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COMPREHENSIVE CENTERS BALK AT "REQUIRING" ALL CONTROL PROGRAMS TO BE FUNNELED THROUGH THEM

"Cancer centers must assist community hospitals, physicians and organizations in providing resources and consultative advice in developing and funding cancer control activities," a workshop on outreach programs in cancer control conducted by NCI agreed recently.

But workshop participants, who included representatives of the comprehensive cancer centers and NCI staff, balked at the suggestion that coordination of cancer control activities could be achieved by "requiring" that NCI grantees and contractors not affiliated with a center establish "working relationships" with one.

"Let's veto that one right now," said David Carr, Mayo. "I want no part of requiring anyone at the Univ. of Minnesota to go through Mayo."

"This would blow the ship right out of the water," said Timothy Talbot, Fox Chase. "It would not work even without resentment, and there would be resentment. Besides, the capability is not there for most

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In Brief

NCI STUDY FINDS NO RELATION OF FLUORIDATED WATER TO CANCER INCIDENCE IN U.S. COUNTIES

FLUORIDATED WATER has no relation to cancer mortality patterns, according to a study by NCI's Epidemiology Branch. NCI studied cancer mortality and incidence statistics for U.S. counties, 1950-69, and "found no trends attributable to the consumption of water that is artificially or naturally fluoridated," the report said. The study was undertaken after a report appeared in the Congressional Record quoting figures compiled by a private organization, the National Health Federation. That report claimed there is a relationship between cancer mortality and fluoridated water supplies. NCI noted those conclusions were based on a comparison of counties containing the 10 largest cities with fluoridated water to counties containing the 10 largest cities with non-fluoridated water, with no attempt to take into account "confounding" demographic variables. . . . **WORLD-WIDE** cost of treating cancer patients totals about $8 billion a year, according to President's Cancer Panel Chairman Benno Schmidt. . . . **NCI DIRECTOR** Frank Rauscher asked the National Cancer Advisory Board to start thinking now about revisions in the National Cancer Act. It comes up for renewal in 1977. Rauscher suggested that one change could be increasing the number of expert consultants NCI can hire under the act from 100 to 150. . . . **THE EXCELLENT** report on the symposium on pancreatic carcinogenesis research which appeared in the August issue of *Cancer Research* has been reprinted by NCI. A limited number of copies are available. Write to Richard Pledger, who coordinated the symposium, at NCI, Div. of Cancer Cause & Prevention, Bethesda, Md., 20014.

WORKSHOP DEVELOPS RECOMMENDATIONS FOR CENTER-COMMUNITY OUTREACH PLANS

(Continued from page 1)

centers to be responsible for their areas. The centers should have responsibility for leadership, demonstration, cooperation, but not in the sense suggested."

Richard O'Brien, Univ. of Southern California, said that "it would be out of the question for us" to coordinate all cancer control grant and contract activities in Southern California. He pointed out that UCLA, the other Univ. of California schools at Irvine and San Diego, Loma Linda Univ., the community cancer center in Bakersfield, and the State Health Dept. "are already coming to the Div. of Cancer Control & Rehabilitation. They wouldn't be happy about it (going through USC for DCCR support) and neither would we."

O'Brien said he was not suggesting "we don't want to know what is going on" in his area. He suggested that such information should be available through DCCR, "and it would be helpful if we could get it without asking for it. But we don't want to imply that anything involuntary, or that the centers would have any control or prior approval" over the programs of others.

Diane McGrath, Duke, said that her institution is participating "in slicing up Virginia three ways," with the Duke, Georgetown-Howard and Hopkins comprehensive centers all assigned portions of the state as part of their respective regions. "When I try to set up some outreach program in Richmond, the Univ. of Virginia people have every right to say, 'What the heck is Duke doing in our territory?' "

Gordon Zubrod, Miami, commented that the "comprehensive centers can and must provide a good deal of leadership, planning and coordination. But what we must not do is claim credit for it."

