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LETTER

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CONSORTIUM CENTERS POSE PROBLEMS TO SOME, BUT CLAIM THEY "COINCIDE WITH CONGRESS' INTENT"

NCI's Cancer Centers Program is in trouble because it isn't getting enough money to continue funding adequately the core grants it has awarded to 64 centers, but money is not the only problem afflicting the program.

The question of how centers should be governed continues to crop up, particularly as the review of existing comprehensive centers

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In Brief

"MASSIVE REASSESSMENT" OF CENTERS GOING ON, TIM TALBOT BELIEVES; WHO DROPS ICRDB SERVICE

TIMOTHY TALBOT, president of the Fox Chase Cancer Center: "It is quite clear there is a massive reassessment (regarding cancer centers) going on at the same time as a massive crunch. We have enthusiastically endorsed the national program, and have enthusiastically outspent ourselves. We must have some kind of new, clear accountability, to counter a widespread attack and the negative attitude toward funding that others sometimes feel we have access to". . . . JONATHAN RHOADS, chairman of the National Cancer Advisory Board, commenting on his appearance at the meeting of virology program contractors: "I told them this was the first \$99 million dinner I had ever attended. They said that that wasn't enough (the entire NCI budget for virology is \$99 million; the contractors' portion of that, funded through the Div. of Cancer Cause & Prevention, is about \$44 million). They feel that center directors are pushing NCI too much in their (the centers') direction". . . . INTERNATIONAL CANCER Research Data Bank update: "Cancerlit," the program in which three CIDACs screen 2,000 journals for cancer related reports, now has compiled over 100,000 abstracts, will add about 30,000 a year. These form the basis for material in "Cancergrams" (*The Cancer Letter*, Dec. 2). "Cancerproj" has collected abstracts on 16,000 ongoing research projects, 3,000 of them outside the U.S. This is updated monthly. "Clinprot" has 1,100 detailed summaries of clinical research protocols which may be retrieved from the computer by type of agent or therapy used or by type of tumor. Cancerproj and Clinprot are available through terminals at the 500 Medline centers in the U.S. They are also available through terminals in Australia, Brazil, Canada, France, Germany, Iran, Japan, Mexico, South Africa, Sweden, the United Kingdom and those operated by the World Health Organization. "WHO is phasing out theirs for reasons unknown or un-understandable," commented Gregory O'Connor, director of NCI's Office of International Affairs. "That will make it difficult to get these out to the developing countries." O'Connor pointed out that ICRDB publications are not copyrighted and there are no restrictions on duplicating them.

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CONSORTIA VULNERABLE TO FEDERAL FUND VAGARIES, SAY THEY ARE MORE STABLE

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proceeds to a conclusion and the reviewers find that many do not meet the National Cancer Advisory Board's requirements in that respect.

There also exists a great variance among the centers in the extent, scope and quality of their regional outreach activities, another "characteristic" demanded of comprehensive centers by the NCAB. Some non-comprehensive centers, in fact, have stronger regional programs than several of the officially "recognized" comprehensive centers.

Finally, NCI staff members and their advisors can't quite figure out what to do about that breed of comprehensive centers which they first allowed in with considerable reluctance—the consortia.

Two of the 20 comprehensive centers are consortium cancer centers—the Colorado Regional Cancer Center and the Illinois Cancer Council. The Colorado center includes the Univ. of Colorado, Colorado State Univ. and Childrens' Hospital of Denver. The Illinois organization includes the Univ. of Chicago, Northwestern Univ. and Rush-Presbyterian-St. Luke's Hospital. Counting the community hospitals, teaching hospitals, universities, government agencies and voluntary organizations, the Colorado center has 35 participating organizations.

The Colorado and Illinois centers are autonomous organizations, corporate entities created by the participating institutions. They consider their mission primarily one of coordination, rather than actual performance, of cancer research and treatment in existing health care facilities throughout their respective regions.

At least two other consortium type organizations are in operation; one—Missouri Cancer Programs—has signified its intention of seeking comprehensive recognition. The other—the Northern California Cancer Program—may do so at some future date.

NCI review groups have been skeptical about the consortium concept—so much so that executives of some of the consortium centers feel their grants may be in jeopardy because the reviewers and NCI staff cannot accept them as bona fide centers, as capable of doing their job as the more traditional cancer centers.

