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P.O. BOX 2370 RESTON, VIRGINIA TELEPHONE 703-620-4646

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NCAB MEMBERS SKEPTICAL ON NCI REORGANIZATION; KING HAS "ALTERNATIVE;" TERRY TO HEAD CENTERS

Director Arthur Upton's reorganization plan that would move grant awarding authority to NCI's program divisions ran into stiff opposition from members of the National Cancer Advisory Board this week. And

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In Brief

RHOADS, SCHMIDT BOW OUT — AMOS, KRIM POSSIBLE REPLACEMENTS; SIBAL ACTING VIROLOGY DIRECTOR

JONATHAN RHOADS and Benno Schmidt, two of the most influential and powerful figures in the movement that led to adoption of the National Cancer Act of 1971 and in the subsequent implementation of the National Cancer Program, presided for the last time this week in their respective capacities as chairman of the National Cancer Advisory Board and chairman of the President's Cancer Panel. The second three year terms of both expired with this week's NCAB meeting; neither is likely to be reappointed by President Carter, and neither wants reappointment, although they probably would accept if offered. Rhoads, professor of surgery at the Univ. of Pennsylvania and former president of the American Cancer Society, provided a gentle but firm brand of leadership that usually managed to bring Board members with disparate interests into agreement on frequently controversial issues. Schmidt was extremely effective as Panel chairman, especially when he had a President who listened to him. A mortgage banker, his grasp of scientific issues always amazes scientists, and he is the best spokesman before congressional committees that the Cancer Program has. . . . ARTHUR KRIM, chief executive officer of United Artists and former treasurer of the Democratic National Committee, may be the new chairman of the President's Cancer Panel. Krim's wife, Mathilde, is a scientist at Sloan-Kettering Institute. Best guess as the new NCAB chairman: Harvard microbiologist Harold Amos, long time member of the Board. Others whose Board terms have expired are Frank Dixon, director of the Scripps Clinic & Research Foundation; Laurance Rockefeller, banker and chairman of the Memorial Sloan-Kettering board; David Hogness, professor of biochemistry at Stanford; Morris Schrier, vice president of MCA Inc.; and Gerald Wogan, professor of toxicology at MIT. Dixon and Rockefeller served six years; the others filled unexpired terms left vacant by resignation. Wogan and Hogness are likely to be reappointed. . . . LOUIS SIBAL has been named acting director of the Viral Oncology Program. He was John Moloney's deputy, will hold down the job at least until a new director is named for the Div. of Cancer Cause & Prevention. . . . ANNUAL MEETING of the Assn. of Community Cancer Centers this weekend (Jan. 27-29) is to be held at the Twin Bridges Marriott Hotel In Washington, not the Key Bridge Marriott where it has previously been held.

MARKS, POWERS FEEL REORGANIZATION WILL MEAN MORE PROGRAMMED RESEARCH

(Continued from page 1)

Thomas King, whose Div. of Cancer Research Resources & Centers would lose its science programs to the divisions, told the Board he had submitted "an alternative plan" to Upton "which would accomplish essentially the same things."

King cracked, "I was fortunate to get the last ticket on the Titanic."

Upton confirmed that he definitely was moving the Cancer Centers Program from DCRRC to his office, and that William Terry would head it.

Paul Marks, member of the President's Cancer Panel, said, "This looks like a move toward more, not less, programmed research, without question. There is grave concern in the scientific community. For the short term, no one questions your intent and that you will provide sufficient safeguards. But for the longer term, the feeling is that the basic constituency needed for a healthy R01 (traditional research grants) program will be eroded."

"I don't view it as programming in the grants area," Upton answered. "The objective is to fund each program area adequately to support high quality grants. . . . Grants will come first. It will be around grants that contracts will be mounted."

"I don't see how you're going to achieve this if, for example, there is a perceived need for something and grants are not providing it without subtle stimulation. It will be like CREGs (Cancer Research Emphasis Grants)," Marks said.

"An important provision of the reorganization is that DCRRC will assume responsibility for all review," Upton said. "Program managers will have to develop complementary contract programs." He said that other NIH institute directors whose organization is similar to the one he is proposing feel it has worked well for them.

