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UPTON CONSIDERS MOVING BASIC RESEARCH CONTRACTS TO GRANTS; STAFF CHANGES POSSIBLE, NEWELL STAYS

The new director of the National Cancer Institute agrees with the chairman of the President's Cancer Panel that "we have to take seriously the criticism" against NCI's use of the contract mechanism to support certain basic research. With both Arthur Upton, who will take over Monday (July 25) as director of NCI and the National Cancer Program, and Panel Chairman Benno Schmidt lined up on this issue, the eventual phasing down of virology and immunology research contracts and the shift of those funds into grants probably is inevitable.

"My colleagues have been concerned about this," Upton told *The Cancer Letter*. "Many of them feel that the same money now going into basic research contracts, put into grant supported investigator initiated research, would be used to better advantage."

Schmidt, while acknowledging that NCI's research contracts in

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In Brief

PATTERNS OF CARE STUDY LEADS "PART TIME" RADIOTHERAPISTS TO DROP OUT, SHELINE SAYS

ONE OF the valuable results of the patterns of care radiotherapy study supported by NCI's Div. of Cancer Control & Rehabilitation "is that some people who were doing radiotherapy are no longer doing it," according to Glenn Sheline, Univ. of California (San Francisco), who is a member of the DCCR Advisory Committee. Sheline explained that many radiologists are primarily diagnosticians, do a little radiotherapy and have not developed much expertise in x-ray treatment of cancer. Many recognized their own deficiencies after seeing the patterns of care questionnaire and have voluntarily stopped offering radiotherapy services. . . . **PROCEEDINGS** of the International Conference on the Adjuvant Therapy of Cancer held last March in Tucson are now available, edited by Sydney Salmon and Stephen Jones, $53.95. Order from Elsevier/North-Holland, at either 52 Vanderbilt Ave., NYC 10017, or P.O. Box 211, Amsterdam. Salmon thinks this set a record for rapid publication of a conference proceedings. . . . **NEW FILM**, "Radiation: The Cancer Fighter," describes in 10 minute sound and color use of radiation in treatment of cancer. It can be purchased for $70 by writing to Charles Honaker, American College of Radiology, 20 N. Wacker Dr., Chicago 60606. The film was produced by the American Society of Therapeutic Radiologists on a grant from Varian Associates. . . . **DESCRIPTIONS** of NIH collaborative research programs, including those at NCI, are included in the July 1 issue of the *NIH Guide for Grants & Contracts.* Write to Guide Distribution Center, Rm 219 Westwood Bldg, Bethesda, Md. 20014. . . . **NEXT MEETING** of the President's Cancer Panel has been moved from Aug. 9 to Aug. 5, when NCI's 40th anniversary will be observed.

UPTON TO GO SLOW ON PROGRAM, STAFF CHANGES, WOULD "CROSS THAT BRIDGE"

(Continued from page 1)

virology and immunology have resulted in "outstanding work," feels strongly that "the fundamental research budget ought to be one, and competitive. There's no need for special stimulants in virology. There's enough scientists with ideas out there. And there's no need for special stimulants in immunology. . . . The question is, is it fair to investigators to to have one pool available to one group of investigators and one pool available to another?"

Schmidt said there are two aspects to the situation that are "most troublesome to me: First, it is said that peer review of contract research functions primarily to determine 'Is this good science and ought it to be done?' It does not have to, to the extent that study section peer review of grants have to, ask the question, 'If you can only do so much, which ones will you do?'

"Second, and even more troublesome, is that when budget cuts occur, and the budget levels off, the dynamics of the internal organization at NCI are such that contract researchers get a better shake in the reduced budget than do grant supported researchers."

Schmidt said, "I can't say these (contentions) are facts, but we can't dismiss them the way we do some other criticism." The charge that peer review of contract proposals is not as good as that of grants "does not have much substance," Schmidt said. "We've made a tremendous effort to strengthen contract peer review. The virology and immunology reviewers are of the same caliber as study sections, at least. . . . Study section peer review has not been all that perfect. It sometimes is talked about as if it were heaven ordained, but sometimes some things fall between the cracks."

The issue has become especially sensitive this year when NCI was able to fund only 30% of approved new investigator initiated grants and 40% of approved renewals. During the big money growth years since 1971, those figures were at least 50%. In Schmidt's words, "an awful lot of good science and good scientists are going unfunded this year."

Upton agreed. "We have to be careful to avoid situations where numbers of able, imaginative, productive scientists who get their grants approved in the top 30-40% are not being supported. It's hard to justify to those scientists that we can spend a lot of money on contracts but can't support their work.