Steven Silverberg, executive director of the Colorado center, developed a statement on the rationale and functioning of consortium cancer centers, with the assistance of Jan Steiner, director designate of the Illinois center, and Stephen Carter, director of the Northern California Cancer Program. That statement, edited somewhat to conserve space, follows:

By means of community outreach activities, comprehensive cancer centers are to provide coordination and leadership within their geographic regions to

assure the availability of complete care for patients with cancer. They are responsible for coordinating multiple sources of support for educational, clinical and research activities to produce a broad attack upon the complex problems of prevention, detection, diagnosis, treatment and rehabilitation.

The vast majority of these centers are either university based or freestanding institutions. Centers with these types of organization fulfill their mission of research and treatment within their own institutional confines as a result of their recognized expertise in the region served.

However, not all regions are similar in needs, expertise and facilities. As a result, a new model of a cancer center has emerged in Colorado, Illinois and Northern California. . . . Acting as autonomous organizations, they coordinate the cancer research, treatment and demonstration activities in existing health care institutions throughout their respective regions. Their mission is not executed at a single institution of expertise as the other models of cancer centers. It is fulfilled through the coordination of activities at numerous community-based institutions throughout their regions.

The purpose of this document is to communicate the rationale and functioning of consortium cancer centers. It is a concept which poses problems to many, either in terms of comprehension or acceptance, yet has benefits which are practical, effective and coincide with the congressional intent of the National Cancer Act.

The National Cancer Advisory Board developed a set of criteria for the establishment, recognition and support of centers. These NCAB characteristics suggest that centers are cooperative and coordinated groups of researchers, educators and clinicians in an interactive setting with management responsibilities vis-a-vis a medical school.

The NCAB characteristics envision a mission-oriented unit geared to implementing the goals of the National Cancer Program within the following broad guidelines:

1. That it be organized within a recognizable institutional framework.
2. That it carry out its programs in conformity with a predetermined plan.
3. That it be geared to multidisciplinary problem solving.
4. That it be adaptable to the changing needs of the ambient community and the scientific community.
5. That it strive for excellence, efficiency and effectiveness in all of its program areas.

Throughout the documentation of the NCAB characteristics there is a clear assumption that the comprehensive cancer center operates within an academic medical center or freestanding medical institution as a quasi-independent or independent unit.

During the past few years, the three consortium

centers have emerged. They are substantially different from the prescribed pattern implicit in the NCAB characteristics and the NCI support grant program in that their primary mission is centered around integrating functions in a given region. These consortium or regional cancer centers do not have as their primary characteristic the conduct of research, education and patient care, but rather the planning and coordination of these activities in their geographic region.

Since neither the characteristic nor the support programs are congruent with this concept, it follows that the peer review process tends to run into difficulty when such centers apply for support or designation as comprehensive cancer centers.

Consortium cancer centers are freestanding operating units which plan, coordinate and manage long-term multi-institutional, multidisciplinary programs. They strive to fulfill the NCAB characteristics as follows:

1. The center conducts the planning and coordination of basic and clinical research, training and demonstration of advanced diagnostic and treatment methods relating to cancer in its participating institutions.
2. The center, through its participating institutions, strives to achieve quality interdisciplinary capability in the performance of diagnosis and treatment of malignant diseases.
3. The center fosters, in its participating institutions, an environment of excellence in basic science geared to ensure the highest quality of basic research.
4. The center organizes, through its participating institutions, joint detection programs and research in relation to this activity.
5. The center maintains a standardized statistical base for evaluation of program results of all of its participating institutions, thus resulting in a broad data base for its region.
6. The center provides to its participating institutions leadership in developing community programs involving active participation by health professionals within the region served by the center.
7. The center seeks to achieve a strong fundamental and applied research base and related training programs in its participating institutions and aspires to coordinate these activities with other facets of the programs of the participating institutions.
8. The center participates in the National Cancer Program by integrating the efforts of its participating institutions with the activities of other centers in an integrated nationwide system for the prevention, diagnosis and treatment of cancer.
9. The center is autonomous in relation to its participating institutions and seeks through its administrative structure to assure maximum efficiency and sound financial practices in its various operations. The administration of the center includes the responsibility for providing assistance with planning

and developing, monitoring and execution of joint programs in the participating institutions. The center administers and manages the core facility (headquarters) staff and has authority to establish the necessary administrative and management procedures for carrying out its total responsibility as defined in the criteria.

