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NCI ADVISED TO SEEK GREATER LOCAL CONTRIBUTION TO CONSTRUCTION PROJECTS; OTHER CHANGES ASKED

NCI's construction program, threatened by the budget squeeze and the perception by key NCI executives and their advisors that construction ranks far behind research in competition for funding, almost certainly will have a new face if in fact it survives the next couple of years.

The National Cancer Advisory Board Subcommittee on Centers & Construction agreed this week to recommend that the 75%-25% ratio of NCI to local support for construction projects (NCI paying the 75%) be changed to a 50-50 split.

The subcommittee also agreed to ask the Board to consider adopting a limit for individual construction grants, holding them to no more than

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In Brief

GUIDE IS LATE, SO RFP DEADLINE EXTENDED; REAL CANCER MORTALITY INCREASE WAS .7%

NIH GUIDE for Grants and Contracts, which includes announcements of impending RFPs, has been having distribution problems. The Guide dated Nov. 8, 1976, actually was not distributed until more than a month after that date. It included announcements of 15 NCI RFPs for immunodiagnosis research projects, with a response deadline of Jan. 7. (***The Cancer Letter*** published the same announcements in the Nov. 12 issue). Because of the late distribution of the Guide, NCI extended the deadline to Feb. 1. The announcement of the deadline extension appeared in an issue of the Guide dated Jan. 3 but which was not delivered to ***The Cancer Letter*** (and presumably others) until Jan. 19. . . . **ACS NEEDLED** those who jumped to the conclusion that an erroneous (as it turned out) report that a 5.2% increase in cancer deaths had occurred in 1975 was due to the growing exposure to chemicals in the environment. Arthur Holleb, ACS senior vice president for medical affairs, said in the current issue of *Ca—A Cancer Journal for Clinicians* that the furor was "an environmental time bomb that never went off." He cited the NCI study by Leonard Chiazze (reported in ***The Cancer Letter***, Jan. 30, 1976) which pointed out errors in the interpretation of raw data by the National Center for Health Statistics. The true increase, Chiazze now reports, was .7% for 1975 over 1974. Holleb said that cancer mortality would be declining except for lung cancer deaths and suggested that those who were so quick to jump on the inflated figure and blame it on chemicals in the environment should take another look at "the most destructive known carcinogen—cigarette smoking". . . . **SIDNEY CUTLER**, who directed the Third National Cancer Survey when he was with NCI's Biometry Branch, has joined the staff of the Lombardi Cancer Research Center at Georgetown Univ. He is chief of the epidemiology and statistics unit, and is professor of community medicine at Georgetown Medical School.

GUIDELINES TIGHTENED UP FOR AWARD OF CONSTRUCTION GRANTS BY NCI

(Continued from page 1)

a certain percentage of the total NCI construction budget.

Finally, the subcommittee accepted a list of additional criteria, drawn up by Chairman Denman Hammond, to be added to existing criteria considered by the Board and review committees in the award of construction grants. These criteria are:

- Appropriate commitment to the Cancer Program by top institutional officials, including evidence of planning for long range stability.
- Administrative stature and authority of the Cancer Program, including appropriate responsibility assigned to the program, authority to carry out responsibilities, and role in institutional policies and priorities.
- Appropriate commitment of budget, staff, program support and space.
- Evidence of local community support.
- Geography—regional need and distribution of national resources.
- Impact of proposed construction on existing Cancer Program and existing cancer facilities. This includes the extent of other facilities related to cancer and the extent of resources related to cancer.
- Extent of fulfillment of NCAB characteristics and guidelines as appropriate for the type of center (comprehensive or specialized).
- Evaluation by site visitors and priority score assigned by review committee.

These are to be added to the existing considerations and guidelines which NCI has been applying to construction grants. They are:

Review and Evaluation Guidelines

Review and evaluation for construction grant applications involves an assessment of the cancer program, both ongoing or developing, to be housed in the new facility. The judgment(s) made in this regard will be the basis for establishing a scientific priority rating.

Criteria—

Scientific merit of the total program and its component parts, with particular attention paid to those programs especially pertinent to the National Cancer Program.

