THE CANCER RESEARCH EDUCATION CONTROL LETTER

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REORGANIZATION ANSWERS NOW COMING IN – VIROLOGY EXTRAMURAL RESEARCH TO BE UNDER CARCINOGENESIS

The reorganization of NCI is beginning to present some answers to the almost endless list of questions that were raised last January, when Director Arthur Upton revealed his intention to move grants into the program divisions, consolidate review away from programs, and phase most research contracts into grants.

Upton and other NCI executives insist the reorganization will not adversely affect existing grantees and contractors. Grantees in most cases will still be dealing with the same people at NCI, with the grant program managers moving from the Div. of Cancer Research Resources & Centers to the appropriate program divisions.

Those with NCI research contracts eventually will feel the difference. It is the intent of the reorganization effort to phase out gradually most research contracts, particularly those involved with basic research. As

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In Brief

PROPOSED DRUG ACT REVISIONS WOULD PROVIDE QUICK APPROVAL OF "BREAKTHROUGHS," IND-NDA CHANGES

MAJOR REVISION of FDA's drug regulatory powers has been proposed by the Carter Administration. Changes would provide for quicker, conditional approval of "breakthrough" drugs and would redefine the IND-NDA process. More data on safety and effectiveness would be released, which HEW Secretary Califano said would "open the doors in this country to medical decisions." Drug industry spokesmen said this would make too much information available to competitors. The proposal also would establish a National Center for Clinical Pharmacology which would be authorized to help medical schools educate their students about drugs, help educate other medical personnel about drugs, produce an annual drug experience assessment, develop new drugs of limited commercial value, and identify areas where research is needed. . . . **PRESIDENT CARTER**, in his proclamation of April as Cancer Control Month, said, "Only through continued support of cancer research and control can we reduce these figures (700,000 new cases, 390,000 deaths per year)". . . . **ROBERT LOVE**, chief of the Program Analysis & Formulation Branch in NCI's Office of Program Planning & Analysis, died March 5 after a heart attack. Love was a pathologist at NCI from 1955-60, then spent 14 years as a pathology professor at Thomas Jefferson Univ. Medical School before rejoining NCI. He was 57. . . . **REGIONAL NURSES** Conference on management of colorectal cancer has been scheduled by the Delaware Cancer Network for June 15-16. Cosponsors are the Univ. of Delaware School of Nursing and ACS-Delaware Div. Preregistration by June 7 is required. Contact Joanne Tully, Delaware Cancer Network, 1202 Jefferson St., Wilmington 19801, phone 302-428-2112.

ORGAN SITE PROGRAMS COULD BE PART OF NEW RESOURCES DIVISION, WITH CENTERS

(Continued from page 1)

each contract approaches expiration, NCI program staff will examine it to determine if it should be renewed or recompeted as a contract, or allowed to expire. If the dicision is to let it expire, the investigators it supports will be encouraged to submit grant applications. It is possible, even likely, that this process will start with some contracts that expire in fiscal 1979 (Oct. 1, 1978-Sept. 30, 1979).

NCI executives say that commercial organizations with research contracts probably will not be affected. However, since they are prohibited by HEW regulation from receiving grants, those firms (they like to be referred to as "tax paying" organizations) will be at a disadvantage as more emphasis is shifted to grants. The fact that a commercial firm is performing well on a contract would weigh heavily in any decision on whether to recompete it as a contract. Staff also will take into account known capabilities of industry in determining if any particular research effort should be supported by contract or left to grants.

As Upton and his staff plunged ahead with the task of completing reorganization plans for submission to HEW for department approval, these decisions have been made:

- The Viral Oncology Program—NCI's first beg research contract effort and the primary target of those who oppose use of contracts as a research mechanism—will go out of business as a separate program. Extramural virology research will be supported under a new associate director for extramural carcinogenesis research in the Div. of Cancer Cause & Prevention. This associate director will have under him a Biological Studies Branch, which will include virology; a Chemical & Physical Studies Branch; and possibly a Prevention Branch. The intramural virology program in the division will remain intact, but totally separated from the extramural activities.
- The contract supported Immunology Program in the Div. of Cancer Biology & Diagnosis will be merged with the entire Immunology Program being brought over from DCRRC into the Immunology Section of the Cancer Biology Branch.

