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CENTRAL ONCOLOGY GROUP PHASE OUT APPROVED; BOARD IMPRESSED BY UNANIMOUS CCIRC VOTE

The National Cancer Advisory Board concurred with the Cancer Clinical Investigation Review Committee's decision to phase out the Central Oncology Group, with funding scheduled to end next January for all members except the group's statistical office and perhaps a few other administrative tasks.

COG thus becomes the second cooperative group to be dropped since the program was moved into the Div. of Cancer Treatment, although questions about COG and the Western Cancer Study Group (to be phased out by July 1) were raised and probation started prior to that move.

COG Chairman William Fletcher, Univ. of Oregon, appealed CCIRC's decision to NCAB. The Board declined to send the recommendation

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In Brief

COLUMBIA'S MARKS SAID TO BE CANCER PANEL NEW MEMBER; EIGHT VCP CREGS AWARDED

PAUL MARKS, vice president for health sciences and director of the Cancer Research Center at Columbia Univ., will be the new member of the President's Cancer Panel, ***The Cancer Letter*** has learned. He replaces Ray Owen of Cal Tech, whose term expired. White House sources would not say when Marks' appointment would be announced. . . . **EIGHT CREGS** (Cancer Research Emphasis Grants) will be awarded by the Virus Cancer Program in the first round of VCP's efforts to convert some research contracts to the new grant form. Two and possibly three more will be awarded from the 37 original applications, a number of which were disapproved. The CREGS will split $1 million in fiscal 1976 money. Three of the eight awarded so far went to former VCP contractors. "Our contractors competed very successfully through the study section process," VCP Director John Moloney said. . . . **VIRAL ONCOLOGY** Program name change may be coming up. Moloney wants to call it "Biological Carcinogenesis" which he said better describes the real nature of the program. There are cynics who will say the proposed change really reflects the diminishing popularity (in Congress, especially) of viruses and the growing popularity of carcinogenesis. The Viral Oncology Program has had nearly level funding the last two years, actually dropped $200,000—from $60.2 to $60 million—from 1975 to 1976 fiscal years. VCP, the extramural portion of the program, dropped from $49.4 to $47.8 million, including the $1 million for CREG. . . . **BETTY FORD** in a recent White House ceremoney turned over $96,000 to NCI Director Frank Rauscher for support of an international meeting on breast cancer, scheduled for late September. The money came from sale of President Ford's inaugural medals. The meeting will be sponsored jointly by the Breast Cancer Task Force and American Cancer Society.

COG LEADERS CITE PROGRESS, CONTEND CCIRC REVIEW WAS UNFAIR, BIASED

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back for further study; CCIRC's unanimous vote after prolonged and intensive review impressed Board members.

One more group, the Cooperative Breast Cancer Group, faces extinction this year. It has been on probation for almost two years, after CCIRC disapproved its last renewal application. The probationary period has been extended longer than usual, and CCIRC is scheduled to take another and perhaps final look at it in June.

The Southeastern Cancer Study Group, placed on probation last year, "has made changes and is starting to move," an NCI executive said. Its chances of surviving are much better now, depending on progress made when the group is reviewed again next year.

Fletcher's appeal, in the form of a letter to NCAB Chairman Jonathan Rhoads, stressed the role surgeons play in cancer treatment and that COG is the only major group in which surgeons are involved in the decision making process, with the exception of the National Surgical Adjuvant Breast Project and the Gynecological Oncology Group. "Surgeons make most of the primary treatment decisions in solid tumor cancer patients and they need access to and input from surgically oriented multimodality groups," Fletcher wrote.

COG members are concerned that "the best interests of their patients and the fullest fruition of the National Cancer Plan are in jeopardy by the apparent trend to fund only groups managed by medical oncologists. Because it logically follows that if COG is not funded, the Radiation Therapy Oncology Group will likely be the next to bow to the omniscience of medical oncology," Fletcher said.

[CCIRC denied RTOG's application for supplemental funds to permit it to become multimodal, contending that it should remain devoted primarily to improving and refining radiotherapy techniques.]

