THE CANCER LETTER

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CLINICAL INVESTIGATORS OBJECT TO HEW PROPOSAL ON COMPENSATION NOTIFICATION IN CONSENT FORMS

"Hospitals will have a hell of a time authorizing clinical research if this thing is allowed to stand," commented James Holland, chairman of Cancer & Leukemia Group B, during discussion on a proposed HEW regulation this week at the meeting of the Cooperative Group Chairmen's Committee.

The proposal would require that informed consent documents in-

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In Brief

BCDDP "DRAMATICALLY" CHANGED U.S. MEDICAL PRACTICE, FINK SAYS; 8% NOT TOO MUCH—DEVITA

BREAST CANCER Detection Demonstration Program has "dramatically changed medical practice in a short period of time," NCI Div. of Cancer Control & Rehabilitation Director Diane Fink says. Concern over the danger of radiation exposure has resulted in mammography dose to .5 rad or less, both in BCDDP and in general practice; mammography is being used more intelligently; requirements for a successful screening program have been better defined; and thermography has been shown to be a screening research tool not yet suitable for large scale screening, Fink contends. BCDDP also has alerted physicians as to the difficulty of diagnosing minimal breast cancer. The fact that mammography in the program has found substantial numbers of early lesions will form the basis for clinical trials. . . . **COMMUNITY BASED** cancer control programs have a role in helping individuals deal with carcinogens, cigarette smoking for example, NCI Director Arthur Upton commented when he visited a New Mexico Cancer Control Board meeting. "More definite effort needs to be made to help those who want to quit," Upton said. . . . **"IS 8% OF THE NCI** budget enough for clinical research?" asked Paul Carbone, director of the Univ. of Wisconsin Comprehensive Cancer Center. "The only thing I am sure of is that 8% is not too much," replied Div. of Cancer Treatment Director Vincent DeVita. "I don't know what is too much. I do know, if we have a high priority program that can't get funded, then we don't have enough." DeVita said Upton has been "more than fair" in allocating NCI funds for treatment. . . . **"IMPACT OF CANCER** on Texas" published by M.D. Anderson and the Texas Dept. of Health shows that "lung cancer is almost epidemic" in the state, with an increase in deaths of 53% from 1969 to 1976. "The study also indicates that while the state's hospital distribution is excellent, the services to cancer patients are not uniformly as good as they should be," MDA's news release on the report said. . . . **"HOW HOSPICE** Happens," a workshop on developing and implementing hospice care, is scheduled Jan. 10-11 at the Park Plaza Hotel, Cleveland, sponsored by the Cancer Center Inc. Contact the center, 11001 Cedar Ave., Cleveland 44106.

COOPERATIVE GROUP CHAIRMEN AGREE ON CLINICAL TRIALS REVIEW AGENDA

(Continued from page 1)

clude a statement as to whether the sponsoring institution has a mechanism to provide compensation for subjects who may incur physical injuries as a result of participating in biomedical and behavioral research.

HEW plans to adopt the proposal as an interim regulation effective Jan. 2, but is soliciting public comment on it. FDA asked for comment on both the basic issue of advising subjects regarding the availability of compensation and the specific amendment itself, including the limitations on its scope.

"The department recognizes that limiting the amendment (to the definition of informed consent) to physical injury and to biomedical and behavioral research may be artificial and unduly restraining," the announcement in the *Federal Register,* Nov. 2, said. "At the same time, however, the department is reviewing the issue of the applicability of the affected regulations and the scope and substance of this amendment will be examined in the light of the outcome of that review."

The amendment specifically says:

"With respect to biomedical or behavioral research which may result in physical injury, an explanation as to whether compensation and medical treatment is available if physical injury occurs and, if so, what it consists of or where further information may be obtained. This subparagraph will apply to research conducted aborad in collaboration with foreign governments or international organizations absent the explicit nonconcurrence of those governments or organizations."

An HEW task force was formed two years ago to develop a mechanism to compensate persons injured as a result of their participation in research. The task force recommendations were accepted, for the most part, by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The commission's report and recommendations on Institutional Review Boards will be published soon.