"If the current philosophy of division directors continues, then I would agree with Dr. Marks," commented Board member Harold Amos. "The division directors favor contracts because they have specific goals. Grants and contracts have two different standards. You can't compare the quality (of grant and contract proposals). The specificity of the RFP (in contracts) rules that out."

"Not if the same people are looking at both. A general assessment of quality ought to be possible," said Panel Chairman Benno Schmidt.

Board Chairman Jonathan Rhoads asked, "Will the program director separate a list of approved grant requests into several categories and then draw the line on how far down he'll go in funding them, or will he consider them as one batch?"

Rhoads offered as a hypothetical situation the prospect that the Div. of Cancer Treatment might receive far more good applications than required for clinical studies of 5-FU, while at the same time getting relatively few for studying bleomycin. "Would you draw the (priority score) line at 300 on bleomycin and 150 on 5-FU? If so, you would have influenced the award."

"The people making those decisions now will continue to make them," Upton said. However, he admitted, "We may be heading further into (the reorganization) than we can go," until more details in implementing it are worked out.

"I don't see how you get around a lot of program control by the division directors," commented Board member David Hogness.

Board member William Shingleton said that a number of investigators now supported by contract have been asking if they should prepare to abandon those contracts and seek grant support.

"I think that depends on the type of contract," Upton said. "There may be some instances where it doesn't make any difference. In others, they may be better off with grants. The divisions have used contracts to support research because grants were not available to them."

Upton insisted, "There won't be a drastic change. It would be a disaster if this were done disruptively."

"If the basic science community thinks there is in somebody's mind a program and that their success or failure (to get a grant) depends on how well they respond to what they think is in that person's mind, then you've got a problem," Schmidt said. "The beauty of investigator initiated research is that it is unfettered."

Leon Schwartz, NIH associate director for administration, was present to add his support for the reorganization. "Most of the institutes have found this movement from mechanism to program has worked well," Schwartz said. The experience has been that money has moved from contracts to grants.

Schwartz noted that NCI was different than the other institutes in that intramural program managers frequently also manage extramural programs. "We should watch that carefully and separate intramural scientists from extramural management," he said.

Schwartz seemed to indicate in that remark that this was the only concern NIH Director Donald Fredrickson had about the reorganization. However, King challenged him on that point, and Schwartz confirmed that this was his opinion and not necessarily Fredrickson's.

Schmidt asked for comments from the division directors. Gregory O'Conor, acting director of the Div. of Cancer Cause & Prevention, said there were some areas in which program leaders in the divisions did not know what was going on in those same areas in grant supported activities. The reorganization will facilitate coordination, he said. He predicted there would be a substantial move in DCCP from contracts to grants.

"What I heard you say is that DCCP will continue

with contracts because you can do what you want done. If that isn't program direction, I don't know what it is," Board member William Powers said.

"That's not what I said," O'Conor answered. "I said that a lot of what is now contract research would be grants."

"But if an investigator is told, here is an area for grants, that is programmed," Powers insisted.

DCT Director Vincent DeVita said, "As a rule of thumb, we (NCI staff) would like to see the institute operate as if we were out there. . . . There are three kinds of contracts. One includes those that should not have been anything, and I hope we are rid of them. One is to purchase supplies or services. The other is research. We (DCT) have only about $5 million in research contracts, and I hope they all will go to grants when they lapse." One exception, DeVita said, would be those that require the expertise in private industry, since commercial firms cannot receive grants.

"I share your concern about program direction," DeVita said, insisting that most NCI staff members were pleased with the reorganization.

Board member Denman Hammond pointed out that a similar type of reorganization took place when the Cooperative Group Program was transferred from DCRRC to DCT in 1975. "It remained grant supported, and developed close cooperation with Dr. DeVita," Hammond said. "That division has continued to award contracts to get some kinds of work done. Clearly, it is the opinion of some in the Cooperative Groups that those contracts competed with them. What was involved in the decision to continue with contracts to support clinical investigation?"

DeVita answered that phase I and II trials remain contract supported because of the specific requirements they entail, especially FDA regulations. "They are an extension of the Drug Development Program," which he indicated he considered mostly in the services and supplies category and would continue using contracts.

"The ones causing the most problems," DeVita said, "are the disease oriented contracts—ovarian and head and neck cancer, the GI tumor study group. I would see them recompeting as grants."