Fletcher's letter continued:

"COG is an amalgamation of several previously reorganized groups and has been truly 'multimodal' for approximately 10 years. It currently involved experienced cancer surgeons, medical oncologists, radiotherapists, gynecological oncologists, statisticians, nurse oncologists, project specialists, and secretaries. It has been one of the primary investigators in the completion of phase I and II studies of new agents including porfiromycin, tubercidin, imidazole carboxamide, adriamycin, BCNU, CCNU, velban, and vincristine.

"Over the past 2½ years COG has developed 1) one of the best statistical offices among the cooperative groups, 2) an effective committee structure, 3) better quality protocols, 4) more expeditious protocol development, review and implementation, 5) a community outreach among highly qualified participants, and it recognizes it must continue to change and develop.

"Toward that end the group has elected a new chairman. The committee structure is in the process of revision and will include a community outreach committee (one of the members is president of the Community Cancer Center organization), disease oriented committees, treatment oriented committees, and an ongoing mechanism to keep abreast of current developments in cancer so that new protocols will reflect investigation at the 'knife-edge' of the problem rather than be reinventions of the wheel.

"In the past there have been delays of up to three years in approval of some of the group's protocols and during the waiting period some very similar protocols have been given out as contracts, or subsequently been developed by other groups. This confusion, or even competition, between the various divisions of NCI no doubt has been resolved by its reorganization. Certainly the approval of protocols, the communication between groups, and the feedback as to what other groups and contracts are doing has improved markedly. The members of COG feel strongly that their group has, in part, been a victim of some of these previous problems and would like an opportunity to complete their better protocols with more effective operation under current NCI guidelines.

"To do that and realize the successful culmination of already started improvements it would require funding of at least one and one-half to two years and the requested supplement for continued radiotherapy input, pathology input, and temporary support for new satellite institutions."

COG Vice Chairman William Wilson, UCLA, said in a letter to DCT Director Vincent DeVita (a copy of which Wilson sent to ***The Cancer Letter***) that he felt the group did not receive a fair review by CCIRC.

"The 'unofficial' reason for not funding COG was that 'it was not a multimodality group'," Wilson wrote. "In actuality, CDEP, which formed in 1960, was one of three groups (Western Drug Evaluation Program, Central Drug Evaluation Program, and Eastern Drug Evaluation Program), that included medical and surgical oncologists and were the primary multimodality groups. The Eastern and Western Groups dissolved, and some members joined CDEP which became COG. Interestingly enough, the old programs were funded on what is now called a contract basis, i.e. a specific amount of money per study. At the time this was subject to considerable criticism. However, it now appears that this is to be the coming vogue (NSABP) and will be an additional method used by the cooperative groups.

"COG is multimodal, and at its January 1976 meeting had the radiologists from 16 of the institutions who met with the various study committees in planning combined protocols. CCIRC was aware of this when they met in February 1976.

"Current COG protocols that are of utmost import-

ance include:

"1. The only well stratified carcinoma of the colon study using 5-FU as an adjuvant.

"2. The only breast carcinoma adjuvant comparing alkeran to CMF (over 200 patients entered in approximately 16 months). The CMF used is intermittent and appears to be less toxic than the Canellos modification of CMF used by Bonadonna.

"3. The group has completed significant single agent lung protocols and pilots, and now has multiple lung protocols stratified by cell type and stage of disease that are rapidly accruing patient entry.

"4. The only group protocol that is utilizing four different regimes of administering 5-FU in patients with metastatic carcinoma of the breast and colon with patient selection on a randomized basis. Until this study is completed, the answer as to the best method of administering 5-FU will not be known, and of more importance is whether the drug has to be given to toxicity.

"5. Multiple melanoma protocols including phase III and adjuvant studies.

"These are some of the ongoing studies, and to have to stop patient entry and lose the follow-up (in adjuvants 3 to 5 years) would mean a lot of wasted time, effort and money."

