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NEW COMMUNITY CLINICAL ONCOLOGY PROGRAMS AIMED AT THREE HOSPITAL TYPES; 30 CONTRACTS POSSIBLE

Expansion of the Clinical Oncology Program supported by NCI's Div of Cancer Control & Rehabilitation into three new contract programs costing from $1.7 to $3.42 million a year received "concept approval"

(Continued to page 2)

In Brief

NCI-FDA RELATIONS TOPS, DEVITA SAYS; UPTON TALKS TO CANDIDATES FOR PROSPECTIVE DIVISION

NCI'S RELATIONS with the Food & Drug Administration are excellent, Div. of Cancer Treatment Director Vincent DeVita told the DCT Board of Scientific Counselors. He credited the current harmony, two years after the two agencies fought bitterly over delays in approving INDs, to the cooperation of FDA Bureau of Drugs Director Richard Crout and Associate Director for Science Marion Finkel. "We meet every two weeks whether we need to or not, like taking a bath on Saturday night," DeVita said. . . . **REORGANIZATION UPDATE:** NCI Director Arthur Upton is still mulling the prospect of starting a new division to house the centers, construction, organ site and education programs. He's been talking with potential candidates, from within and without NCI, to head the division if he decides to go ahead with it. . . . **C.C. CHENG,** Midwest Research Institute scientist working in drug development, is the new director of the Mid-America Cancer Center Program headquartered at the Univ. of Kansas Medical Center. He replaces James Lowman, who became dean of the KUMC School of Medicine last year and has held both jobs while a search for his successor was conducted. . . . **WEST COAST** Cancer Foundation's 14th Annual Cancer Symposium is scheduled for March 23-24. Topic: "Body Image, Self-Esteem & Sexuality in Cancer Patients." Write to WCCF, 50 Francisco St. Suite 200, San Francisco 94133. . . . **DIAGNOSIS & TREATMENT** of Neoplastic Disorders—Medical, Surgical and Radiotherapeutic Aspects, is subject of Johns Hopkins 5th Annual Symposium March 22-23 in Baltimore. Controversial issues, including role of node dissection and prospects for interferon, will be on the agenda. Write to Program Coordinator, Johns Hopkins Medical Institutions, Turner Auditorium Room 22, 720 Rutland Ave., Baltimore 21205. . . . **NEW PUBLICATIONS:** International Directory of Specialized Cancer Research & Treatment Establishments—2nd Edition, from UICC. Includes 679 centers in 82 countries, with addresses, phones, names of directors and department heads, budgets, patient statistics, review of each center's activities in research, treatment and rehabilitation. It also gives an overall picture of the manpower and financial resources each country is devoting to cancer. Price is 100 Swiss Francs, write to Director Sales, International Union Against Cancer, 3, rue du Conseil-General, CH-1205, Geneva, Switzerland.

NEW COP CONTRACTS TO CALL FOR 18 MONTHS PLANNING, 24 IMPLEMENTATION

(Continued from page 1)

from the division's advisory committee last week.

The committee had balked at two previous meetings over expansion of the program, which now includes contracts with seven organizations which are attempting to demonstrate how cancer care can be improved in community hospitals.

Donald Buell, DCCR program director for clinical oncology, convinced the committee at its last meeting that there was little if any overlap and that the various programs complemented each other (*The Cancer Letter,* Nov. 3).

Buell came to the meeting last week armed with a detailed description of each of the three new programs. "This is as close as we can come to bringing an RFP to the committee for concept approval without making everyone in the room ineligible to compete for it," he said.

The three new programs will be the Cooperative Community Oncology Program, the Small Community Clinical Oncology Program and the Single Hospital Clinical Oncology Program. Buell said he estimated that five to 10 projects would constitute a sufficient field test for each model program. He plans to award seven or eight planning contracts for each model with the expectation that five or six will proceed to implementation.

Funding will be at the same level as the existing COP projects. Each contractor will receive $100,000 for 18 months of planning, and $300,000 for 24 months of implementation.