Technical competence of the investigators involved.

Intellectual environment at the applicant institution.

Administrative capabilities of the principal investigator and staff (i.e., scientific and fiscal).

Organization of the proposed cancer research program and its relationship within the overall institutional setting.

Special considerations—

An institution is performing an essential role in the National Cancer Program.

The geographic distribution of cancer facilities is such that the location would be desirable.

The population base is sufficient to support the proposed facility.

The institutions can promptly start construction (i.e., those with advanced plans and available matching funds).

The requested dollar amount in an application is commensurate with the scope of the ongoing research program and with the projected expansion. In general, the net space provided should be sufficient for housing the expected complement of staff two years following completion of the structure. For this purpose, therefore, 200 net square feet per full-time equivalent is used as the basis for calculation.

Only minimal facilities are requested for those institutions with an undeveloped research program (i.e., a concerted cancer research program proposed for the first time). Additional contributions should be a demonstration on the part of the applicant institution staff of its capacity and desire to engage in cancer research, and on the part of the institution's administration for a continuing interest in the support of an effective cancer research program.

Applicants have plans that include net utilizable research space in excess of 60% of the gross.

Patient care facilities are used for specialized patient studies.

Space requirements for training and educational activities are part of a cancer research program.

Evaluation—

In approving applications for construction grants under this part, the NCI Director shall take into account, among other factors, the following:

The relevance of the program for which construction is proposed to the objectives and priorities of the National Cancer Program.

The scientific merits of the program for which construction is proposed.

The scientific or professional standing or reputation of the agency or institution and of its existing or proposed officers and research staff.

The availability, by affiliation or other association, of other scientific or health personnel and facilities to the extent necessary to carry out effectively the contemplated program, including the adequacy of an acceptable biohazard control and containment program where warranted.

The need to accomplish appropriate geographical distribution of facilities.

The financial need of the applicant.

Hammond told the subcommittee that he felt special consideration should be given to the provision requiring that institutions play substantial or significant roles in the Cancer Program to be eligible for construction grants. "There is some feeling that in the past, these grants have not been tied in with the Cancer Program," Hammond said.

NCAB Chairman Jonathan Rhoads said, "The issue I wanted to zero in on was if we should make smaller

grants to more institutions. Constructions funds will be limited for the next year or two. We are no longer in a posture of shouldering the burden for new buildings. I think we could spread more widely the dollars we do have."

Rhoads suggested the new split "be at least 50-50. Maybe we could require local people to put up two thirds of the cost."

Rhoads also favored "some limit on the percentage of our budget that we put into a single institution. The way we do now, the priority score is all important. If an institution gets a priority score of 125, it has just as good a chance of getting $8 million as $2 million."

Thomas King, director of the Div. of Cancer Research Resources & Centers, commented that "it is true the money NCI puts into construction awards has generated a great deal of local support."

Donald Fox, director of the construction program, said that for every dollar of federal money going into cancer construction projects, "at least another dollar above and beyond the required matching funds is generated from local sources."

Rhoads proposed that the new split be 60-40, with local support providing the 60%, but Hammond asked for a 50-50 division. "Sixty percent might be too much of an increase now," King said. King also asked that it not be retroactive. "It would be unfair to have the guidelines changed now for those with applications under review."

Fox suggested that it also would not be fair to those with applications being developed and asked that a June 1 deadline be established. The subcommittee agreed, and, provided the full Board accepts the recommendation, applications submitted by that date will be considered under the 75-25 formula.

The subcommittee met on the night before this week's meeting of the Board. The next day, NCI's decision to reprogram $10 million in construction funds to other areas was criticized by some Board members.

Acting Director Guy Newell reported that the request for permission to reprogram the money had been sent to the congressional appropriations committees, but their decision had not yet been reached. He explained how the money would be distributed—$3.5 million to regular research grants, $2 million to centers, $500,000 to task forces, $2 million to the cooperative groups, $1 million to nutrition, $500,000 to help overcome the histology-pathology backlog in the carcinogenesis testing program, and $500,000 to in vitro test carcinogenesis research.

"The big issue here is that we need to take a major look at what our construction needs really are," said Board member Harold Amos.