"On the other hand," Upton continued, "there is clamor for attention to this problem and that, and we can't guarantee that the response from investigators will meet those needs."

One approach might be for NCI's program divisions to take on more responsibility for administering grant programs in their respective fields. The traditional investigator grants are handled administratively through the Div. of Cancer Research Resources & Centers, and are reviewed by the NIH Div. of Research Grants study sections. The program divisions sometimes maintain liaison with DCRRC in their areas but have little to say about what gets awarded and what doesn't.

Upton said he felt "there may be a good argument for program areas to use both mechanisms." He mentioned expanded use of Cancer Research Emphasis Grants as one means to achieve that. "It is possible we would find that many of the same people who are working on contracts would compete successfully for grants," Upton said.

Because of his background as perhaps the world's top authority in radiation carcinogenesis, Upton is seen as a director who will emphasize prevention. He may well do that as time goes on, but he is cautious now on the subject.

"I don't have enough detailed knowledge of NCI programs in that area to offer valid criticisms right now," he said. "The situation seems to be fluid, with new efforts already undertaken, new positions (in environmental carcinogenesis and epidemiology). I will have to look at it shortly."

NEW ADDRESS, PHONE NUMBER

The Cancer Letter has a new mailing address and a new phone number: P.O. Box 2370, Reston, Va. 22090, and 703-620-4646.

One suggestion he was willing to make: "We need to systematically educate the public. We must try harder to communicate the nature of the problem and carry the message to the public at large." Upton is not pessimistic about reaching the public effectively with important messages related to prevention. "We have seen enormous change in the last few years. Efforts by the responsible media have been impressive. NCI's communications office is better organized and effective."

The problems for science are huge, Upton said. "Our estimates of risk relationships are crude. We just don't have enough knowledge. Even where there is an unequivocal relationship to cancer, it is difficult to assess matters such as dose and exposure. When the scientific community is divided, the public is confused. People tend to just throw up their hands when scientists are confused."

In his own field of radiation carcinogenesis, Upton said, "In the last 20 years, there has been a fundamental change in the attitude in the radiology profession. Twenty years ago, people trained in radiology paid lip service to the idea that one might increase the risk of cancer in a patient by diagnostic radiation. The risk was felt to be so small as to be negligible.

"We have turned the corner. Every effort now is being made to limit radiation exposure only to where

it is clearly needed, and when it is needed to reduce the dose, protect with shields, and so on. That is the philosophy now and it is promulgated in the best circles. The problem now is that a lot of people are still using radiation equipment who went through their training in the period of the dark ages. Only a minor portion of radiation equipment in use today is being used by people trained in radiology. We need to reach those people, to upgrade their training."

Some NCI staff scientists have looked with trepidation on the appointment of an "outsider" to run the institute. Frank Rauscher was one of their own, a man who made his reputation first as an intramural scientist and later as the enthusiastic administrator of the old Etiology Division. His scientific colleagues at NCI always felt, after Rauscher became NCI director, that they had a special rapport with him.

"An outsider can't be expected to understand the system immediately," Upton commented. "Each institution has its own approach to things. But science is a universal language. An outsider won't have any difficulty understanding and appreciating the quality of science here.

"That quality is superb, judged overall. Some may not be uniformly superb. Scientists are like pitchers, boxers, and race horses, they have good days and bad days. The director needs to be in a position to understand, help when they're down, sustain their enthusiasm, help them redirect themselves. An outsider won't know all the people right away, and it will take a while."

An advantage an outsider has is that he might be in a better position to "look critically at the entire institute," Upton said. "Is it organized to optimally perform its mission? I want to take a searching look at the mission and organization. If I'm convinced that some organizational changes are necessary, I'm prepared to cross that bridge."

Upton said he hasn't looked at it closely enough yet to know if any staff changes will be necessary.

Guy Newell, who was Rauscher's deputy and who has served nearly nine months as acting director, will remain as Upton's deputy. "I told Guy I hoped he would stay and he said he would, at least for several months, or a year or longer. It is in my interest and the interest of the institute that he stay. He has been terrifically effective as acting director. His continuing here will make it possible for me to settle in, in the least disruptive way. We'll play it by ear. If we make a good partnership, work well together, divide the responsibilities in a way satisfactory to both of us, we'll continue. If we find that our philosophies are not compatible, then we could decide otherwise."

The National Cancer Act confers on the NCI director certain powers that federal bureaucrats three levels down from the department secretary normally do not have. The NCI director is the final authority in awarding grants, with concurrence of the National Cancer Advisory Board (and without that concurrence for grants under $35,000), including construction grants. The director also is empowered to recognize comprehensive cancer centers and encourage their development.