The virology and immunology research contracts will, probably with a few exception, be allowed to expire with the money now funding them going into the grants pool. Most of the contractors will be encouraged to compete for grants.

One decision still to be made: What to do with the Organ Site Programs and the manpower training programs in DCRRC.

There are four Organ Site Programs, for cancers of the bladder, large bowel, prostate and pancreas. They are unique in that they are administered by grantee headquarter institutions, although they operate under the Organ Site Programs Branch in DCRRC, with Samuel Price as branch chief. They are involved in the full spectrum of research—biology, treatment, epidemiology, etiology, screening, diagnosis.

Upton is now considering three options for the Organ Site Programs, and for the training and education programs administered now by DCRRC:

1. Establish either a new office within Upton's office or a new Div. of Resources, to include the organ site and training programs and also the Centers Program (the decision has already been made to move the Centers Program into Upton's office, unless a new division is formed). The Construction Program, which has been left in DCRRC, also would go to a new Div. of Resources.
2. Split the Organ Sites among the divisions, each going to that division which seems most appropriate to the primary thrust of that program.
3. Keep them in DCRRC. This would require obtaining an exception from HEW, which has a policy of separating program from review.

The Div. of Cancer Research Resources & Centers is due for a change of name.

It no longer has the centers, and it probably will not have any of the research resources. What it will have is the job of reviewing all NCI contracts, all those grants not reviewed by the NIH study sections, and the technical and paperwork involved in processing all NCI grants and contracts. It might eventually be renamed something like the Div. of Review and Evaluation.

The various contract review committees in the four program divisions will be moved to DCRRC, along with their executive secretaries. The two grant review groups not presently in DCRRC—The Cancer Clinical Investigation Review Committee, which reviews the Cooperative Group grants in DCT, and the Grant Review Committee in the Div. of Cancer Control & Rehabilitation—also will move to DCRRC.

Some of the contract review committees also serve as program advisors. They will be separated, with the advisory function left in the divisions.

Upton has not yet decided what to do with two major groups now assigned to his office which might appropriately be located in the review division—the Research Contracts Branch and the Office of Committee Management.

The realignments within the program divisions have been made for the most part. DCT Director Vincent DeVita revealed his changes last week (*The Cancer Letter*, March 17).

DCBD Director Alan Rabson explained how his division will absorb grant programs and staff from DCRRC:

Rabson will have an associate director for extramural research, Ihor Masnyk, who will have responsibility for all DCBD grant and contract supported

research efforts. Three branches will be under Masnyk—Diagnosis, Biology, and Breast Cancer.

The Diagnosis Branch will be headed by William Pomerance, who presently is chief of the Diagnosis Branch in DCBD's Collaborative Research Program. Pomerance will take his present branch intact into the new one and will absorb the diagnosis grant portfolio from the Detection & Diagnosis Section in the Diagnosis & Treatment Branch of DCRRC.

Chief of the Biology Branch will be Barbara Sanford, who is presently chief of the Biology Branch in DCRRC. In addition to her entire biology grant portfolio, she will bring with her the Tumor Biology Section and its head, Brian Kimes, who will continue in that role in DCBD. The Biology Branch also will include an Immunology Section, headed by David Kiszkiss. It will have the immunology grants from DCRRC and also will take over the contracts now in the Immunology Program of DCBD, headed by William Terry.

Chief of the Breast Cancer Program Coordinating Branch will be Jane Taylor, who heads the branch now. The Breast Cancer Task Force, which had the dual role of reviewing the program's contracts and serving as the program's advisory group, will continue in its advisory capacity. The contracts will be reviewed in DCRRC, and most of them eventually will be phased into grants.