"I opposed this transfer originally because I think it is the wrong approach," Board member Philippe Shubik said. "This action says we think construction has a low priority. In my opinion, it has a very high priority. Very few institutions are equipped to do the things we are asking of them. Sixteen million dollars (the amount in the FY 1977 budget before the $10 million is removed) is not enough."

Board member Henry Pitot said that "those of us in carcinogenesis testing can continue only if we have the facilities,LL especially considering the need for new biohazard control construction. Member William Powers said that "with the limits in training funds and limits on construction funds, we won't be able to continue long with the Cancer Program. It will continue only with people and facilities."

"But if we cut grants, already funded at only 30% of those approved, in order to be able to build facilities, we won't have the work to fill those facilities," Newell argued.

"We run the risk of killing programs already funded if we don't have the facilities for them" Pitot responded.

"If we only fund 30% of grants, which will be the number funded without the reprogramming," said Cancer Panel Chairman Benno Schmidt, "the same people who are crying now about no construction money will be in here raising hell with us about funding only 30% of the grants."

"Let's get more money," suggested Board member Mary Lasker.

"I'm all for that," Schmidt agreed.

Rhoads asked Amos to prepare a position paper on the construction issue for presentation to the Board at its next meeting, in May.

FDA RELEASES INDs, CONSIDERS AACI-NCI PLAN TO AVOID FUTURE CONFRONTATIONS

Once again, the Food & Drug Administration, faced with growing pressures from the scientific community, Congress, and NCI, has backed down and released INDs (investigational new drugs) it had been holding up "over insignificant questions." FDA had already released five of the nine INDs it had been blocking since last fall (***The Cancer Letter***, Jan. 14); last week, the agency released the other four.

More important, FDA is considering a plan recommended by the Assn. of American Cancer Institutes and supported by NCI that would reduce the likelihood of similar confrontations in the future. AACI at its recent meeting in Houston adopted a resolution calling on FDA to establish a committee of non-government scientists to review all IND submissions for anticancer drugs. FDA would have to agree to accept the committee's findings and release INDs, unless it could come up with some overriding reason not to. From that point on, NCI would take over and be responsible for protocol design and monitoring the tests.

Richard Crout, director of FDA's Bureau of Drugs, appears to be favorable to such a solution, Vincent DeVita, director of NCI's Div. of Cancer Treatment, told the National Cancer Advisory Board this week.

FDA's sudden attack of reasonableness came exactly a year after it had retreated under similar pressures, releasing seven INDs it had been holding up over procedural matters.

This time, the pressures included the movement to get relief from Congress through legislation to remove FDA authority over clinical tests of anticancer drugs, except for those sponsored by industry. A letter from the American Cancer Society to Rep. Paul Rogers, chairman of the House Health Subcommittee, asking for consideration of such legislation triggered an Associated Press dispatch and led to widespread reporting of the issue in the popular media.

NCI Acting Director Guy Newell told the Board that "progress is being made with FDA. . . It's my position that I would like to see this settled between the agencies. I would prefer that NCI not have regulatory powers. On the other hand, I will not have the nation's only anticancer drug testing program delayed over interpretation of regulations.

"The Div. of Cancer Treatment has the system for monitoring clinical trials that is proven, it's all in the open," Newell continued. "We have the mechanism. It is a bit different than what the drug manufacturers use. Ours is as good as theirs, or better. We have proposed to FDA that they accept our system."

DeVita said he felt FDA would accept it. "But I'll remain skeptical, until I see it." DeVita blamed the IND delays on "insignificant questions" by FDA staff. He said that Crout had admitted his "junior staff did exceed their brief."

Newell said that the next problem with FDA could be over the proposal to require new INDs for each new combination of anticancer drugs to be tested. "Our point is that we have no intention of marketing fixed combinations of drugs in capsules or pills. We vary combinations according to the needs of each patient. FDA rules on combinations are not suitable for us. We've had a lot of experience with combinations. We have had no surprises on toxic effects. We know what to expect with each combination. An IND requirement would force our program to grind to a halt."

