THE CANCER LETTER

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PRESIDENT ASKS 'STANDSTILL' FY 1976 BUDGET FOR NCI, $123 MILLION SLASH FROM '75 SPENDING

The worst fears of those interested in the cancer program regarding the Administration's budget were realized when the fiscal 1976 proposed spending figures were released this week. If Congress allows the Administration to have its way, progress in cancer research and control, measured in terms of new initiatives and followup on new findings, will grind to a halt.

The President asked $605 million for NCI for the fiscal year starting July 1. This would be more than $86 million less than the $691.6 million appropriated by Congress for the 1975 fiscal year and only $5 million more than President Nixon asked for 1975.

Typically, the Administration attempted to put a happy face on the whopping cut and presented it as a substantial "increase" for cancer. The graphs and charts put out by HEW and the Office of Management & Budget claimed that $605 million would include a $36 million in-

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In Brief

COOPER WOULDN'T TAKE NIH JOB, SAYS NO ONE HAS ASKED HIM YET TO TAKE TOP HEALTH SPOT

THEODORE COOPER, who now is acting asst. secretary for health at HEW with the departure last Friday of Charles Edwards, told ***The Cancer Letter*** that he is "not a candidate" for the NIH directorship. Some of his former colleagues at NIH felt that Cooper would rather run that institution than be the nation's No. 1 health official as asst. secretary for health. Cooper said no one has asked him yet to take the job at HEW on a permanent basis, but it's hard to see how President Ford can pass over him. Cooper has performed magnificently on every job the government has given him, including two exhaustive, far-reaching projects he headed in his spare time while running the National Heart & Lung Institute. One was a study of the medical devices regulatory problem which formed the basis for legislation that almost made it through the last Congress and probably will be passed this year. Cooper is a solid administrator and has the respect of the scientific community. . . . **CASPAR WEINBERGER** insisted at the HEW budget briefing that he has no intention of resigning and has not received any indication from the White House that the President wants him to leave. . . . **SENATE HEALTH** Subcommittee has two new members—William Hathaway (D-Maine), who replaced retiring Sen. Harold Hughes, and Robert Stafford (R-Vt.), who replaced the defeated Peter Dominick. Edward Kennedy remains as chairman. Holdover members of the subcommittee are Democrats Harrison Williams (N.J.), Gaylord Nelson (Wisc.), Thomas Eagleton (Mo.), Alan Cranston (Calif.), Claiborne Pell (R.I.), and Walter Mondale (Minn.); and Republicans Richard Schweiker (Pa.), Jacob Javits (N.Y.), Glenn Beall (Md.), and Robert Taft (Ohio).

PRESIDENT'S BUDGET WOULD STIFLE NEW PROGRAMS; FLOOD TO 'TEACH OMB TO READ'

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crease for NCI over the current fiscal year.

That would be true if Congress approved the $123 million recision from the 1975 appropriations the President has asked, cutting NCI spending for the current fiscal year to $568.6 million. It's extremely unlikely that Congress will go along, and the phony figure juggling fooled few.

In a separate budget briefing conducted by NIH, officials handed out tables that revealed the real impact of the budget cuts on cancer and other biomedical research.

The recision would take $365.5 million from the $2.1 billion appropriated for NIH for 1975. And the budget request for 1976 is $285.4 million less than Congress voted NIH for 1975.

Here's how the budget cuts would affect competing (new and renewal) research grants funded by NCI:

* If NCI is permitted to spend the full $691.6 million appropriated for 1975, it will fund 62.3% of approved regular research grants. But if the recision is allowed, only 27% of approved grants will be funded.

* If Congress does not add anything to the NCI 1976 budget over the $605 million, only 24% of approved competing grants will be funded.

* For NIH as a whole, the picture is bleaker. In fiscal 1974, NIH funded 53% of competing grants. In 1975 under the recision budget, it would fund only 26%. And under the President's budget for 1976, NIH could fund only 18% of approved grants.

Broken down by activity, the President's recommended levels for NCI in 1975 and 1976 shows only token increases for most categories from the 1974 levels. In most cases, the increases would not cover inflation, and there would be some actual decreases from 1974 to 1975:

* **Cause & Prevention research**—1974, $139 million; 1975 (under the recision request), $136.9 million; 1976 (the budget request), $147.2 million.

* **Treatment research**—1974, $183.3 million; 1975, $181.4 million; 1976, $195.4 million.