The controversial recommendation was included in the report drawn up by the group considering implementation and management of outreach programs, chaired by R. Lee Clark, Univ. of Texas and member of the President's Cancer Panel. Clark was not present during the second day of the workshop when the reports were presented, and thus was unable to defend it. He later told ***The Cancer Letter*** that "perhaps that recommendation was worded a little stronger than we had intended. But we felt we have to avoid the problems which plagued the Regional Medical Program, with organizations in a region fighting each other and not knwoing what each other is doing."

The report of the implementation and management group follows:

1. The Comprehensive Cancer Center should be the focal point for cancer control activities in its area. This would involve the following major areas of activity.

Coordination. The center could significantly affect the coordination of cancer control activities in its area in various ways such as: acting as the fiscal agent for projects developed by other agencies, assisting other groups in the development of grant proposals and providing certain supportive services to other programs. [NCI could assist in this process by requiring that grant and contract proposals from other groups located in the area of the center establish a working relationship with the center during the development and/or implementation of proposals.] *The workshop participants agreed to drop the statement in brackets.*

Communication. The centers should have information on the various cancer control activities planned and operating in their areas. This would include but not be limited to information on proposed RFPs, review of proposals submitted and/or approved for cancer control programs, and progress reports of ongoing projects in their area.

Relationships. Centers should develop working relationships with other intramural and extramural programs and facilities. This helps to reduce fragmentation and facilitates the transfer of technology from the center to other health professionals and institutions.

2. Each area should develop an overall plan for cancer control.

• Current efforts are fragmented and inadequate. The need exists for building a model program, a checklist for what can and should be done in an area. This would involve working closely with the newly established Health Service Agencies.

3. Planning, development and implementation are sequential and related. The existing cancer control developmental grants evidently have greater capability for moving from planning to implementation than existed in the past. This flexibility can be exercised only through a clarification of grant guidelines and providing site visit teams with additional information on the nature of developmental grants. The review committee, grant applicant and site team should all be provided the same evaluation criteria and guidelines.

4. Strong core support for cancer control is needed in order to provide stability and continuity for the centers program. This would put control staff on equal footing with other center program components. This would involve paying for full time key cancer control personnel, supportive staff and services.

5. Continued education is an important part of cancer control and should be a strong component of the outreach program. It should provide formal as well as location-education for physicians as well as allied health professionals involved in cancer control.

6. There are problems related to the communications projects which are currently being addressed and hopefully, will be solved in the near future. These relate to legal liability for information given over the phone, referrals to specific physicians, the promotion

of centers and in some cases, the relationship to the American Cancer Society.

7. Additional meetings are strongly recommended to explore identified issues in implementation and to set priorities for the continual development of cancer programs.

Another group, chaired by Guy Robbins, Sloan-Kettering, reported on outreach planning and activities. The full report follows:

The Task Force defined an immediate problem of identifying the role of cancer centers with the relationship to cancer control outreach activities. A general consensus provided the following:

"The cancer centers must assist community hospitals, physicians and organizations in providing resources and consultative advice in developing and funding cancer control activities. Recognition of federal legislature activities, specifically creation of Health Service Agencies (HSA) PL 93-641 is an integral part of the coordinative responsibilities of a cancer center."

A role of aggressive (soliciting community involvement) or passive (responding to expressed community needs) leadership is based upon assessment of regional situations. If the former technique is used, the cancer center can allay the fears of the community physicians and organizations with a poanned approach and with the latter technique, the cancer center may respond quickly and gain participation by community advocacy.

The task force then discussed the needs of the cancer centers to perform their role in cancer control outreach. Nine items were discussed:

1. The core staff needs longterm financial stability earned and based upon performance to plan and implement simultaneous cancer control activities. This is a long range program and should be funded separately, either by the cancer center core grant or the available cancer control development grant mechanism. This core staff cannot and should not direct all cancer control activities. It should involve the research and clinical segments of the cancer center with the advice of an active community-involved advisory committee. The leadership of the cancer control core staff should not be mandated by NCI. Rather, it should earn the respect of the community and peers by the positive action that it takes.