"I think we should recommend to Congress that NCI be given an exception from FDA regulation," NCAB Chairman Jonathan Rhoads said. "You can go to the top at FDA and get reasonable answers every so often, but you can't go every month. FDA has an immense bureaucracy, and they are anxious not to be wrong."

"FDA should get it through its head that cancer drugs are different than food additives," Board member Bruce Ames commented. "Can they be reasonable?"

"That depends on who the commissioner is," Rhoads said. FDA has been without a commissioner since Alexander Schmidt left in December. Sam Fine has been acting commissioner.

Cancer Panel Chairman Benno Schmidt objected to the suggestion that NCI take over FDA's authority over anticancer drugs. "If you eliminate FDA, you take on a regulatory function that could be at least as painful as this log jam has been. You would have to say yes or no to foreign drugs, and to others. You don't have the staff or the orientation for that."

Schmidt suggested that a return "to the accommodation we had for many years with FDA" would be a more acceptable route.

"We went through this last year," DeVita said. "It is a matter of lower level staff at FDA accepting our plan and following it. It is a flexible plan. There would be a committee to review IND submissions. Once approved, we would be allowed to monitor it according to our rules.

"The fact that all nine INDs have now been released indicates they were not held up for safety reasons," DeVita said.

"At this time, would you like to see in legislation what Dr. Rhoads is proposing? Or would you like to see a letter from the Board and the Panel to the President? Or just go along with what you are trying to work out?" Schmidt asked DeVita.

"Dr. Crout is involved, and his good faith is obvious," DeVita said. "I would prefer that we not regulate ourselves. I hope we can work it out the way we have proposed—the committee review of INDs plus acceptance of our plan, is the best way."

"The other routes are not forever foreclosed," Schmidt said. "We always have those options available when we need them."

Newell suggested there might be another option. "Our lawyers looked at the FDA Act," he said. "They think that perhaps other federal agencies do not come under FDA's authority."

LESTER BRESLOW OF UCLA SAID TO BE CALIFANO'S CHOICE AS ASST. SECRETARY

Lester Breslow, dean of the UCLA School of Public Health, will be the new HEW Asst. Secretary for Health, reliable sources have told ***The Cancer Letter.*** His appointment is waiting until Joseph Califano Jr. is confirmed by the Senate as HEW secretary.

Breslow refused to discuss the appointment when phoned by ***The Cancer Letter.*** "Anything on that has to come from the secretary," he said.

Breslow is former director of the California State Dept. of Health, and is no stranger to the Cancer Program. He served on an ad hoc committee to review cancer centers two years ago, and last year was commissioned by NCI to report on the risks of mammography. He suggested that routine mammography for asymptomatic women under age 50 might offer more risk than benefit. NCI accepted that suggestion and ordered such mammography stopped in the Breast Cancer Detection Demonstration Project.

Meanwhile, the appointment of Arnold Brown as NCI director awaits the confirmation of Califano and the subsequent designation of his chief health advisor.

Cancer Panel Chairman Benno Schmidt admitted, for the first time publicly, that he had recommended Brown for the job. Schmidt told the National Cancer Advisory Board Monday that he had submitted Brown's name to President Ford last fall.

"But the situation arose so near to the commencement of a new Administration that neither Dr. Brown nor I nor President Ford felt that the appointment should be made unless the new Administration was prepared to clear it," Schmidt said. "I filed an appropriate request with the transition people. The response was that we would have to wait until the HEW secretary was confirmed by the Senate."

Califano's appointment was confirmed by the Senate on Monday.

RHOADS SUGGESTS NCI PUSH FOR 200 CLINICAL CENTERS AROUND THE U.S.

Development of 200 clinical centers for the treatment of cancer patients and located to serve every region of the United States has been proposed by Jonathan Rhoads, chairman of the National Cancer Advisory Board.

Rhoads told the NCAB Subcommittee on Centers & Construction that if the Carter Administration succeeds in developing and implementing a system of national health insurance, "it would raise the question of whether the National Cancer Program should assume a posture that would take advantage of this possibility by providing facilities for the better care of cancer patients, perhaps more centralized. That would mean we would need more centers. Not comprehensive, but clinical, somewhere between the 19 comprehensive centers and the 750 hospitals accredited by the Commission on Cancer (of the American College of Surgeons)."