The minimum level, with five projects for each of the three programs, would cost a total of $6 million over 3½ years, or $1.7 million a year. The maximum level, with 10 projects for each, would cost $12 million over 3½ years, or $3.42 million a year.

The maximum number of contracts, 10 for each program, would be awarded only if DCCR is overwhelmed with a substantial number of first rate proposals. Some observers predicted that the program will create widespread interest among the 4,000 community hospitals in the U.S. which see sufficient numbers of cancer patients to benefit from an organized cancer program.

Here's how Buell described each of the three programs:

Cooperative Community Oncology Program

This program will be directed at larger single communities or multiple geographically related communities in which several hospitals admit cancer patients and which have surgeons, radiotherapists and one or more medical oncologists who can work cooperatively to develop a community-wide program. Unlike the first RFP for Clinical Oncology Programs, this RFP will require specific organizational and planning activities designed to foster community hospital cooperation and community physician involvement. Elements of the model program are derived from the experience of the Grand Rapids and Santa Clara Valley COPs and recommendations of these and other current COP contractors.

This program is limited to communities in which multiple hospitals that admit cancer patients can cooperate to develop a community wide cancer management program. It is further restricted to hospitals which have no major affiliation with a comprehensive cancer center or large university cancer program. Smaller university hospitals are eligible as part of a community wide consortium. Participation as a satellite hospital as part of a cooperative group cancer control program is permitted, but full cooperative group members are excluded. If a university is deemed to have a significant cancer program and exerts a leadership role in the community, it will be ineligible for this contract program and will be urged to apply for a cancer control outreach grant. The participating hospitals must, as a group, see a minimum of 500 new cancer patients a year.

The fiscal agent must be a community hospital or nonprofit organization. A university may not be the fiscal agent.

The following components will be required in the program structure and operation:

- A consortium committee which includes the chief of staff and a trustee from each participating hospital.
- An advisory committee with medical, lay public and patient representation.
- An executive committee to provide immediate direction and guidance to the program.
- A full time executive or administrative director for the program.
- Principal investigator to be a community physician.
- Cancer site committees each to develop management guidelines for a specific cancer(s). The number of such committees will be determined by the program, but overall must include the community physicians who admit at least 75% of cancer patients to the participating hospitals. The site committees will be charged with developing auditing documents and conducting retrospective review of cancer care provided.
- Development of a capacity to identify and refer appropriate patients to tertiary cancer care centers, and the capability to participate in the cooperative group satellite program so that appropriate group protocols will be available as a treatment resource.

Small Community Clinical Oncology Program

This model emerges from the experiences of the Ada/Shawnee and Blue Mountain COPs. Neither of these communities have full time medical oncologists or were able to recruit nurses trained in oncology. Radiotherapy facilities were available. Such programs must establish close working relationships

with a cancer center in order to obtain the expertise necessary to develop and implement a community cancer program. Under this system, consultation is provided on a continuing basis by the cancer center even at some distance away.

If possible, a designated medical oncologist and a consultant radiotherapist will travel to the community to participate in tumor boards, make rounds and advise in an ambulatory clinic on a weekly basis. Under this program, the bulk of cancer care is delivered by the primary care physician-nurse oncologist team. Trained nurse oncologists may be recruited or staff nurses from the community sent for special training in cancer nursing.

As with other COPs, active primary physician involvement is required. Where possible, cancer care will be delivered in the community. Where indicated, specialized care will be delivered at the center. Followup care and coordinated rehabilitative and supportive care services will be based in the community program. As the program becomes established and because of the working relationship with a center, there is increased likelihood that a trained medical oncologist will be recruited to practice in the community. This program will field test and refine models for developing strong local cancer programs which will relate closely to regional centers.

This program is directed at community hospitals in single or multiple geographically related communities to which cancer patients are admitted but in which there are no full time medical oncologists. Radiotherapy and at least one tumor registry must be available. Community hospitals having strong consultative relationships with a cancer center are excluded although limited existing referral relationships are permissible.

