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FIRST SHAKEUP IN UPTON REGIME: PETERS MOVES OUT AS DCCP HEAD TO BECOME "SPECIAL ASSISTANT"

James Peters, director of the Div. of Cancer Cause & Prevention since 1972, became a casualty in the first major shakeup of NCI personnel by Arthur Upton since he took over the institute last July. Effective Oct. 1, Peters will become "assistant director (of NCI) for special programs," and a search committee will start looking for someone to head DCCP.

Gregory O'Conor, associate NCI director for international affairs, will become acting DCCP director, handling both jobs until the position is filled on a permanent basis. He will not be a candidate for the DCCP position.

The following statement was given to *The Cancer Letter*, over

(Continued to page 2)

In Brief

CARCINOGENESIS: DOES THE PROMISE JUSTIFY THE EFFORT? TASK FORCE ATTEMPTS TO FIND OUT

TASK FORCE on Carcinogenesis, appointed by NCI Director Arthur Upton, will "take an overview, to see if the scientific promise of the Carcinogenesis Program justifies the level of effort." Alan Rabson, director of the Div. of Biology & Diagnosis, is chairman. Members are all NIH staff—Elizabeth Neufeld and Joseph Rall, of the National Institute of Arthritis, Metabolism & Digestive Diseases; Edward Scolnick and George Khoury of NCI's Div. of Cancer Cause & Prevention; Ira Pastan, Pietro Gullino and Thomas Waldmann of the Div. of Biology & Diagnosis; Bruce Chabner and Kurt Kohn of the Div. of Cancer Treatment; and John Bailar, editor of the *Journal of NCI.* First meeting was scheduled for this week. . . . **DONALD FREDRICKSON**, NIH director, told the National Cancer Advisory Board last week that "we can't take ourselves too seriously" in developing a consensus on when a new technology is ready to be transferred into practice. "I don't know the ultimate answer to control and NIH's involvement." Fredrickson said the Office of Medical Application of Research, which he plans to establish at NIH, will be available to assist the Cancer Control Program as well as others at NIH. "No institute should embark on any effort to sell a research result without contacting this office," Fredrickson said. "But the office won't attempt to impose its decision". . . . **NEW PUBLICATION**: "Guide to Grant & Contract Programs of NCI," HEW Publication No. (NIH)77-1264. Contains brief explanations of each of NCI's funding mechanisms and of each program supported by grants and contracts. Write to NCI, Office of Cancer Communications, Bethesda, Md. 20014. . . . **ELIZABETH MILLER**, who was selected months ago as the third member of the President's Cancer Panel, finally received her official appointment from the White House and participated in last week's NCAB meeting.

UPTON PROBABLY WILL LOOK FOR TOP NAME IN PREVENTION, CARCINOGENESIS

(Continued from page 1)

Upton's signature:

"After serving five years as director of the Div. of Cancer Cause & Prevention, Dr. James A. Peters has asked to be relieved of the administrative responsibilities of running the division so that he can devote his time to special problems in the area of environmental carcinogenesis.

"As a result, I appointed Dr. Peters, effective Oct. 1, as acting assistant director for special programs, working directly out of my office. He will help us address the mounting concern over the role of environmental factors in the causation of cancer that has demanded so much increased attention by NCI.

"A search committee will be formed to recommend candidates for director of the division. Until a new director has been selected, Dr. Gregory O'Conor has agreed to serve as the division's acting director. Dr. O'Conor's accomplishments in cancer research and his performance as associate director for international affairs qualify him well for leadership of the division.

"In announcing these appointments, I extend my best wishes to Dr. Peters and Dr. O'Conor on behalf of the institute."

There can be no doubt, despite the implication in the statement, that the change was being made on Upton's initiative, not Peters'. It probably will not be the last change in top NCI management that Upton will make. Upton left last Friday for an official trip to the Soviet Union and was not available for further comment.

NCI has come under increasing pressure to place more emphasis on prevention research, especially environmental carcinogenesis. Critics in Congress and elsewhere have hammered away at alleged deficiencies in those areas, and Peters took the brunt of much of that criticism. He was especially under fire for the "backlog" of bioassay reports which built up following a huge increase in the number of chemicals tested for carcinogenicity starting in 1972.

It is somewhat ironic that the backlog is now being rapidly reduced, and will be eliminated by next February, thanks to a reorganization in the Carcinogenesis Program initiated by Peters two years ago.