Hammond said that DeVita and the division "bent over backwards trying not to direct the Cooperative Groups; however, they still feel they are being directed."

DeVita admitted this feeling surfaced in the recent debate at a Cooperative Group chairmen's meeting (*The Cancer Letter,* Jan. 13) over NCI review of group protocols. "But if we don't review the protocols, we have no capacity to run drug development according to regulations," DeVita said.

Alan Rabson, director of the Div. of Cancer Biology & Diagnosis which has large contract efforts for the Immunology Program and the Breast Cancer Task Force, said, "I've always opposed programmed research. I spend a lot of time and effort seeing that it doesn't happen. . . . The part about the reorganization that appeals most to me is the transfer of review to DCRRC."

Diane Fink, director of the Div. of Cancer Control & Rehabilitation, pointed out her division has had grant authority for the past three years. "We started three years ago with zero dollars in grants, and now 30% of our budget goes to support grants," Fink said.

King then made his remark about "alternative plans," indicating that while he would support the reorganization, he opposed some aspects of it and was fighting to retain major influence over grants.

Upton avoided committing himself to any specifics in the reorganization, stating that he and his senior staff have "agreed in principle" that program development, management and budget ought to be separated from review and evaluation," and that funding mechanisms "ought to be complementary."

Schmidt said that reorganization along those lines "has been in the director's mind at least for six years. Dr. Rauscher from time to time would get right up to the threshold of this kind of action, then pull away for one reason or another. (Rauscher told *The Cancer Letter,* "I never felt the time was quite right for it.")

"During most of that time," Schmidt continued, "I confess that I was a foot dragger. That on balance, it was not desirable. I felt that the extramural grants program was among the most important, probably was the most important aspect of the National Cancer Program, if I had to pick one single aspect as most important. . . . I was always worried that the importance of that program might appear to be diminished if it was broken up among the other divisions.

"My second worry was that when the grants programs are administered by those who have their own substantial programs in contracts and intramural, it might be perceived as more central control of basic research. I shudder at the thought that any attempt might be made to improve the quality of basic research by having a central administrator or central committees try to determine what that research ought to be."

In the days of escalating budgets, it was possible to support an appropriate percentage of investigator initiated research and other desirable programs "and let extramural grants be in the division where everyone clearly knew they wouldn't be affected or influenced by the others. Now, going from the era of adequate funds to an era of inadequate funds, something had to give," Schmidt said. And it has been grant supported extramural research that has given. "Funding new R01 applications has been going down for three years, to 30% of those approved last year." Program project grants and center core grants also have suffered.

The crunch has brought Upton to the view that

reorganization was necessary to put more money into grants, Schmidt said. "I still worry that grant programs will move toward becoming a large CREG operation. If it has that effect, I would view it with great concern. Dr. Upton has said that he doesn't believe his division directors will permit that, and he will see to it that they don't."

No Board action was taken. Upton does not need the Board's approval for it, since it is an advisory body. He could in fact proceed even in the face of adamant Board opposition, although that is not likely.

CENTERS JOB PERMANENT, TERRY SAYS; IMMUNOBIOLOGY READY FOR GRANTS

William Terry said this week that he plans to remain as permanent director of the Cancer Centers Program although he will officially have the title "acting director" when he moves to his new job Feb. 1. The only reason "acting" is there is because the government requires it until the bureaucracy gets around to making it permanent.

Terry will continue to head the Immunology Program and the intramural Immunology Branch, in the Div. of Cancer Biology & Diagnosis. Terry has been chief of the branch since 1971 and has headed the Immunology Program, with its contract supported extramural research, since it was started in 1972.

The dual role can't go on indefinitely, and once the reorganization is on its way and it becomes clear what the size and scope of the Immunology Program will be, someone else will get the job or it possibly could be merged with some other program.

Terry received his MD and SUNY (Downstate) and got into immunology as a research fellow at the Univ. of California in 1961. He came to NCI in 1962 as a research associate, worked with Herbert Rapp and John Fahey, and eventually replaced Fahey as Immunology Branch chief.