The fiscal agent must be a community hospital or nonprofit organization. A center or university may not be the fiscal agent.

The following components will be required in the program structure and operation:

- A consortium committee which includes the chief of staff and a trustee of each participating hospital.
- An advisory committee with community medical, lay public, and patient representation and to include cancer center representatives.
- An executive committee to provide immediate direction and guidance to the program.
- A full time executive or administrative director.
- Principal investigator to be a community physician.
- Cancer site committees of community physicians to develop management guidelines for specific cancers. These committees must include physicians who admit 75% of cancer patients to the participating hospitals. Cancer center consultants may serve on these committees. The site committees will be charged with developing auditing documents and conducting retrospective review of cancer care provided.
- Development of a strong consultative working relationship with a geographically appropriate comprehensive or university cancer center.
- The tumor registry, auditing and data handling procedures must be compatible with that of the regional center.

Single Hospital Clinical Oncology Program

This model grows out of the programs at Methodist Hospital of Indiana and Southwest Texas Methodist Hospital in San Antonio. Some large private practice hospitals in this country admit over 500 cancer patients yearly. Although they may have house staff training programs, relationships with university and comprehensive cancer centers are not well established. Generally trained radiation and medical oncologists practice in such hospitals, but where multidisciplinary care and referral patterns are not formalized, there is no assurance of a general high level of acceptable cancer care.

Further, there may be no organized cancer education program for primary care physicians, oncology nursing, or cancer rehabilitative services. Because of the numbers of cancer patients seen, if a program compliant with COP requirements is developed and established in such a hospital, there is significant patient benefit. The relative academic isolation of a large single hospital may be a reflection of a long standing private academic or town-gown alienation.

The COP requirement that close ties be established with a comprehensive or university center is a step which breaks this pattern. The COP program, because it is initiated and funded within the private hospital which then seeks consultation with the center, is much more acceptable to the primary physicians than the center initiated program. This holds true even when the goals and objectives of the two approaches are virtually identical.

We recognize that this proposed program has the potential for strengthening the cancer program in a single hospital in a community while not resulting in benefits to cancer patients treated elsewhere in the same community. Sometimes, as was the case in San Antonio, a community is not ready to institute a community wide clinical oncology program. Since the primary care physicians admit to multiple hospitals, once the benefits of COP management become apparent in a single hospital, the program becomes exportable. To qualify as a participant in the Single Hospital Clinical Oncology Program, a hospital would have to justify its potential impact on the community. Further planning to this end will be required under the contract.

This program is directed at single community hospitals which see at least 500 new cancer patients each year and do not have a major affiliation with a university cancer program or comprehensive cancer center. All facilities and specialists for multidisciplinary cancer management must be available, including

at least one medical oncologist. A hospital in a community where other hospitals admit significant numbers of cancer patients must present and defend a rationale why the community would not be better served by a community wide cooperative program. Cooperative group member institutions may not apply. Hospitals participating as satellites under a cooperative group cancer control outreach program are eligible.

The fiscal agent must be a non-university, community hospital.

The following components will be required in the program structure and operation:

- An advisory committee with community medical, lay public and patient representation. This committee must include representatives from other community hospitals which provide cancer care and must specifically endorse a plan whereby benefits of the single hospital program can be extended to cancer patients in other hospitals.
- An executive committee to provide immediate direction and guidance to the program.
- A full time executive or administrative director.
- Principal investigator to be a community physician.
- Cancer site committees of community physicians to develop management guidelines for specific cancers. These committees must include physicians who admit 75% of cancer patients to the participating hospital. Cancer center consultants may serve on these committees. The site committees will be charged with developing auditing documents and conducting retrospective review of cancer care provided.
- Development of a strong consultative working relationship with a geographically appropriate comprehensive or university cancer center.