To the extent that Peters was the executive responsible for all DCCP activities, he had to share the blame for the buildup in the first place. The backlog was caused by a pathology staff too small to read and analyze the large number of slides produced as the chemicals came off test. But Peters inherited the system just as the increases were being made; it was two years before it became apparent that the system was inadequate. Peters started making changes then, but it was another two years before the reorganization was completed, when the program was divided into the present bioassay and carcinogenesis research components.

Upton probably will try to recruit one of the top people in the prevention or carcinogenesis fields. A big name would go a long way toward convincing the critics that NCI means business in those areas and that if any increase in emphasis is warranted, prevention will get a bigger share of NCI resources.

Gio Gori, Peters' deputy, possibly will be a candidate for the job.

Peters was named an assistant to Frank Rauscher, then director of the division, in 1970, and he became Rauscher's deputy the following year. When Rauscher became NCI director in May, 1972, Peters was named acting division director. Rauscher had intended to take Peters with him into the NCI director's office, but he had the same difficulty in recruiting a top name to run DCCP that Upton is likely to encounter. The job was still unfilled late in 1972, and Peters then agreed to take it on permanently.

So Peters now will take that job in the NCI director's office, but with a lot more experience and a few more scars than he had in 1972.

SUGGESTIONS LISTED FOR NEW RESEARCH IN IMMUNOLOGY APPLICATION, THERAPY

The advisory committees to NCI's Immunology Program are in the midst of their annual RFP development efforts in which they suggest ideas for new contract supported projects.

The committee on application of immunology in cancer cause and prevention, a new area undertaken by the program during the past year, and the committee on immunotherapy have completed their lists of suggested research projects. The committees on immunodiagnosis and immunobiology will complete theirs by the end of October.

Following is the cause and prevention list:

(Note: These are not RFP announcements. They are suggested topics for research, from which Immunology Program staff will develop a few RFPs. The RFPs that come out of these suggestions will not be completed and available until sometime in 1978, probably not before late spring. Do not contact NCI contract or program staff inquiring about their availability. When they have been completed, they will be announced through the usual media, including *The Cancer Letter.)*

–Immunologic mechanisms in cattle.

–Antigenicity of premalignant lesions in humans.

–Identification of persons exposed to carcinogens using the methods of immunology.

–Antigenicity of precancerous lesions in animal models.

–Immunological aspects of hormonal response in tumors.

–Immunization of newborn kittens with prophylactive agents against the development of leukemia in

cats.

—Study of DMBA-induced myelogenous leukemia in animals.

—Study of the role of tumor initiators and promotors.

—Effects of age on the immunology of tumor cause and prevention.

—Effects of diet on the immunology of tumor cause and prevention.

Following is the immunotherapy list:

—Local immune response against tumor.

—New approaches to immunotherapy.

—Usefulness of tissue specific immune responses in treating tumors of non-vital organs.

—Modification of tumor immunogenicity.

—Mechanisms of successful immunotherapy.

—Intralesional BCG-cell wall skeleton in the treatment of tumors of outbred animals.

—Characterization of factors causing inhibition of macrophage function or inflammatory responses.

—Isolation and functional characterization of human tissue macrophages.

—Production of monospecific antibodies against tumor associated antigens.

—Adoptive cellular immunotherapy.

—Adoptive serotherapy of cancer.

—Intralesional studies with BCG-cell wall skeleton.

CENTERS: MEETINGS, NCAB ACTIONS AFFECT THEIR PROBLEMS, FUTURE OPPORTUNITIES

Directors and certain key staff members of most of the country's cancer centers will be getting together at one or both of two meetings in late October and early November. NCI executives also will be on hand, and they most likely will develop earaches from listening to criticism of the proposal to reduce the amount of money available for cancer center core grants by as much as 50% within five years.

Center directors have had plenty to complain about anyway during the past couple of years, as funds available from NCI have leveled off or even declined at a time when centers are reaching a point of their greatest need for support if they are to fulfill the demands placed on them. The new proposal, which would phase out or drastically reduce core support for staff investigators and shared resources, could be disastrous to the Centers Program, in the minds of some.

The first meeting, of the Assn. of American Cancer Institutes, is scheduled for Philadelphia Oct. 24-25. Main item on that agenda is the issue of how a cancer center should be structured and governed. While that is not directly related to the burning issue of how much and what kind of dollar support centers should get from NCI, is does tackle the problem of NCI's guidelines for the organization of centers, particularly the comprehensive cancer centers. What should their relationship be with parent institutions? How much autonomy should a center director have? How demanding can NCI be in matters such as space, beds, and other resources allocated to centers?

