THE CANCER LETTER
RESEARCH
EDUCATION
CONTROL

Vol. 3 No. 2

Jan. 14, 1977

1411 ALDENHAM LANE RESTON, VIRGINIA TELEPHONE 703-471-9695

Subscription $100 per year

CCIRC FEARS MULTIMODALITY STUDIES THREATENED BY COOPERATIVE GROUPS' MISAPPLICATION OF FUNDS

NCI's efforts to emphasize multimodality studies by the Clinical Cooperative Groups may be hampered and perhaps frustrated by misapplication by some of the groups of extra money earmarked for that purpose, the chairman of the Cancer Clinical Investigation Review Committee has charged.

CCIRC Chairman Giulio D'Angio told cooperative group chairmen at their semiannual meeting that the committee, in reviewing cooperative group grant applications, found evidence that funds intended to pay for multimodality studies were merely "increasing the amounts received by the institutions."

(Continued to page 2)

In Brief

CARTER WANTS HIS OWN MAN, SO COOPER IS OUT; NEW PREVENTIVE ONCOLOGY SOCIETY ESTABLISHED

TED COOPER was told by representatives of the President-elect that the Carter Administration wanted its own man as assistant secretary for health. Cooper agreed to submit his resignation effective Jan. 20. His resignation has no connection to the problems with the swine flu immunization program, as implied by the *Washington Post*. Cooper is a Democrat, has done a superb job in the two years since taking over from Charles Edwards, and had hoped he could stay on. Carter is losing one of the best and most respected administrators HEW has ever had. . . . **JOSEPH CALIFANO JR.**, HEW secretary-designate, will appear today (Jan. 14) before the Senate Labor & Welfare Committee for his confirmation hearing. Time is 10 a.m., Room 4232 Dirksen Office Bldg. . . . **NEW AMERICAN** Society of Preventive Oncology is being formed by a group of 35 scientists from around the country and NCI. Its first general meeting is scheduled for Feb. 4-5 at Memorial Sloan-Kettering, with the theme, "Opportunities, Limitations and Future Actions in Preventive Oncology." Write to the society, PMI-Strang Clinic, 55 E. 34th St., NYC 10016. . . . **TWELFTH ANNUAL** San Francisco Cancer Symposium sponsored by the West Coast Cancer Foundation is titled "A Renaissance of Interstitial Brachytherapy" and is scheduled for March 4-5 at the Hyatt Regency. Contact Jerome Vaeth, 50 Francisco St., San Francisco 94133. . . . **ONCOLOGY NURSING** Society has scheduled its second annual convention for May 14-15 in Denver, just prior to the AASCO and AACR annual meetings there. Write to the society's secretary, Daryl Maass, NYU Medical Center, 560 First Ave., NYC 10016. The symposium will focus on models of health care delivery to the cancer patient and family. Panelists will discuss standards of oncology nursing practice; patient, family and staff support; issues of oncology nursing practice; and versatility in the roles of the oncology nurse and its effect on patient care.

GROUP CHAIRMEN RESIST MORE DETAILED GRANT APPLICATIONS, GEOGRAPHIC GROUPS

Continued from page 1)

D'Angio said that the CCIRC had been "troubled by budget pages listing individuals (radiotherapists, surgeons and others listed as participating in multimodal efforts) and percentages of their time but with no money requested for them." This led the CCIRC to suspect that the extra multimodal money requested in those applications might finds its way into other uses.

The CCIRC was considering adopting review guidelines that would give "coherence to the review process" and would assure that the extra funds would be used as NCI intended. When supervision of the cooperative groups was moved to the Div. of Cancer Treatment in 1975, DCT Director Vincent DeVita promised that an extra $2 million would be allocated to the program to assist the groups in moving away from their traditional single modality emphasis into a broader, multidisciplinary approach to clinical research.

D'Angio said that "the only way to clarify this" was to request that grant applications include a separate page for each discipline, with details of participating individuals, percentages of their time devoted to the studies, and money requested for them. He also suggested that each modality representative should sign a statement, that he has seen the proposed budget in the application.