The extramural Immunology Program has a budget this year of $16.4 million, following some cuts which resulted from Director Arthur Upton's decision to transfer $1.8 million in contract money to fund additional immunology grants. Last year, this same amount of money supported $2.88 million in immunobiology contracts, $3.69 million in immunodiagnosis, $5.54 million in immunotherapy, and $1.19 million in a new initiative, immunology of cause and prevention. That doesn't add up to $16.4 million—the balance went into support contracts, and that will continue to be funded by contract.

Terry said that immunobiology has progressed to the point where now most of the contract supported efforts could be converted to grants. Immunodiagnosis and immunotherapy, and the new area of cause and prevention, are still best handled through contracts, he feels.

Terry has been one of those NCI executives with direct responsibility for intramural research conducted by NCI scientists and an extramural program in the same field. This is the situation so often criticized by others, including Benno Schmidt (see preceding article).

"There is potential for abuse," Terry agreed. "But from the start, I tried to design a system to minimize the opportunity for abuse. The rules on how you operate contract programs vary, even within NCI." These include how one goes about generating RFPs and getting the proposals reviewed.

"Early on, we got outside advisers to help generate ideas for research, and the same people helped review the responses. We soon had a body of people fully knowledgeable about the program. We have a national, even international, program that is independent and not under the thumb of anyone at NCI."

Terry and his staff have worked closely with DCRRC, where Barbara Sanford, chief of the Cancer Biology Branch, has been program director for immunology. "We have always felt that our contracts should be complementary to grants," Terry said. "Where our advisers felt an area was soft in grants, was where we would generate an RFP. What goes out in RFPs depends on what is going on in grants, at NCI and elsewhere."

Immunology RFPs were broadly drawn to define an area "and let the investigator in effect then write a grant proposal. We had the best of both mechanisms," Terry said.

Why would an immunologist who has spent nearly his entire career as a scientist and program manager in his field take on the job of running NCI's Centers Program?

"Because Dr. Upton asked me to take it, is the basic reason," Terry said. "Since I think it is an important part of our effort and since he thought I could help the Centers Program and help NCI, I agreed to do it. The cancer centers are an important and major part of the National Cancer Program, and I intend to spend a lot of time and energy working on it."

Upton said the move of the Centers Program to his office was an interim step "until long range matters can be resolved. I don't think it will be permanent."

One possible home for the program: A new Div. of Resources.

CORE GRANT LIMIT FORMULA MUST WAIT ON COMPLETION OF CENTER PROFILES

DCRRC Director Thomas King told the National Cancer Advisory Board that his staff will not be able to develop a workable formula for limiting cancer center core grants until all 62 center "profiles" are in and analyzed.

The Board's Subcommittee on Centers had recommended a formula limit to replace the proposal for changing core grant guidelines to eliminate support

for staff investigators and restrict core payment for shared resources (*The Cancer Letter,* Jan. 6). The subcommittee asked King to have his staff suggest a formula or system of formulae that could be applied to all centers.

King said the staff had agreed there might be operational difficulties in trying to apply a formula. The subcommittee had suggested it be based on the amount of research support a center is getting.

"The amount of research in a center, or in the entire institution?" King asked. "The amount of funded research, or approved and funded? When would be the time of calculation–the time of application?"

Those are just a few of the problems to be resolved.

So far, 38 of the questionnaire "profiles" sent to all 62 centers with NCI core grants have been completed, returned and analyzed. In those 38, King said, funded projects total $180 million, and the funded core grants total $41 million–23%. That might indicate that a formula of about 25% might be workable.

However, that was the mean ratio, King pointed out. The range of core to funded research was 2% to 86%, obviously rendering a 25% formula inapplicable at both ends of the scale.

The Board agreed to King's request that no decision be made on whether to attempt to develop a formula until the rest of the profiles have been analyzed.

Chairman Jonathan Rhoads commented that a formula "might be quite an impetus for a center to enlarge its base by bringing in more grants to the center that are now outside the center (at the same institution). That might be good, within limits."

Upton reported that HEW Asst. Secretary for Health Julius Richmond has indicated interest in the proposal to establish about 200 "mini centers" around the country, primarily in community hospitals, to make available the best cancer care to a greater number of Americans. The proposal is that core grants, $200,000-$400,000 , be made to pay for core staff and equipment. Upton said that since this involved health care delivery more than research, it goes beyond NCI's scope and should include other elements. Richmond is forming a task force to work on the proposal.