Fletcher and Wilson both expressed the feeling, as have others since the phase out became known, that the demise of Western and COG somehow are related to the impending moves of DCT Deputy Director Stephen Carter to San Francisco and former DCT executive Paul Carbone to Wisconsin. Carbone is chairman of the Eastern Cooperative Oncology Group.

"Members of COG observe and are concerned about the 'ripple effect' manifested by the death of existing cancer activities just ahead of the movement of principal NCI individuals into a community," Fletcher wrote. "Whether happenstance or not the quiet death of the Western Oncology Group just prior to Dr. Stephen Carter's move to the Northern California area and now the extinction of COG just prior to the movement of Dr. Paul Carbone into Wisconsin appear to us to merit the close review of the National Cancer Advisory Board relative to the review process and the best interests of cancer investigation and patients."

Wilson wrote, "Another point that appears to be interesting and certainly is conjectural is the movement of certain members of the NCI staff, an example being Dr. Carbone's move to the Univ. of Wisconsin. COG was to be renewed on Feb. 1, 1976, and was supposed to be site visited in late July or early August 1975. This was canceled as 'not enough people were available for the site visit.' Dr. Carbone was considering an appointment at the Univ. of Wisconsin, and the time when he finally accepted the post was the latter part of August 1975 to start on July 1, 1976. COG members were then given an administrative extension of their grants from Jan. 31, 1976, to May 31, 1976.

"The site visit was then held on Oct. 31, 1975, and several members were unofficially informed that they were approved by the site visit team. In mid-November, 1975, COG members received a memo from Dr. Mercado referring to the extension of time. He added to this memo that in the event the renewal applications were not approved, the extension would be considered as terminal funding. This is of course three months prior to the date CCIRC met and disapproved the COG renewal. Since the word was 'released' that CCIRC disapproved the renewal, the Univ. of Wisconsin has elected to join the ECOG. In addition, various members of our group have already been approached by other groups for membership, even before we have had our final review."

The fact that Western and COG have been in trouble with CCIRC for at least two years, before either Carter or Carbone gave notice to NCI, tends to discount that theory. CCIRC is made up of non-government scientists and clinicians, except for Carter. To suggest that Carter and Carbone, or anyone else at NCI, could (or would even try to) dominate the committee to the extent it would kill two major groups just to pave their way into new careers is stretching it a bit.

NCI executives, NCAB members, members of other cooperative groups and CCIRC members have at various times expressed the following deficiencies as problems afflicting the weaker cooperative groups. One group chairman told ***The Cancer Letter*** most of them apply to Western and COG:

—Inadequate protocol design. "They don't ask the right questions, or the questions asked are not significant."

—Too many protocols, too few patients.

—Generally, unimpressive results. "They're just not getting the job done."

That doesn't mean that both groups didn't have many top-notch investigators in their memberships. It is true that a scramble is on among some group chairmen to sign up many present COG and Western members. Fletcher, particularly, would be considered a prize catch by any of the groups.

Some members have taken the initiative in contacting other groups about moving. NCI has made it clear it will facilitate those transfers any way it can. COG and Western members who have not yet done so were advised to contact the chairman of the group that most interests them.

SECRET BUDGET DISCUSSIONS ENDED; HEW OUT TO LIMIT FUTURE NCI FUNDS

Budget discussions are no longer considered a proper subject for closed sessions of federal advisory groups, the government has decided following recent interpretations of the Freedom of Information Act. The public, therefore, is no longer excluded from discussions of how its money will be spent.

One result of that determination was that the first deliberations of the National Cancer Advisory Board on future authorization levels in the National Cancer Act were held in open meeting last week. It revealed the Ford Administration's continuing determination to put a lid on cancer program spending.

The authorization level for FY 1977, the final year of the three-year renewal of the Act, is $1.073 billion. The Administration requested only $687 million, while NCI asked for $948 million. Congress is now working on the appropriation bill, and it will eventually produce a figure somewhere between the $762 million NCI is getting in FY 1976 and the $948 million.