* **Detection & Diagnosis research**—1974, $44 million; 1975, $43 million; 1976, $47 million.

* **Other Cancer Biology**—1974, $96.3 million; 1975, $95.2 million; 1976, $102.4 million.

* **Cancer Centers support**—1974, $21 million; 1975, $22.2 million; 1976, $22.6 million.

* **Research manpower**—1974, $23.9 million; 1975, $21.1 million; 1976, $21.1 million.

* **Construction**—1974, $38.6 million; 1975, $22.6 million; 1976, $22.6 million.

* **Cancer Control**—1974, $34.8 million; 1975, $46 million; 1976, $46.6 million.

In recent years, too much emphasis may have been given to the President's budget requests for HEW by the press and health lobbyists. Congress invariably has added substantial amounts for health, but all the talk about the President's requests has led many to think erroneously that budget cuts for basic research and non-cancer and heart programs at NIH were adopted.

Congress has shown no inclination so far that this year will be any different.

"You can be sure that Dan Flood will give you the maximum amount of money for cancer that can be squeezed out of the 94th Congress," the chairman of the HEW Appropriations Subcommittee told the meeting of the Assn. of Community Cancer Centers Sunday.

"They don't know how to read at OMB," Flood continued. "They read $691 million as $569 million. I hope we can teach them how to read when we act on the recision message."

Harley Dirks, staff director for Sen. Warren Magnuson's Senate HEW Appropriations Subcommittee, told ACCC members that Magnuson would find the Administration's recommendations "unacceptable... It appears we're headed for another confrontation with the White House . . . You can count on Sen. (John) McClellan (chairman of the Appropriations Committee) and Maggie."

It would seem that, with Congress more liberal now than at any time in the recent past, health programs would continue to receive the same solid support at appropriations time. However, a severe economic slump has not previously been a factor. The impact of the recession and the huge budget deficit predicted by the Administration could cause some legislators who have supported generous health funding to transfer their attention elsewhere.

Dirks told ACCC members that they should get to know their own senators and congressmen better. That isn't a bad idea for everyone interested in the cancer program.

FEW ANSWERS, PLENTY OF PROBLEMS AIRED AT ACCC MEETING IN D.C.

Members and prospective members of the Assn. of Community Cancer Centers came to a two-day meeting in Washington D.C. last weekend looking for some answers to problems they are encountering in developing their own local cancer programs.

They didn't find many answers, but many may have come away with a better understanding of their problems along with the feeling that the new organization can help them.

One of the refreshing characteristics of ACCC's membership is their frank appraisal of the quality of treatment provided by community physicians—including themselves.

"All of us, in small and large communities, sense that there are deficiencies in cancer treatment, or we wouldn't be here," commented J.G. Katterhagen,

Tacoma, as he introduced the opening session program.

James Luce, director of the Mountain States Tumor Institute in Boise, probably has dealt with as wide a range of problems as anyone at the community cancer care level. His presentation on relationships of an established community hospital cancer program to smaller non-cancer oriented hospitals and to comprehensive cancer centers touched on them all.

Luce suggested four major problem areas:

"1. How do we get financial support for our cooperative activities with comprehensive cancer centers, community cancer centers, non-cancer oriented hospitals and private physicians?

"2. How do we introduce change in referral patterns to, on one hand, keep the patient as close to home as possible and, on the other hand, deliver optimum care?

"3. How do we disseminate information to health providers and to patients on modern techniques of cancer care and where to get help?

"4. How can I, as a representative of one level of cancer care develop cooperation with the other two levels and with other cancer oriented organizations in order to accomplish the ultimate goal: the best in cancer care for all citizens?"

Luce described some characteristics of a non-cancer oriented hospital: it performs diagnostic surgery, primary patient workup, provides final patient care, is close to the patient's home and to his personal physician, and its tumor board meets weekly or less frequently.

A community cancer center, Luce said, offers specialized surgery, comprehensive cancer workup and staging, specific cancer treatment including radiotherapy and chemotherapy, handles referral pathology, serves as a primary cancer information center, offers primary education programs, and its tumor board meets at least weekly.

Services offered by comprehensive centers include very specialized surgery, comprehensive workup for difficult problems, specialized treatment, referral pathology, complete cancer information, information center for difficult problems, symposia for general practitioners and oncologists, tumor boards for difficult problems, and teaching programs for house staff and community physicians.