Board member Denman Hammond pointed out that the American College of Surgeons Commission on Cancer has approved the cancer programs in about 750 hospitals. "Perhaps NCI should, through review, not designation, give some recognition to this accrediting program as another link in the National Cancer Program," Hammond said. "This is a subset of the nation's hospitals that is clearly apart from the others. One might question the need for 200 more cancer centers, when there are 750 hospitals, many with beds dedicated to cancer, that are offering quality care. The secretary should be made aware of this."

Deputy Director Guy Newell, who heads an interagency working group on laetrile, reported that the group had decided to proceed with a retrospective study, collecting data on cancer patients who have used the substance. NCI will collect the data, and FDA has accepted the review protocol under which a subsequent IND will be filed if a decision is made to undertake a clinical trial. FDA Commissioner Donald Kennedy has agreed that no action will be taken against any physician who furnishes information on his patients who have received laetrile.

With thousands of patients using laetrile, in most cases illegally, "we felt there was in fact a phase II clinical trial going on," Newell said. "We felt the least we could do was to capture that information."

Sen. Edward Kennedy had asked Newell to help defeat a measure in the Massachusetts legislature legalizing laetrile. "He said he would take it as a personal loss if the bill passed," Newell said. Newell and Donald Kennedy presented their views to members of the Massachusetts senate, and the bill was defeated by a 20-18 vote.

CARTER ASKS ONLY $878.8 MILLION FOR NCI IN FY 1979 BUDGET REQUEST

The Carter Administration, as predicted (*The Cancer Letter,* Dec. 16), gave only a token increase to NCI in its budget request for the 1979 fiscal year, asking $878.8 million. NCI is getting $867 million this year, and might receive another $5 million if Congress approves a supplemental appropriation to cover the cost of last fall's pay raises.

The $6 million (or $11 million, depending on the supplemental) increase actually represents a major cut in Cancer Program money when inflation is considered. More than $50 million would be required just to stay even.

President Carter thus differs little from his two immediate predecessors, in paying lip service to the Cancer Program while refusing to seek adequate funds to support it. Congress, which saved the program from the Nixon and Ford cuts, will have to bail it out again.

Once again NCI received the smallest percentage increase of any NIH institute, .7%, except for the Dental Institute's .5%. The request for all of NIH was an increase of only $42 million over the 1978 appropriation, to $2.884 billion.

CONFEREES RECOMMEND NO NEW BLADDER CANCER SCREENING PROGRAMS FOR NOW

The steering committee of the recent state of the art conference on bladder cancer screening has concluded, after reviewing reports presented at the conference, that since there is no evidence that increased

survival results from screening asymptomatic persons, there should be a moratorium on new screening programs for the disease until review and re-analysis of data from existing programs have been completed.

The three day conference covered a wide range of issues relating to the problem—patterns of occurrence of bladder cancer, epidemiological issues, identification of high risk groups, strategies for intervention, natural history and pathogenesis of the disease, current status of screening and diagnosis methods, intervention in relation to stage of disease, treatment modalities and future possibilities, and review of screening data from current programs.

Identification of high risk groups included reports on identification on the basis of exposure to carcinogens and their metabolic products; through epidemiologic techniques; on the basis of occupational hazards survey; and on occupational history.

The screening and diagnosis session included discussion of occupational history, the lesion/hematuria relationship, the lesion/cytology relationship, automated cytology, cystoscopy and biopsy and immunodiagnosis.

The steering committee's recommendations:

1. That data from ongoing programs of screening or surveillance for bladder cancer be re-examined, with the application of additional epidemiologic techniques, for the purpose of:

a. Increasing our knowledge of the natural history of bladder cancer.

b. Providing additional information on the relationship of bladder cancer screening to patient survival.

c. Providing a basis for planning a possible prospective field trial of screening individuals for bladder cancer.