For the next renewal of the Act, which Congress will take up some time next year, HEW has told NCI that it would ask for the same $1.073 billion authorization level for all three years, from fiscal 1978 through 1980.

Director Frank Rauscher told the Board that NCI had suggested new authorization figures $1.202, $1.309 and $1.421 billion for the three years, "amounts we could spend wisely and effectively, our best effort." After discussions with the President's Cancer Panel, however, those requests were trimmed to meet reality—to $1.073 billion in FY 1978, $1.139 in 1979 and $1.214 in 1980.

When Congress takes up the Cancer Act renewal next year, the official request from the Administration (unless there is a new Administration by then) will be $1.073 billion for all three years. Congress in the past has paid more attention to what NCAB has suggested, and Chairman Jonathan Rhoads made it clear the Board and Panel recommendations would be made known to Congress.

Rhoads noted that the figure approved by the Panel for 1980 represented a 60% increase "from present payment to future authorization. That gives us plenty of headroom, or would by bringing the actual appropriation up closer to the authorized amount."

One task citizen groups, institutions and individuals interested in the cancer program will take on this year will be to develop and justify their own suggestions for authorization levels.

Panel Chairman Benno Schmidt commented that "unless inflation comes better under control, the 1978-80 figures (asked by HEW) are probably decreased in constant dollars. There will be either a general shrinkage (in programs) across the board, or institutions will have to absorb more of the cost sharing burden."

Meanwhile, NCI had the happy task of deciding how to split up the extra $74.3 million Congress gave it over the Administration's request for the current (1976) fiscal year.

Rauscher said that $20 million will be channeled into environmental carcinogenesis, a direct result of the growing public and congressional concern in that area. Of that figure, $6.5 million will be added to the budget of Umberto Saffiotti's carcinogenesis program in the Div. of Cancer Cause & Prevention. Most of the rest will fund regular research grants, probably lifting the percentage funded of approved grants in environmental carcinogenesis to 60%, compared to 43% for other grants.

Rauscher told the Board that environmental carcinogenesis headed his "hell or high water list"—programs that would get new money no matter what the appropriation figure turned out to be. Others on the list included interferon research, cooperative groups, the Frederick Cancer Research Center, more discretionary funds for cancer center directors, the new ambulatory care research facility at NIH to which NCI will contribute $8.2 million of FY 1977 money, nutrition research which will get from $4.5 to $6 million before Sept. 30, and cancer patient information systems at the comprehensive centers.

Rauscher sent a memo to the NCI Executive Committee explaining the distribution of the extra money. The memo follows:

"The total amount appropriated was $743,564,-000, which excludes training funds in the amount of $18,163,000. We can spend training dollars under the continuing resolution authorization, since the National Research Service Awards Act has not been renewed, although this is expected shortly. Two apportionment documents were received, (1) $25 million for construction and renovation since that money is available until expended (no-year money), and (2) $718,564,-000 for all other NCI activities with the exception of training. Although it is legal to carry over funds into the wedge period [July-Sept. 30, the period between the old and new fiscal year starting times], I want all 1976 appropriated funds (plus training) obligated by June 30, 1976. Please let me know right away if this causes any problems.

"This memo speaks only to dollars. I expect to make the allocation of new positions to each division by the end of this week. I want to recap and remind you of the previous decisions made on 1976 funding, and also my final decisions on allocation of 1976 funds as a follow-up to the budget review at the Executive Committee meeting on Feb. 12. I'll do this sequentially.

"Decisions at Dec. 9 Executive Committee Meeting. (Based on continuing resolution level of $691 million – Decisions were at the minimal dollar level and are still valid).

"a. DCCP to fund $1 million for nutrition.

"b. Some additional money to be made available to Dr. Fraumeni's program [Epidemiology] by DCCP.

"c. DCT, DCBD, and DCRRC to fund an additional $350,000 each for interferon research.

"Decisions at Feb. 12 Executive Committee Meeting. (Based on the appropriation level.)