On several occasions during the Nixon and Ford Administrations, the White House tried to limit Rauscher on increasing the number of comprehensive centers and stop him from awarding construction grants. Rauscher used persuasion rather than attempt to invoke his powers (not even the President can overrule the director on those issues, although he can fire the director and get someone who will follow his orders). In every instance the Administration backed down before Rauscher had to go that far.

Upton was reluctant to assert himself on that issue now. "My appointment still hasn't been made official. They might change their minds if they read that I intend to defy them, before I even start the job." But he went on:

"The Cancer Program is one of the world's most important scientific and humanitarian efforts. I came here at a personal and family sacrifice, in the interest of that cause. I believe strongly in it. I intend to serve that cause, to the best of my ability, even if someday it means that I have to take a stand that will cost me my job."

EMORY EXECUTIVE OBJECTS TO REPORT ON REHABILITATION CONTRACT PHASE OUT

The article in ***The Cancer Letter,*** Feb. 25, describing results of the merit review conducted by NCI's Div. of Cancer Control & Rehabilitation of the contracts it was supporting noted that seven contracts had been terminated because of alleged deficiencies in performance found by the reviewers. One of the seven was a contract for evaluation of the effectiveness of cancer rehabilitation systems leading to improved education requirements, with Emory Univ. Center for Rehabilitation Medicine.

Carmella Gonella, director of research at the center, took exception to the article. She sent the following statement to ***The Cancer Letter:***

"In the Feb. 25, 1977 issue of The Cancer Letter, you printed extracts of the reviewer's comments on the NCI contract with Emory Univ. (NCI-CN-45134) evaluating the effectiveness of cancer rehabilitation systems leading to the improvement of educational requirements. These comments were taken out of context. The scope of the work was renegotiated; and performance continued until its successful completion on Jan. 31, 1977. To paraphrase the project officer's comments in a telephone call, March 16, 1977, the final report represents a significant piece of work with important ramifications in the immediate application of criteria identified in the three cancer patient groups and in implications for directions of future research."

NCI had supplied summaries of the merit reviewers' comments and the actions taken following

a request by *The Cancer Letter* for the information under provisions of the Freedom of Information Act. NCI insists that the summary of the Emory contract accurately reflected the reviewers' remarks and was not "taken out of context."

The contract was terminated a year ahead of schedule; the renegotiation was done to provide a three month phase out period, a practice generally followed by NCI when contracts or grants are terminated before their scheduled completion.

Larry Burke, the DCCR project officer for the contract, confirmed that the final report in his opinion was well done and represented "a significant piece of work." Emory received praise from the merit reviewers for another project, the Prototype Network Demonstration Project in Breast Cancer.

CARCINOGENESIS WORKSHOPS TO PLAN NEW PROJECTS; COMMITTEES ELIMINATED

The White House has approved the list of NCI advisory committees to be eliminated, as recommended by Acting Director Guy Newell after the Administration had insisted that he submit a proposal in line with President Carter's determination to reduce the number of government "agencies" (*The Cancer Letter*, May 6).

Four major program advisory committees were dropped—Carcinogenesis; Diet, Nutrition & Cancer; Virus Cancer; and the Tobacco Working Group.

The demise of the Carcinogenesis Scientific Advisory Committee came just as the program was being geared up to undertake some major new initiatives. The committee at its first and only meeting had drafted a list of prospective projects for which Gio Gori, the program acting director, had hoped to develop priorities and get some of them into RFPs before the end of the year. The committee was scheduled to meet this week, but the meeting was canceled when word came through that it was out of business.

Gori plans to use a series of workshops, which had been planned anyway to help establish priorities, to move the projects along. "We'll probably have more or less the same faces on the workshops (as were on the committee)," Gori said. "The fact remains that we need advice from the outside scientific community."

As many as eight workshops will be held during the next two to three months, provided the incoming director of the Carcinogenesis Research Program, Richard Bates, agrees.

When they have been completed, a larger workshop will be convened to review their recommendations and establish overall priorities, probably in November. By then, the program's FY 1978 budget should be firmed up, and the projects that can be funded will be put out as RFPs (for contracts) or RFAs (for cancer research emphasis grants).

Gori said he hoped the RFPs and RFAs could still be out before the end of the year.

Some of the RFPs for nutrition research which were withdrawn at the insistence of NIH because they were considered "too vague" have been rewritten and will be readvertised soon. Two of them have not yet been released, and Gori, who also heads the Diet & Nutrition Program, said he did not know when they would be available.