Existing centers range all the way across that spectrum. Some directors whose authority and governmental structure do not meet the critieria established by the National Cancer Advisory Board for comprehensive centers fear that they may be in danger of losing their comprehensive status—or never achieving it if they haven't already—if they don't move closer to those criteria.

The meeting, at the Marriott Hotel, will start on the evening of Oct. 24 when Benno Schmidt, chairman of the President's Cancer Panel, will discuss the National Cancer Program, followed by Thomas King, director of the Div. of Cancer Cause & Prevention, who will talk about the Centers Program.

The program on the next day will be held at Fox Chase Cancer Center, with panels on the governance and structure of cancer centers. The first, covering centers at universities and medical schools, will be chaired by John Yarbro, director of Missouri Cancer Programs Inc. Panel members include John Durant, Univ. of Alabama Comprehensive Cancer Center; William Anlyan, Duke Univ. Comprehensive Cancer Center; and Jules LaPaidus, Ohio State Univ. Comprehensive Cancer Center.

The second panel, covering free standing (corporate) centers and those with general hospital arrangements, will be chaired by J. Palmer Saunders, director of the Univ. of Texas at Galveston Cancer Center. Panel members include John White, Memorial Sloan-Kettering Comprehensive Cancer Center; Joseph Concannon, Allegheny General Hospital; and Emil Frei III, Sidney Farber Comprehensive Cancer Center.

The 2½ day meeting in Memphis, Nov. 2-4, was organized by NCI for representatives of all cancer centers with NCI support (core) grants. It will be held at the Regency Hyatt Hotel.

King and his deputy, William Walter, will open the first day's session with a discussion of cancer centers support. Bernard Keele, their assistant for the Centers Program; staff members Ray Morrison and Mary Hurst; and Richard Harrington of Johns Hopkins will talk about the cancer centers profile which NCI has been collecting from each center.

On Nov. 3, Stephen Carter, director of the Northern California Cancer Program, will chair a panel discussion of regional activities of cancer centers. Other panel members will be Robert Cooper, Univ. of Rochester; Charles Moertel, Mayo Clinic; and David Yohn, Ohio State Univ.

A session on basic science will occupy the rest of the day, led by Mahlon Hoagland, Worcester Foundation; Harry Eagle, Albert Einstein School of Medicine; and William Joklik, Duke. Hilary Koprowski, Wistar Institute, will discuss the role of basic science centers in the National Cancer Program. Henry Pitot, McArdle Laboratory, and Nobelist David Baltimore

will discuss biohazard regulations. Hoagland and Joklik will talk about established cancer investigator awards. Arthur Pardee, Farber, will make a presentation on support for investigator initiated research. And Joklik, Eagle and Baltimore will discuss support for biomedical research not specifically targeted to cancer or the cancer cell.

Concurrently on the afternoon of Nov. 3, NCI staff members will conduct a separate discussion on grants administration.

The final day will start with a discussion of the review of cancer support grants by David Joftes, chief of DCRRC's Review & Referral Branch, and Ernest Borek, Lowell Orbison and John Durant. The meeting will end with a discussion of the relationship of NCI divisions to cancer centers by Deputy Director Guy Newell, division directors Vincent DeVita, Diane Fink and King; Ihor Masnyk, representing the Div. of Cancer Biology & Diagnosis; and whoever will be representing the Div. of Cancer Cause & Prevention.

A variety of other developments occurred recently relating to the Centers Program, mostly in connection with last week's NCAB meeting:

NEW CORE GRANTS, RENEWALS

The Board approved two new grants, seven renewals and one supplement. The new ones went to Univ. of Vermont, Irwin Krakoff principal investigator, $383,258 in the first year, $329,213 in the second, and $357,411 in the third; and the Mighigan Cancer Foundation, Michael Brennan PI, $196,130 first year, $282,163 second year, and $248,124 third year. The figures are for direct costs.

The supplement went to Einstein-Yeshiva Univ., Harry Eagle PI, $633,270, $722,293 and $425,410.

Renewals approved were Farber, Emil Frei III, PI; Hopkins, Albert Owens, PI; Wistar, Hilary Koprowski PI; Univ. of Rochester, Robert Cooper PI; Yale Univ., Jack Cole PI; City of Hope, Charles Todd PI; and Univ. of Hawaii, Lawrence Piette PI (for one year).

PROSPECTIVE NEW COMPREHENSIVE CENTERS

The Board approved requests from two would-be comprehensive centers, in Missouri and Michigan (***The Cancer Letter,*** Sept. 23) for site visits to determine if they are ready for that designation. The optimistically-named Comprehensive Cancer Center of Metropolitan Detroit, headed by Brennan, is made up of the Michigan Cancer Foundation and Wayne State Univ.