"a. DCBD funds are to be increased by $1.5 million – Breast Cancer ($.5 million) and Immunology

($1 million). The Immunology increase is to be used for immunotherapy. DCT and DCCP funds will each be reduced $750,000 for transfer to DCBD.

"b. A director's reserve would be established totaling $3,690,000. Because of the lateness in the fiscal year, I have decided to reduce the reserve to $1.5 million. These funds will be reserved from the NCI divisions as follows: DCRRC–$665,000; DCBD–$110,000; DCT–$250,000; DCCP–$280,000; DCCR–$115,000; and OD–$80,000. Any reserve funds not utilized by May 15 will be released to the NCI divisions on a competitive basis. You should have documents ready to sign for possible use of any funds still in the reserve account on May 15.

"Decisions on Allocation of 1976 Appropriation (follow-up to the Executive Committee meeting of Feb. 12, and after receipt of impact memos from DCRRC, DCCP and DCT.

"a. Nutrition. With the high priority of this program along with the congressional earmark, we should fund at least $4 million this fiscal year. At least $2 million should be funded by DCCP, $1.5 million by DCT, and $.5 million by DCRRC. No transfers of funds are involved here. These monies should be considered as funding the total NCI Diet, Nutrition & Cancer Program.

"b. Cancer Centers (Core Grants, Program Projects and Exploratory Projects). DCRRC has requested $7.3 million above the dollar level reflected in the 1976 Congressional Budget. Of this total, $2.3 million is being reprogrammed within the division. I have decided to make $3.5 million available ($2.5 million by transfer) from other divisions of NCI. The 1976 appropriation level will be adjusted by reducing DCCP by $1 million and DCT by $1.5 million and transferring this money to DCRRC. In the case of Cancer Control, we cannot move funds out of that budgeted line item. However, Dr. Fink and Dr. King and their staffs are to continue to review closely the grant applications of centers and identify portions of cancer center core support grants that are for cancer control activities totalling $1 million in order to alleviate the funding shortage in the centers program. This would, of course, mean identifying activities at centers which actually represent support to cancer control and rehabilitation.

"c. Regular Research Grants. I realize that this program is not being funded at the level desired by the Board and Panel. However, the total funds appropriated to NCI are far below the level requested by NCI. The balance of regular research grants with the other programs of the institute seems about right, and we will have to fund at the approximate level contained in the 1976 appropriation (43% of approved competing traditional grants). As discussed at the Executive Committee meeting on Feb. 12, priority funding should be given to grants with environmental carcinogenesis research.

"d. NIH Management Fund (Clinical Center). If we must provide $500,000 to the Clinical Center to cover drug procurement and other shortages, that amount will be taken from the Director's reserve. This would be true of any other possible shortages that might be assessed NCI by NIH.

"In summary, the National Cancer Program has received an additional $74.3 million as a result of the veto override by Congress. In terms of mechanism of funding, this increase will be obligated as follows: Grants–65.1%; Contracts–30.2%; Interagency agreements–2.0%; Intramural–2.7%. I believe this allocation to be the best possible within mandates of the National Cancer Act, recommendations of the Panel and Board, additional justifiable needs of the NIH and is compatible with opportunities in cancer research and control. That's no mean accomplishment which could not have been done without your willingness to "trade-off" for the good of a best NCP. Thanks very much and let's get on with it."

Here's the breakdown by program, comparing 1975 with the final 1976 appropriation (in thousands):

	1975 Actual ($699,305)	1976 Appropriation Level ($761,727)
Research Grants:		
Traditional	$112,258	$129,871
Clinical Trials	19,213	22,327
Cancer research centers	116,132	127,412
Task forces	11,167	14,100
Research career program	2,806	3,240
Clinical education program	5,033	7,492
Radiation Development program	4,005	2,700
Cancer research emphasis grants	—	7,532
Total research grants	**$270,614**	**$314,674**
Fellowship and training grants	23,104	18,163
Research and development contracts (includes interagency agreements)	199,585	215,551
Intramural research and direct operations	105,649	125,202
Program management	5,104	6,331
Cancer control	50,273	56,806
Construction	44,976	25,000
Total	**$699,305**	**$761,727**

NCI WARNS OF PILL'S POSSIBLE RELATION TO LIVER TUMORS, PLANS NEW STUDIES

NCI has issued a statement describing the possible association of liver tumors with the use of oral contraceptives and outlining what the Institute plans to do about it.