10. Through the commitment of existing facilities at its participating institutions, the center has an appropriate number of cancer beds for interdisciplinary clinical research and treatment of inpatients, giving the program cohesion and identification.

11. The center utilizes its network of participants to assure the transfer of the latest technology in research results and demonstration activities to practitioners throughout the region.

12. The center develops appropriate liaisons with other agencies within its region (national, state and private, such as regional HEW, state departments of health and American Cancer Society) which are geared to identical or related goals for the purpose of assisting in the integration of coordination of these activities for the ultimate benefit of the cancer patients in the region.

The characteristics which distinguish the consortium cancer centers from other center models are the following:

1. Regionalization. The primary emphasis upon planning and coordination of activities in participating institutions within the relevant region distinguishes the consortium cancer center from the other types in that it itself does not conduct any of these activities unless they are not available in participating institutions or are more efficiently and effectively coordinated by the center. The consortium center usually does not directly engage in research or patient care activity, although it may act as an applicant for support of such activities on behalf of its consortium partners.
2. Autonomy. The consortium cancer center, as an autonomous organization within a region, is capable of acting as "neutral ground" in facilitating and implementing cooperation among its participating partners and providing a bridge between town and gown. It can give leadership to and bring together in effective interaction diverse academic and community-based units without impinging upon their respective individual goals or organizational and management structures.
3. Cost effectiveness. The consortium center can achieve greater effectiveness in utilization of its core support by virtue of the larger institutional forum which it serves. Duplication of headquarter staff services to the participating institutions can be avoided. Undue duplication of facilities and resources in the region can be similarly avoided or pre-existing duplication can be eliminated through recognition of institutional interdependence. These strategies are designed to achieve a more cost effective and eco-

conomic implementation of the National Cancer Program within the center's geographic area.

4. Relationship to regional agencies. The National Health Planning & Resources Development Act provides for creation of a network of state and area Health Planning Agencies. These agencies (HSAs and SHPAs) have as their fundamental mission an increase in the accessibility, acceptability, continuity and quality of health services, the restraining of increases in the cost of care and the prevention of unnecessary duplication of health resources. These goals are congruent with those of the consortium cancer centers which can readily relate to and accept surrogate roles as categorical disease planning agencies. The consortium centers act in this respect as a bridge between the two programs in the cancer field and may indeed constitute models for interactive ventures in this program.

Because consortium centers represent an unusual, supra-institutional and autonomous organizational entity, they are particularly vulnerable to the vagaries of federal funding. However, due to their unique composition, financial stability can and is being sought through different avenues. Financial contributions and in-kind services are being provided by participants in the consortium. Support from industry and private foundations is proving encouraging, as they seem enthused by this type of arrangement.

COMMUNICATIONS, SERVICE—DONE WELL, A REGIONAL PROGRAM WILL SUCCEED: MAYO

While regional activities might be the forte of consortium centers, the free standing and university-based centers are expected to conduct similar programs, in the regions they are supposed to serve. Some do, very effectively, and one of those is the Mayo Clinic.

Charles Moertel, director of the Mayo Comprehensive Cancer Center, discussed his regional efforts recently with other center directors. An outspoken critic on occasion of some of NCI's policies, Moertel opened by commenting, "I am rather surprised to find myself on this panel. Judging by past evaluations of our regional programs by the DCCR (Div. of Cancer Control & Rehabilitation) I should really be down there listening instead of up here talking. We have been severely criticized for failing to have an organized planning effort based on demographic, epidemiologic, and statistical data, and for not developing coordination strategy and evaluation protocols for assessments of programs—whatever all that means. We have also been criticized for not descending upon our region with mass cancer screening, and particularly we were characterized as presenting our cancer control program like a Sears Roebuck catalogue.

"Clearly us guys out in the Midwest cornfields have no comprehension of the sophisticated nuances

of modern cancer control. So I guess mine is to be a presentation of the brand X regional program, not to be emulated if one has ambitions for lush cancer control funding."

The Mayo Clinic is located in southeastern Minnesota. The closest major medical centers are the Univ. of Minnesota, 90 miles to the north, the Univ. of Wisconsin—200 miles to the east, and the Univ. of Iowa, 200 miles south. To the west there are no large cities or university medical centers between Mayo and the Rocky Mountains.