2. Support for planning. This support in dollars and cents is already available through DCCR development grants. The caution extended by this committee stressed that the technical peer review site visitors be made well aware of the goals and objectives of the grant and the criteria for evaluating the cancer control performance standards of the centers.

3. Support of advisory and evaluation activities of the cancer centers as related to cancer control. The mechanism for financial support is available through the cancer control development grants. At this time the guidelines are not fully developed, but the committee cautioned NCI that a thorough orientation of the site visitors and technical reviewers of the essential criteria is necessary.

4. Support for developmental cancer control programs. Again, financial mechanisms are available through DCCR. The cancer centers should be allowed to determine the feasibility of implementation before implementation is activated. This criteria must be fully explained and understood by reviewers (site visitors) of the program.

5. Directory of cancer control and rehabilitation projects for the American Assn. of Cancer Institute (AACI) members. This is not totally the responsibility of NCI, but is also a responsibility of the cancer center. It is a necessary part of the coordinative role of the cancer center core staff. Possible mechanism for support is a contract.

6. Minimum standards for cancer control. By developing a directory of cancer control projects within a region, certain minimal criteria will evolve. These criteria will set a standard for other cancer control centers and be a basis for evaluation of cancer control programs. The standards must be discussed and be evaluated by AACI, peer advisors and NCI.

7. Support for consultative services. Consultative services are necessary both within the cancer control programs of a cancer center and to a cancer center itself. It is necessary to develop cancer control programs that are non-duplicative, non-fragmented and non-related. A cancer control program can benefit from experience of others, be they other cancer centers, related health fields, or federal experiences. A word of caution to reviewers and consultants—programs differ due to environmental, socio-economic and cultural bases.

8. Adequate data base for evaluation. The cancer centers recognize this need for cancer control programs as it contributes to the accountability and evaluation of a successful cancer control program. An adequate data base provides a basis for information exchange but the information must be standardized with a single or collection of projects. NCI can contribute to this by assisting in disseminating data information and experiences of other cancer control centers and programs.

9. Awareness of local, state and federal cancer related activities. Cancer centers must be aware of legislative actions pending at the local, state and federal level. An example is the local structure and subsequent impact of the Federal Health Service Agency legislation. With this type of awareness, cancer centers may take pre- and post-positive action in influencing the cancer control emphasis within their region. Can NCI help? And if so, how?

Conclusion – NCI needs your advice on formulating programs in cancer control that will benefit the cancer centers, the American provider and the community.

A third group, chaired by John Hartmann, Hutch-

inson, developed recommendations for evaluation and review. Its report follows:

The task force on evaluation and review was charged with identifying key issues and problems in evaluating comprehensive cancer center cancer control activities and proposing alternative solutions.

Time did not permit the group to fully explore all the issues and arrive at a consensus. The findings presented below include the major points brought out in discussion.

1. Evaluation should be an integral aspect of every comprehensive cancer center control program.

2. Evaluation cannot be separated from the planning process. Both are continuous and should be integrated into all levels of program activity.

3. Prior to implementation, it is necessary to establish (a) realistic objectives, (b) evaluation parameters which can be utilized to measure progress toward achieving those objectives, (c) data requirements and (d) initiate collection of that data so that baseline data will be available for evaluation purposes.

4. There is a need for three types of evaluation: strategy or activity (intermediate measures), process (qualitative measures) and impact (end results).

5. Every effort must be made to quantitatively evaluate cancer control efforts of the centers. However, it may be either necessary or desirable to evaluate certain aspects of control, such as the feelings, attitudes and emotions of patients and professionals, using qualitative or descriptive data.

6. Both internal and external review is important. Each center will want to examine how well it is doing over time and in relation to other centers. However, it was emphasized that each center is unique.

7. The centers will require assistance on developing their evaluation methodoloties. Several approaches were suggested.

- Sponsor regional evaluation workshops for center staff where information should be presented on currently existing resources and programs.
- Develop in-house evaluation capabilities of the centers by enabling them to seek ongoing consultation from evaluation specialists, health economists, medical sociologists, and anthropologists may be particularly helpful in developing evaluation strategies.
- Identification of methodologies to evaluate cancer control activities with regard to cost effectiveness, behavioral change and coordination of resources.