The action followed a decision by the National Cancer Advisory Board last week to put its prestige behind the preliminary warning to American women. The Board acted after Philippe Shubik, chairman of

its Subcommittee on Environmental Carcinogenesis, reported on the subcommittee's consideration of the problem at its last meeting (*The Cancer Letter*, March 12).

The subcommittee recommended that NCI take immediate steps to establish the occurrence of benign and cancerous liver tumors in the United States, and determine whether, in fact, there has been an increase; to determine whether a relationship between liver tumors and one or more types of oral contraceptives exists; to investigate any association with the type of oral contraceptive used; to examine whether tumors disappear following withdrawal of contraceptives; and to study diagnosis and treatment problems related to the disease.

The subcommittee reported that 107 cases of such tumors have been published in the medical literature, but noted that this number may not reflect the magnitude of the problem. Most of the tumors are benign, and these are not recorded in cancer registries. In addition, no other routine mechanisms existed in the past to document cases of the disease.

Director Frank Rauscher said NCI will take action on each step outlined by the subcommittee and will coordinate these activities with those of other federal agencies, including FDA and the National Institute of Child Health and Human Development, which have been concerned with this problem.

A warning statement as to the possibility of liver tumors has appeared in the FDA-approved labeling of oral contraceptives for more than a year.

Two ongoing studies in Great Britain and one in California have been looking for side-effects in women using oral contraceptives.

NICHD, in cooperation with the Center for Disease Control, is about to initiate a study of liver tumors in the registry of the Armed Forces Institute of Pathology. The study will trace the use of oral contraceptives in women who developed the liver tumors. The registry was established in 1960 and contains about 100 cases.

The reported number of women with liver tumors is a very small percentage of the estimated 35 million American women who take or have taken the pill. The problem, however, is of special interest to the NCI, Rauscher said, because the delayed action of tumor-inducing substances makes it possible that the occurrence of liver tumors may be even higher than preliminary reports indicate.

NCAB Chairman Jonathan Rhoads asked Shubik, "Are you prepared on the basis of 107 lesions and the animal data to make a statement of a warning nature?"

"I am indeed," Shubik answered. "I have never had a doubt that we should not market a drug that produces hepatomas in mice given at the same levels as the doses taken by humans. It is not like the situation where you give massive doses to animals of products which humans ingest at much lower levels. The fact that the tumors have appeared within five years is frightening. If we had one sixtieth the number of cases resulting from a pesticide, there's no doubt what we would do. There's much more evidence, and many more cases, than were produced by vinyl chloride.

Board member Denman Hammond noted that the natural history of benign hepatomas is that they regress once the oral contraceptive is withdrawn, provided they are found before becoming malignant.

Board member Laurence Rockefeller noted that the warning offered no suggestions or alternatives. "We're not telling them to do anything but worry."

NCAB DECLINES COMP CENTER MINIMUM BED ORDER, BUT NCI GETS THE MESSAGE

A proposal by NCAB member Mary Lasker to require that cancer centers have at least 20 beds assigned exclusively to interdisciplinary clinical research in order to be considered for comprehensive designation was sidetracked by the determined opposition of another Board member, Irving London.

The Lasker proposal, approved earlier in the week by NCAB's Subcommittee on Construction, would change "characteristic No. 10" in the guidelines for comprehensive centers to require that a minimum of 20 beds—grouped, if possible, and under the control of the center director—be used for interdisciplinary research.

"This will be interpreted as a power grab by the oncologists," London said. "We shouldn't be trying to dictate, to dot every i. These characteristics are supposed to be guiding principles. If we start stipulating minimum numbers of beds, we'll start quantifying other elements. NCAB should not be specifying elements. We must permit more flexibility. We're making too much of a deal out of this, too much administrative intervention. I would rather see the review committee look at all other requirements, how centers live up to the principles in general. This is really an inordinate emphasis on a relatively minor point."