The Missouri Cancer Programs Inc., headed by Yarbro, includes seven institutions—St. Louis Univ., Univ. of Missouri at Columbia, Univ. of Missouri at Kansas City, Cancer Research Center at Columbia, Elliot Fischel State Cancer Hospital, Kirksville College of Osteopathic Medicine and Kansas City College of Osteopathic Medicine.

The Board agreed with Keele's request to postpone the two reviews until after the Board site visits to review existing comprehensive centers has been completed. Still to be visited are the Colorado Regional Cancer Center, Oct. 6-7; Los Angeles County-Univ. of Southern California Comprehensive Cancer Center, Oc.t 13-14; Johns Hopkins Oncology Center, Oct. 20-21; Sidney Farber Cancer Institute, Oct. 31-Nov. 1; Univ. of Texas System Cancer Center, Nov. 29-30; Roswell Park Memorial Institute, Dec. 8-9; Yale Univ. Comprehensive Cancer Center, Feb. 6-7; and Illinois Cancer Council, Feb. 16-17.

All other comprehensive centers except UCLA have been reviewed. UCLA will escape this round of Board review since it received comprehensive designation only this year.

Keele said it would be next April before the staff would complete its analysis of the reviews and be ready to undertake review of Missouri and Michigan.

A special meeting of the NCAB Subcommittee on Centers will be called before the next Board meeting (in November) to consider the reviews already completed of existing comprehensive centers. The subcommittee will report its findings and recommendations, if it has any to make, to the Board in November.

For the most part, those recommendations will be in the nature of how individual centers can improve and strengthen their programs. None of those reviewed so far is in any danger of losing comprehensive designation, at least not yet.

The Board could recommend to NCI Director Arthur Upton that he withdraw comprehensive recognition if sufficient deficiencies are found to warrant such drastic action. That would create a political storm from the congressional delegations of affected states, but NCI staff and some NCAB members have expressed determination to do that if they feel it is appropriate.

When the Missouri and Michigan requests were presented to the Board, member Harold Amos commented that the reviews should be postponed until after the proposed new analysis for comprehensiveness has been completed.

William Powers, member of the Board and senior scientist for the Cancer Research Center, one of the components of the Missouri program, objected, ing he felt "it was inappropriate for this decision to be tied to a budget presentation" (the Board earlier had heard the report from the centers subcommittee on core grant changes and budget limitations). Powers then left the room as conflict of interest regulations require.

Amos said, "My reservation was not tied to the budget." But Board member Frank Dixon indicated his reservation was. "In view of our discussion on the budget problems, are we still going to be considering new centers?" Dixon asked.

"We're not limited to any particular number, althoughwe should try not to do too many," Board Chairman Jonathan Rhoads responded. "We can still

leave it open for new centers. Old centers cannot preclude competition from new ones. If we can't afford two new centers, then perhaps we should then phase out a couple of old ones."

Schmidt had some suggestions for members of the site visit teams. "I think these site visits are good for NCI, and good for the centers. A lot of things can be implemented as a result. But we're on the horns of a dilemma. We would like the comprehensive centers to be all the things they should be, but we don't have the money to continue to increase their resources so they can be all things.

"I urge site visitors to not encourage centers to enter areas they are not already in, except for those things that are necessary for comprehensiveness," Schmidt continued. "Comprehensive centers need good multidisciplinary clinical care, and good basic research. But a center that has good clinical care and is strong, for example, in molecular biology and immunology but not in chemical carcinogenesis, should then leave chemical carcinogenesis to those centers already doing it."

Board member Bruce Ames objected, contending that the time to consider those factors "is when we're doing the review here, not on the site visit."

"But if the center director gets the idea he's being downgraded because he's not doing an activity, it discourages him and at the same time encourages him to enter into something he should not do," Schmidt said.

Ames agreed that "it would be silly to expect every center to have everything, but the fact is that very little chemical carcinogenesis research is going on."

"I didn't mean to downgrade carcinogenesis," Schmidt said. "I was just using that as an example."

"The problem is to encourage people to get into it," Ames said. An example, he offered, would be for a center to encourage epidemiologists to look at the high incidences of particular cancers in the region it serves and to find the source of contamination that might be responsible.

"That would be one of the things that could come out of this review," Schmidt said. "All I meant was that we do not have the funds for every center to be as comprehensive as the most comprehensive center. They should do the things they do extremely well, rather than to get into second quality things."