Meanwhile, HEW said, it feels that where research presents risk of physical harm, subjects should be advised at the outset whether there will be any financial protection for them if they are injured.

John Cooper, president of the Assn. of American Medical Colleges, in a memo to his members objected to adoption of notification requirements before the payment mechanism has been developed.

"Recent events and forces of growing magnitude made it almost inevitable that directives would be issued to require and provide compensation to injured subjects," Cooper wrote. "These events include the intrinsic merit of the proposal; the recommendations of an internal HEW committee; the recommendation of the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research; and the interest of Secretary Califano in ethical issues. However, the unexpected and precipitate release of notification requirements before the development of an adequate compensation mechanism may seriously perturb clinical research activities. Accordingly you might wish in your comments to urge the secretary to take measures at once to assist institutions engaged in federally supported clinical research to arrange and to finance appropriate insurance coverage."

Div. of Cancer Treatment Director Vincent DeVita urged the Cooperative Group chairmen to send in their comments. "They're listening. This one is controversial."

Comments should be sent to Robert Backus, Acting Director, Office for Protection from Research Risks, NIH, Bethesda, Md. 20014.

The Group chairmen agreed to an agenda for the clinical trials review next March by the DCT Board of Scientific Counselors.

The chairmen had strongly objected to the first agenda proposed by DCT staff at the chairmen's meeting last June. The new, acceptable agenda will include:

Day 1—Opening remarks by DeVita; pediatric malignancies, presented by Denman Hammond; breast cancer, by Barth Hoogstraten and Bernard Fisher; gastrointestinal cancer, by Charles Moertel; lung cancer, by Robert Livingston and E. Carmack Holmes; and sarcoma, by John Durant. Time will be allowed for discussion after each presentation.

Also on day one, presentations will be made on special resource needs by George Lewis, gynecology; Robert McDivitt, pathology; Marvin Zelen, statistics; Jan VanEys, pediatric oncology; Simon Kramer, radiotherapy; Donald Morton, surgery; and Holland, multidisciplinary studies.

Day 2 will lead off with an overview of clinical trials, which will include:

Scope—Paul Carbone, Holland and Franco Muggia; Mechanisms—Hoogstraten, grants; Fisher, contracts; DeVita, other forms; Review mechanisms—Jerome DeCosse, the CCIRC review of the Groups; Luther Brady, contract review; and David Joftes, others.

A general discussion on advantages and disadvantages of current approaches will wrap up the review.

DeVita said the "other forms" of support for clinical trials which will be discussed will be those now being considered by HEW, which he mentioned last week to cancer center representatives—consortium grants and cooperative agreements.

"I think there will be a lot of information coming out of this meeting that will be of interest to those people who think that prevention can be done in the absence of treatment," DeVita said.

At the risk of being misunderstood, DeVita said he would "only as a point of discussion" bring up his

suggestion that "if we were to start all over again now in organizing clinical trials, we probably would be more regional than we are. Would we change the existing mechanism? If so, how, and at what speed? It was never our intention to put a map on the wall and divide up the country. If you don't want to go regional, we won't do it."

DeVita pointed out that the Cooperative Group budget has grown from $19.2 million in 1975, when DCT assumed responsibility for the program, to $29.4 million in fiscal 1978. The projected budget for the current fiscal year is $31.2 million, if NCI's appropriation is not cut.

DeVita recalled that in a discussion of the Cooperative Groups at a National Cancer Advisory Board meeting in 1974, Holland had commented that the Groups could use $35 million. "We're just about there," DeVita said.

Holland remembered. "Bernie Fisher was sitting behind me and he whispered, 'You dumb oaf, you should have doubled that'."

DeVita said the estimates for FY 1980, at two budget levels, were $34 and 36 million.

Daniel Kisner, reporting on DCT's nutrition program, said that the proposal rejected by the Board of Scientific Counselors (*The Cancer Letter*, Oct. 27) had been reworked and "an RFP should be on the street by the first of the year."