CCIRC SURGICAL SUBCOMMITTEE SUGGESTS WAYS TO ENHANCE ROLE OF SURGEONS

The report to the Cancer Clinical Investigation Review Committee of its Surgical Subcommittee, delivered at the CCIRC meeting last month by Theodore Grage, was included in *The Cancer Letter* (July 8) coverage of the meeting.

The complete subcommittee report included a number of suggestions for enhancing the role of surgeons in the Cooperative Group Program and for making better use of surgeon talent in specific clinical research areas that were not included in the article. Additional excerpts from the report follow (serving on the subcommittee with Grage were Theodore Beattie and Jerome DeCosse):

Historically, surgeons have played a major role in the design, development and conduct of adjuvant controlled clinical trials through participation in the National Surgical Adjuvant Breast Project (NSABP), the Central Oncology Group (COG), and the Veterans Administration Surgical Adjuvant Study Group (VASAG). Rough calculations indicate that surgeons have placed well over 10,000 patients on a large number of adjuvant protocols during the past few years.

The Potomac Conference in 1975 had a major impact on reorganization of the four major adult multidisciplinary cooperative groups (CALGB, ECOG, SWOG and SEG) with increasing thrust toward developing controlled clinical trials designed to study the effect of multiple modalities in the treatment of early solid tumors. Additional funding has been made available to these cooperative groups to bring surgeons, radiation therapists, pathologists, and immunologists into the mainstream of cooperative clinical cancer research.

In the VASAG and NSABP, surgeons dominate the activities and membership, whereas in the four major multidisciplinary groups medical oncologists dominate with nearly all the group chairmen and essentially all principal investigators being medical oncologists, while the major therapeutic thrust now is toward those patients who are seen and treated almost 90% by surgeons and radiation therapists. Recent significant advances in our understanding of cellular kinetics, new drug development and development of better combination drug regimes in the treatment of patients with advanced malignant disease obviously provide opportunities for improving salvage rates in such neoplasms as carcinoma of the breast, carcinoma of the colon and rectum, squamous cell carcinoma of the head and neck region, testicular carcinomas, ovarian cancers, soft tissue sarcomas and osteogenic sarcomas and malignant melanoma.

The activities of NSABP and VASAG are clearly success stories. They are capable of launching and accruing large numbers of patients rapidly. They are capable of completing even "unpopular studies," such as radical mastectomy vs. simple mastectomy, with and without radiation therapy in the treatment of early breast cancer, or surgical treatment of rectal cancer with and without preoperative radiation therapy.

Similarly, the Children's Cancer Study Group has functioned for many years as a multimodal, multidisciplinary group with strong participation by pediatric oncologists, radiologists, surgeons and pathologists.

The four major adult, multidisciplinary cooperative groups,

CALGB, ECOG, SWOG, and SEG are integrating surgeons into their activities with varying success, albeit slowly, and the number of patients with early, potentially curable neoplasms placed on controlled clinical trials is small compared to the huge number of patients being treated in these cooperative groups for advanced malignant disease.

WHAT ARE THE OBJECTIVES?

1. To bring an increasing number of academic surgeons into the cooperative clinical trials program.

2. To take advantage of their special expertise in the care of the cancer patients in the conduct of clinical cancer research.

3. To strengthen and organize the discipline "surgical oncology" with the help of the Cooperative Group Program.

4. To rapidly increase the number of patients with potentially curable neoplasms on adjuvant trials.

FUNCTIONS OF SURGICAL ONCOLOGISTS IN COOPERATIVE GROUPS

The chief role of surgical oncologists in cooperative groups is to participate in the design, development, and conduct of cooperative clinical group trials. Surgeons must increasingly take the leadership in conducting adjuvant studies combining the disciplines of surgery, chemotherapy, and radiation therapy in various combinations and sequences in the treatment of patients with early, curable neoplasms. Just to cite a few examples where major opportunities for significant progress exist today:

1. High dose systemic methotrexate with citrovorum rescue, with and without cis-platinum, preoperatively in the surgical management of head and neck cancer, with and without postoperative radiation therapy.

2. Evaluation of local excision plus radiation therapy, vs. more radical resection, or even amputation in soft tissue sarcomas and osteogenic sarcomas, with and without systemic postoperative adjuvant chemotherapy.

3. Segmental mastectomy plus radiation therapy vs. segmental mastectomy plus systemic chemotherapy vs. standard surgical resection plus systemic chemotherapy in the treatment of breast cancer.

4. Definition of the role of value of pre vs. postoperative radiotherapy in the management of patients with head and neck cancer and carcinoma of the rectum.

5. Trials of combination chemotherapy and surgery in the early treatment of cancer of the breast, colo-rectum and other GI cancers.

