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NCAB URGES SWITCHING MORE FUNDS TO GRANTS FROM CONTRACT PROGRAMS OVER NEXT THREE YEARS

Despite a plea from NCI Director Frank Rauscher that "we not get into the grants vs. contracts thing again," the National Cancer Advisory Board approved a resolution calling on him to "work toward increasing funds budgeted for investigator-initiated research by 1 to 1½% of the discretionary portion of the NCI budget each year for the next three years."

Board member Harold Amos led the effort to increase NCI's commitment to investigator-initiated research. Amos noted that in the budget projections for the 1977 and 1978 fiscal years, funds earmarked for regular research grants were 17.1% of the total NCI budget; and that in 1970 and 1971, the last years before the effect of the National Cancer Act were felt, regular research grants received 20% of the NCI budget.

The Board for the past several years has insisted that 50% of NCI's budget should go into grants. NCI has kept reasonably close to that

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In Brief

WHITE HOUSE FINALLY OKAYS MARKS TO PANEL; NCAB SEEKS MORE DATA IN RFP ANNOUNCEMENTS

APPOINTMENT of Paul Marks, director of the Columbia Univ. Cancer Research Center, to the President's Cancer Panel (*The Cancer Letter*, April 2) has finally been cleared by the White House. . . . **RECOMBINANT DNA** research guidelines have been finalized, ordered into effect by NIH Director Donald Fredrickson. They ban certain experiments considered too dangerous, impose strict lab safety standards for others. . . . **RESOLUTION** approved last week by the National Cancer Advisory Board supports the Kennedy-Hart bill that would tax the higher tar and nicotine cigarettes and use the money for biomedical research. Main thrust of the bill is to encourage smokers to use the less hazardous brands. An attempt was planned for this week to attach major provisions of the bill to the tax reform legislation now being debated in the Senate. . . . **RECENT ADVANCES** in cancer treatment is the subject of a symposium sponsored by the European Organization for Research on Treatment of Cancer, Sept. 23-24 in Brussels. Vincent DeVita, director of the Div. of Cancer Treatment, will head NCI's delegation. . . . **SIZE OF CONTRACT, CREG** programs should be indicated in the RFP and RFP announcements, NCAB requested. Board member Frank Dixon asked that the size of the program, including the probable number of awards, consistent with federal procurement regulations, be carried in the announcements to give potential respondants some idea of the program's extent. Regulations prohibit revealing dollar estimates in announcements or the RFPs. However, RFPs usually include manpower estimates which could be included in the announcements.

NCAB ASKS MORE FOR GRANTS, APPROVES BUDGET DISTRIBUTION PLAN FOR FY 1978

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percentage, with 47.3% in 1976, an estimated 47.8% in 1977, and 48.8% in 1978 at the mid-level budget estimate (See ***The Cancer Letter***, June 18 and 25, for the 1978 mid and upper level budget figures.)

But those percentages include support for all grants, not just those of the traditional, investigator-initiated variety which permit the freedom and encourage the creativity which many feel is necessary for significant progress in biomedical research. NCI grants also support the Clinical Cooperative Groups, program projects, task forces, radiation development, cancer center core and planning, training and fellowship programs, construction and some cancer control programs.

Amos was arguing for more money for regular research grants, not so much for the other grant programs although agreeing that program projects did fall into the category of investigator-initiated research and thus could be included in the terms of the resolution.

Amos pointed to "the enormous increase" in research contracts, from $46.8 million in 1972 to an estimated $136.3 million in the 1978 mid-level budget, with the percentage increase from 12.6 to 14.3 of the total NCI budget.

"Maybe that's enough to get another Nobel Prize," commented R. Lee Clark, member of the President's Cancer Panel. Three recent Nobel Prize winners were supported by NCI contracts.

Amos argued that contracts usually go to "people well along in their careers; young people generally are not involved in the big contracts and CREGs (Cancer Research Emphasis Grants)." But Clark said that contracts usually are carried out with the assistance of "a multiplicity of post doctoral fellows." And Benno Schmidt, Panel chairman,said "There's no reason why young investigators can't participate in CREGs."