Other group chairmen objected strenuously. Denman Hammond, who heads the Children's Cancer Study Group, said, "Each group and institution has a leader. You can hold him responsible. Funding modalities and funding groups independently is counter to what the groups and institutions are all about."

"But we still have the problem," D'Angio said. "Multimodal studies are being hampered."

"That can be solved by effective grant application guidelines," Hammond said. "I would object to requiring the signature of each modality representative, that he's seen the budget. That's unnecessary and demeaning. It is counter to the concept that you have a leader, the principal investigator."

"He would only see the budget page," D'Angio said.

"These things happen because you have people trying to get around the system," commented Paul Carbone, chairman of the Eastern Cooperative Oncology Group.

"That sum of money is to the institution," Hammond insisted. "You have a team leader. The principal investigator should have the authority."

"But we want to make sure that multimodal money goes to that, and is not merely increasing money to the institution," D'Angio said.

"You have to give some flexibility to the PI," said James Holland, chairman of the Acute Leukemia Cooperative Group B and also chairman of the group chairmen's committee.

"I would expect the PI to approve redistribution of funds and advise the CCIRC," D'Angio said. "But we've got to be sure that multidisciplinary care funds are not being used by the PI to feather his nest."

"I urge you not to put in requirements for unnecessary details or for renegotiation of small items," Holland said. "The groups can discipline their members themselves."

The group chairmen were skeptical of DCT's plan to consider development of new geographic cooperative groups which would involve clinical research with a number of diseases at several institutions in a limited geographic area. NCI has received one application, from the Northern California Cancer Program, and several inquiries about this plan.

"That will mushroom," said Barth Hoogstraten, chairman of the Southwest Oncology Group. He suggested that the situation in Northern California may be unique, with "four or five medical schools around one town, and none in an existing cooperative group."

Holland said that "Cancer Control shouldn't be overlooked" as a source of funds for such a group, noting that the format of "one mother hen with a lot of chicks" fits into the concept of community outreach, an activity supported by the Div. of Cancer Control & Rehabilitation.

Holland also wondered if the proposed geographic groups, with heavy involvement of community hospitals, would "stand the same kind of intellectual exchange" enjoyed by groups whose members are mostly at larger institutions. "The satellites are not co-equal," Holland said.

D'Angio said that he agreed, that with heavy involvement of community hospitals, the geographic groups might "not have the expertise for full multimodal studies, which might be difficult for them to mount and pursue."

Holland said that the group chairmen's executive committee had approved the new geographic groups, based on the scientific merit in their applications. He asked for and obtained approval of a resolution, to fund no more than two such groups, limited to two years, with a consolidated statistical office.

D'Angio agreed that regional groups "is a meritorious idea" and that funding by two divisions—DCT and the Div. of Cancer Control & Rehabilitation—"is a good way to get out to the grass roots."

Holland referred to a proposal to establish a cooperative group for the study of head and neck cancer. Several investigators in the South and two on the West Coast had joined to submit an application to the CCIRC, which was disapproved. CCIRC did not shut the door, noted that it had meritorious aspects, and that the deficiencies were subject to modification. The group was advised to reapply.

Holland wondered if there was a need for a new

national specialty group. "It seems to me that, unless there is an irrevocable personality conflict," clinical research on head and neck cancer could be accomplished in existing groups. "This is not so much different from other cancers. I think we should explore what kinds of factors keep this group from joining with their brethren in existing groups."

Hoogstraten commented that "some regard it as their exclusive territory. There is a tremendous opportunity in our group to establish a head and neck study."

D'Angio said that the problem "turns on the relationship of the surgeons. . . They want to attack the problem in their own way. There is a flowering of expertise and enthusiasm, they are willing to work with each other, and they talk the same language.

"It is not necessarily appropriate for people who want to pull together a new group to come before this group, where there are vested interests," D'Angio said pointedly to his fellow group chairmen.