"Perhaps we should encourage new centers to get into these areas of need," Ames said.

Board member William Shingleton, chairman of the Subcommittee on Centers, suggested that "new funds don't have to be all NCI funds. Some business organizations are becoming interested in finding out the problems (relating to cause of cancer) in their communities, and are willing to help out."

LOCATION/POPULATION ACCESS

The practice of recognizing, or "identifying" as NCI prefers to put it, comprehensive cancer centers around the U.S. grew out of the National Cancer Act of 1971. The Act includes language that encourages NCI to support the development of "centers of excellence," to be distributed geographically to bring the benefits of the expanded research efforts to the greatest number of Americans.

In implementing that legislative direction, the NCAB determined that these centers should be "comprehensive" in nature, to include elements of basic research as well as multidisciplinary clinical research. The Board approved 10 "characteristics" which these centers should have, and those 10 were to be used by reviewers and the Board to determine if a center fit the description of a "comprehensive cancer center."

Eventually, it became clear that Congress saw these centers of excellence more as the means by which the fruits of research progress could be passed on to their constituents, rather than primarily as research institutions. When the congressional investigative agency, the General Accounting Office, reviewed the centers program last year, its conclusion was that comprehensive centers were not adequately distributed to serve the greatest number of people.

NCI's response in general was that it was not necessarily in the business of creating such centers where no centers existed. Rather, it would encourage and assist those centers with the potential, to develop to the point where they could be identified as "comprehensive." Geography might be one consideration but not the only one, probably not even a major factor.

Rhoads and others suggested that the problem of assuring that every cancer patient has reasonable access to the best and latest treatment technology would be to support establishment of a number of clinical cancer centers, with most of the elements of comprehensive centers except the basic research requirement. Rhoads felt this would require perhaps 200 such centers, including many already in existence.

Former NCI Director Frank Rauscher, early in the development of the Centers Program, felt that the ideal setup would be to have a comprehensive center (later either a comp or clinical center) within 50 miles of 90% of the American population. This would permit cancer patients to travel to a center, receive treatment or consultation, and drive home the same day.

That is a goal that probably never will be achieved, and probably will not even be necessary. But a study by NCI Centers Program staff has found that 90% of Americans are now living within 200 miles of either a comprehensive or a clinical cancer center.

The comprehensive centers are in Birmingham, Ala.; Los Angeles (2), Denver, New Haven, Washington D.C., Miami, Chicago, Baltimore, Boston, Rochester, Minn.; New York City, Buffalo, Durham, Columbus, Ohio; Philadelphia, Houston, Seattle and Madison.

The clinical centers included in the survey are Northern California Cancer Program, Palo Alto; Emory Univ. Cancer Center, Atlanta; Cancer Center of Hawaii, Honolulu; Northwestern Univ. Cancer Center, Chicago; Univ. of Chicago Cancer Research Center, Rush Cancer Center, Chicago; Mid-America Cancer Center, Kansas City, Kan.; Boston Univ. Cancer Research Center; Missouri Cancer Programs, Columbia; Albert Einstein College of Medicine Cancer Research Center, Bronx; Hospital for Joint Disease & Medical Center, New York City; Columbia Univ. Cancer Research Center, New York City; New York Univ. Medical Center, New York City; Univ. of Rochester Cancer Center, Rochester; Cancer Research Center, Chapel Hill, N.C.; Oncology Research Center, Winston-Salem, N.C.; Cleveland Cancer Center; Oklahoma Cancer Center, Oklahoma City; Puerto Rico Cancer Center, San Juan; Roger Williams General Hospital, Providence, R.I.; Memphis Regional Cancer Center; Univ. of Texas Health Science Center, Dallas; Univ. of Texas Medical Branch, Galveston; Medical College of Virginia/Virginia Commonwealth Univ. Cancer Center, Richmond; and Medical College of Wisconsin, Milwaukee.

Combined, clinical and comprehensive centers reach 45% of the population within 50 miles of one or the other, or 97.7 million persons; 64% or 132.5 million within 100 miles; and 90%, or 185 million, within 200 miles.

The comprehensive centers by themselves cover 37% of the total population, or 74.8 million, living within 50 miles of a center; 49% or 98.5 million within 100 miles; and 73% or 148.4 million within 200 miles.

If the 200 mile radius and 90% coverage figures can be considered acceptable, it could be argued that sufficient geographic distribution of cancer centers has already been achieved. The only reason then to establish a new center, as far as serving the people is concerned, would be if a new one can do the job better than an existing one.