Board member Denman Hammond noted that, since CREGs were originally designed to be supported with funds transferred from contracts, the budget for contracts should be growing at a lesser rate.

Rauscher answered that it is too soon yet for CREGs to put much of a dent in the contracts budget; contract programs can be switched over only as the commitments expire.

"We're funding CREGs mostly out of new money," Rauscher said. "They are having an impact. Without CREGs, the $6 million going into nutrition would be entirely for contracts."

NCAB Chairman Jonathan Rhoads said, "I've been over these figures three times, and I'm more impressed with the balance than with any imbalance."

The Board's Subcommittee on the Budget, chaired by Dixon, had recommended that the annual increase of 1 to 1½% be based on the entire NCI budget. Rauscher objected strenuously.

"You're asking me to increase those programs by $36 million over three years," Rauscher said. "But there are certain amounts locked in. The $80 million that stays on campus (Intramural research, library, computer support and other overhead including staff salaries) is uncuttable."

Schmidt pointed out that funds for cancer control are earmarked by Congress and also are uncuttable. "And we better not cut any of the clinical activities," Schmidt said.

Rauscher said "we can certainly try" to meet the 1-1½% goal, but with the mandated programs in nutrition and control, all the clinical research NCI supports, and the increasing pressures from Congress and the public for emphasis on environmental carcinogenesis, "it doesn't leave us much room."

"I would like for the Board to realize that you are putting on the director exactly the opposite pressures being exerted by Congress," Schmidt said.

Amos replied, "On the other hand, Congress created the National Cancer Advisory Board because it recognized that it did not have the capability of running the cancer program. It is our responsibility to do what we think should be done, and we should go on the record."

Board member William Powers suggested that cancer control and program management be deleted from the base budget to which the resolution would apply. In rephrasing the motion, Rhoads inserted the term "discretionary portion of the NCI budget," and it was approved unanimously.

Rhoads noted that the resolution is not binding on the director since the Board acts only as an advisor, except in the award of grants exceeding $35,000, when the Board's approval is required. Rauscher observed that he could not recall "a single instance" when he had not followed the Board's recommendation.

The Board approved without dissent all other distributions proposed by NCI for the 1978 mid and upper level budget estimates.

DEFINITIONS OF CENTERS, NEW CATEGORIES SUGGESTED BY DEPARTING PROGRAM CHIEF

"Numerous, unresolved issues," including the classification of centers, establishing new categories of centers, defining their various roles and providing for review, evaluation and support were tackled by Simeon Cantril in a report he submitted before departing last week as director of NCI's Cancer Centers Program.

The classification and new categories Cantril suggested were along the lines of those he had previously discussed with ***The Cancer Letter*** (April 30).

The National Cancer Advisory Board Subcommittee on Centers will undertake a review of the recommendations at a meeting in August. Approval by the

NCI director will be necessary before the recommendations, or any version of them, become policy. Frank Rauscher has already expressed support for many of the suggestions but is not likely to put them into operation without the concurrence of NCAB and the President's Cancer Panel. He probably also will discuss them at length with representatives of the American Assn. of Cancer Institutes.

The major effect of the recommendations would be to establish a new class of centers to serve the clinical, educational and outreach needs of geographical regions. That function is now required of comprehensive centers and would continue to be under Cantril's plan, but the new class of centers would not be required to conduct basic research.

Cantril's recommendations also would recognize community and specialized centers as two of the four categories, along with regional and comprehensive. He advised that NCI continue the practice of "identifying" or "recognizing" comprehensive centers as they reach the stage where such recognition is justified. The regional centers also would be identified or recognized, but Cantril suggested that formal recognition should not be made of community and specialized centers.