There are some specific surgical questions that need clarification or better definition of their potential role:

1. Infusion chemotherapy in squamous cell carcinoma of the head and neck area.

2. The role of infusion chemotherapy vs. hepatic artery dearterialization vs. systemic chemotherapy in primary and metastic neoplasms of the liver.

3. The value of hyperthermic perfusion of the extremities in the treatment of early melanomata and sarcomata.

4. Deliberate reoperation as a planned therapeutic step such as the "second look" procedure in carcinoma of the colon and retroperitoneal sarcomas. The availability of the CEA assay may be able to better select patients suitable for the second look procedure than blind reoperation in all patients with poor prognosis.

5. Definition of the value of surgical staging procedures in: a.) Hodgkins disease and malignant lymphoma; b.) The role of surgical staging in the treatment of bronchogenic carcinoma such as deliberate and precise sampling of mediastinal nodes, which may lead to a different therapeutic approach; c.) Operative staging of squamous cell carcinoma of the cervix uteri; d.) Restaging of Hodgkins disease for therapeutic decisions; e.) Elective lymphadenectomy in patients with carcinoma of the breast or malignant melanoma may be as important as a staging procedure than as a therapeutic procedure to select patients for postoperative adjuvant chemotherapy; f.) Increasingly aggressive surgical approach to the treatment of metastatic or residual disease after chemotherapy or radiation therapy such as multiple thoractomies, plus chemotherapy for patients with osteogenic sarcomas and soft tissue sarcomas. Surgical resection of residual squamous cell carcinoma of the head and neck after attempt at curative radiation therapy.

METHODS TO ACHIEVE FULL INTEGRATION OF SURGICAL ONCOLOGISTS IN GROUP ACTIVITIES

1. The Cooperative Groups

A. Within the cooperative groups the surgeons have organized themselves and formed a surgical committee with membership on specific disease-oriented committees. Medical oncologists, surgeons, radiation therapists can well work with each other. However, they will not function well when they are expected to work for each other and for this reason the principle of a co-equal partnership within the cooperative group is absolutely essential and surgeons must be given an opportunity to be represented in the administrative and executive functions of a cooperative group.

B. Some specific responsibilities of the surgeons within the cooperative groups are: The designing of forms, e.g., "on-study forms," which include details of the natural histories of the disease, to the extent it is useful for a particular research objective, development of "operative forms" which clearly make provision for description of the extent of the disease at the time of the operation, the pattern of spread, whether or not biopsies of residual disease were performed. The development of uniform surgical guidelines, e.g., what is the minimum acceptable standard procedure for a bowel resection or for a resection of a head and neck carcinoma, or a melanoma. These guidelines will need to be spelled out in detail, recorded and have to be retrievable. The development of "in-hospital forms," which will permit the recording of complications, secondary to the operation, secondary to radiation therapy, secondary to chemotherapy, e.g., blood loss with and without preoperative radiation therapy, or with and without preoperative chemotherapy. All too often such forms are non-existent, or at times too much is asked for without defining what the specific information is needed for.

C. Educational activities within cooperative groups. There is a significant educational task ahead in the mutual interplay of radiation therapists, surgeons, and medical oncologists. Surgeons frequently are not very familiar with the science of chemotherapy. The groups may seriously consider development of workshops with participation by surgeons, radiation therapists, medical oncologists and pathologists to assess the state of the art, to educate each other in their respective expertise, to search for existing opportunities and develop an in depth logical program for each major disease.

D. With the multimodality and multidisciplinary activities have developed certain growing pains. Maybe the time has come for each cooperative group for self-assessment, either as part of a general group meeting or as a separate meeting to conduct an in depth review of what the addition of surgeons, radiation therapists, pathologists and other disciplines has really meant to the group; to define their respective responsibilities, to define what would be an appropriate mix of phase I, phase II and phase III and adjuvant studies for that particular group; are they administratively optimally designed? Do they need a new constitution and by-laws? A reassessment of the capabilities of the group, where are their strengths, and their weaknesses. Should the group really attempt to cover all of the potential tumor areas or should it confine its studies in areas in which it is know to have strength and expertise? Is the group too small, too big? How many studies can the group reasonably do well? What function does a group meeting have in relationship to the entire direction the group is taking? Could the groups learn from each other? What is the ideal way of doing clinical research? Is it best to have two active ongoing studies, like NASBP, or is it better to have 100 active ongoing studies like in SWOG, or is there a happy medium?