Samuel Taylor, Rush-Presbyterian-St. Luke's, noted that "nowhere in the three reports is there mention of the American Cancer Society," which he said was preeminent in cancer control activities long before the National Cancer Act created control responsibility for NCI.

Hartmann agreed that "we could never have a program without ACS. . . ACS has been in on control programs from the beginning. It would be foolish to start something without ACS and its 4 million volunteers."

Robbins said that in working with other institutions, "sometimes we have problems, sometimes we work very well together. Some do feel that we compete for funds."

"ACS has as much to learn from us as we from them," Talbot said. "We work with four divisions. Three are great, and one is an absolute bastard."

"We've got one we can give you," Robbins quipped.

The ACS national organization is very cooperative, and most problems are with the local divisions, Robbins commented. "But national won't meddle with the locals. If we had an Alan Davis (ACS vice president for public affairs) in every division, they would all be just like the Chicago and Washington divisions."

Zubrod pointed out five areas of potential conflict with ACS:

1. Fund raising. "We've agreed for the center to keep a low profile during the ACS March, April and May fund drives."
2. Communications.
3. Soliciting of volunteers. "In some areas, recruiting of volunteers is considered a prerogative of ACS."
4. "John Durant mentioned that in Alabama, expansion of the cancer program at the center placed too many demands on ACS."
5. "It seems to be a great concern with ACS that if close cooperation is developed between the comprehensive and community centers, it will take away some ACS prerogatives."

NCAB SUBCOMMITTEE CRITICIZES DRG FOR MAKEUP OF SPECIAL STUDY SECTION

The new study section which the NIH Div. of Research Grants created to deal with grant applications in the field of environmental carcinogenesis does not meet the requirements spelled out by the National Cancer Advisory Board's Subcommittee on Environmental Carcinogenesis. It was the subcommittee's urging, backed by an NCAB resolution, which moved NIH to establish the new study section on an ad hoc basis.

"Considerable dissatisfaction with the choice of membership of the study section" was expressed by members of the subcommittee, Phillipe Shubik, chairman of the group, reported to NCAB.

"The subcommittee had expressly avoided telling DRG who to appoint to this study section," Shubik said. "They had, however, recommended the disciplines to be represented; this had not been done. In particular, the field of environmental carcinogenesis requires the melding of laboratory and epidemiological disciplines, and the latter was notably absent.

"Some distinguished scientists in the field of chem-

ical carcinogenesis were part of the group, but several members were not experts in the area."

Shubik said he intended to meet with a DRG representative in an effort to rectify the situation. "It is possible that some of the needs of this field cannot be met through the study section review system; there would seem to be an overriding requirement on the part of the study section that all applications be 'new and innovative' research. It would seem that testing a chemical suspected of causing human cancer from an epidemiological study or by reason of its chemical structure could never conform to this precept."

The need for the new study section, in the view of the subcommittee and NCAB members, was brought on by the failure of existing study sections to perceive the importance of grant proposals in this field and the absence from the groups of persons with the background required to properly review them.

Shubik said he hoped "our efforts to establish this study section may not only assist us in the area of chemical carcinogenesis, but that it may assist DRG in dealing with the updating of its peer review process."

NCI still has not received any formal applications for the $25,000 planning grants to establish specialized cancer centers for environmental carcinogenesis. But Shubik reported that Thaddeus Domanski, chief of the Biomedical Research Programs Branch in NCI's Div. of Cancer Research Resources & Centers, "is continuing to discuss potential units with several promising institutions and individuals."

Shubik admitted that the "response to our announcement has been relatively slow, but the responses so far have been of a nature that encourages one to believe that progress can be made along these lines. It is obviously not possible to mount a crash program in this area in a reasonable manner—I do not believe that any of us have had this in mind. I do feel, however, that this Board may find itself faced with a situation in a year or so where it may have to consider vigorous action to meet national needs in a field that acquires more and more public attention each day."