"The public—and particularly Congress—is concerned about the regional impact of cancer centers," Cantril wrote. "To develop comprehensive centers to serve the regions takes both time and money as well as manpower. We probably don't have the manpower in basic sciences. We don't have sufficient money and Congress and others have indicated it might be desirable to speed up the process. Some compromises have been made in order to spped up the process of recognizing comprehensive centers. It is not recommended that further compromises be made at this time. However, it is proposed that in order to meet the regional requirements for cancer centers of excellence, which can conduct quality programs in clinical cancer care, clinical research, clinical education and training, and outreach and demonstration, an additional category of cancer center be identified —that is, a Regional Cancer Center. It is proposed that these regional centers meet the same standards as comprehensive cancer centers with the exception of the breadth and excellence of programs required in fundamental research. With sufficient time, many such regional centers will evolve into comprehensive centers, expanding the national network."

Cantril described the characteristics each type of center should have:

"• Community Cancer Centers—Cancer centers based in community hospitals and clinics which have, as a minimum criteria, quality multidisciplinary programs in cancer diagnosis and treatment. Broader programs in clinical cancer research, education and outreach are encouraged. Effective relationships between the community cancer center and neighboring regional and/or comprehensive cancer centers are expected. NCI should encourage and applaud the development of such centers. Most will not request NCI support. Those that apply for support should be reviewed like any other application—on the basis of merit. NCI should take no position as to the numbers or locations of such cancer centers at this time.

"• Specialized Cancer Centers—Cancer centers addressing specialized programs in multidisciplinary cancer research (clinical and/or fundamental) with or without programs for clinical cancer diagnosis and treatment, education and training or outreach. Effective relationships between specialized cancer centers and neighboring regional and/or comprehensive cancer centers are expected where appropriate. NCI should encourage such specialized centers where scientific quality exists and support such centers on the basis of competitive peer review for merit. There should be no NCI position as to the numbers or locations of such centers at this time.

"• Regional Cancer Centers—Cancer centers meeting specific criteria for program breadth and excellence in the areas of clinical cancer diagnosis and treatment, clinical cancer research, clinical education and training and regional cancer programs (outreach). In addition, each regional center must meet certain other criteria regarding commitment, administrative structure, program accountability and participation in the National Cancer Program in order to qualify. NCI should develop a plan for the analysis of potential locations and numbers of such centers and a mechanism for their review as regional cancer centers. Component program, core and construction support for such centers should be provided through the normal competitive peer review mechanisms.

"• Comprehensive Cancer Centers—Cancer centers meeting the specific criteria for program breadth and excellence in both clinical and non-clinical programs of cancer diagnosis and treatment, clinical and fundamental research, education and training and regional cancer programs (outreach). In addition, each comprehensive cancer center must meet certain criteria regarding commitment, administrative structure, program accountability and participation in the National Cancer Program in order to qualify as a comprehensive cancer center. Each will function, by definition, as a regional cancer center. NCI should continue its current policies and plans for the promotion and development of such centers of excellence and program breadth and implement fully the currently developing methods for the review of such centers. Component program, core and construction support should continue to be provided through the normal competitive peer review mechanisms."

The lack of a definition of a cancer center has been bothering many of those involved in the program. AACI members recently called on NCI to spell out in more definitive terms just what a cancer center is supposed to be. Cantril acknowledged that "each

special interest group defines a cancer center somewhat differently depending on its own unique perspective. Yet there exists a concrete cancer center concept consistent with each apparently different and, at times, conflicting definition."

Cantril suggested the following definition of "the cancer center concept:"

A cancer center is a mission-oriented unit geared toward facilitating and providing leadership in the implementation of the various programs of the NCI in pursuit of the goals of the National Cancer Plan. To achieve this, the center must:

- Be organized within a recognizable institutional framework.
- Carry out its program in conformity with a predetermined plan.
- Be geared to multidisciplinary problem solving.
- Be adaptable to the changing needs of the community and science.
- Strive for excellence and effectiveness in all of its program areas.

Cantril said the missions of cancer centers shall include one or more of the following:

Cancer Relevant Research—It is intended that a cancer center will conduct research programs in one or both of the following areas:

—Multidisciplinary clinical investigation in prevention, detection, diagnosis pretreatment evaluation, treatment and/or rehabilitation.

—Interdisciplinary non-clinical research to advance the state of knowledge regarding the biology, cause, prevention and/or treatment of cancer.