Masnyk presently is associate director for collaborative research, which includes the breast cancer, diagnosis and immunology extramural programs as well as the division's intramural research labs, including immunology. As head of the extramural program in the reorganization, Masnyk will have no responsibility in the intramural efforts.

Terry, who recently became director of the Centers Program, will remain for the present as DCBD associate director for intramural immunology research but will have no responsibility or authority on the extramural side.

Terry and the other intramural lab chiefs will report to Rabson, who will hold a spot open for an associate director for intramural research but does not plan to fill it soon.

Things aren't quite as far along in the Div. of Cancer Cause & Prevention because Upton and staff thought it would be a good idea if the new division director could have something to say about it.

The search committee has made its recommendations to Upton, and a decision is expected within two weeks.

DCCP for the first time will have a Board of Scientific Counselors, which will serve both as an advisory group on policy and as the review body for the division's intramural research. DCT and DCBD have similar boards, and DCCR has an advisory committee. DCCP at various times had advisory committees for carcinogenesis, viral oncology, nutrition, and smoking & health, but those were abolished last year in the Administration's cutback of advisory groups.

The new Board has been approved and chartered and will be operating soon after the new director is on the job.

Gregory O'Conor has been serving as acting director of DCCP. "I don't want to imply that viral oncology is being destroyed or abandoned," O'Conor said. "So much of the current work is related to transformation mechanisms, that it is not illogical to handle virology and carcinogenesis research under a single associate director."

Each of the branches under the Carcinogenesis Research Program will be organized along scientific lines, O'Conor said. The Biological Studies Branch might have a DNA Virus Section, an RNA Virus Section, and a Co-carcinogenesis Section. The Chemical & Physical Studies Branch might have sections for Metabolism & Chemistry, In Vitro Transformation, and Pathways of Carcinogenesis.

"Those aren't locked in concrete," O'Conor said. The new director and the new Board will be in on the final phases of this part of the reorganization.

O'Conor insisted "there will be no reduction in the intramural effort," either in carcinogenesis or virology. The organizational structures and work of intramural scientists will not be affected by the reorganization.

Thaddeus Domanski, chief of the Cause & Prevention Branch in DCRRC, will bring his grants and probably most of his staff to DCCP. If a new Prevention Branch is created, he probably would head it. That branch also would pick up DCCP's smoking and health and nutrition contracts.

One major activity of DCCP still very much up in the air is the Bioassay Program, which at present is the government's only major effort to test chemicals for carcinogenicity. HEW is considering a number of options, including moving NCI's Bioassay Program into some new agency that would be responsible for all toxicity testing on a greatly increased number of compounds.

Cancer Control & Rehabilitation is the division least affected by the reorganization. DCCR already has its own grants program, and there are no corresponding grants or staff in DCRRC which could be moved. From two-thirds to three-fourths of DCCR's Office of Committee & Review Activities staff are involved in contract or grant review and will move to DCRRC.

CLEARINGHOUSE, CHEMICAL SELECTION GROUP DIFFER ON DICHLORVOS TESTING

The process through which NCI selects the chemicals it enters in its Carcinogenesis Bioassay Program involves the collection and summarizing of data on suspect compounds, human exposure, etc., by a contractor (Stanford Research Institute). That information is considered by the Chemical Selection

Working Group, which includes NCI staff, representatives of the National Institute of Environmental Health Sciences and of the regulatory agencies. The CSWG then makes its recommendations of chemicals to go on test; the final decision is made by NCI staff.

With the advent of the Clearinghouse on Environmental Carcinogenesis, another layer of advice was superimposed on the process. The Clearinghouse Chemical Selection Subgroup was charged with the task of advising the Bioassay Program on chemicals that should be tested.

The subgroup, chaired by David Clayson of the Eppley Institute, has been offering its advice; the CSWG does not always with with it.

Dichlorvos, a widely used pesticide, generated a controversy of this sort between the Clearinghouse and the CSWG. Dichlorvos went through the NCI bioassay and the staff report was issued last year. The staff felt there was insufficient evidence to support the carcinogenicity of the chemical, despite a small number of esophageal tumors which were found in test animals.