Hoogstraten responded that "DeVita gave us a role, an advisory one, and we're doing it. Our advice is to not let it (the proposed head and neck group) flower too far if it is not going to work out."

"I disagree with Dan, that to the extent we can do so as selflessly as possible, we should advise on development of new groups," Holland said.

Franco Muggia, who heads DCT's Cancer Therapy Evaluation Program, discussed the division's proposal for funding new clinical research. One half would be allocated to grants (meaning the cooperative groups) and one half to contracts. "We want the cooperative groups to be part of our advisory process, to have input on RFPs," Muggia said. "We will set aside some funds for the groups if we sense they are interested."

"We were originally told (again, when DCT assumed responsibility for the cooperative groups) that we would have the right of first refusal on any new programs," Holland said. "Now we're told that one half will go to grants, one half to contracts."

"If it is felt that people outside the groups are more capable, then we'll go to an RFP," Muggia said.

"But what if the groups disagree?" Holland asked. "Will you put aside the money?"

"Not unless it is felt appropriate," Muggia said.

"That's not what we were told yesterday (at the executive meeting)," Holland said. "We were told we would get half. We're trying to bring urologists and others into the groups. We'll never be able to do it if we don't know we will have the money."

Muggia said that DCT's policy is "constantly evolving, to make competition (between the cooperative groups and investigators supported by contracts) a healthy one."

"But you've told us we can't compete as cooperative groups on RFPs," Carbone said.

"But you can come in a for a grant supplement," Muggia said.

NCI-FDA AGREEMENT NEAR; YOUNG SAYS HE WAS TRYING TO SPEED RUBIDAZONE STUDY*

Robert S.K. Young, the Food & Drug Administration's group leader for oncology who has been the key figure in the delay and interruption of new clinical drug trials (***The Cancer Letter***, Jan. 7), said that at least one of his orders halting a study was aimed at moving the drug more quickly into advanced trials.

Young acknowledged that he had ordered stopped phase I and phase II studies with rubidazone conducted by the Southwest Oncology Group, and that he had asked why the group had included all adult leukemias in its protocol. That question outraged Southwest Chairman Barth Hoogstraten, who pointed out that this was a common and justifiable practice for phase I and II studies and claimed that Young's lack of understanding about it was proof of his inexperience and inexpertise.

Young told ***The Cancer Letter*** he had learned of studies with rubidazone in France and at least one as yet unpublished study in the U.S. in which the drug had been demonstrated as "very active" against acute myelogenous leukemia.

"Based on this, it seemed that we could go right into phase III studies and skip phase I and II for AML," Young said. "I put this into the form of a question, to explore that possibility."

Hoogstraten, contacted at the Univ. of Kansas Medical Center where he is director of the Clinical Oncology Div., said Young's position was "nonsense."

"We know those things better than he does," Hoogstraten said. In the first place, the French study showed activity against acute monoblastic leukemia, not acute myelongenous leukemia, he said. "In any case, the efficacy of rubidazone has not been firmly established. It needs to be evaluated in large scale studies. It's been shown over and over that studies from a single institution are of little value. Efficacy must be demonstrated in a larger population."

Young's attempt to speed things up by bypassing further phase I and II studies "is not his prerogative," Hoogstraten said. "The issue here is that not only is he out of his field of competence, he is out of his area of responsibility."

Hoogstraten was critical of NCI staff for "backing away" from a confrontation with Young. "He is a single individual imposing his will on others of greater competence. NCI staff backs away from him, and they don't need to."

Responding to criticism by Hoogstraten and Div. of Cancer Treatment Director Vincent DeVita that he lacks the experience and knowledge to question the judgment of investigators who have spent their lives in clinical cancer research, Young said, "If the suggestions I make are reasonable and have some scientific merit, then I'm right. If they are destructive, then I'm wrong."

Pressures from NCI, investigators and others may be having an effect. Here's how the situation stands

at the moment:

• • Five of the nine INDs blocked by FDA have now been released, including those for rubidazone and hycanthone.