Patient Management—It is intended that a cancer center may conduct programs which will:

—Provide multidisciplinary diagnosis, treatment and consultation in the management of selected cancer patients as one segment of the health care delivery system.

—Provide a specialized resource for the referral of cancer patients for diagnosis confirmation, treatment and consultation.

—Provide a focus for demonstration of advanced interdisciplinary methods of cancer detection, diagnosis, treatment and rehabilitation.

Education and Training—It is intended that cancer centers will provide new resources by the education and training of manpower dedicated to the center problem.

Providing Unique Resources—It is intended that cancer centers may develop and provide unique resources to:

—Stimulate, coordinate and integrate cancer programs in their service region.

—Provide a resource to the scientific and academic community and to practicing health professionals.

—Provide a special resource to the state and local agencies to implement both governmental and non-governmental programs.

—Provide a special resource to all the programs and divisions of NCI in carrying out the goals of the National Cancer Program.

To achieve these missions, a center must have the following operational attributes, Cantril suggested:

- Be an organized operational entity.
- Have identified missions, objectives and purposes.
- Have an identified leader (director) to whom the authority and responsibility of the center and its programs are delegated.
- Have sufficient autonomy to achieve its goals and objectives and to fulfill its missions and responsibilities.
- Have sufficient identified resources—personnel, space, facilities, equipment, patients and funds—to carry out its program objectives.
- Have excellence in its cancer programs.
- Have the capability for self-evaluation.
- Have mechanisms for ongoing planning and development.

Cantril noted that the "emphasis to develop comprehensive centers and thus on the identification and designation of such centers [forced] a simple but not particularly functional classification system: comprehensive and non-comprehensive (or comprehensive and specialized). This classification scheme for centers is inadequate. It fails to identify centers from non-centers. It fails to allow for evaluation of similarly designed centers and it fails to take into account many of the practical and current operating realities in the medical and scientific communities. This two-tiered system is insufficient primarily because:

"Smaller community cancer centers—a relatively new and as yet undeveloped approach at a community level which has spontaneously evolved—really do not fit into either category. These developing community cancer centers represent a major spin-off of the centers program.

"Large non-comprehensive but multifunctional cancer centers with significant regional responsibilities and outreach programs are not adequately characterized as 'specialized' cancer centers and at the same time cannot (and may never) be categorized as 'comprehensive' because the breadth and depth (scope) of their research programs are insufficient to satisfy the 10 characteristics requisite for being considered 'comprehensive.'"

Cantril described the various levels and types of review presently in use for cancer center programs and said that the present systems of peer review for grants and contracts should be recognized as the best alternatives:

Traditional Research Project Review—Concentrating entirely on the merit of disassociated scientific, educational or demonstration endeavors.

Research Contract Review—Concentrating on the technical scientific merit and cost effectiveness of proposals submitted in response to NCI (or NIH) generated research ideas or needs.

Program Project Review—Concentrating on the review of collaborative scientific endeavors with emphasis, however, on the scientific merit of each component as the primary determinant of judgment.

Core (Cancer Center Support) Grant Review—Concentrating on the fiscal and scientific apporach to the evaluation of groups of traditional grants, research contracts and program projects in a rational and fiscally responsible method of sharing of resources. In a sense, the emphasis in core grant review is on the same scientific merit as with the review of traditional grants or program projects except for these projects being aggregated. The assessment for the need for developmental funds in core grants is greared to the evaluation of future potential. Only a limited component of this review of core grants addresses itself to the capability of the center director to provide the leadership or to the relationships (organizational and administrative) of the center to the parent institution. Yet the core grant review must relate to the center concept, and is technically and scientifically different from the review of program projects in basic science or clinical investigation.

NCAB Review of Centers—It has become apparent that naother level of review (an overview) of centers is desirable and necessary. This overview is particularly important in considering the borad programmatic and regional mandates of Congress relative to cancer centers. In the past 18 months a mechanism has been developed for the review of comprehensive cancer centers. A large portion of that review of centers for comprehensiveness has been impressive. The very process of "recognition" has encouraged centers and their parent institutions to make appropriate and significant alterations and commitments to ensure conformance of the center to NCI (NCAB) characteristics. This has resulted in significant commitments and has greatly accelerated (if not insured) the development of some centers.