The Clearinghouse Data Evaluation/Risk Assessment Subgroup after considering the report asked NCI to retest dichlorvos. But the CSWG emphatically voted against any retest. The Clearinghouse Chemical Selection Subgroup came right back and demanded a new test, contending that the money spent so far in testing dichlorvos would be wasted without some additional testing. Subgroup members gave a dichlorvos retest a priority score of 8.0 (on a scale of 1-10), the highest of 14 compounds it rated for testing at that meeting.

On another occasion, the Chemical Selection Subgroup wound up on the side of the CSWG in opposing a request by the Data EValuation/Risk Assessment Subgroup for retesting EDTA. The DE/RA Subgroup had asked for a new test for the compound, because of the low doses in the original test. CSWG refused, and Chemical Selection Subgroup members shrugged off the request by giving retesting a priority score of 1.0.

Other chemicals rated by the Subgroup in recommdations to the CSWG:

Gluteraldehyde—Used in the tanning, paper and hospital industries, with some use in food preparation. NIOSH estimates 50,000 workers are exposed, and additional exposure is expected because its use as a cold sterilization product will increase following OSHA's decision to restrict the use of ethylene oxide. The CSWG gave it a low priority, but the Subgroup priority was 6.7.

2,3 dibromo-l-propanol—Used as a chemical intermediate in production of flame retardants, insecticides and pharmaceuticals. Believed capable of getting into the water supply, although it has not yet been found in any. Priority rating of 6.5.

2-butanone peroxide—Produced at a rate of 6 million pounds per year, with 20-25,000 workers exposed. Priority rating of 6.2.

1-amino-2,4 dibromoanthraquinone—One of three aryl bromides considered. Used as a chemical intermediate in dye production. Priority score of 5.7.

Organidin—Representative compound of the alkyl iodides. Substantial human exposure used as a drug. Priority score of 5.5

Wollanstonite—A silicate, it may eventually replace asbestos, with considerable human exposure. Priority score of 4.8.

Ethyl bromide—One of the alkyl bromides, used in flame retardance. Priority score of 4.7.

Bromobenzene and p-dibromobenzene—Two of the aryl bromides, used as chemical intermediates. They have been detected in tap water. Priority score of 4.5 for each.

2,2-bis (bromoethyl)-1,3-propaneidiol—Used in flame retardance. Priority score of 3.3.

Sodium alumino silicate—Priority score of 3.8.

1,3-dibromopropane—Another of the alkyl bromides. Limited human exposure. Priority score of 2.5.

The mean rating of the priority scores was 4.7, with the standard deviation 2.0. This could be interpreted to mean that any score over 6.7 is a very high priority score, any score over 4.7 is high priority, 2.7 to 4.7 is medium priority, and under 2.7 low priority.

The Chemical Selection Subgroup had previously expressed in a resolution its feeling that more of the burden of testing should be placed on manufacturers. The subgroup amended that resolution to read:

"In those instances where a drug or other regulated chemical is recommended for carcinogenicity testing under the Bioassay Program, the regulatory body should first pursue all legal procedures to place the burden of that testing on the manufacturer or manufacturers."

ACS, AACI, CANDLELIGHTERS PRESENT CANCER PROGRAM SUPPORT AT HEARINGS

Although NCI's presentation on behalf of renewal of the National Cancer Act left something to be desired (***The Cancer Letter***, March 10), other organizations were not so timid. The American Cancer Society, the American Assn. of Cancer Institutes, and the Candlelighters all made solid presentations to the House Health Subcommittee describing the Cancer Program's accomplishments and requirements.

The ACS presentation was made by LaSalle Leffall Jr., president elect, and Benjamin Byrd, past president.

Leffall called for an authorization of $1.036 billion for NCI in fiscal 1979. "Anything less would delay dividends to the taxpayer for your past investment in this program. The $1.036 billion is a fair figure. Other NIH institutes have gained 65% in appropriations in the six years after the Cancer Act passed, compared to 56% in the six years before the

Act. They have not been short changed," Leffall said.