"By virtue of these demographic factors the Mayo Clinic is, in fact, a regional medical center for a very large area of this country," Moertel said. "In spite of our location in the middle of the cornfields, each year we see in excess of one quarter million patients. Among these will be over 20,000 total cancer patients—some 8,000 new cancer patients. In largest measure these patients are drawn from our immediate region—70% of our patients come from Minnesota and the immediately adjacent states.

"The maintenance and continual increase of a practice of this magnitude from our relatively isolated location does not occur by accident. It requires meticulous day by day effort to maintain the best possible relationships with the people and the physicians of our region. We've long ago learned that the essences of successful regional relationships are communications and service. With these jobs well done a regional program will inevitably succeed. Without these ingredients, you can have all the fancy planning and highfalutin organizational structures, but your program will inevitably be a failure.

"With these considerations in mind we divided our regional cancer control programs into three separate but interrelating endeavors. The first—communications and service within our own institution; the second—communications and service for the people of our region; and the third—communications and service for the physicians of our region. All of these programs are coordinated by Dr. David Carr, who is associate director of our cancer center. Dr. Carr has had extensive background and several decades of experience in control programs. . . .

"First, the programs within our institution. At the Mayo Clinic at any one time we have over 1,000 physicians, as well as over 5,000 paramedical personnel. These in turn make contact with many hundreds of thousands of regional patients and patient family members each year. By simply moving within our own walls we can have one of the largest cancer control programs in this country in terms of physician and patient contacts. So members of our cancer center are involved on a day by day basis with the educational, research and practice activities of the medical and surgical departments within our institution. We're available for their grand rounds, their conferences, their seminars. Cancer informational material is regularly distributed to all of our staff and

we make frequent presentations of the activity of our cancer center at general staff meetings. We also have regular cancer educational sessions for the paramedical personnel within our cancer center—secretaries, nurses, desk attendants. Every female employee of the Mayo Clinic, for example, has been formally instructed in breast self examination with the urging that she in turn spread the word to her family members, friends, and neighbors.”

Moertel mentioned the Mayo medical museum. “I don’t know how this little place ever got so popular. Farm families drive in on weekends. School buses come from all over our region loaded with kids and their teachers. Over one hundred thousand visitors each year. We’ve saturated this museum with cancer exhibits and cancer educational material. In short, the Mayo Clinic has for many years been a proven successful vehicle for delivery of regional medical care and we’ve felt that the best road to a successful regional cancer program is to get our whole organization into the act.

“Communication and service to the people in our region. How do we best accomplish this? Obviously this can’t be done on a one on one basis—you have to rely on mass communication media. This, however, becomes a very delicate operation. Regardless of how good your intentions might be, any use of the mass media by a single medical institution is quickly construed by the medical community at large as advertising. You very soon have a hostile medical community on your hands. Right then your whole regional program goes down the drain. On the other hand, if you are willing to conduct a public communications program with anonymity you’ll find you have an awful lot of good people who are anxious to help you. We don’t issue press releases from our cancer center or from our institution and you’ll have a very hard time identifying us at all with our public communications efforts. Much of these are carried out through the Minnesota Cancer Council. This was established and organized by Dr. Carr to represent the whole medical community within our state, and we only have a small bottom line representation.

“When the Mayo Comprehensive Cancer Center accepted a contract to provide a Watts Line cancer information service, we did this through the vehicle of the Minnesota Cancer Council and our program got off the ground immediately. The American Cancer Society didn’t get mad at us, the state medical association didn’t get mad at us—they were helping us. In this setting, we were able to carry out a major promotion campaign utilizing all of the major media—television, radio, newspapers, the back of department store buildings, full page ads in Playboy and all other major periodicals distributed in our region. All of this associated with a dramatic upswing in calls to our service.

“When we distribute cancer information to the

health professionals in our region, it’s not as the Mayo Comprehensive Cancer Center Bulletin—it’s as the Cancer Newslite published by the Minnesota Cancer Council.

“How else do we communicate with the public? We make ourselves available whenever there is an appropriate opportunity to make contact with a lot of people. This year we accepted invitations to speak, for example, at the convention of the ladies auxiliary of the Veterans of Foreign Wars, and the Fraternal Order of Eagles. It sounds sort of silly, but there were over 2,500 auxiliary ladies in that audience—there were over 4,000 Eagles. A regional cancer telethon—we were asked to help—so six of our staff each gave short cancer educational presentations that were played repeatedly over a 24 hour period to a viewing audience totalling over 50,000.