Some additions to the review process are needed, however, Cantril said:

- The current process and policies regarding recognition of comprehensive cancer centers be continued and refined as experience is gained and that only those centers which have demonstrated their compliance with fulfilling, as far as can be expected, the established characteristics for comprehensive cancer centers be recognized as such.
- In addition to comprehensive cancer centers, NCI and NCAB initiate a process for the review and recognition of regional cancer centers based on the same characteristics and procedures applied to the comprehensive cancer centers with the exception of the requirements relating to fundamental cancer research and education.
- NCI and NCAB do not establish a formal review or recognition process for either specialized cancer centers or community cancer centers but instead endorse the concept of both these entities in principal, and provide support for each strictly on the basis of competitive merit peer review.

Evaluation and Re-evaluation: The Cancer Centers Program should develop a capability for program evaluation and accountability, Cantril said. In addition, NCI and NCAB should institute a process for overview evaluation and re-evaluation of the entire Cancer Centers Program and in particular those cancer centers recognized ("designated") as either regional or comprehensive. This overview should be done to assess trends in the development of the national network of centers, measuring and documenting its overall quality and assessing the plans for future developments for attaining the goals and approaches outlined in the National Cancer Plan. In addition, overview evaluation of individual centers should be accomplished to assure compliance, as far as it possible, of each center recognized as a regional or comprehensive center with the established criteria for such centers and for providing constructive criticism to these centers in order to assist them in their continued development.

The Cancer Letter observed that re-evaluation opens up the prospect that designated comprehensive or regional centers could lose their designations if found not in compliance with a sufficient number of the required characteristics, or not making progress toward compliance.

Cantril agreed that withdrawal of recognition was the ultimate threat but preferred to view evaluation as a positive force which would bring about necessary progress.

Withdrawing NCI's recognition of a cancer center as comprehensive (or regional, if Cantril's recommendation is adopted) might be politically impossible. ***The Cancer Letter*** asked one person closely involved in the Centers Program (not Cantril) how that could be accomplished.

"You wouldn't have the NCI director put out an announcement that the Throckmorton Cancer Center was no longer to be considered a comprehensive cancer center," he said. "But if, after the review process had been carried out, and after a probationary period in which every effort had been made to help the center overcome its problems it still could not meet the requirements, the NCI director would notify the Throckmorton director that the comprehensive recognition was withdrawn. No press release or other announcement. But the next time NCI would have occasion to put out a list of comprehensive cancer centers, Throckmorton would not be on it."

Cantril concluded his report bycalling for stronger "committed, continuing leadership" for the Centers Program—from NCAB, the Panel, directors of NCI and the Div. of Cancer Research Resources & Centers, the director of the Centers Program, and the centers community itself. He also asked for greater flexibility in program management and experimental approaches, adequate program budget, a data base

for evaluation and planning, knowledgeable advice and counsel and effective communication.

More staff for the program is essential, Cantril insisted. He suggested "an imaginative approach to staff recruitment including the opportunity for dual appointments with other divisions, rotational assignments, and flexibility in staff assignments."

SHUBIK GROUP FINISHES CRITERIA, PRESENTS FINAL DRAFT TO RAUSCHER

Last September, NCI Director Frank Rauscher asked Philippe Shubik if the National Cancer Advisory Board Subcommittee on Environmental Carcinogenesis which Shubik chairs would "undertake, with your members and consultants and whatever additional consultants you find necessary, to determine whether the current state of the art will permit the development of definitive and interpretive guidelines" for assessing the evidence for carcinogenicity of chemicals.

Nine months, a half-dozen one and two-day meetings and a foot-high stack of meeting transcripts later, the job was finished.

Shubik brought the document so painstakingly prepared to last week's NCAB meeting and presented it to Ruascher as "an amazing thing—we succeeded in getting a consensus of opinion" from a group that included some of the nation's top pathologists, chemical biologists and epidemiologists. It also included representatives of the regulatory agencies, the Food & Drug Administration and Environmental Protection Agency, which will be living with the document in countless courtroom confrontations.