"Data flowing from clinical trials are much more successful than the general public is aware of," Leffall continued. "In such a fast growing cancer as lung cancer one team has produced 100% survival after one year. Another has produced 85% after 2½ years. For the first time, we have a drug specifically active against bladder cancer (cis-platinum). Metropolitan Life Insurance Co. in its latest annual figures, for 1976, shows a 3% decline in death from cancer among its policy holders, compared to 1971-1975."

Leffall elaborated on some of the progress being made. "You have looked at tons of health statistics. After all of that would you expect to learn that one of our projects has produced among lung cancer victimes 85% survival after 2½ years? It is a phenomenal figure and the only reason it cuts off at 2½ years is that there has not been time enough yet to get longer terms into the statistics. The work was accomplished at the Johns Hopkins Univ. Lung Project. Mayo Clinic and Sloan-Kettering have parallel projects and results.

"I have attached a statement from Dr. Melvyn Tockman, of Johns Hopkins, which shows that new screening methods have tripled the rate at which early lung cancer can be found.

"Dr. Tockman points out that most of the survivors are experiencing comfort enough to return to work and lead a normal life.

"In a study published two years ago Stage I squamous cell cancer and adenocarcinoma showed the advances made in early diagnosis so that surgery alone resulted in 77% survival after one year and surgery plus BCG administered intrapleurally, or directly into the lung cavity, produced 100% survival after one year.

"These kinds of results—in a disease, lung cancer, which still kills 92,400 persons per year—could not be reported when the National Cancer Program began.

"My own institution, Howard Univ. School of Medicine, has taken part in development of markers for prostate cancer. Work done in several places, including the Virginia Mason Clinic in Seattle, under research funding including American Cancer Society funding, has produced two new markers in prostate. We have already begun to use these markers and have found that blacks experience a four times higher positive test for prostate cancer than others experience.

"So we have matched individuals in the United States with individuals near Ibadan, Nigeria. It seems pretty clear that our men are experiencing something in their lives to cause the high rate of prostate cancer, because the Ibadan individuals don't show the excessive rate for blacks.

"So we now know we should start the search for something in the life style, the environment, or some other factor in the United States which could help us prevent this disease and reduce sickness and death."

Leffall continued, "There has been comment in the press repeatedly about the absence of real progress in cancer therapy. Yet colon and rectal cancer, solid tumors which casual observors tell us is an area of no progress, have shown significant response to treatment. Surgical removal of the colon and rectal cancer has been the standard treatment for decades. It is essential now. Adding to it chemotherapy and immunochemotherapy has made feasible reduced surgery in many cases and has doubled the survival time in one study as compared to surgery alone. In another study the effectiveness of short term fluorouracil chemoprophylaxis, preventive medicine after surgery, was evaluated and it was found in Stage III (Duke's class C) patients, 213 of them, five-year survival moved from 24.3% under surgery, alone, to 57.5% with fluorouracil. Even better results were achieved with patients whose cancers were not so far advanced. I emphasize, the data refer to five-year survivals.

"These are not peripheral cases. In 1978 there will be an estimated 102,000 new cases of colon-rectal cancer. But these cases will fare better than cancer patients have ever fared before. An estimated 51,900 will die of colon-rectal cancer in 1978 whose treatment began when research results were not as far along as they are now.

"Surgery, again, is the essential treatment in most head and neck cancer, but new methods are showing true improvements. At Northwestern University 17 Stage III and Stage IV patients were given a two-week course of drugs before surgery and radiotherapy. After being in the study a minimum of two years, 4 patients had died, one was alive with a tumor, and 12 were disease free, a remarkable record for this group of patients, 10 of whom were Stage IV and 7 were Stage III. Since this was reported last year another 40 patients' experience has been entered into the study and the preliminary results are being duplicated in the larger group, which now has a median patient term in the study of 12 months. We are talking about over 70% disease free after two years in the preliminary group. These are not the kinds of percentages one would gather are being experienced if one were to go by conventional wisdom alone.