• DeVita and some members of his staff will meet next week with Richard Crout, director of FDA's Bureau of Drugs, and certain members of his staff to discuss policy matters which are at the root of the NCI-FDA problems. A similar meeting two weeks ago resulted in some progress, enough to encourage DeVita to the point where he feels that an agreement is possible.

BROWN'S APPOINTMENT PROBABLY WON'T BE MADE NOW UNTIL AFTER JAN. 20

Appointment of Arnold Brown as director of the National Cancer Institute had not been made this week as *The Cancer Letter* went to press and it now appears likely that it won't be made until after Jimmy Carter takes office.

The President's Cancer Panel had recommended Brown to President Ford (*The Cancer Letter*, Oct. 22), and Panel Chairman Benno Schmidt had hoped Ford would make the appointment before the end of the year.

The situation changed somewhat when Ford was defeated by Carter. Brown decided that his appointment should be cleared first by Carter's HEW secretary-designate, and it wasn't until late December before Carter announced that Washington attorney Joseph Califano Jr. would be named to that post.

Califano has not been answering questions about appointments, and in any case, the NCI director is a Presidential appointee. While Califano's recommendation certainly would carry considerable weight, it would be surprising if he would presume to speak for the President at this point.

Schmidt has declined to comment on the situation, and Brown told *The Cancer Letter* that he has not heard from anyone in either the outgoing or incoming administrations.

BIG COMMUNITY PROGRAMS IN DETROIT, NEW MEXICO UNDER WAY; OTHERS NEAR

This will be the year when NCI's ambitious and controversial Community Based Cancer Control Program will gets its first real test. Two multi-million dollar contracts for implementation were awarded to widely varying "communities" last year—Detroit and New Mexico—and at least four others will be awarded this year.

The Long Island Cancer Council, with John Dibeler as principal investigator, has cleared NCI review and been approved for implementation. The award will be announced in April, assuming negotiations scheduled for Feb. 28-March 1 produce no hitches.

Two of the nine communities which were awarded planning contracts failed to meet NCI requirements and have been dropped from the program. Those were the Genessee Region Community Cancer Control Program in Rochester, N.Y., and the Fred Hutchinson Cancer Research Center in Seattle.

Three others are in the final stages of their planning process—Rhode Island Dept. of Health, with Fiorindo Simeone and Louis Leone principal investigators; Los Angeles Community Cancer Control, with Helene Browne as PI; and the Univ. of Hawaii, with Lawrence Piette as PI.

NCI has completed its review of those three proposals, and has extended their planning periods for a short time. Barring some unforeseen major difficulty, the three will receive implementation awards this year.

The fate of the final three with planning contracts will be determined later this year, starting Jan. 21 when NCI will complete its review of the Univ. of Wisconsin proposal. Harold Rusch is the PI. The review will be conducted by the Cancer Control Community Activities Review Committee, in Bldg 31 Conference Room 8. The meeting will be open from 8:30-9:30 a.m. (This meeting was previously scheduled for Jan. 20-21, with a two hour open session on the first day. Those planning to attend should note the schedule change.)

NCI has just received the proposal from the Connecticut State Health Dept., with William Schell as PI, and has not yet received a proposal from the Univ. of Pittsburgh, with Bernard Fisher as PI.

For the purposes of the program, NCI defined a "community" as a health service area with a population of 1.5 to 3 million. It may include a metropolitan area with its suburban and rural fringe, as the three county area that is included in the Detroit program; a segment of a large city, such as the Los Angeles effort; a large rural area as the small towns and countryside represented by the Long Island Cancer Council; or an entire state, as in the New Mexico and Rhode Island programs.

The Michigan Cancer Foundation, headed by Michael Brennan, put together the Detroit program. It will receive $10.7 million from NCI over five years. Local matching funds, which can be in kind or cash, will bring the total program cost to about $21.5 million.

The Univ. of New Mexico Cancer Research & Treatment Center in Albuquerque organized the program there. Morton Kligerman is director of the center. It will receive about $6.8 million from NCI, with local contributions bringing the total cost to $13.7 million.

