

The seminars will develop an awareness by industrial management of the National Cancer Plan and the role of industry in the cause, control and prevention of cancer from chemicals. The factors necessary in considering the potential cancer risks from various aspects of industrial activities and the need for considering these factors in planning will be emphasized.

The contractor will develop for each of the seminars a program which will identify techniques, materials and concepts necessary for providing guidance to industry on reducing cancer risks. The seminars are intended to enhance management's understanding of the risks to society of carcinogens and motivate positive concern for prevention attitudes and practices.

Techniques for assessing and forecasting the effects of technological developments, material products and use patterns on health shall be emphasized.

The contractor shall organize and conduct the seminars. They will be conducted for several types of industrial activities including the agricultural chemicals, industrial chemicals, petroleum, plastics, rubber, mining, and metals industries. Coordination with industrial societies such as the National Agricultural Chemical Assn. and Manufactures Chemists Assn. is recommended.

The seminars shall provide management and technical specialists from a variety of disciplines an opportunity to meet and exchange ideas and professional opinions with regard to cancer control and prevention.

The seminars will focus on those health factors which should be considered by industry in the development of new products, or changes in operational activities. With regard to the development of new products a review of testing protocols which might be utilized for carcinogenity, mutagencity and teratogencity will be discussed. The problems associated with the contamination of products with carcinogens during production, the breakdown of compounds during storage, microbial degradation, photodecomposition, incineration, buildup and persistance of chemicals in the environment, possible antagonistic, additive and synergistic mechanisms will be considered.

The contractor shall prepare a separate proceeding on each of the seminars conducted. The proceedings will be prepared in camera ready form and be suitable for publication and distribution to federal agencies, state governments, professional societies and industry.

Contract Specialist: Donald W. Broome
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55176-03

Title: *A survey of exposure to chemical carcinogens and recommended control and intervention programs*

Deadline: *Dec. 4, 1974 (A previous notice of this RFP appeared in the Sept. 27 issue of The Cancer Newsletter before the deadline was established)*

The contractor shall identify several key chemical carcinogens for which cancer control and prevention programs are warranted. He shall prioritize these key chemicals based on information received from various sources including the NCI, various federal and state agencies, the open literature, and the scientific and industrial community.

The basis for the determination of the appropriateness of the substance for development of cancer control and intervention programs will include a review of chemical and physical data, the production, principle uses, and occurrence of the substance. In addition, biological data relevant to evaluation of the carcinogenic risk to man and correlations derived from past experiences and theoretical models and the extent of exposure of occupational and general public to the substance will be included.

Past toxic substances incidents (e.g., dioxin, DDT, diethylstilbestol, vinyl chloride, asbestos), will be

considered in identifying salient features that might be useful in anticipating future problems. Where possible, measures or indicators from these experiences will be identified and applied to determine where similar situations may exist or be created.

The relevant considerations that will receive emphasis are as follows:

(a) What is the extent of manufacture, distribution and disposal of the substance?

(b) What is the extent of exposure of the occupational and general public to the substance?

(c) What morbidity and mortality information is available on exposure of humans to the substance?

The contractor shall identify practical methods for reducing exposure and the methods and techniques for implementation of a cancer control and prevention program for each of the substances identified.

The relevant considerations which will be included are as follows:

(a) What types of technological innovation can increase or reduce carcinogenic risks to society from the substance?

(b) What considerations are involved in the manufacture or use of substitute and alternate materials?

(c) What intervention measures are available for reducing exposure to the substance?

The contractor shall prepare a separate monograph on each of the substances reviewed. The monograph will be prepared in camera ready form and be suitable for publication and distribution to federal agencies, state governments, professional societies and industry.

Each monograph shall also include plans for educating individuals and groups, motivation techniques which might be applicable and educational materials and delivery procedures appropriate to accomplish these objectives.

The monograph will be part of the CCP effort to provide carcingen information and dissemination to various segments of the community including federal agencies with regulatory responsibilities. The information will support efforts for maximum protection of potentially exposed populations.

Contract Specialist: Donald W. Broome
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55179-06

Title: *Mammography training for the detection of early breast cancer*

Deadline: *Dec. 23, 1974 (A previous notice of this RFP appeared Sept. 20 in The Cancer Newsletter before the deadline had been established)*

The purpose of this procurement is to expand the capability of health professionals for performing breast cancer screening examinations utilizing the techniques of mammography thermography and clinical examination of the breast.

The proposal must contain descriptions of how the offeror plans to:

–Initiate and/or develop new or expanded educational programs for the training of physicians and other health professionals in mammography, thermography, specimen radiography and clinical examination of the breast.

–Develop course plans or curricula using educational methods and instructional media consistent with the background and experience of the proposed trainees in each type of course or other type of educational activity.

–Develop a recruitment plan which will attract adequate numbers of appropriately qualified and motivated trainees. A trainee shall be described as (a) a physician who completes a core-course in mammography thermography, specimen radiography, and clinical examination of the breast, or (b) a radiologic technologist, other health professional, or individual qualified by background or interest who completes a course in breast cancer screening technology.