All three programs will have these requirements:

- A cancer nursing committee to develop the nursing component of the program and develop site specific nursing care guidelines.
- A rehabilitation and patient supportive care committee to develop site specific rehabilitation guidelines, identify and develop community wide patient counseling and supportive services, and develop a functional mechanism to assess and meet cancer patient needs.
- A baseline study of cancer management practice during the year prior to contract award will be conducted and interpreted in light of the developed management guidelines.
- Unlike the previous COPs, these programs will have a common evaluation plan designed to document the processes of establishing the cancer program, changes in community oncology practice and the number of patients receiving appropriate care. A uniform data set will be developed for submission to NCI. There will be multiple contractors meetings during the planning phase. Guidelines, auditing procedures, and modifications of the tumor registry must be completed before implementation mya proceed.

There will be planning and implementation phases, with implementation being cost-shared with the community on a 50-50 basis. The program must bring true multidisciplinary evaluation and treatment to the level of the primary care physician and institute advanced methods of cancer rehabilitation and supportive care. The program must develop a plan for self-sufficiency when federal funding ceases. A professional education program will be included.

BONADONNA'S RESULTS AT FOUR YEARS: STILL BIG IMPROVEMENT FOR CMF GROUP

The adjuvant breast cancer study conducted by Gianni Bonadonna in Milan continues, at four years, to show significant improvement for the CMF treated group over the untreated controls. Most of the improvement is in the premenopausal group.

Franco Muggia, director of the Cancer Therapy Evaluation Program in NCI's Div. of Cancer Treatment, related Bonadonna's four year figures to the National Cancer Advisory Board this week:

Percent Recurrences	**Control**	**CMF**
Total	52.7	34.4
Premenopausal	59.2	25.0
Postmenopausal	47.6	43.8
Percent Survival		
Total	73.6	83.0
Premenopausal	70.6	89.6
Postmenopausal	75.4	76.5

Bonadonna's study began in June, 1973, and the last patients were entered in September, 1975. The figures Muggia reported were actuarial results from time of mastectomy. Only patients with positive nodes were eligible, and were randomized into the control and CMF groups, 180 in each. Half were premenopausal, half post.

"We can state with confidence that chemotherapy has altered survival in breast cancer, particularly for women under 50," Muggia said.

ACS WILL REFUSE TAX MONEY FOR JOINT PROJECTS WITH GOVERNMENT IN FUTURE

The American Cancer Society House of Delegates has voted not to accept funds from local, state and federal government agencies—including NCI—in any future projects jointly sponsored by government and ACS.

The most notable such project is the Breast Cancer Detection Demonstration Program, in which ACS' participation will end when the project has completed five years.

In the fiscal year ending last Aug. 31, ACS received about $1.8 million from local, state and federal tax supported agencies.

"In voting not to accept tax dollars in the future,

we have taken a quiet but important step to reassert the society's independence," said Joseph Young, chairman of the ACS board of directors. "The amount of money involved is not very large in terms of our total budget, but a major principle is involved.

"The action will further strengthen the society's position as an objective champion of the public which supports it, and in particular as a guardian of the interests of cancer patients and their families," Young continued. "It will provide the society with a stronger voice on cancer related issues."

An example, Young said, is ACS' continuing advocacy of a strong federally financed National Cancer Program. "Henceforth, when we speak out in favor of larger appropriations for the National Cancer Institute, no one will be able to suggest that there's any financial advantage in it for us. As a voluntary agency we will continue to make a major contribution to the struggle against cancer by speaking without equivocation and acting without hesitation."

The transition to totally private funding will begin immediately, with a small number of projects permitted to phase out over a maximum of five years.

Total contributions to ACS during the fiscal year amounted to nearly $125 million, highest in the society's history and more than 8% ahead of the previous year. The budget for research was $44 million.

FCRC DECISION DUE IN 90 DAYS, UPTON SAYS; FOUR YEAR PHASEOUT LIKELY

The future of the Frederick Cancer Research Center is still up in the air, but NCI Director Arthur Upton told the National Cancer Advisory Board this week that he hoped there would be "a definitive" decision within 90 days.