Luce described some difficulties that frequently arise in the relationship between community cancer centers and the smaller hospitals: inadequate staging and orientation at the small hospitals; private physicians don't know what facilities are available at the community centers, they are afraid of losing their patients after referring them; other health personnel don't know what services and facilities are available for cancer patients; physicians are reluctant to change traditional referral patterns.

He also listed problems existing within community centers that adversely affect non-cancer oriented hospitals, their physicians and patients: community center personnel sometimes are too busy to answer their phones, and are away at too many meetings to provide continuous care and consultation; center personnel sometimes have no more expertise than the referring physicians; center personnel frequently won't visit the smaller hospitals for consultation and to attend tumor board meetings; center personnel are not compensated for time spent on work not directly related to patients.

David Wishart, who runs a cancer program in a rural area (Olympia, Wash.), cited three general categories of problems in establishing a program in a non-urban area—adequate demonstration of the need for a cancer program to the people of the community; inducing the providers to take part in a cooperative effort; and logistics.

Understanding the attitude of the rural MD is important, Wishart said. "Survival of a physician in a large center depends on his success in increasing his income and his publications," Wishart said. "For the non-urban physician, his survival depends on being loved."

The economics of the team effort frequently stand in the way, Wishart said. "A physician will say he has no time to attend meetings, or do committee work. What he means is that he would rather spend more time in his office so that he can make more money."

Other problems of the rural MD in handling cancer patients: When do you refer a patient? Where do you refer him? Who do you consult if needed? When is the time for me to seek more education? Where do I get it? How can I leave my practice?

"I always feel real smart in Olympia," Wishart said. "And then I leave. What about the physicians who never leave?"

Wishart cautioned those who run small centers to seek guidance before buying equipment, and warned not to buy sophisticated new machines "until you can run it."

John Nelson, Jacksonville, Fla., discussed the problems he has encountered in running a cancer center in an urban setting:

1. Obtaining sufficient space and support of the hospital administrators.
2. Getting everything "under one roof" (several Jacksonville hospitals cooperate in the cancer program).
3. "We don't have a chemotherapist in the program and have been trying to find one," Nelson said.
4. Educating practitioners in the surrounding area. "People don't take the time to go and learn the latest modalities."
5. Organizing a good library, and finding the money to pay for a librarian.
6. Raising the standards in a community hospital to prevent inadequate use of instruments.

Simeon Cantril, San Francisco, explains some of the problems involved in developing a cancer net-

work. He is affiliated with the West Coast Cancer Foundation which has an NCI contract to develop a breast cancer treatment network.

The program attempts to include as participants local physicians, hospitals, medical societies, volunteer agencies, local and state government units, civic, labor and other organizations, and third party carriers.

NCI intended for the contractor to coordinate the program, managing the flow of information to the participants and getting feedback from them which gets into the organized information flow.

"That's a nice concept, but in the real world it doesn't work that way," Cantril said. Participants have their own information sources and contacts and the interplay among them frequently bypasses the contractor.

One result, Cantril said, is that it will be difficult to measure the impact of the program and to justify its cost.

John Sauer, administrator of the California Hospital Medical Center in Los Angeles, reported on how his organization handled problems that developed in establishing a hospital-based cancer program. Sauer said the center:

- Established a multidisciplinary cancer committee and charged it with setting protocols for cancer management.
- Established a medical oncology program.
- Decided to limit the research program to $250,000 a year and put it on notice that it had to be self-supporting within three years.
- Negotiated a support contract for radiotherapy.
- Upgraded the screening program, adding mammography and thermography.
- Worked to improve community relationships, especially with the comprehensive center at USC.

Sauer pointed out that the new Health Planning & Resources Development Act will have a broad effect on the development of cancer programs. In most cases, expansion or construction of new facilities will require a certificate of need from the state.

The Professional Standards Review Organization and Health Maintenance Organization legislation will have substantial impact on cancer programs, Sauer said. Hospitals may contract with HMOs to provide cancer care, for instance.

NCI Director Frank Rauscher told the group that "after all the money is spent (on the cancer program), it is you who have to do the work . . . If you have a problem in dealing with NCI, I want to know about it. If you can't find out what's going on, we're not doing our job."

Jonathan Rhoads, chairman of the National Cancer Advisory Board, said "there's a tremendous amount to be done in getting information into medical practice. What we need is just the kind of thing you are doing here."