The subcommittee has studies in some detail reports on the new mutagenicity tests which hold promise for providing rapid testing of suspected carcinogens without the lengthy and expensive animal studies now in use. Shubik told the Board that NCI is still evaluating these test methods. "There would appear to be a consensus that, although mutagenicity tests in single organisms are a useful screen for potential carcinogenicity, they cannot be considered to be proof of such biological activity. Similar caveats exist for other rapid test procedures which are not yet available for this program, but which hold much potential for the future. The basic test procedures used in the animal screen have been considered inadequate by some investigators and require continuous revision."

Shubik emphasized that the subcommittee feels one of the most difficult problems concerns epidemiology. "There is an urgent need for increased epidemiological investigation in all areas," he said. "This absolutely requires an increase in the number of positions in NCI. The epidemiologists in the Div. of Cancer Cause & Prevention are a distinguished small group of investigators whose contributions are considerable and out of all proportion to their numbers. Their recent publication of the distribution of cancer on a county-by-county basis in the U.S. has widespread merited attention. They are a first line of defense in detecting some new potential cancer hazard that may be missed in our various screens and appears for the first time in man.

"It is hard for us to realize now that we are still in the midst of an every-increasing epidemic of lung cancer from manmade sources. The recent announcement that the cancer incidence in this country appears to have increased by 5% in the last year may or may not be substantiated; that there is some increase is unquestioned. We must have adequate personnel to meet the task of answering such problems at once.

"To belabor a point I have made before—there is no question that the pill induces hepatomas, albeit mostly benign in young women. Can one even imagine the situation we would find ourselves in if we overlooked a possible larger occurrence of this disease? This area is lamentably understaffed. New positions at this institute are an urgent requirement, and I hope and pray that an effort will be made to remedy the situation as soon as possible. Extramural expansion is, of course, also recommended, but cannot we meet the major needs of the program which must have a larger intramural component."

Shubik reported that "the much vexed question of the effects of low levels, often minute levels," of carcinogens was considered by the subcommittee.

"Various theoretical models have been proposed by the biometrists; it was a consensus of opinion that no model is available to predict safety to man, but that such should be sought. A meeting between a small group of mathematicians, biometricians, and biologists is needed to plan programmed approaches to this problem and review the matter. The more recent meetings on the subject have tended to segregate the groups—integration is needed.

"It is a universal opinion that cancer can be attributed to environmental factors in the main," Shubik concluded. "I shall not belabor the matter of percentages since this seems to serve no useful purpose; cancer is largely a preventable disease. Methods of prevention of great variety are at hand. Many more need to be developed, and the approaches and methods for accomplishing this end are at hand. I feel I can say no more than this and hope that this Board will proceed on this information."

FDA ADVISED TO DROP GUIDELINES, BUT REMAINS UNMOVED ON NEW DRUG DELAYS

The Food & Drug Administration has been advised by its Oncologic Drugs Advisory Committee to forget about adopting the controversial proposed guidelines for clinical testing of anticancer drugs.

Michael Shinkin, chairman of the committee, had suggested that NCI and FDA get together and resolve their differences on the guidelines. The committee later decided in closed session, however, to recommend that no formal guidelines be adopted by FDA for publication in the *Federal Register*. Instead, the committee suggested that the two agencies collaborate on writing a loose set of guidelines acceptable to both, for publication in a professional journal.

Regulations published in the *Federal Register* have the force and effect of law, although FDA has insisted that its guidelines for clinical trials are not mandatory. "That's what they say," an NCI executive told ***The Cancer Letter***. "But any investigator who deviates from them had better be prepared to justify every move. They tend to become a straight jacket."

FDA is not bound to accept the advisory committee's recommendations, but Vincent DeVita, director of NCI's Div. of Cancer Treatment, told the President's Cancer Panel Monday that it appears the guideline issue is dead.

That was a comparatively minor problem in the current difficulties between FDA and NCI, however. DeVita told the Panel that FDA has not budged in its recent decision to interpret regulations in the "strictest sense, even though the law permits them to be interpreted differently."