2. What Can the CCIRC Do?

A. It can and does recognize the principle of a co-equal partnership between the various therapeutic modalities.

B. The development of a separate budget page on the research grant request has been a significant step forward with each modality being responsible for developing justification for funding for academic, non-academic personnel, travel, supplies and patient costs, commensurate with the input by each of these disciplines. As surgeons demonstrate their capability of conducting and participating in group studies, supplemental funds may need to be made available. The surgeons do not want a free ride, but clinical research is time consuming and expensive and if the program will succeed, there must be a different mix in the available funds. It cannot run 10 to 1 in favor of one discipline.

C. The CCIRC should discuss the role of the principal investigator. As it stands now, almost all principal investigators are medical oncologists and maybe this is the way it should be since much of the recent progress in cancer research has come through the field of medical oncology rather than surgery or radiation therapy. On the other hand, having all principal investigators medical oncologists makes it appear that all of the creativity, the scientific leadership and the willingness to work hard is the exclusive property of one specialty. Should one consider rotating the principal investigatorship from grant period to grant period among the various disciplines?

D. This issue of the role of the principal investigators vs. coprincipal investigators has assumed important aspects with the recent request for so-called "core support." These are presumably funds needed to defray the additional administrative expenses incurred by the addition of several disciplines to each institutional group. The institutions are already receiving 40 to 50% of the grant as overhead and now the amount of core support requested is as high as the amount of support for surgical participation, or for participation of radiation therapists. Furthermore, these additional funds are going to that discipline that already has the lion's share of the funds. What the cooperative groups need is money for research, not for additional administration.

E. Establishment of a surgical subcommittee on the CCIRC to review the activities of surgeons, funding of surgeons, and the organizational efforts of surgeons to provide ongoing feedback to the committee, whether the discipline of surgical oncology is succeeding as a strong, effective enterprise within the cooperative groups.

F. The CCIRC should keep a running log of the number of studies dealing with multiple disciplines vs. single disciplines, the number of patients on single discipline studies vs. multiple discipline studies, and the actual number of patients on adjuvant trials.

A quick glance at these figures from year to year should provide an easy way of assessing to what extent the groups are succeeding in their efforts to go multidisciplinary and multimodal.

G. Suggestions have been made for a second Potomac Conference. However, during this period of transition this may be too soon. Planning for such a conference certainly should get underway.

3. Surgical Oncologists

It is the responsibility of the surgical oncologists themselves to define what the field of surgical oncology is, how it should get organized, what certification it ultimately seeks. It is up to them to define the content of a training program in surgical oncology and up to them to establish within their respective institutions divisions of surgical oncology with appropriate visability and training programs.

The surgeons within cooperative groups should organize themselves to become effective in the affairs of the Society of Surgical Oncology, the Society of Head & Neck Surgeons and to be an effective voice for the field of surgical oncology and its relationships with other organized bodies of American Surgery, such as the American College of Surgeons.

4. What Can NCI Do?

We strongly urge NCI to accept and activate the recommendations made by the Ad Hoc Committee, headed by Bernard Fisher, which has recommended certain administrative changes with the formation of a Surgical Therapy Evaluation Program (STEP) and additional funding for both surgical oncology research and funding of training programs at all levels in the field of surgical oncology.

SUMMARY

The creation of the multidisciplinary cooperative group programs provides a unique opportunity for clinical cancer research, often representing the leading edge with significant advances having been made in the management in several tumor categories. But this development has also fundamentally changed the nature, the size, the aims, and composition of cooperative groups. With this have come some growing pains. The responsibility for bringing about the needed changes for this program to succeed fully rests primarily with the investigators, but significant help will need to come from the CCIRC, NCI, and outside surgical organizations for surgeons to be fully integrated into the cooperative group trials program.

(Grage is associate professor of surgery at the Univ. of Minnesota; Beattie is chairman of the Dept. of Surgery at Memorial Sloan-Kettering Cancer Center; and DeCosse is chairman of the Dept. of Surgery at the Medical College of Wisconsin.)

MURPHY PUTS ROSWELL PARK ON RECORD IN DEFENSE OF NATIONAL CANCER PROGRAM

"It is important that we do not raise false hopes that a cure can be found tomorrow . . . and it is of equal importance that we do not cruelly dash the hopes of those afflicted with cancer by telling them they are doomed," Gerald Murphy, director of Roswell Park Memorial Institute, said in a statement prepared for the Fountain subcommittee hearings.

Murphy was unable to attend the hearings, but he submitted the statement for inclusion in the record. The statement was cleared with the New York State Dept. of Health and represents the policy of the department, Murphy said.

(Many New York health officials were appalled by the remarks at the hearings of Roswell Park statistician Irwin Bross, who attacked the Cancer Program with a series of unproven charges.)