"This committee has heard before the story of how lethal doses of methotrexate are administered to bone cancer patients along with citrovorum, a rescue factor, antibiotics, platelet transfusions and leucocyte transfusions as necessary. The historical rate of two-year survival for osteogenic sarcoma was about 20-25%. It is now above 95% and, when more time has passed, the much longer term survival can be documented, the scientists are convinced.

"The intensification of chemotherapeutic methodology which helped to bring these results in recent years was not a matter of serendipity. It was planned."

Arguing for the $1.036 authorization, Leffall said, "The administrators at NCI tell us that they expect there will be some 1,900 regular program project grants reviewed and found scientifically promising in fiscal 1979. But if only $900 million were appropriated to the institute that would allow funds for a bit more than a third of the approved applications, about 647 competing grants worth $55 million. That would be 34.5% funded of all competing grants.

"Even at a $1.036 million level, only 925 grants would be funded and the percentage would still only be 49.3% of those approved, not at all out of line with the levels at other NIH institutes."

Byrd reviewed areas of significant progress and said, "The excellent results which have been reported to you could not have been achieved if, time and again, this program weren't aided by the President's Cancer Panel. Particularly in the earlier stages of the Conquest of Cancer effort there were frequent needs to move with vigor at the departmental and White House levels.

"For instance, Congress through NCI put in motion a quantum expansion in the program at a time when the Office of Management & Budget was phasing out the training of biomedical researchers. Secretary Weinberger was particularly insistent on this phaseout. Only a full presentation of the situation by the President's Cancer Panel at the White House worked out the total contradiction between the expansion and contraction policies. There were other occasions where, I am sure, members of the Panel could tell you that they were instrumental in redirecting the Conquest of Cancer Program to fit policy developed above the NIH level or vice versa.

"I am not at all sure that appointment by the HEW department of the NCI director and National Cancer Advisory Board members would attract the men and women with the public affairs and administrative background necessary for success in this kind of communicating and negotiating.

"It is my belief that the government can certainly get someone to work in these unpaid jobs a whole lot easier and more effectively through Presidential than through secretarial appointments."

The bill by Congressman Paul Rogers, chairman of the House Health Subcommittee, for renewing the Cancer Act would not eliminate the Cancer Panel, as some critics have asked. It would change appointment of the NCI director and Board members from the Presidential to secretarial level.

"We are deeply concerned about the waste of past investment which will take place if activities already in motion are brought to a premature halt," Byrd said. "This happens with disturbing frequency in the federal picture, as you know, fortunately not as often in the jurisdiction of this subcommittee as in the jurisdiction of other subcommittees of the Congress.

"We are dealing with the careers of young researchers, young physicians, and with men who have spent decades shaping and pruning their programs in research, education and treatment.

"It took two or three years for many in the biomedical community to become convinced that Congress meant it when it enacted the National Cancer Act of 1971. It then took some participants years to explore their own work to see how it could legitimately apply to the cancer questions. Careers have been adjusted. Some construction has taken place. Departments have been reorganized. Entirely new vistas have come into view through outreach, technology transfer, continuing education, critical self-examination of procedures considered routine for years—x-ray diagnosis for example—and centers in many areas have developed after dozens of conferences, seminars, planning sessions, and false starts, working relationships with community hospitals, medical schools, voluntary health organizations including the American Cancer Society. The leaders in this always difficult work have put their reputations on the line. They have sought and won commitments of program and resources. They have created piplines.

"To turn off the tap, to leave those pipelines dribbling, instead of carrying a good fiscal flow, would be one more action, after too many such actions, highly discouraging to everyone involved.