Shubik acknowledged that there may be some need to add to or revise the document and suggested that the new National Clearinghouse for Environmental Carcinogenesis may want to make some changes. That would not be surprising, since many of the members of Shubik's group--subcommittee members and consultants—will serve on the clearinghouse, shubik included. Arnold Brown, one of the consultants, will be chairman.

The final document did not differ greatly in substance from the previous "final" draft published in ***The Cancer Letter*** March 12. A number of editorial changes were made as the group continued to haggle over nuances and grammatical interpretations right up to the last minute of its last meeting.

Copies of the final document, dated June 2, 1976, and entitled "General Criteria for Assessing the Evidence for Carcinogenicity of Chemical Substances" may be obtained from NCI's Office of Cancer Communications, Bethesda, Md. 20014.

At the final meeting, Shubik permitted members of the public to comment and found that two consumer groups, both of which had had some reservations about earlier drafts, now generally were in agreement with the final document.

Anita Johnson, a lawyer with the Ralph Nader-backed Health Research Group, had three suggestions:

- The document places the burden of proof on the government, in regulatory proceedings, in determining whether a tumor is benign or malignant. She suggested that instead, it consider a tumor malignant unless there is a consensus that it is benign.
- The document should "at the very least list the tumors you consider malignant, so that these things do not have to be fought out at the agency level."
- The subcommittee should "reconsider whether a demonstration of metastases is really a hard and fast necessity."

Subcommittee member Edward Burger commented that "We ought to stick as closely as we can to a scientifically valid document, everything else aside," meaning that the legal ramifications Johnson referred to should not be a factor in writing the final draft.

"That is the only framework within which we are qualified to operate," Shubik answered.

Joseph Highland, representing the Environmental Defense Fund, said that the subcommittee in its discussion that morning had cleared up some points he had previously made in a letter to Shubik. He had some further suggestions which involved editorial clarification, and the subcommittee agreed to the changes.

Rauscher told NCAB that completing the writing of the document "is one of the most important accomplishments we've made."

James Peters, director of the Div. of Cancer Cause & Prevention, said that organization of the Clearinghouse is almost completed and it will have its first meeting in October or November. There will be 30 positions, with representatives from science, industry, labor, consumers and regulatory agencies. About 20 will be filled to start with, leaving openings to be filled as the group may determine.

The Clearinghouse will advise NCI on selection of chemicals to be tested, protocol development, bioassay evaluation and risk assessment. All deliberations will be in open meetings, so the information on which chemicals are selected (even those chemicals being considered for selection) will be available to the public immediately, before they are tested. Preliminary data, before evaluation, also will be available.

"We will have a problem with premature disclosure," Rauscher said, "but we'll just have to live with that."

OBEY STRIKES AGAIN, TILTING THIS TIME BY EARMARKING NCI POSITIONS

David Obey, the Wisconsin congressman who can display good judgment and leadership qualities on occasion, once again has acted with an amazing degree of ignorance dealing with the National Cancer Program.

Obey last week was the leader in the attempt to trim the power of the House Administration Committee and cut back on certain allowances granted to

members of Congress, an aftermath of the Wayne Hays scandal.

On the other hand, Obey's determination to meddle with the Cancer Program demonstrates the mischief that can be caused by an uninformed politician when he indulges in a little demagoguery. He first attacked NCI last year when he charged that the Cancer Program was not supporting enough basic research. He dropped that after learning that half of NCI's budget goes into basic research.

As a member of the House HEW Appropriations Subcommittee, OBey is in a position to help or hurt the fight against cancer. His latest actions, if permitted to stand, won't be fatal but they certainly will not be of any help.

Obey was last seen interrogating Frank Rauscher at the hearing on NCI appropriations; he was critical of the NCI director for not giving then-Carcinogenesis Program Director Umberto Saffiotti all the positions he had requested. (***The Cancer Letter,*** March 5). "I understand he needs a minimum of 80 more people," Obey said.