NCI insisted during the planning and negotiation phases of the contracts that provisions be built in for self-sufficiency at the end of five years.

The program is controversial because some feel that its major thrust—development of a coordinated effort of a community's resources to improve prevention, diagnosis and treatment of cancer—is necessary or even desirable in many communities. Others

object because they see the millions going into this program that they feel could be better spent elsewhere.

If it is successful, the program could be NCI's showcase on cancer control—a solid demonstration that a research agency can do the best job of transferring its own technology advances into widespread, practical use.

NCI has emphasized that these are strictly demonstration programs, that it will have no commitment to continue funding any of them after five years and that it also will have no obligation to expand and continue the program beyond those communities now included in it. If the approach is demonstrated to be successful, and has significant impact on cancer morbidity and mortality, other communities will be expected to develop their own financial support if they wish to establish their own programs.

In describing the Michigan and New Mexico programs, NCI said, "Although the ultimate goal is substantial reduction in rates of cancer occurrence and deaths within the community, short-range objectives include significant increases in the awareness of cancer risk, in understanding of the importance of early detection, and in the use of early detection resources. The two programs will test whether the use of community-based professional manpower and facilities, coordinated by community leadership of all cancer-related interests, will have a greater impact than a fragmented approach. The programs will include major efforts in public and professional education.

"The community-based cancer control programs do not attempt an all-out attack on all types of cancer. Special needs of high-risk population groups (such as the elderly, the poor and industrial workers exposed to certain cancer hazards), and the availability of community facilities for screening, diagnosis, treatment and rehabilitation determined which cancers are included in the program."

The Detroit program will integrate community efforts involving cancers of the breast, uterine cervix, colon-rectum, and head and neck. The New Mexico program will focus initially on cancers of the breast, uterus and colon-rectum.

Brennan and Abraham Brickner, director of community programs for the Michigan Cancer Foundation, discussed the community-based program with the Cancer Control & Rehabilitation Advisory Committee this week.

Brennan said that about 15,000 new cancer patients are diagnosed in Detroit each year, and estimated that about $3,000 in medical care is spent on each, a total of $45 million. "We are spending $2 million (in the program) to alter the shape of the care process, and to add on prevention and detection components where there are none now, and continuing care and rehabilitation components where there are very little now. This is a modest amount, and if we're not careful in describing the program, we'll trap ourselves into the same hole the antipoverty programs got into (with excessive expectations).

"This is not a saturation program," Brennan said. "A saturation program in detection of cervical cancer alone would cost $10 million a year."

A key part of the Detroit program is the plan to upgrade the quality of treatment and speed clinical research advances into practice through use of medical advisory panels (MAP). Each MAP will be chaired by a senior member of the Wayne State Univ. School of Medicine, and each will include at least one member of the professional staff of each of the 10 clinical demonstration hospitals participating in the program.

Those 10 hospitals are William Beaumont, Grace, Henry Ford, South Macomb, Oakwood, Detroit Osteopathic, Providence, St. John, Sinai and Wyandotte General. They range in size from 305 to 1,150 beds and have from 176 to 1,537 cancer patients a year.

The MAPs will prepare, publish and continually update guidelines for special treatment problems related to the management of the four target-site neoplasms. They also will collaborate to standardize methods and procedures among the 10 hospitals in such areas as diagnostic workup, clinical staging and description, tumor grading, pathological staging, terminology, operative notes, radiation dosimetry, radiation records, and followup schedules and examination.

The first of the MAP guidelines should be published next month. Brickner told ***The Cancer Letter*** that since many physicians resent and resist anything described as "guidelines," the MAP publications would be called "Criteria for Decision Making."

Brickner said the "criteria" would be available for distribution to individuals, hospitals, and any other groups and organizations around the country that may want to see them.

Brennan said that a review of breast cancer treatment in Detroit hospitals found that there was no correlation between the type of mastectomies performed—partial, simple, modified, radical—and the axillary node status of patients. "That just doesn't make sense. . . . We have to improve our review of the literature if we are going to hurry up technology transfer," Brennan said.