"My main concern is with the response to this important piece of federal health leadership. I know that this subcommittee has struggled manfully with the problems of change and lack of change in the health care world. I am heartened by your many successes but also feel that the response to your leadership would be clearer, quicker, more definite if those in the ranks were convinced that the leadership is firm, unshakable, consistent. I do not think that the cancer community across the country will receive that impression if the authorization limits in H.R. 10908 are enacted." The bill calls for $1.01 billion, $1.017 billion, and $1.02 billion for the next three years.

"The National Cancer Advisory Board has probably been closer to this question than any other group anywhere. They've approved $1.2 billion in authority for fiscal 1979, sypport more than $1.3 billion for fiscal 1980, and nearly $1.4 billion for fiscal 1981," Byrd said.

The Candlelighters supported the higher authorization levels and asked for specific statutory authorization for six comprehensive cancer centers for childhood and adolescent cancers.

Grace Monaco, one of the founders of the Candlelighters, a national coalition of families of children affected by cancer, presented the organization's statement to the Rogers committee.

In addition to the six centers, Monaco asked for establishment of a national comprehensive cancer

registry for childhood and adolescent cancers; outreach programs for the demonstration of successful methods of treating those cancers; and for an increased effort by NCI in nutrition research and information dissemination.

These efforts are needed, Monaco said, to:

"Encourage a more effective advancement in the biomedical and behavioral sciences by focusing upon innovative, creative investigation in childhood and adolescent cancer.

"Develop through investigation, curative treatment for this patient population which would not include compromising either the quality of life or their individual basic human rights as research subjects and as minors.

"Extend survival with disease by 'curing' more children and adolescents more efficiently."

Monaco continued, "Although the inclusion of a pediatric oncology center in an adult institution need not necessarily thwart development, our conversations with noted oncologists confirm that the comprehensive cancer centers authorized by this committee are almost exclusively oriented toward the adult cancers.

"Childhood and adolescent cancers present differently, may have different causes, also respond differently from the adult cancers. The research breakthroughs in pediatric cancer therapy have largely originated from centers specifically devoted to pediatric cancer. Further, the apparently prevailing view in these centers is that pediatric cancer is a small percentage of cancers, and thus shouldn't receive the attention or program status that adult cancers receive.

"The need for a nationwide, coordinated approach to childhood and adolescent cancers arises from:

"(a) A need to insure that all children with cancer have access to effective diagnostic and treatment modalities.

"Candlelighters of Metropolitan Washington surveyed its members on the problems of diagnoses. The results, drawn from 54 case histories, showed that 61% of the cases, involving 13 types of cancer, were accurately diagnosed within 16 days. But diagnosis for the remaining 39% took anywhere from 16 days to a year.

"The chairman of the American Academy of Pediatrics Neoplastic Disease Committee, Dr. Frederic Silverman, confirms that 'any given pediatrician in the course of his 30 or 35 years of practice is only going to see a few cases of actual cancer. Consequently, he's not in a position to deal with it unless he can get some real help and get to the experts in the field.'

"(b) The need to develop less toxic therapies to avoid adverse complications in children with cancers which can now be successfully treated.

" 'For the longevity of life, we paid dearly. He lived for a long time (seven years) but the results of his living with this disease caused extensive damage to his lungs and cataracts in his eyes. The children are living longer, but the drugs are still as toxic as ever. It becomes a serious question of the deterioration in the quality of life' —Annandale, Va. mother of a 10-year-old son recently deceased from acute leukemia.

"(c) A need for sufficient accrual of child cancer experience in certain cancer categories, which have been resistant to therapy, and require increasing research attention.

"(d) A need to follow meticulously the long term effects including tetragenic, carcinogenic, mutagenic, neurological and long and short term risks in pediatric and adolescent cancer treatment (survivors).

These latter needs arise from a welcome phenomenon. Children with leukemia, lymphoma or Hodgkins disease may now be treated adequately in community hospitals. Demonstration outreach programs in community hospitals and pediatric oncologists treating children in a multi-center study funded by NCI have clearly established, using a children's hospital as an evaluation and re-evaluation center, that in excess of 50% of these children will probably attain a five year survival.