Until recently, NCI had received 37 consecutive approvals for investigational new drugs (IND) from FDA without a single rejection. All went into clinical trials, with resulting incidents or problems. In the past four months, FDA has rejected seven consecutive INDs (***The Cancer Letter***, Nov. 14), although they followed the previous formats exactly.

Bowing somewhat to pressure from NCI, FDA did agree that NCI could start testing one of the drugs, maytansine, at the NIH clinical center but could not make it available to other investigators. "That doesn't flatter our colleagues around the country, and it is not based on any scientific judgment," DeVita said.

Rejections of the INDs are based on 15 requirements which FDA suddenly decided to enforce, "many of which are absurd," DeVita said. One example: FDA requires that the sponsor of a new drug maintain in its files a statement of the qualifications of each investigator attached to the protocol the investigator is using. NCI has such qualification statements but only one copy on each investigator. "One investigator has filed 73 protocols with us, and FDA is telling us we have to have a qualification statement with each," DeVita said.

The problems at FDA originated with Robert Young, group leader for oncologic drugs. A young scientist who, ironically, received much of his training at NCI, Young has been the FDA only a few months.

"The problem is, there's a new man who wants to do things his way," said Panel Chairman Benno Schmidt. "Unfortunately, we live in an era when supervisors are afraid to overrule a subordinate who cloaks himself in the law, or his interpretation of it."

NCI Director Frank Rauscher agreed to discuss the problem with FDA Commissioner Alexander Schmidt (no relation to Benno). If that doesn't work, Benno Schmidt may have to take it up with the President.

NITROSOUREAS SEMINAR TO INCLUDE WORKSHOPS ON GI, CNS NEOPLASMS

The Seventh New Drug Seminar sponsored by NCI's Div. of Cancer Treatment will be held as scheduled despite delays by the Food & Drug Administration in approving new drug applications for two of the compounds to be discussed, BCNU and CCNU (***The Cancer Letter***, Nov. 28).

The seminar will be held in the Washington Hilton Hotel Dec. 15-16. The subject will be the class of drugs known as nitrosoureas, of which BCNU and CCNU are two. BCNU and CCNU are available to investigators under FDA's investigational new drug procedure, and NCI has been supplying them to cooperative group members and DCT contractors. Although they are available to qualified investigators, they will not be commercially available until the NDAs are approved, probably in mid-1976.

As part of the seminar, there will be two minisymposia on the treatment of the two major indications for the nitrosoureas—advanced gastrointestinal cancer, and the CNS neoplasms with emphasis on the malignant gliomas.

NCI said the seminar will be geared to the practicing oncologist and will attempt to place the nitrosoureas in their proper perspective within the clinical oncologist's armamentarium.

DCT Director Vincent DeVita and his deputy, Stephen Carter, are cochairmen of the seminar.

No preregistration is required, nor is there a registration fee.

The program:

Monday, Dec. 15:

9 a.m. Welcome and Introduction—DeVita

9:10 Historical Development of the Nitrosoureas—Saul Schepartz

9:30 The Chemistry and Structure Activity Studies of the Nitrosoureas—John Montgomery

9:50 A Review of Experimental Tumor Activity—Frank Schabel

10:10 A review of Mechanism of Action Studies—Vincent Bono

10:30 Coffee
11:00 The Pharmacology of the Nitrosoureas – An Overview–Vincent Oliverio
11:20 The Pharmacology of the Nitrosoureas with Special Emphasis on CNS Pharmacology–Michael Walker
A. Survival Studies–Julius Wolf
B. Combination Approaches–Robert Livingston
11:40 The Nitrosoureas which have been Clinically Evaluated – An Outline of Common Schedules and Toxicities–Todd Wasserman
1:30 p.m. Studies of the Nitrosoureas in Hodgkin's Disease
A. The Use of BCNU in Advanced Hodgkin's Disease and its Use as a Remission Maintenance Agent –Robert Young
B. Studies of Acute Leukemia Group B–James Holland
C. Studies in the ECOG–John M. Bennett
D. Studies in the Southeast Group–John Durant
Discussions on the Role of the Nitrosoureas in Advanced Hodgkin's Disease
3:00 The Nitrosoureas in Multiple Myeloma–Sidney Salmon
3:20 The Nitrosoureas in Other Tumors–Milan Slavik
3:40 The Nitrosoureas – Aspects of Practical Utilization–Philip Schein
4:10 The Nitrosoureas – Thoughts for the Future –Carter
1:30 p.m. Workshop on Malignant Gliomas
A. Natural History and Prognostic Factors–Walker
B. Surgery–Joseph Ransohoff
C. Radiotherapy–Glenn Sheline
D. Chemotherapy–Charles Wilson
3:00 Nitrosoureas Studies at the Baltimore Cancer Research Center and in the Brain Tumor Study Group–Walker
3:30 Roundtable Discussion