“In 1974 Dr. Carr developed the idea of a question and answer column for publication in regional newspapers. It was built around the Ann Landers format—all reader questions are answered by personal letter and the most interesting questions are chosen for a published reply. This was started in our Rochester paper with a circulation of 35,000. An evaluation showed the public reception to be excellent. With this in our pocket we began soliciting other regional newspapers. We only did this, however, when we achieved the sponsorship of the local medical society and the local chapter of ACS. How have we done so far?” Moertel showed slides depicting the dozens of newspapers now using the column, with circulation of more than 400,000.

“Perhaps more important than cancer communication with the public at large is communication with the individual patient who has cancer and with his family members. Frequently the only real information they get is a short discussion by a busy doctor under circumstances that are too emotionally charged to permit any retention. They could write to NCI and get a three-four page pamphlet, but here’s a situation where their life is at stake and they would get more information than that if they went out and bought an egg beater.”

Mayo, using young professional writers working physicians, produced a book for children with leukemia, and their parents. “We’ve already received requests for more copies of this book than there are children in this country with leukemia, some 14,000 to date.” Other books followed—one for the laryngectomized patient, another for the colon cancer patient who requires total colectomy and an ileal pouch, still another for the lung cancer patient. In planning is a book for children with solid tumors.

“We feel this has been a very productive program for our patients, for patients in our region, and indeed for patients the country over,” Moertel said. “It’s been a program conducted at remarkably low cost. Predictably it’s a program which we will have to curtail because of no funds. I guess there isn’t

enough money for this plus the massive mammo-
graphy programs as well.

"And you will notice I have not said anything about regional cancer screening programs—nor will I. We are very active in scientific evaluation of cancer screening methods by randomized controlled studies and we are very active in programs to develop truly cost effective means of cancer screening, but this is all done in a research setting. To take our current expensive and grossly inadequate screening methods and descend upon the general population with them in programs whose impact can never be adequately evaluated—we feel this is an unconscionable waste of public funds to which we will not be a party."

Moertel described Mayo's programs to communicate with an to serve the physicians in its region. "I feel that our best means of communication involves the individual patient, and as a part of our cancer center program we do the best to make such communication very easy and very meaningful for the regional physician. The Mayo Clinic phone number is a constantly open hot line for cancer communication. If a patient comes to us for care, summary letters are on their way to his local physician before the patient is dismissed from our care and this a personal letter, not an illegible xerox of a medical record. Sure, all of this is a nuisance but if you are going to be truly successful in meeting the needs of your region, we feel these items demand the highest priority.

"We don't go out to tumor boards or tumor clinics in our region—the distances are too great and we don't feel this would be a cost effective use of our cancer center personnel. We do, however, send out journeyman pathologists and diagnostic radiologists. This is cost-effective because they can deal with a large amount of patient material in a short time. They also provide the first guidepost to physicians as to how cancer patients could best be managed."

Moertel described Mayo's regional physician education programs—arrangements with hospitals for regular education programs; cancer center staff participation in regional meetings of county and state medical societies, dental and nursing associations, ACS programs, and many others.

Another effort is a three day program, geared to the practicing physician, known as Clinical Reviews, with cancer heavily represented. Clinical Reviews enroll about 1,700 per month. "Because many of these physicians expressed a special interest in the cancer presentations last year we initiated Cancer Reviews. We had 200 registrants, excellent evaluations. We're expecting twice as many next year." Special educational conferences are held for regional physicians and regional paramedical personnel—laryngectomy, ostomy, refresher courses for cytotechnologists. "We've inserted cancer programs into our annual dental reviews—we invade everything in sight. We've also used two Mayo Clinic publications for cancer education. The Mayo Clinic Proceedings—our month-

ly journal with circulation of 69,000, the Mayo Alumnus, circulation of 8,000. One whole issue devoted to cancer.

"Our greatest effort in regional programs over the past two years has been the development of the North Central Cancer Treatment Group." Moertel had slides showing distribution of cancer centers and national cooperative groups around the country, but none in the North Central area.