He understood wrong. Saffiotti actually had requested 160 positions, and was getting 129, which Rauscher quickly pointed out.

Obey was not deterred. When the subcommittee's report on the appropriations bill was written, Obey managed to work in a statement earmarking 60 positions to the Carcinogenesis Program. Also earmarked were 17 additional positions to the Environmental Epidemiology Branch, headed by Joseph Fraumeni. Not a single new position would be available for any other NCI activity.

The subcommittee report said, "The Carcinogenesis Program, which constitutes the government's major effort for testing suspected cancer-causing chemicals on animals, has, for several years, received only 6% of NCI's total budget, and, according to its director [Saffiotti at that time] its staff will soon drop to the lowest level since 1971. The committee is also concerned about NCI's lack of effort in examining the relationship between cancer rates in population groups and their exposure to various chemical and environmental factors. Only four professional staff members have been involved in the study of environmentally induced cancer in human populations and only 2 of the 81 new positions provided to NCI in the fiscal year 1976 appropriation bill were assigned to the Environmental Epidemiology Branch for such studies.

"Because the committee feels that these problems demand more urgent attention, a total of 17 new positions are provided for the Environmental Epidemiology Branch and 60 new positions for the Carcinogenesis Program for fiscal year 1977 and NCI is directed to provide the necessary additional space for these activities."

NCI probably will get around those directions, one way or another. But if not, a situation would develop in which the Carcinogenesis Program would have more people than it could use efficiently while others would be starved for help.

Obey wasn't finished. In the same bill, he managed to get the subcommittee to delete funds for the Cancer Surveillance Unit of the Center for Disease Control. In his weekly newsletter, Obey said the unit was "duplicative and inefficient," and was not doing work of any significance that was not being performed better by other government agencies, including NCI.

The fact is that NCI considers the CDC unit a valuable resource, particularly the Environmental Epidemiology Branch so favored by Obey. The branch has just negotiated a $100,000 contract with the unit to do two studies of cancer "hot spots"—the high incidence of lung cancer along the Georgia Coast, and the high rate of mouth cancer in women in certain areas of the south.

"We don't have a large group, so this contract is an effort to compensate for that," Fraumeni told ***The Cancer Letter.***

If the CDC unit is forced out of business by Obey's actions, perhaps some of the epidemiologists there could find jobs among the 17 new positions Fraumeni would get.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS SCHEDULED FOR JULY, AUGUST

President's Cancer Panel—July 2, NIH Bldg 31 Room 7, 9:30 a.m., open.

Meeting on Non-Specific Immune Stimulation in Experimental and Clinical Cancer Treatment—July 5-6, Bucharest.

Workshop on Computers in Radiotherapy in Europe—July 5-10, Vienna.

Combined Committees of the Breast Cancer Task Force—July 7, Bethesda Holiday Inn, 8:30 a.m., open.

Clinical Cancer Program Project Review Committee—July 7-8, NIH Bldg 31 Room 5, open July 7, 8:30–10 a.m.

Breast Cancer Treatment Committee—July 8, NIH Bldg 31 Room 9, open 8:30 a.m.—noon.

Breast Cancer Experimental Biology Committee—July 8, Landow Bldg Room C418, open 8:30 a.m.—12:30 p.m.

Breast Cancer Epidemiology Committee—July 8, NIH Bldg 31 Room 4, open 10 a.m.—adjournment.

Breast Cancer Diagnosis Committee—July 8, NIH Bldg 31 Room 7, open 8:30–10:30 a.m.

Cancer Control Community Activities Review Committee—July 16, NIH Bldg 31 Room 7, open 8:30-9 a.m.

Drug Development Committee—July 23, NIH Bldg 31 Room 7, open 9–9:45 a.m.

10th International Congress of Biochemistry—July 25-31, Hamburg.

International Assn. of Laryngectomees Annual Meeting—July 27-31, Chicago.

Cancer Control & Rehabilitation Advisory Committee Subcommittee on Reimbursement—Aug. 2, NIH Bldg 31 Room 8, 8:30 a.m.—3 p.m., open.