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 & 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 NO1-CN-55213-08

Title: *Design task for surveys of patient attitudes and knowledge about cancer control and rehabilitation*

Deadline: *March 6*

Two surveys will be undertaken. In one, the primary unit of analysis will be the non-institutionalized civilian residing in the United States. This survey will attempt to determine the general public's knowledge about and utilization of cancer control and rehabilitation services. In the second, a more in-depth survey of cancer care and rehabilitation will be made of the civilian population with cancer at selected sites.

The contractor shall provide all of the necessary qualified personnel, facilities, materials, and services (including travel and subsistence) required to design the instruments for a national survey of the civilian population and a national survey of the cancer population by selected cancer sites, in accordance with the subtasks and time constraints set forth below.

Subtask 1: The contractor is required to review and summarize the relevant information from surveys of knowledge and attitudes of cancer detection, treatment and rehabilitation that have taken place in the last five years. This will help to identify key issues and available instrumentation, although the proposed new surveys will not be limited to the questions asked in these earlier surveys.

Subtask 2: Before developing any instrumentation, the contractor shall identify and develop a comprehensive set of issues which are relevant to the general public and the cancer population. While some of the issues are clear from the results of prior surveys, they must be explicityly identified, fully developed, and assigned a value to reflect their importance on a spectrum of desirable, important, and essential questions. The contractor shall submit for project officer's review an analysis of past surveys and an assessment of the degree of comparability therewith that can be built into the new survey before proceeding to Subtask 3.

Subtask 3: Separate field instruments are to be developed to obtain data on individuals in the general

)pulation, the cancer patient, the treatment facility, id the patient's family. The family data may, in)me cases, be completed using data collected by 'rsonal interview of the patient. A separate instru- ient may be required to interview selected patients)n their perception of their cancer and the appropri- ateness of care they have received since the onset of the disease, depending on determinations to be made early in the task.

If this is done, the final report for the task shall set forth explicit hypotheses, identify likely sources of bias, and propose specific techniques to control for such bias in the full-scale survey.

Subtask 4: The contractor shall, after any required instrument clearances and the approval of the project officer of a field work plan, conduct a limited, but adequate field test of instrumentation and interviewing procedures. If set forth in the approved field work plan, this field test may include personal or mail interviews with the general public, cancer patients and their families. Detail records of cost shall be maintained so that costs for national surveys can be estimated. A limited number of alternative approaches may be utilized as a basis for recommending the most efficient way to do national surveys. All problems encountered in the field test shall be fully documented.

Contract Specialist: Anita H. Schwartz
Control & Rehabilitation
301-427-7984

RFP NO1-CN-55214-08

Title: *Psychological aspects of breast cancer*
Deadline: *March 6*

(A brief summary of this RFP appeared earlier)

This procurement will be divided into three major phases: planning, implementation or demonstration, and evaluation.

PHASE I

Task 1. Perform a thorough literature search to identify all relevant psychological variables related to breast cancer. Particular emphasis should be given to the effect of the malignancy and its management on the patient's emotional and psychological adjustment, self image, fears and defense mechanisms; sexual adjustments; husband and marriage; children, particularly the females; and employability and attitude toward employment.

Task 2. The contractor shall prepare an annotated bibliography of the literature findings identified under Task 1.

Task 3. Under this task workshops or seminars shall be held to examine in depth those variables identified in Task 1. Consultants (not less than 7) with expertise in those disciplines relating to the variables identified in Task 1 shall be included.

PHASE II

Task 4. The contractor shall apply relevant psychodiagnostic testing to better understand the psychological status of the patient for the purposes of a more rational psychological intervention. Some degree of emphasis shall also be given to the patient's family (where indicated) to preclude subsequent family crisis and/or potentiate adjustment to the patient-family interaction.

Task 5. The contractor shall pretest the demonstration model developed under Phase I. The model shall incorporate the following components:

A. What should a newly diagnosed breast cancer patient (and her family) be told?

How should the diagnosis be communicated?

Who is the appropriate person(s) to communicate it?

What considerations should affect the discussion of her diagnosis, prognosis, and treatment?

B. What is the ideal team, and who are the appropriate personnel, to interact with the patient and her family in the best interests of her psychological well being after diagnosis, during treatment, rehabilitation and continuing care, and if necessary in preparation for death?