"It is understandable that questions should be raised (about the program) so that the public can fully understand what is being done in the fight to curb its incidence and hopefully someday to defeat it," Murphy said. "While efforts to cope with cancer have met with frustration sometimes, failures sometimes, there also have been successes.

"The creation of the National Cancer Act in 1971 has added substantial muscle to the nation's fight. For the first time, the nation's resources—financially as well as intellectually—were mobilized through the National Cancer Program to fight cancer. . . .

"In such a vast National Cancer Program there are bound to be disagreements and misunderstandings, but there can be no question that the effort must go on. I think the record is clear. Since the creation of the National Cancer Act in 1971, the fight against cancer has shown steady progress."

Murphy mentioned research that has produced new treatment approaches for lung and bone cancer and leukemia, development of the CEA test for diagnosis and prognosis of colon-rectal cancer, and the blood test for early detection of prostate cancer developed at Roswell Park.

"There may be legitimate dispute in some areas over priorities with the National Cancer Program but those of us involved in implementing cancer programs before the establishment of the National Cancer Act know all too well how this program has focused national and international effort to conquer this disease," Murphy concluded.

NEWELL, FREDRICKSON QUESTION ETHICS IN PROPOSED LAETRILE CLINICAL TRIAL

Because a growing number of cancer patients are using laetrile and because a number of state legislatures have legalized it, "medical experts at NCI and elsewhere have reluctantly concluded that a clinical trial of laetrile should be considered," NCI Acting Director Guy Newell told Sen. Edward Kennedy's

Health Subcommittee last week.

"The results of such a trial, if negative as we expect they would be, would not convince the most avid proponents of laetrile but would be of value to state legislators and to physicians who care for cancer patients," Newell said. "The ethical, moral and legal implications of testing in humans a compound proved to be of no value in animals has made even consideration of a clinical trial controversial."

NIH Director Donald Fredrickson said, "The issue simply put is: Are useless nostrums to be substituted for treatments should be to safe and useful by scientific methods? We are discussing today, therefore, a problem far greater than cancer or any other disease."

Fredrickson pointed out that in the 25 years that laetrile has been known, "no scientifically acceptable evidence has been presented of its effectiveness against cancer, in either animals or man, for either prevention or cure. . . . Clinical trials have been based on the principle that drugs are tried in patients only when there is scientific evidence they might help them. Have we the right to deprive a patient of a potentially useful drug and provide instead a compound for which there is no reasonable probability of usefulness?"

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, citing the RFP number. Some listings will show the phone number of the Contract Specialist, who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Their addresses, all followed by NIH, Bethesda, Md. 20014, are:

Biology & Diagnosis Section — Landow Building
Viral Oncology & Field Studies Section — Landow Building
Control & Rehabilitation Section — Blair Building
Carcinogenesis Section — Blair Building
Treatment Section — Blair Building
Office of the Director Section — Blair Building
Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CM-87169-18

Title: *Provision, maintenance & transfer of tumored laboratory animal models for investigation*

Deadline: *Approximately Aug. 22*

These animals will be involved in experiments undertaken at the NIH campus by Clinical Oncology Program investigators. Animal species under study include rats, mice, rabbits, chicks, hamsters, and guinea pigs. Animals will be furnished by NCI.

These services will include specifically the caging, daily maintenance, and regular transport of animals (daily, or weekly depending on the experiment) to the specified NCI laboratories. In addition, some animals will bear tumors and the respondent should demonstrate the capability of inducing and transporting tumors in such animals. These tumors will be furnished by the government.

The offeror must be located in close proximity to NIH and turnaround time must be within one hour because of need to minimize the transportation effect on experimental animals. It is anticipated that the project will require 2¾ technical and support man-years of effort per year.

Contract Specialist: H. Lee
Cancer Treatment
301-427-8125

RFP DU-77-B219

Title: *Environmental carcinogen and mutagen storage, handling and weighing room*

EPA plans to issue an RFP for an environmental carcinogen and mutagen storage, handling and weighing room to be built in an existing room at the Environmental Research Center, Research Triangle Park, N.C.

Environmental Protection Agency
Contracts Management Division (MD-33)
Office of Administration, Attn: NCCM-J
Research Triangle Park, N.C. 27711

SOURCES SOUGHT

RFP NCI-CP-FS-71047-55

Title: *Study of alternative methods and/or supplementary sources to NCI's present program to produce data concerning cancer incidence, cancer therapy, extent of disease and associated survival, trends in such data, and national estimates.*

Deadline: *Undetermined*

The Field Studies & Statistics Program of NCI is seeking sources with interest in and capability for: (1) assessing the present program for its Cancer Surveillance, Epidemiology, and End Results Reporting (SEER) to determine adequacy of population coverage and to evaluate data acquisition procedures; (2) suggesting alternative sampling methods; (3) suggesting differing or supplemental sources of data; and (4) designing feasibility studies for the field testing and evaluation of proposals for any methods suggested.