The facilities included in the 90%, 200 mile radius coverage vary widely in capability. Not all of them can be expected to treat optimally every type and stage of cancer. Most of the clinical centers included in the survey work with smaller hospitals, both in outlying areas and in their own communities.

It is the feeling of some NCI staff members and advisors that all of the clinical centers and most of their collaborating hospitals should, with appropriate referrals, be able to provide the quality of care that cancer patients would expect to receive at comprehensive centers.

Considering that the American College of Surgeons Commission on Cancer has approved cancer programs at about 750 hospitals (many of which are included in the clinical and comprehensive centers named above), the NCI survey indicates that the primary consideration in assuring the best care to the greatest number of cancer patients is the continual improvement of existing centers and programs rather than adding significantly to the total number.

NCOG, NEW TYPE OF COOPERATIVE GROUP, GETS $400,000 FROM NCI, $50,000 ACS

The first clinical cooperative group designed specifically to conduct trials on a regional basis with community physicians performing much of the research and providing many of the patients has been funded by NCI.

The Northern California Oncology Group, headed by former NCI Div. of Cancer Treatment Deputy Director Stephen Carter, received a grant of $400,009 from NCI's Cooperative Group Program. NCOG also received an additional $50,000 from the American Cancer Society to help pay for outreach activities.

NCOG was formed under the aegis of the Northern California Cancer Program, which Carter also heads. NCCP is a consortium of 17 universities, hospitals and cancer and health associations in Northern California and Northwestern Nevada.

NCOG committees are developing protocols for the various cancers that will be treated in the specific disease orientation, multidisciplinary trials. The protocols will be made available to the member institutions and experimental drugs will be provided by NCI, as with the other cooperative groups.

NCOG program development has been guided by its executive planning committee chaired by Carter. Members of the committee are Neil Andrews, Univ. of California (Davis); Malcolm Bagshaw, Stanford; Byron Brown, Stanford; Richard Cohen, Mt. Zion Hospital; John Daniels, Stanford; Michael Friedman, Univ. of California (San Francisco); Richard Kempson, Stanford; Jerry Lewis, Univ. of California (Davis); Glenn Justice, Letterman Army Medical Center, Naval Regional Medical Center and David Grant USAF Medical Center; James Luce, West Coast Cancer Foundation; Theodore Phillips, Univ. of California (San Francisco); Saul Rosenberg, Stanford; Herman Schwartz, Kaiser Foundation Hospitals; Jordan Wilbur, Pacific Medical Center; and Charles Wilson, Univ. of California (San Francisco).

NCI APPROPRIATIONS STILL HUNG UP AS NEW FISCAL YEAR APPROACHES

The 1978 fiscal years starts Saturday, Oct. 1, and NCI (at ***The Cancer Letter*** press time) still did not have authority to spend any money after that date. The HEW appropriations bill, hung up for months over the abortion issue, had not cleared Congress, although a number of attempts to puth it through were on the schedule.

If no bill is passed nor any interim funding provided, NCI payments under grants and contracts would be held up, and staff salaries probably would not be paid.

ADVISORY GROUP, OTHER CANCER MEETINGS FOR OCTOBER, NOVEMBER

Third Biennial Medical Oncology Review Course—Oct. 3-7, American College of Physicians, Pasadena, Calif.

Clinical Cancer Education Committee—Oct. 5-6, NIH Bldg 31 Room 7, open Oct. 5, 8:30–9:30 a.m.

Cancer Research Manpower Review Committee Subcommittee on Etiology & Prevention—Oct. 6-7, NIH Bldg 31 Room 6, all closed.

21st Western Occupational Health Conference—Oct. 6-8, San Francisco Fairmont Hotel—"Carcinogens, Mutagens, Teratogens; Some Delayed Effects of the Occupational Environment." Contact Mary Zerwas, 333 Ravenswood Ave., Menlo Park, Calif. 94025.

Symposium on Malignant Melanoma—Experimental and Clinical Aspects—Oct. 6-7, Brisbane.

Carcinogenesis Program Scientific Review Committee A—Oct. 6-7, Landow Bldg Room C418, open both days, 8:30–9 a.m.

Cancer Research Manpower Review Committee Subcommittee on Detection, Diagnosis, Treatment & Restorative Care—Oct. 6-7, NIH Bldg 31 Room 7, all closed.

Cancer Research Manpower Review Committee—Oct. 8, NIH Bldg 31 Room 6, open 9–9:30 a.m.

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

Cancer Control & Rehabilitation Advisory Committee Subcommittee on Prevention—Oct. 12, NIH Bldg 31 Room 7, 9 a.m., open.