The Board had not been impressed with a plan to spend $2.4 million a year to study total parenteral nutrition as an adjunct to antineoplastic therapy. A Board subcommittee was appointed to work with DCT staff in drawing up a new proposal.

Issues involved with intergroup studies were discussed, and DeVita said that the CCIRC "always struggles with the review" of such studies.

Holland argued against a proposal by Giulio D'Angio, chairman of the Wilm's Tumor Study Group for development of a central repository for data generated in intergroup pediatric studies. "I think the most productive research occurs when group participants have a role in devising studies," Holland said. "The nature of intergroup studies is such that delegates to intergroup meetings come back to their institutions and tell them what studies to do."

Hammond said that intergroup studies in rhabdomyosarcoma and Ewing's sarcoma were set up "so we would not have to organize a separate group for each disease." If as has been suggested, intergroup studies are reviewed and funded as separate grants, "it would be divisive," Hammond said.

D'Angio said the repository was needed to collect and analyze five year survival data, incidence of second tumors and other important information.

DCT prepared a statement describing administration and review of intergroup studies:

Intergroup studies are composed of four basic types:

1. A separately funded group with its own statistical center and central headquarters, with major participation by various Cooperative Group members as well as by individual institutions not participating in other cooperative group studies (example: the National Wilms' Tumor Study).

2. A separately funded group with its own central headquarters, as well as support for pathologic and radiologic studies, with participation only by members of various cooperative groups. Data is processed by the statistical center of one of the participating cooperative goups and is not supported under the intergroup grant (examples: intergroup rhabdomyosarcoma and Ewing's studies).

3. A disease-oriented study conducted by a committee of members from the involved groups, utilizing facilities for data processing and administration of one or more of the respective groups, but supported by group funding earmarked for the intergroup study, and subject to the peer review of its components (example: intergroup Hodgkin's study).

4. Miscellaneous studies between two or more groups, with a designated study chairman from each group. The data is separately analyzed and presented in each group's minutes by the use of shared information in each statistical office (example: RTOG-CCG hypoxic cell radiosensitizer studies).

The review of these programs is the responsibility of the CCIRC. The separately funded studies undergo periodic merit reviews, with reverse site visit by the liaison committees. A formal summary statement with scientific recommendations and critique is generated. This leads to budgetary recommendations for the intergroup grants (types 1 and 2) and for the component Cooperative Groups at the time of their regular grant renewal period (type 2).

The disease-oriented and miscellaneous studies (types 3 and 4) receive merit review at the regularly scheduled time for the component groups, subject to further revision if circumstances change; i.e., the project increases in scope enough to demand a separate review.

ACOS STUDIES SHOW SHIFT TO LESS SURGERY FOR BREAST CANCER PATIENTS

A significant shift away from the Halsted radical mastectomy to less extensive surgery for breast cancer patients has been noted in surveys conducted by the American College of Surgeons Commission on Cancer.

ACOS conducted two surveys this year—a long term study of breast cancer patients who received initial definitive treatment before December, 1972, to allow time for five year survival data; and a short term study of patients with histologically confirmed carcinoma of the breast admitted during 1977.

The long term study found that 24.3% of the patients received modified radical mastectomy with full axillary dissection, while 47.6% received the radical (Halsted) mastectomy. Those were all patients

treated prior to 1973.

The short term study discovered that the two figures have almost been reversed–57.7% were treated with modified radical mastectomy with full axillary dissection in 1977, while only 21% received the Halsted surgery.

Differences between pre-1973 and 1977 cases for other surgical procedures were not so marked, although they follow the trend to less surgery (first figures are long term, pre-1973 cases):

Wedge excision–3$, 4.1%; total mastectomy only–10.5%, 6.6%; total mastectomy with low axillary dissection–6.3%, 5.3%; radical mastectomy with internal mammary node biopsy–2.4%, .8%; super radical with enbloc removal of chest wall–.4%, .1%.

Another figure that might be significant is that in the earlier long term study, only three, out of the larger gorup of more than 24,000, refused surgery. In 1977, of 15,000 patients, 648 did not have surgery.