Rhoads said there are at least 10 centers now, that are not recognized and which do have good cancer care. "Notable is the city of Atlanta." The centers would have to be capable of doing clinical investigation but not basic research. Subcommittee Chairman Denman Hammond suggested that they would be obliged to provide leadership in outreach activities, and Rhoads agreed.

"I think most cancers (but not skin cancer) could be better managed in not more than 200 hospitals or centers," Rhoads said. He agreed with the suggestion that existing community based centers would be included.

"We need a new approach to Congress. I don't think they'll give us a sudden large surge in money for research. We'll do well to get incremental increases to keep up with inflation. I think something new might be more interesting to them."

A plan to create a new category of clinical centers to meet all the requirements of a comprehensive center except basic research was suggested by NCI executives, including former Director Frank Rauscher and incorporated into the report drawn up by former Centers Program Director Simeon Cantril last year. The Cantril plan did not mention any estimated number of centers that would be needed, but it did suggest that they would involve NCI recognition and require NCI support. The question was dealt with by an intrainstitute committee studying the centers program. The committee recommended that NCI not undertake the task of "recognizing," "identifying," or "designating" the clinical centers.

Rhoads commented that the Hill-Burton hospital construction program "had the effect of diffusing patients into 50-bed hospitals. The effect of what I have in mind would be to gather them into 500 bed institutions."

CANCER CONTROL BUDGET STILL $4 MILLION SHORT; MORE REPROGRAMMING ON THE WAY

President Ford's last budget request for NCI is now a matter of record, the Carter Administration is in the process of determining whether or not it will ask for any increase, and congressional appropriations committees will start hearings next month to determine just how much they will add to it.

That's for the fiscal year of 1978, which will start next Oct. 1. Meanwhile, NCI is still agonizing over how it will spend the $815 million it is getting in the current, 1977 fiscal year. The agony was brought on by the discovery that, not only does $815 million fall substantially short of meeting the expectations generated during the fast growth years of the Cancer Program, it does not even meet many commitments NCI has made.

Nowhere is this more painful than in the Cancer Control Program. The Div. of Cancer Control & Rehabilitation has one advantage over other NCI divisions—it does not have to fight with other divisions to keep all the money originally allocated to it. The DCCR budget is a line item in the appropriations bill, and its money must be spent by the division. Of course, that protection has the disadvantage of working both ways—neither can DCCR raid the budget of another division.

Although Congress decreed that NCI should have cancer control responsibilities, it did not give DCCR enough this year to continuing funding its existing programs, much less take on substantial new initiatives. The division had requested $78 million for FY 1977; Congress appropriated $60.4 million. DCCR Director Diane Fink told her advisory committee this month that at the moment, this would fall $4.6 million short of meeting existing contract and grant commitments and funding approved new grants and contracts.

This shortfall occurs even after DCCR frees up about $4 million as the result of its merit review of ongoing contracts. This review brought about the cancellation of some contracts because of substand-

ard performance, and termination or phase-out of others because projects and demonstrations were deemed to have been completed or to have reached the point where no further benefit could be expected. Because phase-out periods were granted in most cases, that savings will not all show up this year.

Fink said it appeared that another $3.8 million might be reprogrammed, which would still leave a deficit of $800,000. But, the National Cancer Advisory Board was to have considered another $1 million in approved cancer control grants this week. If all are approved for funding by the Board, that would put the division's deficit back to $1.8 million, assuming all the reprogramming can be accomplished.

Fink presented several views of how the 1977 budget has been allocated:

In house expenses (staff salaries, office space, committee costs, other overhead)—$3.1 million. WATS line costs, $750,000.

Amount approved for extramural projects—$60.1 million (hence, the $4.6 million deficit).

Programs getting $2 million or more this year include the Breast Cancer Detection Demonstration Project, $9.1 million; State Cervical Cancer Programs, $4.3 million; Breast Cancer Treatment Network, $4.2 million; Head & Neck Cancer Treatment Network, $2.6 million; Community Based Cancer Control Program, $5.5 million; cancer center outreach grants, $6.4 million (this includes competing and noncompeting renewals plus new, approved grants).