National Prostatic Cancer Project Working Cadre—Oct. 12, Roswell Park, open 8:30–9 a.m.

Biology & Diagnosis Board of Scientific Counselors—Oct. 14-15, NIH Bldg 31 Room 7, open Oct. 14, 9 a.m.–5 p.m.

Australian Cancer Society Biannual Meeting—Oct. 19-21, Melbourne.

Cancer Control Rehabilitation & Continuing Care Review Committee—Oct. 20-21, NIH Bldg 31 Room 8, open Oct. 20, 8:30 a.m.–3:30 p.m., Oct. 21, 8:30 a.m.–adjournment.

International Conference of Radiology—Oct. 23-29, Rio de Janeiro.

Cancer Treatment Board of Scientific Counselors—Oct. 24-25, NIH Bldg 31 Room 6, open Oct. 24, 8:30 a.m.–3:15 p.m; Oct. 25, meeting at Frederick Cancer Research Center, open 9:30 a.m.–3 p.m.

Conference on Governance & Structure of Cancer Centers—Oct. 24-25, American Assn. of Cancer Institutes, Philadelphia.

Committee on Cancer Immunodiagnosis—Oct. 25, NIH Bldg 10 Room 4B14, open 1–1:30 p.m.

Third Czechoslovak Congress on Oncology—Oct. 26-29, Bratislava.

Committee on Cancer Immunobiology—Oct. 27-28, NIH Bldg 1 Wilson Hall, open Oct. 27, 7–7:30 p.m., open Oct. 28, 8:30 a.m.–11:30 p.m.

Clearinghouse on Environmental Carcinogens—Oct. 31, NIH Bldg 31 Room 6, 8:30 a.m.–5 p.m., open.

Cancer Control Grant Review Committee—Oct. 31-Nov. 1, NIH Bldg 31 Room 9, open Oct. 31, 8:30–9 a.m.

American Society of Therapeutic Radiologists—Nov. 1-5, Denver Hilton, annual meeting.

Clearinghouse Chemical Selection Subgroup—Nov. 1, NIH Bldg 31 Room 4, 8:30 a.m., open.

Clearinghouse Experimental Design Subgroup—Nov. 2, NIH Bldg 31 Room 4, 8:30 a.m., open.

Cancer Center Directors—Nov. 2-4, Memphis Hyatt Regency.

National Pancreatic Cancer Project Working Cadre—Nov. 2, Chicago Continental Plaza Hotel, open 8:30–9:30 a.m.

12th Annual Joint Working Conference of the Virus Cancer Program—Nov. 2-4, Hershey, Pa., Motor Lodge, 9 a.m. each day, open.

Clinical Cancer Investigation Review Committee—Nov. 7-9, NIH Bldg 31 Room 6, open Nov. 7, 9–10 a.m.; Nov. 8, 8:30 a.m.–noon.

Immunotherapy of Human Cancer—Nov. 9-11, Houston Shamrock Hilton Hotel.

Anaesthesia in the Cancer Patient–Blood Pressure Problems—Nov. 10, Roswell Park continuing education in oncology.

Cancer, A Cooperative Concern for Care—Nov. 10-11, Yale Univ., contact Marion Morra, 205-436-3779.

Cancer Control Community Activities Committee—Nov. 10-11, NIH Bldg 31 Room 10, open Nov. 10, 8:30–9 a.m. and 2–5 p.m., Nov. 11, 8:30 a.m.–adjournment.

Combined Modality Committee—Nov. 14-15, NIH Bldg 31 Room 4, open 8:30–9 a.m. both days.

National Cancer Advisory Board—Nov. 14-16, NIH Bldg 31 Room 6.

Developmental Therapeutics Committee—Nov. 16, Blair Bldg Room 110, open 9:30 a.m.–noon.

Committee on Cancer Immunotherapy—Nov. 17, NIH Bldg 10 Room 4B14, open 1:15–1:45 p.m.

Cancer Control Prevention, Detection, Diagnosis & Pretreatment Committee—Nov. 17-18, Blair Bldg Room 110, open Nov. 17, 8:30 a.m.–5 p.m.

Cancer Center Support Grant Review Committee—Nov. 18-19, NIH Bldg 31 Room 6, open Nov. 18, 8:30–10 a.m.

Clearinghouse Data Evaluation/Risk Assessment Subgroup—Nov. 28, NIH Bldg 31 Room 6, 8:30 a.m., open.