C. What is the best setting for the postmastectomy patient to be given continuing psychological support (hospital where medically treated, community mental health clinic, at home, etc.)?

D. What are the significant demographic characteristics which must be considered across all intervention areas of cancer management as they are related to the above psychological variables?

E. What physical rehabilitation regimens, vocational considerations, and funding resources (governmental agencies, home health agencies, vocational rehabilitational services, etc.) should be considered to enhance the patient's psychological well-being, as well as to preclude any obstacles which could adversely affect emotional adjustment.

F. What already active patient-to-patient psychological support programs or components of these programs (e.g., Reach-To-Recovery) can be employed in this effort, taking into account the individual differences of each patient and other relevant individual circumstances.

Task 6. After pretesting evidence has been obtained suggesting the success of the model, and with concurrence of the project officer, a full implementation of the model shall be initiated.

PHASE III

Task 7. The contractor must develop a methodology to evaluate the success of the demonstration models. Teh evaluations should be directed towards those elements identified under Tasks 1, 5 and 6 and they should include address to both the reliability and validity of the results achieved. This implies prior definition of measurable criteria for the degree of success in achieving objectives of the demonstration model.

Contract Specialist: Anita H. Schwartz
Control & Rehabilitation
301-427-7984

RFP NO1-CN-55216-01

Title: *Measurement of the cost of cancer care*
Deadline: *March 10*

(A brief summary of this RFP appeared previously in The Cancer Letter)

In order to better utilize available and new methods to reduce the morbidity and mortality from cancer, a data base constituting the direct costs of care for the most common cancers is needed.

This information, related to diagnosis treatment, rehabilitation and continuing care shall be obtained so that it will be applicable for planning and evaluation purposes.

Direct costs of specific diseases (by organ site and stage) may be modified by site of residence, employment and family status and these modifications may be reflected in costs to insurors, governmental and voluntary agencies, as well as out-of-pocket costs.

The data obtained will provide a base line against which changes due to the National Cancer Program efforts, such as networks and centers, may be ascertained.

In addition, the cost of specific regimens (chemotherapy, radiotherapy, etc.) as modified by other variables noted, can be used in planning for changes of costs as practices and services deemed appropriate for specific diseases change over time.

The contractor shall provide all of the necessary qualified personnel, facilities, materials, and services (including travel and subsistence) required to design appropriate instruments and collect the necessary data so that the direct costs of treating cancer of selected organ sites can be determined. The specific tasks are:

Task 1. Review of previous studies–The contractor shall review and summarize previous studies on the cost of cancer diagnosis, treatment and rehabilitation, with particular attention being given to the methodologies used to measure these costs. This will help to identify available methodologies and their relative merits, although the proposed new study will not be limited to methodologies used in previous studies.

Task 2. Identification of important categories of cost and forms of payment–The contractor shall list and classify all important elements of the cost of cancer treatment and rehabilitation. These will include, but not be limited to, hospital services, physicians fees, drugs, patient transportation, nursing, special treatments, and laboratory services. They shall also include costs of rehabilitation (including special appliances and devices) and continuing care, such as nursing home charges, homemaker services and transportation and housing costs for accompanying family members. Other indirect, but real out-of-pocket costs, such as, lost income of family members who accompany the patient to treatment centers shall be included. Likewise, the sources of payment of cancer costs shall be listed and classified. These should include both public and private sources.

Task 3. Development of methodology–The contractor shall develop methods to measure the costs and sources of payment under Task 2. If there are several alternative measures available, their relative advantages and disadvantages should be stated, with particular reference to relative cost of collecting the data and estimates of the validity of the results. The data collected shall be sufficiently broad based so that reliable national estimates can be made. There shall be a review process by the National Cancer Institute at the completion of Task 3. If the items developed in Task 3 are approved, the contractor shall be permitted to continue with Task 4 and Task 5.

Task 4. Collection and analysis of data–The contractor shall collect, by the most appropriate means, and analyze the data so that reliable estimates can be made of diagnosing cancer and providing treatment for the first six months after diagnosis of the following sites and types: breast, colon and rectal, lung, leukemia, lymphoma, prostate, uterus, overy pancreas, stomach, larynx and oral, and urinary tract. There should be sufficient data so that the effect of important variables, such as family income, place of residence, age, race, sex, occupation, education, employer, and family composition can be determined. Other important variables identified during Task 1 should be included.