"However, since pediatric malignancies are much less common than adult cancers (1%) and since children treated in community hospitals are not generally included in research studies, the ability to follow and utilize them as research subjects in developing less toxic therapy and in following long term effects of childhood cancer is clearly diminished. This problem for research innovation and treatment will increase as more and more pediatric cancers move into community hospitals for treatment. Since childhood cancer is the model for the study and understanding of all tumor types, these falling patient accrual rates pose a threat to the entire cancer research efforts."

Gordon Zubrod, AACI president, said in a telegram to Rogers that "almost all of the advances in cancer care over the past 25 years have originated in cancer centers.

"The creation of new centers has provided a network across our country that makes these advances widely available to most patients. . . . They have become the primary instruments for rapid technological transfer of emerging information for the diagnosis and management of cancer.

"Inflation plus the dilution of available funds by the creation of new centers," Zubrod continued, "has resulted in reduction of support for most existing centers. In a number of centers effective programs in cancer control, education and clinical application of research findings are being sharply curtailed. We would strongly urge that in HR 10908 steps are taken to support centers at a highly effective level."

Zubrod said AACI supports a three year renewal,

with authorizations starting at $1.3 billion in fiscal 1979, $1.4 billion in 1980 and $1.5 billion in 1981.

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 NO1-CN-85414-02

Title: *Study on science program information systems*
Deadline: *Approximately June 1*

NCI is requesting proposals for evaluation of existing science program information systems within NCI in terms of their content, quality, capabilities and usage. This study is not intended to determine NCI's needs for science information systems, per se, but rather to (1) identify the science program information systems used by or available to NCI program administrators (2) characterize these systems in terms of the nature and quality of the input data, data base structure and content, classification schema system features and capabilities (search/retrieval capabilities, output optional and usage) (3) clarify similarities and differences between the systems; and finally, (4) develop recommendations concerning possible consolidation elimination and/or modification of the systems.

This study focuses on systems providing information on the scientific content of the programs, and excludes fiscal and budgetary systems and those dealing with publications.

Competition will be restricted to those offerors having operational facilities within a 50 mile radius of the NIH reservation. Firms which have participated in the development and maintenance and/or operation of NCI's Science Information System as either a prime contractor to the government or as a subcontractor, will not be eligible for award.

A bidders' conference will be scheduled for the above project. Details concerning the conference will be contained in the RFP. Copies of the RFP will be available on or about April 10.

Contracting Officer: Susan Yablon
Cancer Control,
301-427-7984

RFP 210-78-0032-0000

Title: *Carcinogenicity of aromatic amines - azo dyes*
Deadline: *Approximately May 15*

NIOSH is soliciting proposals from organizations interested in a study to test two azo dyes, disperse yellow 3 and acid black 52, in subchronic and chronic studies by weekly intratracheal (IT) instillation.

RFP 210-78-0033-0000

Title: *Carcinogenic potential of condensed pyrolysis effluents from iron foundry casting operations*
Deadline: *Approximately May 15*

NIOSH is soliciting proposals from organizations interested in performing a study to compare the carcinogenic potential of the pyrolysis effluents obtained from baked and no-baked types of binder systems.

Contracting Officer for above 2 RFPs: M. Stitely
National Institute for Occupational Safety & Health
5600 Fishers Ln., Rm 8-29
Rockville, Md. 20857

CONTRACT AWARDS

Title: Mammography training program, renewal
Contractor: Georgetown Univ., $31,000.

Title: Assessment of radiation therapy equipment needs
Contractor: WSA Inc., San Diego, $59,630.

Title: Study of mammmary gland responsiveness to multiple hormones
Contractor: Scripps Clinic & Research Foundation, $67,700.

Title: Study effects of nucleic acid preparations on the biological properties of mammary carcinomas, continuation

Title: Studies on the oncogenic potential of viruses, continuation
Contractor: Pennsylvania State Univ. Milton S. Hershey Medical Center, $482,460.

Title: Pediatric tumor resource, continuation
Contractor: Johns Hopkins Univ., $27,904.

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