NIH Director Donald Fredrickson is considering a proposal approved by all NCI division directors to phase out the $25 million a year contract with Litton Bionetics and convert the facilities at the former Ft. Detrick Army biological warfare center into an extension of the NIH campus (***The Cancer Letter,*** Oct. 27).

If that is Fredrickson's decision, the phaseout probably would be accomplished over the remaining four years of the contract. A new contract, on a greatly reduced scale, for support services probably would be competed through an RFP. After the phaseout, all research activity would be by NIH (including NCI) intramural staff.

Litton Bionetics has about 850 employees at FCRC as scientific and support staff working under the contract.

Upton told the NCAB that "several trends are emerging" from the review of FCRC being conducted by a staff committee headed by John Moloney. "It is generally acknowledged that a great deal has been accomplished there, in productive, high quality research. I think we will see a gradually changing merger of NIH and NCI intramural programs with the contractor. It will help decongest the NIH campus."

NEW LOBBYING, EDUCATION GROUP FORMED FOR PREVENTION, ENVIRONMENTAL HEALTH

A new organization, the "National Coalition for Disease Prevention and Environmental Health" which has the backing of soon-to-retire Congressman Paul Rogers, is being put together with the aim of creating an effective lobbying group.

Jeffery Schwartz, a member of the House Commerce Committee staff (Rogers is the fourth ranking Democrat on that committee) was the chief spokesman for the organizers at a meeting last week in the committee's meeting room in the Rayburn Building. Other organizers include Steve Connolly, a staff member on Rogers' Health Subcommittee, and Steve Roberts, staff member for the House Subcommittee on Environment.

A document describing the goals of the organization emphasized the need for "an organized coalition of diverse national groups dedicated to concerted education and political action to prevent disease and to encourage disease prevention programs." The document cited the "overwhelming political focus of most health groups" on "cure of disease....This limited viewpoint has been reflected in the federal government's legislation and administrative and budgetary practices" with the result that health financing, planning, services delivery and research systems "are geared predominantly toward care or cure of the already ill."

Rogers addressed the meeting, commenting that 140 national groups have indicated they would join the coalition and said the organization would have two main functions:

"One would be to set up an environmental clearinghouse or center, a place where we could bring together information and make it available to the public." The other function would be to "stimulate action when information calls for action. It is not always possible, before action is taken, to wait for perfect information. We're trying to shift from the theory that we have to have the deaths before we take action."

Responding to a question on whether he would be appointed HEW secretary by the President, Rogers said "That's just a rumor." He said he had not decided what he would do, except that he would be active with the new coalition "on a pro bono basis, which means for free."

Solomon Garb, chairman of the Citizens Committee for the Conquest of Cancer, suggested that a statement be added to the goals and purposes of the organization, that the "coalition supports those who work for improved basic biomedical and behavioral research, treatment, rehabilitation and other

measures to help those for whom prevention has not sufficied. . . . I'm not suggesting this group become involved (in those areas) but just express sympathy with others involved in treatment and research."

Jay Dobkin, a member of the organizing committee, said the coalition "was not intended as a rejection of what is going on outside the area of prevention."

NCI CONTRACT AWARDS

Title: Preparation of 11 compounds
Contractor: SRI International, $6,532.

Title: Conduct research on immunoprevention of cancer in cats
Contractor: Ohio State Univ., $397,716.

Title: Production of oncogenic or potentially oncogenic viruses, continuation
Contractor: Electro-Nucleonics Laboratories Inc., $162,499.

Title: Support services to maintain studies of type C RNA tumor viruses, continuation
Contractor: Microbiological Associates, $29,621.

Title: Production of avian and mammalian oncogenic viruses, continuation
Contractor: University Laboratories, $345,611.

Title: Preparation of antisera to oncogenic or potentially oncogenic viruses
Contractor: Huntingdon Research Center, $427,918.