Total grant outlay—$14.1 million; total contract outlay, $46.9 million.

"This may appear to be a preponderant amount for contracts," Fink said. "But you must consider we started out exclusively with contracts. I think we've done well to go from zero to 23% of our budget with grants, in the short time (a little over two years) since we started accepting grant applications for cancer control."

Oliver Beahrs, committee vice chairman and acting chairman in the absence of William Shingleton, asked if the number of grants in relation to contracts would continue the "drift toward a balance."

"We'll need the advice of this committee to determine that," Fink said. Grants "probably" would level out to about 30-35%, "but that question is still open."

Beahrs said that, "as a general statement, it is reasonable to assume the staff and this committee should be in a flexible position. However, the contract mechanism permits extensive models and programs to be funded where the need and capability exist. Grants are not as well adapted for that."

Fink presented the results of a study of where the division has spent its money since the 1973 fiscal year, a total of $156.8 million:

—Comprehensive cancer centers, 29%.
—Non comprehensive cancer centers, 8.6%.
—Medical schools, 22.3%.
—Community hospitals, 7.7%.
—Professional societies, 2%.
—Non profit organizations, 10.7%.
—For profit organizations, 3.9%.
—State and local government agencies, 6.6%.
—Other federal agencies, 3.1%.
—Inhouse, 4.2%.

"It's easy to see which ones have organized lobbies," commented committee member Lyndon Lee. "The centers and the medical schools. This committee ought to be able to help dilute those pressures."

But Beahrs said he felt "this appears reasonable to me."

"It will be interesting to see where our successes and failures are," Fink added.

Fink said she has been "spending a lot of time thinking about what our problems are in control . . . How do we develop a consensus for control? We have to take a hard look at intervention activities, to determine if a scientific basis exists to move something into control."

ADVISORY GROUP, OTHER CANCER MEETINGS FOR FEBRUARY, MARCH

Clearinghouse on Environmental Carcinogens Subgroup on Chemical Selection—Feb. 2, NIH Bldg 31 Rm 10, 8:30 a.m., open.

Clearinghouse Subgroup on Experimental Design—Feb. 3, NIH Bldg 31 Rm 4, 8:30 a.m., open.

Combined Modality Committee—Feb. 3-4, NIH Bldg 31 Rm 7, open Feb. 3, 8:30—9 a.m.

Carcinogenesis Program Scientific Review Committee A—Feb. 4, Landow Bldg Rm C418, open 9—9:30 a.m.

American Society for Preventive Oncology—Feb. 4-5, Memorial Hospital, NYC, contact Dnaiel Miller, Strang Clinic, 55 E. 34th St., NYC 10016.

President's Cancer Panel—Feb. 8, NIH Bldg 31 Rm 7, 9:30 a.m., open.

Cancer Special Programs Advisory Committee—Feb. 10-12, NIH Bldg 31 Rm 8, open Feb. 10, 9—10 a.m.

Electron Microscopy as an Aid to Tumor Diagnosis—Feb. 10, Roswell Park Continuing Education in Oncology; contact Claudia Lee, Cancer Control.

Carcinogenesis Program Scientific Review Committee B—Feb. 11, Landow Bldg Rm C418, open 9—9:30 a.m.

Committee on Cancer Immunobiology—Feb. 15, NIH Bldg 10 Rm 4B14, open 2—2:30 p.m.

Biometry & Epidemiology Contract Review Committee—Feb. 15-16, Landow Bldg Rm C418, open Feb. 15, 7—11 p.m.

Diagnostic Research Advisory Group—Feb. 16, NIH Bldg 31 Rm 9, open 8:30—10:30 a.m.

Diagnostic Radiology Committee—Feb. 23-24, NIH Bldg 31 Rm 5, open Feb. 23, 8:30—9 a.m.

Clinical Cancer Education Committee—Feb. 23-24, NIH Bldg 31 Rm 7, open Feb. 23, 8:30—9:30 a.m.