2. That current screening/surveillance programs for bladder cancer be augmented as necessary and where possible to provide data on:

a. Histologic type, grade, stage and evidence of multicentricity of bladder tumors.

b. Age at time of exposure to known carcinogens and at time of detection, treatment and death.

c. Dates when exposure started, stopped or changed, with intensity of exposure during each time interval, if known.

d. Time of appearance of symptoms or signs, including micro- or macro-hematuria, which should bring patients to seek medical examination.

e. Time of appearance of positive urine cytology.

f. Types and times of treatment.

g. Appropriate followup information including evidence of recurrence or spread, new bladder neoplasms, additional treatment administered, and the quality and length of survival, with special attention to:

(1) Survival experience of those cases of papillary bladder cancer detected by cytological screening in the asymptomatic state.

(2) Survival experience of cases of papillary bladder cancer detected because urinary tract symptoms caused the patient to seek medical examination.

3. That current screening/surveillance programs standardize, document and improve the quality control aspects of data collection and screening procedures including:

a. Techniques for collecting, shipping and processing specimens.

b. Technique for cytologic evaluation.

c. Compliance of subjects with requirements of the program.

d. Quality control of cytology and pathology laboratories used.

e. Recording personal, demographic and epidemiologic data including exposure to carcinogens, where possible.

4. That NCI's Div. of Cancer Control & Rehabilitation work with other appropriate agencies to develop educational materials and programs, both for new instruction and continuing education for the following:

a. Groups at high risk for bladder cancer, including individuals over age 60, and workers who have been exposed to bladder carcinogens, regarding the need to consult a physician promptly on the appearance of urinary tract symptoms. Notification of such workers of their exposure would be a prerequisite to such an educational effort.

b. Family and industrial physicians to whom these individuals may come because of the development of urinary tract symptoms regarding the use and interpretation of urine cytology examinations and the indications for referral to a urologist.

c. Urologists regarding the appropriate use of urinary cytology in the clinical management of patients with bladder cancer.

d. Cytotechnologists and cytopathologists regarding appropriate methodology and quality control for urinary cytology.

e. Pathologists regarding the correlation of urinary cytology with pathological findings.

5. That there be a moratorium on the use of federal funds to support new screening programs for bladder cancer in asymptomatic individuals until the review and re-analysis of data from existing programs have been completed.

The medical value of urinary cytology in the diagnosis and followup of bladder cancer cases is not questioned. Any individual presenting with urinary tract symptoms should be considered for diagnostic urinary tract workup, including urinary cytology.

6. That the National Bladder Cancer Project and appropriate divisions of NCI be encouraged to intensify research on the detection and diagnosis of bladder cancer, including biological and immunological approaches, and on the proper treatment of non-invasive neoplasms of the bladder.

7. That, after review of current screening/sur-

veillance programs, consideration be given to the organization of a carefully controlled, prospective study of high risk groups for bladder cancer, comparing the results of detection by periodic screening of asymptomatic individuals with those of detection on the basis of urinary tract symptoms.

8. That NCI establish a mechanism or structure to assure the continuity of action in regard to these recommendations and to evaluate any new research developments which may prove ready for application in screening for bladder cancer. This structure should have access to the highest levels of expertise available in the many disciplines required.

9. That, since the secondary prevention of bladder cancer at present appears to be possible in a rather small percentage of patients, industry, labor and appropriate government agencies should be encouraged to devote increased effort to primary prevention by eliminating exposure to bladder carcinogens to the maximum feasible extent.

ADVISORY GROUP, OTHER CANCER MEETINGS FOR FEBRUARY, MARCH

Workshop on Cancer of the Uterus—Feb. 6-10, UICC Program on Experimental Oncology, Geneva.

Committee on Cancer Immunotherapy—Feb. 7-8, NIH Bldg 31 Room 9, 9 a.m.—6 p.m. both days, all open.

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

Cancer Control & Rehabilitation Advisory Committee— Feb. 9-10, NIH Bldg 31 Room 7, 9 a.m.—5 p.m. both days, all open.

Carcinogenesis Program Scientific Review Commitee— Feb. 9-10, Landow Room C418, open both days 8:30—9 a.m.

Hematologic Problems in the Cancer Patient— Feb. 9, Roswell Park continuing education in oncology, contact Claudia Lee.

Committee on Cancer Immunodiagnosis—Feb. 14, NIH Bldg 10 Room 4B14, open 1—1:30 p.m.

Developmental Therapeutics Committee—Feb. 14-15, Blair Room 110, open Feb. 14 9—9:45 a.m.