"One alternative would be to teach all the practitioners in the region how to deliver the best standard cancer care. We immediately rejected that because as far as we're concerned for most tumor types the best standard cancer care is a lot of garbage. You just have to look at our end result statistics to see that. Most cancer patients want at least the hope of something better than what standard cancer treatment has to offer today." Moertel insisted that "the best overall cancer care is given to a patient entered on a well designed and conducted clinical research program.

"Another alternative was to try to get patients in this region entered on protocols through satellite relationships with a major cooperative group. For the common tumor types, we also rejected this plan—there are thousands of patients out there with breast cancer, gastrointestinal cancer, lung cancer, and it would be absurd to suddenly flood some national cooperative group with this mass of entries. The national groups are already glutted with such patients exceeding their protocol requirements, and drowning their statistical centers with unneeded data.

"We therefore elected to begin a new type of cooperative group that would, in a research setting, carry out phase III clinical trials on a community level. It would also meet many other cancer control objectives for this large region." Group members are located in clinics throughout the region. "There are well trained oncologists, therapeutic radiologists, as well as all the other accoutrements for high quality multidisciplinary practice. . . . We have assisted these groups by bringing their cancer data handlers and oncology nurses to us for training. Our radiation therapists have gone out to them to assist in upgrading their radiation therapy facilities. It has been arranged for the group members to participate in Eastern Cooperative Oncology Group protocols for the less common oncologic problems where their contribution would be of value to ECOG. For the more common tumor types the group will carry on its own protocols for all stages of disease from surgical adjuvant through terminal care.

"We join with the group members in designing their protocols, we provide them with an operations office, and a statistical center. Through an arrangement with the Div. of Cancer Treatment we supply them with appropriate investigational drugs, and we monitor the use of these investigational drugs for DCT. We provide them with cancer educational material and each group meeting is in essence a profes-

sional educational meeting as well. We've found the members of this group anxious to carry out truly meaningful clinical research studies. They wish to randomize trials, and they are not afraid of untreated controls where the situation justifies. They are anxious to have rigid quality control of their data and they don't have preconceived hang ups that require compromise of best scientific method in clinical research.

"We are thoroughly convinced that not only will this group enhance the quality of cancer care in the North Central region but it will also produce high quality medical research. The average total cost per patient entry is less than 10% of the average cost per patient entry in a national cooperative group. We feel the North Central Cancer Treatment Group corrects a glaring deficit in the National Cancer Program and we feel it represents the first small ripple in a very large wave of the future.

"This is just a capsule summary of the Mayo cancer control programs. . . . We will continue without apology to offer our programs from the pages of a Sears Roebuck catalogue, being opportunistic and meeting the needs of our region as they appear and as we are capable of meeting them," Moertel concluded. "I should point out that over the past century the readership of the Sears Roebuck catalog in this country has been exceeded only by the Holy Bible."

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-87026

Title: *Acquisition of chemical and drug samples*

Deadline: *Dec. 20*

Sources, not affiliated with chemical or pharmaceutical organizations, to provide support services related to the: -1) acquisition of chemical and drug samples from various sources for experimental testing as potential antitumor agents, 2) preparation of chemical and structural data for entry into an automated chemical information system, 3) control of samples pending the registration of compounds by the computer and disposition of samples, 4) generation of data for suppliers and managements, and 5)

management of documents related to compound submissions and acquisition.

Support services will require combination of technical and managerial skills to:

1) Establish new sources of materials, and maintain effective liaison with existing and potential new suppliers from industry, government, and other non-industrial organizations with the objective of acquiring a minimum of approximately 10,000 samples of chemical and drugs per year from the collection effort.

2) Perform on-site collection of samples, including the preparation of data sheets containing the chemical structure, molecular formulas and other data related to the samples collected.

3) Receive up to 10,000 samples per year (with associated data sheets) submitted to the Drug Synthesis & Chemistry Branch of the Div. of Cancer Treatment from domestic and foreign suppliers, and prepare related data processing entry forms.

4) Store the samples in freezers or refrigerators, as required, pending the processing of data and disposition of samples.

5) Correlate various outputs of the data processing system with samples in temporary storage.

6) Assure the completeness of documentation required to accompany samples and transfer these documents and samples to the storage and distribution contractor.

7) Prepare cover letters reporting data to suppliers.

8) Forward operation and management reports to DSCB.

9) Manage compound related documents, and

10) Provide support in the development, refinement and implementation of compound selection criteria. Under the general direction of the government project officer and in cooperation with other members of the Developmental Therapeutics Program staff, the contractor will examine and select from potential sources compounds with the most promise for biomedical activity. Selected compounds are procured through correspondence with and/or by the collection team.