Virus Cancer Program Scientific Review Committee B—Feb. 23-25, Frederick Cancer Research Center Bldg 426, open Feb. 23, 9—10 a.m.

Virus Cancer Program Scientific Review Committee B—Feb. 28, Landow Bldg. Rm C418, open 9—9:30 a.m.

Committee on Cancer Immunodiagnosis—Feb. 28-March 3, NIH Bldg 1 Wilson Hall, open Feb. 28, 7—7:30 p.m.

Cancer Clinical Investigation Review Committee—Feb. 28-March 2, NIH Bldg 31 Rm 10, open Feb. 28, 8—10 a.m., March 1, 8—11 a.m.

Clearinghouse Executive Subgroup—Feb. 28, NIH Bldg 31 Rm 5, 8:30 a.m., open.

Cell Differentiation & Neoplasia–30th Annual Symposium on Fundamental Cancer Research–March 1-4, Shamrock Hilton, Houston, sponsored by M.D. Anderson.

International Conference on Adjuvant Therapy of Cancer–March 2-5, Doubletree Inn, Tucson, sponsored by Univ. of Arizona College of Medicine.

Renaissance of Interstitial Brachytherapy–12th Annual San Francisco Cancer Symposium–March 4-5, Hyatt Regency, sponsored by West Coast Cancer Foundation.

Psychological Issues: Dying, Death, Bereavement & Living With Illness–March 10-11, Park Plaza, New Haven, Conn.

Recent Advances in Diagnosis & Management of Breast Cancer–March 10, Roswell Park Continuing Education in Oncology, contact Claudia Lee, Cancer Control.

National Conference on Breast Cancer–16th Annual Conference on Detection & Treatment–March 14-18, Hyatt Regency, Houston, sponsored by American College of Radiology and College of American Pathologists.

(Additional listings for March will appear in the Feb. 25 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-CM-77141

Title: *Operation of genetic production center for rodents in bio-containment environments*
Deadline: *Approximately March 1*

Develop and maintain colonies of inbred and outbred rodents of required genetic characteristics, and with defined microflora. Some of the tasks include substitutions and additions of strains and stocks, and the production of large numbers of rodents in barrier environments. Successful contractors must have an existing facility with, as a minimum, an absolute filtration system, mechanical cage washing machines, auxiliary generators, autoclaves (steam sterilizers) with sufficient capacity for large numbers of caging equipment, and large volumes of animal food and bedding.

Responders must be capable of demonstrating a minimum of two years experience in the maintenance of barrier type facilities. Evidence for this experience shall include a minimum continuous period of two years in the production and distribution of laboratory rodents for biomedical research; and a minimum two years in maintenance of barrier enclosed production colonies.

To accomplish program objectives, the following task levels are required: Task 1–Approximately 525 mouse cages maintained as foundation colonies in associated flora isolators. Approximately 4,000 mouse cages maintained under strict barrier conditions as pedigreed expansion colonies. Task 2–Approximately 1,000 mouse cages maintained as foundation colonies under strict barrier conditions as pedigreed expansion colonies. Task 3–Approximately 2,300 mouse cages maintained as foundation colonies in associated flora isolators. Approximately 800 mouse cages maintained under strict barrier conditions as pedigreed expansion colonies. Task 4–Approximately 2,000 mouse cage equivalents maintained as foundation colonies. Approximately 11,000 mouse cage equivalents maintained under strict barrier as foundation and expansion. Task 5–Approximately 3,000 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 23,000 mouse cage equivalents maintained under strict barrier conditions as foundation and expansion colonies, of which approximately 9,000 must be maintained in Europe (Italy).

Only one task will be awarded to any one contractor. It is expected that full and true competition will occur only as Task 1 level. In order to avoid disrupting the movement of inbred animals from the centers to the program, competition at Task 2 – Task 5 level will be restricted to those contractors who are presently performing in the program at the genetic center level. Isolators will be supplied to successful respondents.

It is anticipated that awards will be for three year incrementally funded periods of performance.