International Seminar on Hypopharyngeal Carcinoma—Feb. 15-17, Milan.

National Pancreatic Cancer Project Working Cadre—Feb. 17, LaSalle Bldg, New Orleans, open 8:30—9:30 a.m.

Combined Modality Committee— Feb. 21, Landow Room C418, open 8:30—9 a.m.

Clinical Cancer Education Committee—Feb. 22-23, NIH Bldg 1 Wilson Hall, open 8:30—9:30 a.m.

Second International Conference on Integrated Cancer Management— Feb. 22-25, Phoenix Carefree Inn & Resort, sponsored by Good Samaritan Hospital and ACS-Arizona Div.

Cancer Special Programs Advisory Committee— Feb. 23-24, NIH Bldg 31 Room 8, open 9—10:30 a.m.

12th Annual Symposium for Referring Physicians—Feb. 24-25, St. Jude Children's Hospital, Memphis.

Cancer Clinical Investigation Review Committee—Feb. 27-28, NIH Bldg 31 Room 6, open Feb. 27, 9 a.m.—5 p.m., Feb. 28, 2 p.m.—adjournment.

31st Symposium on Fundamental Cancer Research— Feb. 28-March 3, M.D. Anderson, Houston.

Tutorial on Management of the Patient with Early Cervical Neoplasia & Vaginal Adenosis—March 2-4, Chicago, International Academy of Cytology.

Committee on Cancer Immunotherapy—March 2, NIH Bldg 10 Room 4B09, open 1:15—1:45 p.m.

Cancer Control Prevention, Detection, Diagnosis & Pretreatment Review Committee— March 2-3, Blair Room 110, open 8:30 a.m.— adjournment March 2, 8:30 a.m.—noon March 3.

Combined Effects of Chemotherapy & Radiotherapy on Normal Tissue Tolerance— March 3-4, San Francisco Hyatt Regency, 13th annual San Francisco Cancer Symposium, sponsored by the West Coast Cancer Foundation.

New Leads in Cancer Therapeutics—March 3, Roswell Park continuing education in oncology.

Third International Symposium on Oncology—March 4-8, Tehran, National Cancer Society of Iran.

Antiviral Mechanisms in the Control of Neoplasia—March 5-11, Corfu, Greece.

17th National Conference on Detection & Treatment of Breast Cancer— March 6-9, San Francisco, sponsored by American College of Radiology and others.

Biometry & Epidemiology Review Committee—March 6-7, NIH Bldg 31 Room 4, open March 6, 7 p.m.—10:30 p.m.

Clearinghouse on Environmental Carcinogens Data Evaluation/Risk Assessment Subgroup—March 6-7, NIH Bldg 31 Room 6 on March 6, Room 7 on March 7, open 8:30 a.m.—5 p.m. both days.

Cancer Control Grant Review Committee—March 6-7, NIH Bldg 31 Room 8, open March 6, 8:30—9 a.m.

Clearinghouse Experimental Design Subgroup—March 7, NIH Bldg 31 Room 9, open 8:30 a.m.—5 p.m.

Clearinghouse Chemical Selection Subgroup—March 8, NIH Bldg 31 Room 6, open 8:30 a.m.—5 p.m.

Cancer of the Lung— March 9, Roswell Park continuing education in oncology.

Committee on Cancer Immunotherapy— March 9, NIH Bldg 10 Room 4B09, open 1:15—1:45 p.m.

Developmental Therapeutics Committee—March 9, Blair Room 110, open 9—9:30 a.m.

Committee on Cancer Immunotherapy—March 13, NIH Bldg 10 Room 4B09, open 1:15—1:45 p.m.

Div. of Cancer Treatment Board of Scientific Counselors—March 13-14, Baltimore Cancer Research Center, open March 13, 8:30—9 a.m. and 1:30—5 p.m.; March 14, 8:30 a.m.—5 p.m.

Bladder & Prostatic Cancer Review Committee—March 13-14, Landow Room C418, open March 13, 8:30—11 a.m.

President's Cancer Panel—March 14, NIH Bldg 31 Room 7, 9:30 a.m., open.

Diagnostic Research Advisory Group— March 15-16, NIH Bldg 31 Room 10, open March 15, 11 a.m.—adjournment; March 16, 8:30 a.m. —adjournment.