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-87173

Title: *Effect of regulations on the conduct of cancer treatment research*

Deadline: *Approximately Nov. 7*

Initiate and coordinate an investigation of the impact of government regulations on the conduct of clinical treatment research in cancer. In particular, this research will address how the pace and efficiency of cooperative group and institutional studies of experimental chemotherapy, funded by grants or contracts of NCI, are affected by regulations which concern protection of the research subject from undue risk and from coercion.

This project will be considered through analysis of the relevant HEW, PHS, FDA and NIH regulations and policies (and, where appropriate, state and local statutes and common law as well). It will also involve an assessment of the attitudes toward and understanding of cancer treatment research on the part of research subjects and patient organizations, clinical investigators and their administrative staffs, and institutional review boards or committees.

Where necessary, conferences and workshops can be used to bring together representatives who are engaged in or associated with clinical trials research at various organizational levels. Other participants or consultants would include scholars in areas such as

law, political science, sociology, and medical ethics, as well as members of related NCI, NIH, and FDA staffs.

A major objective of this project is to make recommendations, based upon the data gathered in the study, which would speed the clinical testing and aid in the development of new anticancer therapy. Where appropriate, this activity would include suggestions for modifying existing regulations and policy both with respect to protection of human subjects and the organization and conduct of clinical trials.

It is anticipated that one award will be made and it will require approximately 2.25 technical man-years per year; however, the number and level of effort of any contract awarded will be at the discretion of the government. It is estimated that two years will be required to complete the study outlined above.

Contract Specialist: S. Gane
Cancer Treatment
301-427-8125

SOURCES SOUGHT

RFP GENS-2

Title: *Large animal preclinical toxicologic studies of antineoplastic agents*
Deadline: *Oct. 23*

Perform studies utilizing the protocols and requirements of "Procedures for Preclinical Toxicologic Evaluation of Cancer Chemotherapeutic Agents: Protocols of the Lab of Toxicology" (Cancer Chemotherapy Reports, Part 3, Volume 4, No. 1, Jan. 73). In order to qualify, firms must have experienced and qualified personnel, as well as facilities/equipment for the studies described in the above referenced document. Specific requirements are:

1) An investigator with experience in toxicologic evaluations using beagle dogs and rhesus monkeys, 2) a qualified staff capable of undertaking the required pathologic examinations, 3) facilities for holding and treating up to 50 beagle dogs and 20 rhesus monkeys at one time, 4) suitable clinical chemistry and hematology capability, 5) overall capacity to completely evaluate at least three antineoplastic agents undergoing the full protocol series (Studies I, II, II, IV, and V-d, plus compound identity and purity analysis, mouse LD50 determinations and blood compatibility and local tissue reaction testing) or an equivalent mix of studies in a one-year period.

Battelle Toxicology Program Office
Suite 220 7405 Colshire Dr.
McLean, Va. 22101

CONTRACT AWARDS

Title: Synthesis of radiosensitizing agents
Contractor: Institute of Cancer Research, Royal Cancer Hospital, Surrey, England, $565,854.

Title: Production of novel antineoplastic compounds using fermentation, biotransformation, and co-metabolism techniques
Contractor: Univ. of Iowa, $314,953.

Title: BCG immunotherapy in patients with recurrent superficial bladder cancer
Contractor: Sloan-Kettering Institute for Cancer Research, $44,144.

Title: Intratumoral BCG prior to radiation and cystectomy in patients with bladder cancer
Contractor: Sloan-Kettering Institute for Cancer Research, $48,943.

Title: Clinical evaluation of immunodiagnostic tests for cancer
Contractor: Kaiser Foundation Research Institute, $88,969.

Title: Induction of functional differentiation of T-cells
Contractor: Tufts Univ., $256,671.

Title: Diagnostic use of cross-reacting microbial antigens
Contractor: Univ. of Texas System Cancer Center, $83,297.

Title: Cell mediated reactivity of normal persons to human TAA's
Contractor: UCLA, $68,509.

Title: Diagnostic use of leukemia-associated antigens
Contractor: Health Research, Inc., Roswell Park, $62,397.

Title: Breast Cancer Detection Demonstration Project, modification
Contractor: University Science City Center, Philadelphia, $24,099.

Title: Prevention of mammary preneoplastic lesions
Contractor: Michigan State Univ., $248,900.

Title: Pathogenic models of malignant and premalignant disease of the breast
Contractor: Fred Hutchinson Cancer Research Center, $161,150.

Title: Serum collection from patients biopsied for benign and malignant breast lesions
Contractor: Wilmington Medical Center, $161,300.

—*Editor* JERRY D. BOYD

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