It would be necessary for the contractor to produce a report containing: (1) an evaluation of the present program specifying the deficiencies and problem areas, and procedures or methodologies for obtaining the SEER objectives using methods which could include sampling and/or use of data sources other than population-based cancer registries. This part of the report may include an assessment of alternative approaches and evaluations of these approaches and evaluations of these approaches regarding practicality and feasibility; and (2) a protocol for field testing and evaluating proposed alternatives.

Any alternative or changed program shall be consistent with the present objectives of the SEER pro-

gram. These objectives emphasize collecting the data necessary to assess the trends in cancer incidence, the utilization and outcomes of different therapeutic modalities, and the survival of cancer patients. The objectives also include using the same sources for developing and carrying out epidemiologic field studies.

The present program collects data from population-based cancer registries in the U.S. covering different areas for which demographic data are available. Information on cancer patients is obtained from medical and vital records coded in a prescribed manner which excludes specific patient identification. The coded information includes demographic data about the patient, description of the cancer with diagnostic detail including its primary origin within the body, the histologic nature of the tumor, the extent of disease, the therapy given, and the vital status of the patient at specific time periods.

In part, participants in the SEER Program have been chosen to provide populations with different demographic factors and different risk factors for a variety of cancers. These choices were made to provide covereage of the U.S., and to lead to epidemiologic studies and analyses. Another criterion for selection was the availability of a medically oriented organization capable of obtaining the cooperation of the medical community and having the capability of developing in-depth studies suggested by the data.

Submit resumes of capabilities. The RFP will be issued to qualified sources.

Contract Specialist: F. Shaw
Viral Oncology & Field Studies
301-496-1781

CONTRACT AWARDS

Title: Laboratory services for the support of NCI long-term studies in carcinogenesis and related activities
Contractor: Microbiological Associates, $133,870.

Title: Coordinating committee for the radiologic physics centers, renewal
Contractor: American Assn. of Physicists in Medicine, $885,913.

Title: Northeast Center for Radiologic Physics, renewal
Contractor: Memorial Hospital for Cancer & Allied Diseases, $1,138,277.

Title: The growth of normal and tumor virus cells
Contractor: Meloy Laboratories, $256,332.

Title: Thyroiditis as immunotherapy
Contractor: Columbia Univ., $71,012.

Title: Cancer Control Radiologic Physics Center, renewal
Contractor: Allegheny General Hospital, $887,069.

Title: Human tumor associated antigens and corresponding antibodies
Contractor: Sloan-Kettering Institute, $72,527.

Title: Cervical Cancer Screening Program, renewal
Contractor: Arizona State Dept. of Health, $82,864.

Title: Technical support services for the ICRDB, renewal
Contractor: Franklin Institute, $64,678.

Title: Studies of the transcriptional regulation of eukarytotic gene sequences, continuation
Contractor: Columbia Univ., $68,200.

Title: Research on immunobiologic responses of the cat to feline oncornaviruses, continuation
Contractor: Ohio State Univ., $220,000.

Title: Research on the role of humoral and cellular immunity in determining outcome of herpesvirus saimiri infection in squirrel monkeys, continuation
Contractor: Tulane Univ., Delta Primate Center, $50,939.

Title: Support for the cancer surveillance system
Contractor: Fred Hutchinson Cancer Research Center, $209,614.

Title: Population-based Cancer Epidemiology Research Center, continuation
Contractor: Univ. of Iowa, $250,941.

Title: Tumor registry training program and allied activities, continuation
Contractor: Univ. of California (San Francisco), $48,852.

Title: Search for genetic material in cancer and studies on mechanism of oncogenesis, continuation
Contractor: St. Louis Univ., $458,332.

Title: Search for RNA virus specific genetic material, continuation
Contractor: St. Louis Univ., $247,500.

Title: Radiologic physics centers
Contractor: Univ. of Wisconsin, $250,977.

Title: Breast Cancer Detection Demonstration Program, renewal
Contractor: Univ. of Pittsburgh, $408,000.

Title: Mammography training, renewal
Contractor: UCLA, $95,182.

Title: NCI Immunodiagnostic reference center
Contractor: Meloy Laboratories, $257,000.

—*Editor* JERRY D. BOYD

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