Cancer Control & Rehabilitation Advisory Committee Subcommittee on Prevention—Aug. 5, Blair Bldg Room 100, 9 a.m.—3 p.m., open.

President's Cancer Panel—Aug. 11, NIH Bldg 31 Room 7, 9:30 a.m., open.

Committee on Cancer Immunotherapy—Aug. 12, NIH Bldg 10 Room 4B14, open 1–1:30 p.m.

Cancer Control Intervention Program Review Committee—Aug. 19, NIH Bldg 31 Room 8, open 11:30 a.m.—adjournment.

National Prostatic Cancer Project Working Cadre—Aug. 20-21, Roswell Park, open Aug. 21, 8:30 a.m.—adjournment.

National Pancreatic Cancer Project Working Cadre—Aug. 23, New Orleans, open 8:30—9 a.m.

National Large Bowel Cancer Project Working Cadre—Aug. 26-28, Anderson Mayfair Hotel, Houston, open Aug. 26, 1—1:30 p.m.

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-T5830-57

Title: *Total parenteral nutritional support as an adjunct to cancer therapy in the pediatric patient*

Deadline: *Aug. 2*

The objectives of this multidisciplinary, multi-institutional cooperative study are to determine whether total parenteral nutritional support alters the rate of tumor growth; to determine whether total parenteral nutritional support alters the status of the pediatric cancer patient such that the patient's tolerance to antineoplastic therapy is increased and the efficacy of therapy is increased; to determine whether specific antineoplastic therapy impairs utilization or causes complications; and to determine how total parenteral nutritional support affects the host-tumor response and host-immune response to cancer therapy.

Prospective offerors shall submit separate business and technical proposals for each or any of the following tumor type/therapy modalities: (1) mixed modality—head and neck (radiotherapy with or without concomitant chemotherapy), (2) chemotherapy—leukemia, acute myelogenous or lymphoblastic at first or second relapse, and (3) chemotherapy—neuroblastoma. Prospective offerors shall have a minimum of 10 patients equally divided between control and total parenteral nutritional support treatments to allow each segment proposed to be completed in a one year period with a two year follow-up period. Several awards are anticipated.

Contract Specialist: Joe Federline
Cause & Prevention
301-427-7463

RFP NCI-CB-74084-32

Title: *Studies and investigations on adjuvant systemic therapy in patients for stage I carcinoma of the breast*

Deadline: *Oct. 18*

Conducting clinical studies to evaluate therapy of patients with previously untreated breast cancer, histopathologically stage I (UICC Staging T1, T2, T3, N-, MO).

The studies should be designed to test the effects of systemic adjuvant treatment upon the duration of the recurrence free interval and upon survival. Complications of therapy, short term and long term, are of major concern and must be considered in detail in the proposal. Interested organizations should be able to admit to the study during a two year accrual period sufficient patients to provide statistically significant follow up data. It is considered essential that measurements of appropriate biological markers be a part of the study.

RFP NCI-CB-74083-32

Title: *Studies and investigations on methods to predict chemotherapy sensitivity*

Deadline: *Oct. 18*

Conducting laboratory studies directed at the development of effective test systems for predicting the sensitivity of individual human breast cancers to chemotherapeutic agents. The agents are: cyclophosphamide, methotrexate, 5-fluorouracil, vincristine, L-phenylalanine mustard, and adriamycin. The predictive assays should select the drugs which have the greatest potential for therapeutic effects and should eliminate those which are least likely to cause tumor regression.

These predictive test systems might include: 1. Evaluation of cell viability or growth in the presence of achievable drug concentration. 2. Assay for metabolic parameters that correlate with drug effects. 3. Determination of the presence or absence of particular cellular characteristics essential to the activation or to the action of the drug. 4. Utilization of transplants of mammary cancer cells in athymic mice.

Organizations interested in the project should be aware that the Breast Cancer Task Force can supply several human breast cancer lines and animal mammary tumor models.

Contract Specialist for above 2 RFPs: P.J. Webb
Biology & Diagnosis
301-496-5565

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