Tuesday, Dec. 16:
8:30 a.m. Workshop on Advanced Large Bowel Cancer
A. Natural History and Prognostic Factors–Charles Moertel
B. The Current Status of Chemotherapy–Carter
9:15 Discussion
9:30 Specific Studies in Advanced Gastrointestinal Cancer with the Nitrosoureas
A. Mayo Clinic–Moertel
B. Wayne State University and in the Southwest Oncology Group–Lawrence Baker
C. Studies in the Eastern Cooperative Oncology Group–Harold Douglass
10:40 Coffee
11:00 The Nitrosoureas in the Treatment of Malignant Melanoma–David Ahmann
11:30 The Nitrosoureas in the Treatment of Lung Cancer

NCI ADVISORY GROUP, OTHER CANCER MEETINGS SCHEDULED IN DEC., JAN.

Committee on Cancer Immunobiology–Dec. 9, NIH Bldg 10 Room 4B14, open 2–2:30 p.m.
Diagnostic Radiology Committee–Dec. 9-10, NIH Bldg 31 Room 7, open Dec. 9, 8:30–9:30 a.m.
Temporary Committee for the Review of Data on the Carcinogenicity of Cyclamates–Dec. 10, NIH Bldg 31 Room 4, 9 a.m., all open.
Symposium on Recent Advances in the Treatment of Genitourinary Tumors–Dec. 11, Roswell Park, registration required.
Drug Development Contract Review Committee–Dec. 12, NIH Bldg 31 Room 8, open 10:30 a.m. to adjournment.
New Drug Seminar on Nitrosoureas–Dec. 15-16, Washington D.C. Hilton Hotel, 9 a.m. Dec. 15; 8:30 a.m. Dec. 16, all open.
Committee on Cancer Immunodiagnosis–Dec. 16, NIH Bldg 10 Room 4B14, open 1–1:30 p.m.
Committee on Cancer Immunotherapy–Dec. 18, NIH Bldg 10 Room 4B14, open 1–1:30 p.m.
Breast Cancer Task Force, All Committees–Jan. 7, Bethesda, Md., Holiday Inn, 8:30 a.m.–5 p.m., all open.
Recent Advances in the Diagnosis and Treatment of Lung Cancer–Jan. 13, Roswell Park, registration required.
Carcinogenesis Program Presentation on Perinatal Carcinogenesis–Jan. 19-21, Tampa, Fla., Holiday Inn Central, open 9–5 each day.
President's Cancer Panel–Jan. 21, NIH Bldg 31 Room 7, open 9:30 a.m.–noon.
Clinical Cooperative Group Chairmen–Jan. 27, NIH Bldg 31 Room 4, open 9 a.m.–5 p.m.
Assn. of Community Cancer Centers Annual Membership Meeting–Jan. 31-Feb. 1, Jacksonville, Fla., Hilton. 8:30 a.m.–5:30 p.m. Jan. 31; 8:30 –11 a.m. Feb. 1, all open.

CONTRACT AWARDS

Title: Studies of tumor viruses in nonhuman primates
Contractor: Rush Presbyterian-St. Luke's, $67,930.

Title: Study of transplacental carcinogenesis in brythrocebus patas
Contractor: Meloy Laboratories, $433,472.