Contracting Officer: Daniel Abbott
Cancer Treatment
301-427-7463

RFP NCI-CP-VO-71004-54

Title: *Interaction between host cell and oncogenic virus genomes*
Deadline: *March 10*

Scope of work – RFP No. 1

Objective: To study the site(s) of integration of tumor viral genome in eukaryotic cell DNA by genetic approaches.

Background: It has been shown that integration of oncogenic viral genetic material into the host cell genome is a prerequisite for cellular transformation by tumor viruses. However, the exact site(s) of integration of viral material within the host cell genome are unknown. The possibility that the site of integration

may affect the outcome of the infectious process must first be explored by determining whether certain sites of integration are favored and, if so, in what frequency. Classical genetic analysis of crosses between animals of the same species bearing defined genetic constitutions may be used to determine the linkage group associations of specific genes under consideration. Another means of identifying gene order in mammalian cells is creation of somatic cell hybrids between cells of different species and correlating the survival of gene products with the presence or absence of identified chromosomes. This project will utilize present methodologies in vivo or in vitro genetic analysis and biochemical analysis of viral gene products to determine the site(s) of integration of viral genetic material in cell DNA.

The contractor may determine the site(s) in cellular DNA of integration of endogenous and/or exogenous oncogenic viral genome by either of the following methodologies (all points under chosen method must be addressed):

1. Mapping by genetic approaches in cell cultures

a. Create somatic cell hybrids between cells of diverse origin carrying defined viral genomes. The problem of prevention of reinfection by any released complete virions must be addressed.

b. Monitor the hybrids for karyotype by appropriate cytogenetic techniques.

c. Monitor the hybrids for presence of viral gene information.

d. Correlate the results of (b) and (c) to determine the probable location(s) of integrated viral DNA within the host cell genomes.

2. Mapping by genetic analysis of appropriate animal crosses

a. Utilize standard genetic analytical techniques in an appropriate animal model to determine the frequency of occurrence of oncogenic viral information with linkage group(s).

b. Monitor markers appropriate to the linkage groups of the chosen model.

c. Monitor expression of viral information in cells of progeny cells by appropriate in vitro techniques.

d. Correlate (c) with the several markers in (b) to determine the probable site(s) of integration.

Scope of work – RFP No. 2

Mapping of oncogenic genome integration sites by electron microscopic techniques.

Objective: To visulaize the sites of integration of oncogenic viruses in eukaryotic cell DNA by electron microscopic techniques.

Methods of visualizing complete viral and cell genomes by electron microscopy are available and portions of the genome may be copied and tagged with markers which can be identified in electron micrograph. This project will apply current methods and/or devise more sensitive methods to visualize integration of viral sequences in cellular DNA.

The contractor may address either or both of the following tasks:

1. Apply heteroduplex mapping techniques to visualize integration sites of cacogenic viruses in eukaryotic cells.

2. Apply and/or develop more sensitive electron microscope techniques for the detection of integrated viral gene sequences by either molecular hybridization or in situ hybridization.

Scope of work – RFP No. 3

Objective: Biochemical identification and purification of integrated oncogenic viral sequences in cellular DNA.

Background: Biochemical definition of integrated viral sequences in eukaryotic cell DNA has been impeded by the small amount of viral information integrated into the relatively enormous cellular genome. Development of techniques for fragmenting cellular DNA and isolating specific fragments containing viral information are necessary for determining the molecular structure of the integrated viral information and for determining mechanisms of integration. This project will address the problems of isolations of viral sequences from DNA of cells containing integrated viral DNA sequences of endogenous or exogenous tumor viruses and identification of the molecular structure of the integration sites.

The contractor will: 1. Ultilize standard techniques, such as solid phase hybridization, salt gradients, or column fractionation, isolate fragments of cellular DNA enriched for viral gene sequences; or,
2. Determine the location of these fragments in the cell DNA by appropriate sequencing and hybridization techniques.

It is estimated that the annual level of effort will be approximately a total not to exceed two professional man-years per annum and four technical man-years per annum.

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CONTRACT AWARDS

Title: Development, management, and support services to the Diet, Nutrition & Cancer Program
Contractor: Enviro Control, $47,206.

Title: Applied mathematics and analysis studies
Contractor: Arthur D. Little Inc., $567,449.

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