Title: Research on application of Epstein-Barr virus markers to diagnosis and prognosis of nasopharyngeal carcinoma
Contractor: Mayo Foundation, $458,585.

Title: Tumor registry training program and allied activities, continuation
Contractor: Univ. of California (San Francisco), $196,140.

Title: Population based cancer registry for Surveillance, Epidemiology and End Results, continuation
Contractor: Commonwealth of Puerto Rico, $93,125.

Title: Nutritional assessment parameters in patients with malignant diseases
Contractor: Duke Univ. Medical Center, $470,848.

Title: Extension of gustatory evaluation of cancer patients
Contractor: Univ. of Pennsylvania, $35,569.

Title: Isolation and purification of human polycyclic hydrocarbons and production of antisera to the pure enzymes
Contractor: Vanderbilt Univ., $189,161.

Title: Selective inhibition of RNA polymerase II activity as a diagnostic tool to detect potential carcinogens
Contractor: Thomas Jefferson Univ., $104,998.

Title: Research on oncogenic viruses, virus production and vaccine development, continuation
Contractor: Merck & Co., $132,000.

Title: Research on integration sites of papovirus genomes in transformed cells, continuation
Contractor: Univ. of Illinois, $96,790.

Title: Immunoprevention of cancer in cats
Contractor: Univ. of Southern California, $412,000.

Title: Serum collection from volunteer participants in the breast cancer detection demonstration projects, continuation
Contractor: Cancer Research Center, Columbia, Mo., $41,275.

Title: Development of methods and procedures to test the feasibility of screening for early endometrial cancers by means of uterine sampling
Contractor: Montefiore Hospital, Bronx, $657,079.

Title: Detection and localization of bronchogenic carcinoma, continuation
Contractor: Mayo Foundation, $2,300,000.

Title: Study innovative techniques for passage of colonoscope into cecum, continuation
Contractor: Lahey Clinic Foundation, $278,636.

Title: Pharmacologic studies of antitumor agents
Contractor: M.D. Anderson Hospital, $1,111,128.

Title: Quantitative evaluation of protected environments, continuation
Contractor: M.D. Anderson Hospital, $1,866,873.

Title: Research on genetic analysis of immune response of mice to recombinant gp 70 oncornavirus
Contractor: Scripps Clinic & Research Foundation, $236,590.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS SCHEDULED THROUGH MARCH

Fourth Congress of Medical Oncology Society—Dec. 2-4, Nice.

Seminar on At Home Rehabilitation for Cancer Patients and Families—Dec. 6, Park Plaza Hotel, Cleveland, sponsored by The Cancer Center Inc.

Endocrinologic Aspects of Cancer— Dec. 7, Roswell Park continuing education in oncology, contact Claudia Lee.

Large Bowel Cancer Contract Review Committee— Dec. 7-8, Prudential Bldg, Houston, open Dec. 7, 7:30–8 p.m.

Cause & Prevention Scientific Review Committee— Dec. 8, Landow Room A, open 9–9:30 a.m.

Cooperative Group Chairmen's Committee—Dec. 11, NIH Bldg 31 Room 8, open 1 p.m.–adjournment.

President's Cancer Panel—Dec. 12, NIH Bldg 31 Room 7, 9:30 a.m., open.

Clearinghouse on Environmental Carcinogens Chemical Selection Subgroup—Dec. 12, NIH Bldg 31 Room 10, 9 a.m., open.

Tumor Immunology Committee—Dec. 13, Westwood Room 803, open 1:30–2 p.m.

Clearinghouse Data Evaluation Risk Assessment Subgroup—Dec. 13, NIH Bldg 31 Room 10, 9 a.m., open.

Clinical Cancer Program Project Review Committee—Dec. 14-16, NIH Bldg 31 Room 6, open Dec. 14, 8:30–10:30 a.m.

Pacific Endocurietherapy Society—Dec. 15-17, Wailea Beach Hotel, Maui.

Bladder Cancer Review Committee—Dec. 16, Sarasota Hyatt House, open 8:30—9 a.m.