Cancer Immunotherapy Review Committee—March 16, NIH Bldg 10 Room 4B14, open 1;15—1:45 p.m.

National Cancer Advisory Board Subcommittee on Centers— March 16 Westwood Room 825, open 9 a.m.—5 p.m.

National Prostatic Cancer Project Working Cadre—March 20, NIH Bldg 31 Room 8, open 8:30—9 a.m.

5th Cuban Congress on Oncology— March 21-28, Havana

Cancer Centers Support Grant Review Committee—March 23-24, NIH Bldg 31 Room 6, open 8:30—10 a.m.

Breast Cancer Task Force—March 29-31, NIH Bldg 1 Wilson Hall, open March 29, 8:30 a.m.—adjournment.

Committee on Cancer Immunotherapy—March 30, NIH Bldg 10 Room 4B14, open 1:15-1:45 p.m.

Clinical Trials Committee—March 30-31, NIH Bldg 31 Room 8, open both days 8:30—9 a.m.

Clinical Cancer Program Project Review Committee—March 30-April 1, Chevy Chase, Md. Holiday Inn, open March 30, 8:30—10:30 a.m.

Virus Cancer Program Scientific Review Committee—March 30-31, Landow Room C418, open March 30, 9—9:30 a.m.

Committee on Cancer Immunobiology—March 31, NIH Bldg 10 Room 4B14, open 2—2:30 p.m.

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-CB-84268-31

Title: *Development of new reagents for characterization of subpopulations of human cells important to the immune response*
Deadline: *March 15*

NCI seeks laboratories to develop new reagents for characterization of subpopulations of human cells important to the immune response as well as reagents for characterization of new subpopulations of these cells.

RFP NCI-CB-84271-31

Title: *Development of methods for in vivo destruction of mononuclear phagocytes*
Deadline: *March 15*

NCI seeks laboratories to develop methods for selective in vivo destruction or sustained functional inactivation of mononuclear phagocytes. These methods should be more specific and have lesser in vivo side effects than silica or carrageenan.

RFP NCI-CB-84269-31

Title: *Study of T-cell macrophage cooperation resulting in macrophage activation*
Deadline: *March 15*

NCI seeks laboratories for studies of those interactions of T-cells or their products with macrophages that lead to activation of macrophages for reaction against tumor cells (specific or non-specific tumor cell cytotoxicity or cytostatis).

RFP NCI-CB-84270-31

Title: *Examination of the relative sensitivity of normal and tumor targets to cytotoxic activated macrophages*
Deadline: *March 15*

NCI seeks laboratories to study the relative sensitivities of normal and tumor targets to cytotoxic or cytostatic activated macrophages. First selective cytotoxicity must be clearly demonstrated and then mechanisms are to be studied.

RFP NCI-CB-84272-31

Title: *Mechanisms that operate in the local site of tumor development or proliferation whereby tumor cells escape destruction in the face of specific immunity*
Deadline: *March 15*

NCI seeks laboratories to study mechanisms whereby tumor cells escape destruction in the face of specific immunity. Local factors such as tumor products, genetic defects, local pH conditions, presence of passenger viruses and others can be studied.

Contracting Officer for above 5 RFPs: Harold Simpson
Biology & Diagnosis
301-496-5565

CONTRACT AWARDS

Title: Distribution and assembly of committee books
Contractor: Small Business Administration, Washington, D.C., $116,000.

Title: Inter- and intraspecies identification of cancer cell in vitro, continuation
Contractor: The Child Research Center of Michigan, $260,786.

Title: Maintenance of low temperature repository and establish cell lines from tumors, continuation
Contractor: Flow Laboratories, $227,188.

Title: Demonstration of tumor specific transplantation antigens in animal tumors, continuation
Contractor: Fred Hutchinson Cancer Research Center, $27,210.

Title: Breast Cancer Detection Demonstration Project, renewal
Contractors: Pacific Health Research Institute, Honolulu, $297,089, and University City Science Center, Philadelphia, $56,184.

Title: Radiologic physics center, renewal
Contractor: Univ. of Texas System Cancer Center, $111,254.

Title: Coordination of mammography training program, renewal
Contractor: American College of Radiology, $68,894.

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