Task 5. Preparation of final report–The contractor shall prepare a detailed final report that will be suitable for publication as a book. This will include a description of previous work done, a detailed presentation of the results of this study, and a thorough discussion of the results, with particular emphasis on the implications for the National Cancer Plan. The report is due prior to expiration of the contract. The maximum period of performance is two years.

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

RFP NIH-NCI-CN-55197-07

Title: *Development and evaluation of cancer care coordinating team*
Deadline: *March 7*

(A brief summary of this RFP appeared late last year)

The management of cancer patients beyond specific therapies, such as radiation, surgery, chemotherapy, etc., is seldom well coordinated without considerable expenditure of a practicing physician's time. In order to better coordinate patient care and improve both its adequacy and continuity, it is proposed that a model cancer care coordinating team, providing ready contact with the patient, be developed and field tested.

The offeror shall submit plans to train teams of two public health nurses in oncology as it relates to treatment, rehabilitation, and continuing care. This training shall be no more than six months and no less

than five months. Existing courses in oncology nursing may be utilized if they will be supplemented to meet the other requirements of this RFP. This training shall cover definitive and palliative therapy, rehabilitation, social agencies (including voluntary, such as American Cancer Society, etc., and government supported agencies) available to help the cancer patient, and all other training necessary for the coordination of individual patient care, within the hospital and the community.

The training of the team shall include an introduction to the counseling of the cancer patient and the patient's family. This training should provide the team members with ability to recognize which patients or families should be referred for counseling. In addition, the team shall be sufficiently trained in counseling that its members will be able to provide short-term or emergency counseling until definitive arrangements for counseling can be made. It is expected that a goal of this team will be to determine the need for counseling and to arrange for such counseling sufficiently early to avoid reaching a crisis situation.

Contract Specialist: Luther C. Holland Jr.
Control & Rehabilitation
301-427-7984

RFP NO1-CO-55222-04

Title: *Cancer Information Dissemination and Analysis Centers (CIDACs)*

Deadline: *Probably late March*

The NCI associate director for international affairs is requesting proposals for the establishment of four Cancer Information Dissemination and Analysis Centers (CIDACs) for the International Cancer Research Data Bank (ICRDB) Program. Each CIDAC will specialize in one of the four areas listed below:

Phase A – Cancer Diagnosis and Therapy – This will include cancer chemotherapy information, clinical aspects of other types of therapy, clinical aspects of methods for detection, diagnosis, and prognosis, all aspects of cancer patient care and rehabilitation and cancer control-related data not included below.

Phase B – Chemical, Environmental and Radiation Carcinogenesis – This will include chemical carcinogenesis, environmental and occupational carcinogenesis, carcinogenesis induced by plastics, mineral oil, and other agents, epidemiology of human cancer and similar studies of animal populations and cancer prevention information.

Phase C – Cancer Virology – This will include all aspects of virus causation of cancer in humans and animals, immunology of cancer ciruses, replication and other biology of cancer viruses, including mechanism of cell transformation and antiviral agents as related to cancer virology.

Phase D – Immunology and Other Basic Cancer Biology – This will include cancer immunology other than clinical immunotherapy and immunology of cancer viruses, cancer biochemistry, cancer cell biology, mechanism and control of cell division and tumor growth rate, endocrine-related aspects of cancer other than clinical endocrine therapy and endocrine-related carcinogenesis and radiation biology of cancer other than clinical radiotherapy and radiation carcinogenesis.

The major activities of each center are briefly summarized below:

(1) Developing a current awareness or alerting system which will provide cancer researchers with a steady stream of 'Current Cancer Research Information Update Sheets' (subsequently called Cancer Update Sheets or simply Update Sheets) containing about 2-4 pages of the most recent abstracts and project descriptions covering narrow, specific areas of cancer research (Current Research Awareness Topics).

(2) Producing technical bulletins (special bibliographies), each containing all abstracts and project descriptions entered into the ICRDB data base on one significant cancer topic over the past several years. The activities required for producing these products are almost identical to those required for producing Update Sheets, except that they result in single issues of discrete monographs covering data collected on one 'High Interest Topic' over a multi-year period.

(3) Responding rapidly to requests for information in given subject areas. This will usually involve on-line searching by CIDAC subject specialists of the CANCERLINE system.

(4) Developing procedures for summarizing or describing important new scientific findings in monthly reports to the ICRDB Program. This alerting service involving update sheets is a system for Selective Dissemination of Information (SDI) to small groups of cancer researchers.