The MAPs also will organize annual updating and reporting workshops, seminars and demonstrations on the four target-site neoplasms, and will facilitate research access to clinical resources, including patients when they express the desire and willingness to participate in experimental approaches.

Other aspects of the Detroit program include:

Pre-clinical activities—public and professional education and detection—are organized regionally, on county boundaries, and are population based. Clinical activities—diagnosis, treatment and rehabilitation—are organized around existing locations of cancer care

delivery located in the 10 more or less self-contained medical care delivery districts of metropolitan Detroit.

Cancer control efforts in Detroit will focus on facilitating the earliest possible detection, diagnosis and treatment of the disease. Intensive public education efforts will emphasize what individuals can do on their own to detect cancer symptoms, and the desirability of participating in screening projects for cancers of the breast and cervix to detect these cancers before symptoms develop. To so inform and motivate Detroit residents, it is anticipated that $2.5 million annually will be donated in media services.

Instruction in breast self-examination will be provided through small group educational sessions. Discussions of risk factors will encourage women at higher-than-average risk to participate in breast cancer screening programs, which will also provide Pap tests at no cost.

For the past two years the Community Outreach Detection and Care Project (CODAC), has provided 25,000 examinations for cervical cancer to women in high-risk groups. This project uses indigenous community outreach health education aides and a targeted public information campaign. Health aides go from door to door attempting to interview each adult female in the household. They describe the problem of cervical cancer, the purpose of the Pap test, provide information about the next CODAC clinic, and invite the women to register for the clinic. About 25% of the women screened are having their first Pap test.

The program will expand this health education effort to cover Wayne and Macomb counties the first year, and will include information about the other cancer sites–breast, colon-rectum, and head and neck.

Because useful screening techniques for the detection of early colon-rectum cancer have not been demonstrated on a wide scale, public education will stress symptom recognition. Since physician delay as well as patient delay often occurs in cases of colon-rectum cancer, individuals will be encouraged to request appropriate examinations and tests when cancer is suspected. The program anticipates that 40,000 men and women between 55 and 69 will be reached.

The program will sponsor public information activities to increase public awareness of the signs and symptoms of head and neck cancers, and the kinds of behavior associated with these cancers. For professionals, it will sponsor a series of teaching seminars for dental hygienists, industrial medical staffs, dentists and physicians on recognition of early oral and laryngeal cancers.

To meet the increased public demand resulting from public education campaigns, the program will ensure availability of screening facilities in the three counties and arrange easy access to these facilities by population groups most likely to be at higher-than-average risk from cancers of the breast, cervix, head and neck.

Two regional stations in addition to nine local unit offices of the Michigan Cancer Foundation, and the county office and branches of the American Cancer Society, will be the locations for education and screening activities.

The public information campaigns will direct high-risk individuals to regional stations and other locations. Individuals will receive specific instruction in cancer self-screening, general information on cancer, and specific cancer detection screening. They will be invited to enroll in prescribed regimens of continued self-examination and to report the self-examination results periodically to the program as part of its demonstration effort.

Breast cancer screening participants will be instructed in the techniques and usefulness of breast self-examination with the use of visual aids and instructional models. They will also be advised about symptoms of other cancers.

Each person will be examined by a specially trained nurse-examiner who will observe the woman performing her own breast self-examination. She will be given a set of postcards on which to report monthly the results of her self-examinations.

Women with lumps in the breasts or breasts directly suspicious for cancer will be adivsed to obtain xeroradiographs. Appointments will be arranged for an immediate xeroradiographic examination at the Breast Cancer Dection Center of the Michigan Cancer Foundation or elsewhere if desired. At the Foundation the xeroradiographs will be provided at cost, free of charge in case of need. All enrollees will be assigned reexamination schedules. When the clinical, historical, and xeroradiographic results have been assembled, a report will be sent to the woman's physician of record. In case of suspicious findings, the physician also will be contacted immediately by telephone. Followup contact will be made within two weeks by the nurse-examiner or medical staff to determine what action has been taken.