Offerors should identify a training program director whose educational background includes not only expertise in radiographic and other breast cancer screening techniques but who in addition is recognized by his/her peers as an expert in this area. It is also essential that he/she has had considerable experience in the organization and conduct of educational programs of this type.

Offerors should designate a training program coordinator whose major responsibility will be the organization of course content, scheduling of training programs, recruitment and selection of trainees, procurement of appropriate teaching materials, and supervision of record maintenance for the training programs. This individual should have a sound appreciation of breast cancer screening techniques and should also qualify as an instructor. His/her time will be divided between supervision of trainees and organizational aspects of the program.

Offerors must select or recruit additional faculty from the disciplines sharing responsibilities for appropriate training in breast cancer screening techniques. These should include as a minimum the fields of radiology, pathology, internal medicine, physiology, surgery and radiologic technology as appropriate.

Contract Specialist: John P. Campbell Jr.
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55183-05

Title: *Integrated cancer rehabilitation services*

Deadline: *Dec. 23, 1974 (A previous notice of this RFP appeared Oct. 4 in The Cancer Newsletter before a deadline had been established)*

This procurement addresses the need for combining community facilities and resources to improve rehabilitation of cancer patients. It is directed only toward large community and nonspecialty hospitals. It is directed towards demonstrating that separate medical facilities within a given catchment area, when

properly affiliated, can provide the total resources and services necessary for the comprehensive rehabilitation of cancer patients.

Objective I: Organization. To establish patient-oriented rehabilitation programs involving three or more medical facilities within a given catchment area in which the various disciplines and departments within each facility are coordinated to provide for the total rehabilitative needs of the cancer patient. The proposed program shall provide for the treatment and rehabilitation of all organ site cancer.

The program and all coordinating responsibilities must be under the direction and supervision of a physician. The following basic rehabilitative resources shall be available within the proposed affiliation.

1. Department of Physicial Medicine and Rehabilitation—hydro-unit, gym, all-purpose room, vocational assessment unit.
2. Physician supervised physical and occupational therapy.
3. Rehabilitative aspect of oncology nursing.
4. Speech therapy.
5. Maxillofacial prosthodontia.
6. Counselling, psychosocial-vocational.

Objective II: Methodology. Develop an overall plan to ensure the optimal functioning of the facilities within the proposed program toward the specific goal of improved cancer patient rehabilitation. The availability of oncology patients, patterns of referral into the rehabilitation system and the relationship of the attending or referring physician must be clearly described in the proposal. Anticipated cooperation between the offeror's institute and community agencies must be documented with a letter of intent.

Objective III: Implementation. The coordinators shall operate within a defined functional area, but may utilize consultation when necessary. The prime emphasis shall be upon sharing of resources, facilities, and trained health personnel in a program structured for the maximum rehabilitative benefit to the cancer patient. The implementation of this program may require the additional training of coordinators in the use of shared facilities for cancer rehabilitation. The training for this new orientation is the responsibility of the offeror.

When successfully implemented, this project will establish rehabilitation as a valid component in the continuum of care, from early diagnosis, through definitive treatment and follow-up, within the patient's own community at a cost both the patient and the community can afford.

Objective IV: Evaluation. A methodology for evaluating the effectiveness of coordinated, integrated rehabilitation program shall be developed. Included in this objective is the criteria for patient selection, the time intervals for measuring patient progress, and the measurement instruments or procedures to be employed.

Contract Specialist: Shelby Buford
Control & Rehabilitation
301-427-7984

RFP NCI-CN-55184-05

Title: *Training programs for maxillofacial prosthodontists and maxillofacial dental technicians*

Deadline: *Dec. 23, 1974 (A previous notice of this RFP appeared Oct. 4 in The Cancer Newsletter before a deadline had been established)*

The number of patients reported to suffer from cancer of the head and neck has increased significantly over the past 20 years. Treatment procedures have improved to such an extent that more patients are surviving for longer periods of time. Unfortunately, however, many of the treatment procedures for patients with cancer of the head and neck result in serious functional and cosmetic impairments which require lengthy and complicated restoration procedures. Cooperative efforts between surgeons and maxillofacial prosthodontists and other specialties are required for the rehabilitation and functional restoration of these patients. There is a shortage of and an increasing demand for maxillofacial prosthodontists and other specialties required for the rehabilitation and functional restoration of these patients.

The objective of this procurement is twofold:

A. To provide for the training of additional prosthodontists in the use of maxillofacial prostheses for rehabilitation of patients with cancer of the head and neck.

B. To provide for the training of additional maxillofacial dental technicians in the fabrication of prosthetic devices and appliances necessary to the rehabilitation of patients with head and neck cancer.

This procurement provides for the implementation of comprehensive programs of training for maxillofacial prosthodontists in the specialized techniques and practices used in the functional and cosmetic rehabilitation of patients with cancer of the head and neck.

Trainees are to be heavily involved in patient care. Involvement should include participation during diagnosis and treatment and in the development and implementation of a rehabilitation plan for each patient. Attendance at appropriate rounds, conferences and workshops during the period of residency may be included.

Contract Specialist: Shelby Buford
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