(5) Identifying and implementing new and innovative projects designed to promote the communication and exchange of technical information between cancer researchers.

As can be seen by considering the in-depth technical, subject-specific input required for each of the major activities described above, each CIDAC must be staffed primarily by scientists who have a thorough and detailed understanding of the subject area in order to deal effectively with increasingly complex technical aspects of research results and projects entered into the ICRDB data base. If the staff has been actively engaged in research, it will be in an even better position to communicate with researchers who describe their information needs in specialized technical terms.

In addition to scientific staff, input from information scientists will be required for the successful operation of each CIDAC. This input is needed for familiarizing the CIDAC staff with procedures for interaction with on-line systems, and procedures for formulating and optimizing search strategies needed

for the preparation of the Cancer Update Sheets and the Technical Bulletins.

Ideally, one member of the CIDAC staff should have some experience in the information science area as well as extensive subject competence. However, there are several other acceptable alternatives including arrangements to work closely with information scientists on the local library staff or to employ information scientist consultants who will work closely with CIDAC staff during the early stages of the contract.

In order for each CIDAC to focus on one assigned subject area, **no organization will be awarded a contract for operating more than one CIDAC.** However, proposals will be accepted and reviewed for more than one CIDAC from the same organization. Bidders conference will be scheduled for the project. Notice concerning the conference will be mailed with the RFP.

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

RFP NO1-CP-55670-57

Title: *Development of detailed methods and protocols for carcinogenesis screening using cell culture assays*
Deadline: *March 17*
Budget Estimate: *$1 million first year*

Organizations are sought having the necessary capabilities and facilities to evaluate and determine the usefulness and reliability of in vitro cell transformation systems as initial assays in determining the carcinogenic potential of chemical compounds.

Experimental conditions for cell growth and frequency and type of transformation obtained have been described in the literature for a number of systems. Among the systems to be considered are those in which direct action of a carcinogen on the cell leads to transformation and those in which the activity of a compound is mediated by appropriate metabolic activation of virus infected cultures.

A specific aspect of this project will be the development of metabolic activation systems. The system included for study and development utilizes: 1.) Balb/3T3 cells 2.) Fisher rat embryo cells 3.) Fisher rat embryo cells infected with Rauscher leukemia viruses 4.) Hamster embryo-host mediated 5.) Epithelial cells from a variety of species.

In order to fully evaluate these systems it is the Government's initial intention to have a single laboratory study only one system. The real value of in vitro assays for reproducibility and standardization. The initial group of chemical carcinogens and analogues to be used in setting up the systems will include: 3-Methylcholanthrene; Antracene; 7,12-Dimethylbenz (A) Antracene; Phenanthrene; Benro (A) Pyrene; Pyrene; Dibenz (A.H) Anthbancene; Benzo (E) Pyrene; N-Methyl-N-Nitro-N-Nitrosoguanidine; Diphenylnitrosamine; Dimethylnitrosamine; Methylazoxymethanol Acetate; and N-Acetoxy-N-2 Fluorenylacetamide.

When there is sufficient confidence with the system an additional group of 90 reference chemicals, consisting of both carcinogens and non-carcinogenic analogues will be assayed to determine the response of the assay systems.

All chemicals will be supplied by NCI. Multiple contracts will be awarded for these studies (probably at least five).

Contract Specialist: Anna Beattie
Cause & Prevention
301-496-6361

SOLE SOURCE NEGOTIATIONS

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

Title: Breast cancer detection demonstration project
Contractors: Stella and Charles Guttman Diagnostic Institute, New York; Good Samaritan Hospital and Medical Center, Portland, Ore.; Cancer Research Center, Columbia, Mo.; and Rhode Island Hospital, Providence.

Title: Studies on type-C viruses in relation to oncogenic potential
Contractor: Flow Laboratories, Inc.

Title: Support services to maintain studies of spontaneous and virus induced neoplastic transformation
Contractor: Meloy Laboratories.

Title: Research and development and monitoring of biohazards facilities.
Contractor: Dow Chemical Co., Midland, Mich.

Title: Studies of tumor viruses in nonhuman primates
Contractor: Rush-Presbyterian-St. Luke's Medical Center.

CONTRACT AWARDS

Title: State cervical cancer screening program
Contractor: Illinois State Dept. of Public Health, $815,177.

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