An oral cancer diagnostic clinic will be located at each of the program's regional stations to provide screening examinations and detection assistance. The clinics will be staffed through collaborative arrangements between the Univ. of Detroit Dental School, Sinai Hospital, the Detroit Medical Center and the Wayne State Univ. School of Medicine.

Cancers will be detected in a relatively small number of screened individuals. When cancer is suspected, appointments at the nearest referral clinic will be made and transportation provided when required. Every effort will be made to assist the person to obtain diagnosis, treatment and continuing care.

The clinical demonstration hospitals will have continuing care teams that include an oncology nurse-practitioner and a medical social worker within the hospital, joined with a volunteer patient service organization outside the hospital.

Experience at four Detroit hospitals (three serving

a large number of inner-city patients and the fourth a predominantly middle and upper class clientele) has demonstrated the validity of this approach. Evidence is clear that these teams have made a real contribution

Details on the New Mexico program will appear in next week's issue of ***The Cancer Letter.***

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. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Their addresses are:
Biology & Diagnosis Section—Landow Bldg
Viral Oncology & Field Studies Section—Landow Bldg
Control & Rehabilitation Section—Blair Bldg
Carcinogenesis Section—Blair Bldg
Treatment Section—Blair Bldg
Office of the Director Section—Blair Bldg
The Landow Bldg is located in downtown Bethesda, and the Blair Bldg in Silver Spring, Md., but the correct mailing address for both is the same as the NIH main campus, Bethesda, Md. 20014.
All requests for copies of the 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-CP-VO-71011-63

Title: *Immunization of mice with MMTV polypeptides: Characterization of the immune response*
Deadline: *March 7*

The Viral Oncology Program will make available to interested contractors a request for proposal to develop a viral vaccine using purified mouse mammary tumor virus polypeptides in efforts to immunize mice against the onset of spontaneous breast cancer.

This project will explore whether beneficial effects can be achieved by using immunogens which do not contain oncogenic material and viral genetic information. In addition, the contractor will be expected to determine the type of immunity that is required to effectively control virus replication and dissemination in the stages preceeding tumor appearance.

Contract Specialist: W.L. Caulfield
Viral Oncology
301-496-1781

RFP NCI-CB-74139-39

Title: *The growth of normal and tumor virus cells*
Deadline: *Feb. 9*
(A brief announcement of this RFP appeared in the Jan. 7 ***Cancer Letter.****)*

This project is seeking to develop improved methods of viral detection and to further understanding of factors regulating viral expression and cellular transformation. There are two parts to this project. One deals with C-type mammalian RNA tumor viruses, while the other is concerned with a DNA tumor virus, the human papilloma virus.

For C-type virus expression, mammalian leukemia and sarcoma viruses are currently being studied as a model system, since sensitive quantitative assays of these viruses are available. This part of the study will focus on the uses of transfection, a method for demonstrating biologic activity of isolated viral specific DNA. This test has been made quantitative and reproducible.

NCI is also developing sensitive quantitative assays for the human papilloma virus. Aside from being the etiologic agent of warts, the virus has also been implicated in the pathogenesis of squamous cell cancers of patients with epidermodysplasia verruciformis (EDV).

These reagents will permit an analysis of the immunologic relatedness of viral isolates from various clinical lesions as well as of their nucleic acids by restriction endonuclease digestion and/or nucleic acid hybridization.

Studies of the regulation of virus expression and the role of virus in cellular transformation should provide critical information on the pathogenesis of viral tumorigenesis. The results will contribute to the understanding of the control, integration, and expression of genetic material. Transfection may prove to be a useful technique for detecting viruses in man or other species.

The development of reagents specific for the human papilloma progress in the study of the papilloma virus has been hampered by the inability to propagate this papova virus in tissue culture in a reproducible manner. However, methods have been developed for purifying large numbers of viral particles from tumor tissue. These particles can be used to induce antibodies for use in fluorescent and radioimmune assays of viral protein and as a source of viral nucleic acids which can be isotopically labeled in vitro.