We're only talking about 17 comprehensive centers," Lasker responded. "They receive substantial support and ought to be willing to treat at least 20 people. How can a comprehensive center be comprehensive if it's not willing to treat a minimum number of patients?"

NCI Director Frank Rauscher and NCAB Chairman Jonathan Rhoads suggested a compromise, dropping the number to 20 but leaving the rest of the statement requiring "adequate" or "appropriate" numbers of beds for multidisciplinary or interdisciplinary research.

R. Lee Clark, member of the President's Cancer Panel, said, "I rather liked the modification. It pointed out the main deficiency of institutions wishing to be recognized as comprehensive, that they do not have an interdisciplinary program. Some may think 20 is an adequate number, but it really is not." Clark said he felt that stating 20 as minimum would lead some

centers to consider it as a maximum.

London said some institutions "have delusions of grandeur," attempting to devote 150 beds to interdisciplinary studies "when they can't possibly mount a program that size." On the other hand, London said, 10 beds "obviously is not enough."

Subcommittee Chairman Denman Hammond reworded the proposal, dropping the number 20, and the Board voted unanimously to accept it.

"I'll accept," Lasker said. "I know when I'm beat. But there is no use making this big effort if comprehensive centers are not willing to have a minimum number of beds for treatment."

"Don't worry, Mary," Rauscher said. "My staff has the message. I can't imagine any center being accepted without having at least 20 beds."

$20 MILLION IN CONSTRUCTION GRANTS APPROVED; HAWAII MONEY RELEASED

The National Cancer Advisory Board approved over $20 million in construction grants at 14 institutions last week, permitting NCI to complete the job of spending $23.5 million in its FY 1976 construction budget for cancer centers.

NCI also has learned that $2.6 million for a new construction grant to the Univ. of Hawaii has been released by HEW. This grant had been approved for funding by NCAB last year. White House policy is to automatically refuse funds for new construction, releasing them only when the agency appeals (and sometimes not then). The Office of Management & Budget, after being forced to back down and release construction funds on several previous occasions, has now assigned appeal responsibility to HEW. The decision by HEW to release the Hawaii funds was the first under the new procedure.

A number of grant applications for new construction will be presented to NCAB at its October meeting, setting up the NCI-HEW confrontation again. The practice of withholding and delaying release of the funds is nonsense, of course. OMB and now HEW have not been willing to test their authority to stop federal support of cancer center new construction. Explicit and clear language in the National Cancer Act gives the NCI director, with NCAB approval, sole and final authority to award construction grants, including new construction. A legal challenge based on the Act and on congressional intent as expressed in appropriations measures should have no problems in the courts. No center has yet been forced to make that challenge, but the appeals process has caused delays and resulting construction cost increases.

The construction program faces another serious problem in the 1977 fiscal year with a severe budget limitation. The President asked for only $17 million for NCI-supported construction. Of that, NCI will be obligated to assign $8 million to NIH for its share of the cost of building a new Clinical Center ambulatory care facility. As usual, the Cancer Program will have to rely on Congress to put enough money into the program to over come the Administration's stubborn antipathy to construction support.

Grants approved last week by NCAB included the following:

Univ. of Michigan, Univ. of Wisconsin (two awards), State Univ. of New York at Stony Brook, Rockefeller Univ., Sidney Farber Cancer Center, Harvard Univ., MIT, Memorial Hospital (New York), Sloan-Kettering, Northwestern Univ., Univ. of Rochester, and Fred Hutchinson Cancer Center.

Supplements were approved for Einstein, Hopkins, and Howard Univ. The money ran out before they got to Howard, which will be paid when the 1977 appropriation becomes available.