2nd International Conference on Inorganic and Nutritional Aspects of Cancer—Jan. 3-5, Univ. of California (San Diego-La Jolla).

Workshop on Human Tumor Cloning Methods—Jan. 3-5, Univ. of Arizona Medical Sciences Center, Tucson.

National Cancer Advisory Board—Jan. 15-17, NIH Bldg 31 Room 6 (schedule for Board and subcommittee meetings not yet available).

Biomedical & Epidemiology Contract Review Committee—Jan. 22-23, Landow Room A, open Jan. 22, 8 p.m.

Cancer Control Intervention Program Review Committee—Jan. 23, NIH Bldg 31 room 8, open 8:30—9 a.m.

Pancreatic Cancer Review Committee— Jan. 25, Tidewater Place, New Orleans, open 8:30—10 a.m.

Symposium on Fundamental Cancer Research—Radiation Biology in Cancer Research—Feb. 27-March 2, Houston Shamrock Hilton.

National Conference on Breast Cancer—18th Annual Conference on Detection & Treatment—March 5-8, Atlanta. Sponsored by the American College of Radiology, the College of American Pathologists, the Educational Foundation of the Society of Plastic & Reconstructive Surgery, the American Academy of Family Physicians, in cooperation with the American College of Obstetricians & Gynecologists.

5th Annual Symposium on Diagnosis & Treatment of Neoplastic Disorders—March 22-23, Johns Hopkins Medical Institutions.

14th Annual San Francisco Cancer Symposium, "Body Image, Self Esteen & Sexuality in Cancer Patients"—March 23-24, San Francisco Hyatt on Union Square, sponsored by the West Coast Cancer Foundation.

2nd International Conference on the Adjuvant Therapy of Cancer—March 28-31, Univ. of Arizona, Tucson.

Additional meetings which will be scheduled later will be listed in the Jan. 5 issue of ***The Cancer Letter.***

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-95428-05

Title: *Model post masters fellowship program in oncology nursing education*

Deadline: *Feb. 1*

The Div. of Cancer Control & Rehabilitation of NCI is seeking proposals for the development of a model post masters fellowship program in oncology nursing education. This program will utilize existing advanced oncology nursing programs to provide qualified nurse educators with advanced training instruction in oncology nursing.

It is the intent of this procurement to demonstrate such a program for nurse educators in the underserved areas of the United States in order that well trained faculty will be available, and they, in turn, can train oncology nurse clinicians for health care agencies in their regions. The contractor will be required to admit a minimum of 20 qualified nurse fellows during the contract period. Offerors must agree to collaborate with other program participants, including development of a consensus curriculum and an overall evaluation plan, including a followup evaluation of program fellows.

Contract Specialist: Helen McEwan
Control & Rehabilitation
301-427-7984

RFP NCI-CM-97269 (SOURCES SOUGHT)

Title: *Quality control of radiotherapy treatment for for Head & Neck Carcinoma Contracts Program*

Deadline: *(For resumes) Dec. 1*

Only one source is known to NCI which can perform the effort above. That source is the Radiation Therapy Oncology Group of the American College of Radiology. Radiation Therapy Oncology Group is one of eight members of the Head & Neck Contract Program. Specifically, the work required involves the review of the radiotherapy treatment plans and localization films for an estimated 200 patients per year.

The source must be familiar with the program protocols. Besides the initial review, portal films will be received on each patient, at least every two weeks. Isodose distributions, treatment records and date forms indicating cumulative doses will also be analyzed, at the completion of treatment for each patient.

If any organization feels that it has the demonstrated technical capabilities required to perform the aforementioned work, the submission of a brief, concise summary of capabilities is invited. This summary should include a complete resume of the proposed therapeutic radiologists outlining their experience in conducting large scale quality control review. Resumes of other support personnel should be included, giving their training and experience. Responding organizations must clearly indicate their ability to review all localization films and treatment plans and recommend any corrections within 72 hours of receipt.