Title: Study of tissue interactions in induction and perpetuation of hormally-induced permanent cellular alteration
Contractor: Stanford Univ., $93,883.

Title: Prototype clinical chemotherapy program in cancer control
Contractor: Mt. Sinai School of Medicine, $468,952.

Title: Clinical oncology program
Contractor: Institute for Medical Research, Santa Clara County, Calif., $71,374.

Title: Development and utilization of rehabilitation and/or continuing care resources and services
Contractor: Medical College of Virginia, $519,285.

Title: Human lung cancer: Evaluation of BCG therapy
Contractor: Univ. of Florida, $50,000.

Title: Twelve additional tasks involving alterations, renovations, A&E services, maintenance and upgrading of Frederick Cancer Research Center facilities
Contractor: Litton Bionetics, $476,901.

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 NCI-CM-67067

Title: *Monitoring of immunologic competence in cancer patients*
Deadline: *Approx. Jan. 23*

The Surgery Branch in the Clinical Oncology Program, Div. of Cancer Treatment, requires technical support services for assisting in monitoring the immune competence of cancer patients. These services will include providing courier service for pick-up and delivery of blood serum and tissue samples, separating serum and lymphocytes from blood, cryopreservation of lymphocytes, operating and maintaining a serum and lymphocyte bank, maintaining human and animal tissue culture lines, performing a panel of in vitro assays of human immune competence.

It is anticipated that the project will require nine technical man-years of effort per year.

Contract Specialist: J.M. Cooper
Cancer Treatment
301-427-7463

RFP NO1-CP-65737-62

Title: *Establishment of a rodent production colony*
Deadline: *Jan. 28*

The NCI Carcinogenesis Program has assumed the obligation to provide animal resources to the bioassay contractors for the screening of chemicals. The bulk of these animals are Fischer 344 rats and $B_6C_3F_1$ mice. At the present time the animals are distributed from the animal farm project at the Frederick Cancer Research Center. It is the intent of this RFP to solicit for another production cology for the rat strain and the mouse hybrid to supplement and complement that source.

The objective of this project is to develop a rodent production colony conducted under the best concepts of what is commonly considered a "barrier" system. The breeders for the barrier rooms will be supplied by a pedigreed expansion colony of associated flora status, held in isolators. The expansion colony will, in turn, be supported by a germ-free pedigreed nucleus originating from a pedigreed nucleus of animals shipped by the NIH inhouse colony to the contractor. The expansion and production colonies will not recycle breeders; only the nucleus colony will be self-sustaining. Breeding animals must not be older than 10 months.

At 12-month periods, pedigreed animals will be received from the genetic unit of the NIH inhouse colony to restart this contract's nucleus foundation and maintain genetic homogeneity with the NIH strains. It is a requirement that a barrier room will be utilized no longer than two years before being phased out of production, sanitized and restocked with breeders. The level of production must be maintained while barrier rooms are being recycled.

Proposals should reflect an issuable weanling level of 2000 Fischer 344 rats and 4000 $B_6C_3F_1$ hybrid mice, of equal sex distribution, monthly. It is anticipated that the $C_{57}BL/6$ and C_3H/He colonies will only be carried to the pedigreed expansion stage.

At the direction of the project officer or his designated representative, the contractor will distribute the weanling animals to using laboratories by either contractor owned vehicles or common carriers as most suitable. Directions given will be exact as to species, sex, age, weight and numbers. The animals will be shipped in approved filtered containers. Because of existing and increasing difficulties in transportation, a discussion of how transportation problems will be handled must be included in the proposal. The discussion should address both the easily accessible testing laboratory and the one that is in an isolated, difficult-to-reach place.

Contract Specialist: Dorothy Britton
301-496-6361

SOLE SOURCE NEGOTIATIONS

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

Title: Assembly and distribution of committee books
Contractor: Information Planning Associates, Inc.

Title: Research on oncogenic and potentially oncogenic viruses, virus production and vaccine development
Contractor: Merck & Company, Inc.

Title: Detroit SSMA population-based cancer registry
Contractor: Michigan Cancer Foundation.

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