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-CP-65793-68

Title: *Literature study to evaluate health parameters in various human populations in relation to diet*

Deadline: *May 10*

The objective of this study is to ascertain the availability and quality of published and unpublished literature on health parameters in relation to diet, particularly in populations with a high or low incidence of cancer. This literature study will be utilized to distinguish human populations with unique health and dietary parameters in which hypotheses developed from epidemiology and animal studies regarding the relationship of diet and cancer can't possibly be studied. Prospective offerors should have a familiarity with both relevant published and unpublished literature sources and the ability to conduct critical scientific reviews of the literature.

RFP NO1-CP-65780-68

Title: *Literature study on indicators of health and nutritional status with emphasis on primitive populations*

Deadline: *May 5*

The objective of this study is to ascertain the avail-

ability of adequate methodologies for assessing health and nutritional status of primitive populations in relation to dietary intake. This information will be utilized to develop guidelines for future studies. Prospective offerors should have a familiarity with both relevant published and unpublished literature sources; the ability to conduct critical scientific reviews of the literature; and the ability to formulate health and nutrition surveys for specific populations.

RFP NO1-CP-65781-68

Title: *Literature study on primitive populations in relation to diet*

Deadline: *May 3*

The objective of this project is to ascertain the availability and quality of published and unpublished literature on primitive populations in relation to diet. This literature study will be utilized to determine whether dietary patterns of primitive populations may be useful in studying the physiological evolution of man. Prospective offerors should have a familiarity with both relevant published and unpublished literature sources and ability to conduct critical scientific reviews of the literature.

RFP NO1-CP-65792-68

Title: *Literature study on morbidity and mortality rates in nonhuman mammals in relation to diet*

Deadline: *May 10*

The objective of this study is to ascertain the availability and quality of published and unpublished literature on morbidity and mortality rates in nonhuman mammals in relation to environmental alterations, particularly dietary alterations. This literature study will be utilized to develop animal models for the study of diet, nutrition and cancer. Prospective offerors should have a familiarity with both relevant published and unpublished literature sources and the ability to conduct critical scientific reviews of the literature.

Contract Specialist for the four above RFPs: S.W. Ranta
Cause & Prevention
301-496-6361

RFP NO1-CN-65375-05

Title: *Implementation of the "hospice" concept for the care of terminal cancer patients*

Deadline: *May 13*

The objective of this procurement is to provide for a limited demonstration program to field test in the United States the St. Christopher's Hospice concept for care of the terminal cancer patient. While social/cultural differences between England and the United States may very well preclude exact duplication of all aspects of the St. Christopher's Hospice, it is requisite that the St. Christopher's philosophy of care be reflected and implemented in the offeror's proposed program.

Task I—The offeror shall present the details of a plan to implement a hospice program solely for the care of cancer patients who have received maximum definitive treatment without achieving cure, remission or control of the disease and for whom further medical treatment has not been recommended. Using St. Christopher's in England as a model, the proposed hospice program shall consist of two major components: a large home care program (admitting 60-125 patients within the first year), and a 15-24 bed inpatient facility. Under the supervision and direction of a medical doctor both components shall function as a single program, centrally administered, fully coordinated and utilizing a common staff to achieve a common goal.

Task II—Evaluation Plan—The offeror shall include as a part of the written proposal a plan for the evaluation of the total hospice program. Such a plan shall define the data to be collected, the method for collecting the data and the plan for the systematic analysis of the data.

Additional Requirements:

1. It is expected that the offeror shall have the physical facility, adequate space, any specialized equipment as well as the office equipment necessary to initiate and conduct a proposed program.
2. The cost for any new construction, major renovation, or direct patient care cost will not be funded by the Div. of Cancer Control & Rehabilitation.
3. Funds for certain expendable supplies, certain prosthetic and orthotic appliances that relate to the demonstration of the hospice concept will be allowed when properly documented. Such funds must be approved by the Project Officer prior to allowance.
4. The use of consultants in the program will be supported by the Div. of Cancer Control & Rehabilitation, when the required areas of expertise are not available among the offeror's staff.
5. Attention should be given to plans for the continued support of the program from sources other than the National Cancer Institute at the termination of contract funding period.

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