Information submitted must be pertinent and specific in the technical area under consideration. Unnecessary elaborate brochures are neither required nor desired. Resumes must be submitted in 10 copies.

Contract Specialist: Charles Lerner
Cancer Treatment
301-427-8125

RFP NCI-CM-97242

Title: *Establishment and operation of rodent production centers for inbred hybrid and outbred rodents*

Deadline: *Approximately Jan. 3*

NCI is seeking organizations with the capability and facilities for producing and supplying various inbred, hybrid and inbred, and outbred rodents as (1) progenitors for large-scale production colonies and (2) for laboratory investigations sponsored by the Div. of Cancer Treatment. To be considered for award of a contract, respondents must meet the following criteria:

1. Contractors must be accredited breeders with the Drug Development Program of DCT and must have, for the maximum barrier facility type award, an existing barrier facility with, as a minimum, an absolute filtration system, mechanical cage washing machines, auxiliary power sources, autoclaves (steam sterilizers) with sufficient capacity for large numbers of caging equipment, and large volumes of animal food and bedding.

2. Contractors must have a minimum of two years experience in the production of inbred and/or hybrid and/or outbred laboratory rodents. This experience shall be based upon the production and sale of a minimum of 1500 rodents per week. The contractor will be expected to maintain and operate a 6000 to 7000 cage rodent production center as inbred foundation and expansion colonies using rodent inbreeding procedures under modified conventional conditions. All breeding stock will be supplied by the government.

The characteristics of a modified conventional environment shall be the same as for a maximum barrier facility; however, the animals maintained within such a facility are not isolator derived. It is anticipated that one award will be made as the result of this RFP. It is also anticipated that award will be for a three year incrementally funded period of performance.

Contracting Officer: Daniel Abbott
Cancer Treatment
301-427-8125

RFP NO1-CO-85429-09

Title: *Analytical support services for the Cancer Centers Program*

Deadline: *Jan. 9*

NCI intends to issue an RFP to obtain the services of an organization with demonstrated capability of providing the Cancer Centers Program with analytical support services. Work to be accomplished will be in four areas:

1. Assistance to the Cancer Centers Program staff in budget and financial analysis—Collection and display of fiscal information available in NCI records, grantee reports, grant applications, and other available information sources; analysis and presentation of financial information on retrospective and/or prospective (i.e. forecasting) basis; analysis and review of grant applications and grant award statements for research projects, program projects, Center support grants, and training grants. Additionally, patient care reimbursement practices (fee for service and prepaid health plan) and cost sharing programs will be considered for analysis. The contractor will prepare special budgetary and fiscal reports as required to fulfill requests from higher levels of the NIH, DHEW, and OMB, as well as from the National Cancer Advisory Board.

2. Assistance to the Cancer Centers Program staff in resource analyses—Cellection and display of information concerning resources supported by the program (manpower, services, facilities, equipment, etc.). Conduct detailed analyses to provide timely information and response to requests from program management and administrative officials.

3. Assistance to the Cancer Centers Program staff in program and project analyses—Collection and display of information on specific programs and projects supported in one or more individual cancer centers. Program information will include national and state population access to cancer cetners, cancer patients seen in cancer centers (by site, stage, age and sex), programs and projects in clinical investigation, education, basic research, and outreach. From information collected, analyses will be performed to result in preparation of one-time and/or continuing reports involving program concepts, operational problems, shared program services (i.e., conjoint activities between institutions), etc.

4. Assistance to the Cancer Centers program staff in special analytical support—Services required under this category will include statistical analysis, systems design, program evaluation planning, development of evaluation guidelines and methodologies, special evaluation analytical services, and special research facilities analyses.

Offerors shall be limited to those firms having operating facilities within a 50 mile radius of Bethesda, Md., as daily person-to-person contact is often necessary.

An RFP will be mailed to requestors on Dec. 1, with a pre-bidders' conference planned for Dec. 18.

Contract Specialist: Earl Klevins
Office of Director
301-427-7984

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