The contractor shall be responsible for the following:

1. Propagation of cells and virus in mass culture.
2. Establishment of cell lines derived from tumor tissue.
3. Purification of virus and viral components (nucleic acids and proteins) by cesium chloride and sucrose density gradient ultracentrifugation, DEAE-cellulose chromatography, and polyacrylamide and agarose gel electrophoresis.
4. Purification of cellular DNA by cesium chloride ultracentrifugation and by methods of Gross-Bellard, Hirt, and Marmur.
5. Purification of cellular RNA by cesium chloride ultracentrifugation.

6. Radioisotopic labeling of cellular and viral components in tissue culture and in vitro (including iodination of viral proteins).

7. Synthesis of radioisotopically labeled viral-specific DNA probes complementary to specific portions of viral RNA genomes.

Tumor tissue and initial seeds of cells and virus will be provided to the contractor by the project officer.

Offerors should make their own assessment of the level of effort required to accomplish the work as described above and should develop their proposals accordingly.

Contract Specialist: Thompkins Weaver Jr.
Biology & Diagnosis
301-496-5565

CONTRACT AWARDS

Title: Study of toxicity and carcinogenicity associated with fungal growth on foodstuffs
Contractor: Massachusetts Institute of Technology, $221,376.

Title: Validation and utilization of microbial mutagenesis systems as prescreens for chemical carcinogens
Contractor: Inveresk Research International, Edinburgh, Scotland, $272,682.

Title: Isolation, purification and characrerization of human prolactin
Contractor: Univ. of Manitoba, $60,437.

Title: Assembly and distribution of committee books
Contractor: Information Planning Associates, $37,620.

Title: Technical assistance for the radiation program
Contractor: WSA, Inc., San Diego, $12,525.

Title: Implementation of a comprehensive plan for developing cooperative action and common practices among cancer institutes
Contractor: Assn. of American Cancer Institutes, $273,562.

Title: Development and large scale production of DNA ligase and DNA polymerase I from E. coli
Contractor: Stanford Univ., $58,000.

Title: Maintaining low temperature repository and establish cell lines from tumors
Contractor: Flow Laboratories, $222,042.

Title: Conduct study on influence of virus-related genes on susceptibility to cancer
Contractor: Sloan-Kettering Institute, $385,143.

Title: Study sequencing of the 3^{1} end of RSV 35^{s} RNA implications for replication integration and chemotherapy
Contractor: Massachusetts General Hospital, $82,500.

Title: Maintenance and utilization of population based cancer registry
Contractor: Univ. of New Mexico, $42,360.

Title: Provide support services for the application of animal virus model system to human neoplasia
Contractor: Litton Bionetics, $469,897.

Title: Immunological studies on the relationship of embryonic antigens to virus induced tumor antigens
Contractor: Univ. of Alabama, $32,945.

Title: Research on oncogenic viruses and vaccine development
Contractor: Merck & Co., $146,986.

Title: Support services of immunological and biochemical studies of mammalian viral oncology
Contractor: Meloy Laboratories, $427,023.

Title: Support services for studies of spontaneous and virus induced neoplastic transformation
Contractor: Meloy Laboratories, $104,160.

Title: Study of host restriction of Friend luekemia virus
Contractor: Albert Einstein College of Medicine, $79,015.

SOLE SOURCE NEGOTIATIONS

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

Title: Development and application of methods for N-nitroso compounds and their precursors in the environment
Contractor: Univ. of Mississippi.

Title: Carcinogenesis bioassay data support system
Contractor: EG&G/Mason Research Institute.

Title: Support services for studies of type C RNA tumor viruses
Contractor: Microbiological Associates.

Title: Murine mammary tumor virus production facility
Contractor: Meloy Laboratories, Inc.

Title: Support for the U.S. National Committee on the International Council of Societies of Pathology
Contractor: National Academy of Sciences.

The Cancer Letter—*Editor* JERRY D. BOYD

Published fifty times a year by The Cancer Letter, Inc., 1411 Aldenham Ln., Reston, Va. 22090.