The project will require daily person-to-person interaction between DSCB staff and the contractor. To facilitate this interaction the contract facility must be located within the Greater Washington, D.C. Metropolitan Area, and the contractor must provide transportation for samples and compound-related documents and for contractor staff between the locations. Award of a contract will not be made to organizations which are engaged in research that is in conflict with the research efforts of any supplier that has submitted chemicals and drugs to NCI. Requests from organizations engaged solely in the manufacture and/or sale of chemicals will not be honored.

John Palmieri
Contracting Officer: Cancer Treatment
301-427-8125

RFP NCI-CM-87190

Title: *Development of plant tissue and cell culture fermentations as a source for antineoplastic agents*

Deadline: Feb. 15

Determine the feasibility of plant and cell fermentations and tissue culture as a source for antineoplastic agents. The contractor must provide and operate a plant cell fermentation, chemical isolation laboratory with scale-up fermentation capacity.

It is planned that one contract will be awarded for a three year period of performance. To be considered for such a contract, candidates must show experience in plant cell tissue culture, fermentation (shake flask, stir jar) as well as expertise in plant cell maintenance and selection, fermentation optimization, chemical natural products isolation, and purification of plant cell derived materials.

It is anticipated that the level of effort required during the period of contract performance will consist of a three man year effort for year 1 and 2 and a five man effort for year 3.

RFP NCI-CM-87186

Title: *Biochemical and molecular biological characterization of antitumor drugs*

Deadline: Jan. 20

The Div. of Cancer Treatment is seeking investigators who will identify or provide clear leads to the biologically significant biochemical properties of new antitumor drugs, and will evaluate whether these antitumor drugs have biochemical mechanisms of action similar to those of clinically established antitumor drugs. The purpose of the work is to channel research efforts along the lines which will provide the NCI program with information needed to establish priorities for the development of new drugs for clinical trial and for the more effective use of clinically established drugs.

RFP NCI-CM-87180

Title: *Synthesis of natural products and their analogs as potential anticancer agents*

Deadline: Jan. 20

The Drug Synthesis & Chemistry Branch of NCI is seeking organizations having capabilities, resources and facilities for the synthesis of unique compounds of interest to the program as potential anticancer agents. The objective of this project is to design and develop methods for the synthesis of natural products and their analogs. Samples, greater than

one gram, fully characterized, will be prepared and submitted to the NCI for antitumor evaluation.

It is anticipated that one contract of approximately four technical man years per year will be awarded for a period of three years. The principal investigator should be trained in a branch of chemistry at the PhD level, from accredited schools and must be experienced in the synthesis of a variety of complex chemical structures. He must be named and available to the project for a minimum of 60% of his time. Except for the biologist (approximately 520 man hours), all other technical supporting personnel are required to be trained chemists. They must devote at least 50% and preferably 100% of their time to the project. Laboratories must be equipped with modern facilities for synthesis, analysis and preliminary testing (in vitro) of compounds. Library resources must be adequate.

Contracting Officer

for above three RFPs: John Palmieri
Cancer Treatment
301-427-8125

RFP CANCELLATION

RFP NCI-CM-87181 has been cancelled. Due to budgetary constraints the Div. of Cancer Treatment made a programmatic decision to cancel the above RFP entitled "Synthesis of Nucleosides as Potential Anticancer Agents."

CONTRACT AWARDS

Title: Selection and propagation of somatic cells having specific physiological mutations

Contractor: Univ. of California (San Francisco), \$250,191.

Title: Maintain animal holding facility and provide attendant research services

Contractor: Cor Bel Laboratories Inc., Rockville, Md., \$176,934.

Title: Cancer Immunotherapy: Animal models for treatment of minimal residual systemic tumor

Contractor: Pennsylvania State Univ., \$151,373.

Title: Breast Cancer Detection Demonstration Project, renewals

Contractors: St. Joseph Hospital, Houston, \$359,000; Dule Univ., \$287,177; and College of Medicine & Dentistry of New Jersey, \$310,000.

Title: Support services for the Div. of Cancer Research Resources & Centers

Contractor: Capital Systems Group Inc., \$709,670.

The Cancer Letter —Editor JERRY D. BOYD

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