Five year survival data in the long term study show that 59.2% of patients in all stages were still living–74.5% of those with localized disease, 48.8% with regional disease, 12.1% distant, and 44.4% of those whose stage was unknown.

Five year end results by race and stage in general followed patterns noted in other studies–non whites do not do as well as whites. Of those with localized disease, 74.5% of whites were surviving, 72.7% non whites; regional, 50% of whites were alive, only 37.7% non whites; distant, 12.3% of whites were alive, 11.4% non whites. The stage unknown category included only three non whites, two of whom were alive, while only 43.8% of the 32 whites in that category survived.

Significant changes in distribution by treatment modality were observed in the two studies. In the earlier survey, 57.5% of patients were treated with surgery only; 2.2% radiation only; 30.6% surgery plus radiation; 2.2% chemotherapy and hormone; 2.3% surgery, chemotherapy and hormone; 2.1% radiation, chemotherapy and hormone, and 3.1% surgery, radiation, chemotherapy and hormone.

The preliminary report on the short term study of patients treated in 1977 does not show a breakdown for patients treated with surgery only. It does show that 95.6% of all patients received surgery either alone or in combination with other modalities. The distribution:

Surgery with pre-operative irradiation, .7%; surgery with post-operative irradiation, 17.2%; irradiation only, 2.1%; chemotherapy, either alone or in combination with other modalities, 17.8%; immunotherapy, either alone or in combination, .3%; hormone manipulation (ablative)–oophorectomy, 1.1%; adrenalectomy, .2%; hypophysectomy, .007%; no treatment, 2.1%.

The long term study was based on each participating institution entering a minimum of 50 patients who received initial definitive treatment before December, 1972. The hospitals were asked to report only female patients with histologically confirmed cancer of the breast, diagnosed either prior to or after admission. All hospitals were asked not to include patients with carcinoma of both breasts, patients previously treated for carcinoma of one breast, male patients, or those diagnosed by autopsy only.

The short term study includes patients with histologically confirmed carcinoma of the breast admitted during 1977, who had had no prior definitive treatment for the affected breast and no previous treatment for carcinoma of the other breast.

A total of 498 hospitals participated in the long term study, reporting on 24,125 cases. There were 629 hospitals in the short term study, with 15,468 cases.

Both reports noted that the results should be considered preliminary and invited further analysis and discussion. A later report will be made in January.

The studies were conducted by Roswell Park investigators. Roswell Park Director Gerald Murphy is chairman of the ACOS Patient Research & Evaluation Committee. Others working on the study were Josef Vana, Ramez Bedwani, and Takuma Nemoto.

Other information included in the preliminary report on the long term study included distribution of cases by:

- Age compared with the same information from the Third National Cancer Survey (SEER).
- Age and stage.
- Race and stage.
- Tumor size and positivity of axillary nodes.
- Stage and tumor size.
- Histologic type.
- Histologic type and stage.
- Histologic type and race.
- Five year followup and age.
- Five year followup by number of positive axillary nodes.
- Five year survival free of cancer by status of axillary nodes.
- Five year survival by histological diagnosis.

The report on the short term survey included much of the same type of information, plus some additional data related to changes in medical practice since the early 1970s.

Tumors were first discovered by 70.6% of the patients, with 21.5% found by physicians, 5% with mammography and 2.9% unknown. "That indicates the public education programs are correctly zeroed in," Murphy told ***The Cancer Letter.***

The number of patients who were given estrogen binding tests was 44.1%, with 55.5% of those showing positive results, 40.9% negative (including borderline) and 3.6% unknown. "This is technology transfer plus," Murphy commented.

The short term study showed that while 96.4%

of all patients received complete physical examinations, only 47.6% had rectal exams, 45% pelvic exams and 30.9% Pap smears. Some clinicians have wondered critically why their colleagues are not making a greater effort to look for other malignancies in breast cancer patients.

FINAL ISSUE OF THE CANCER LETTER FOR THE YEAR—NEXT, JAN. 5, 1979

This issue of ***The Cancer Letter*** is the last one for 1978 and the final issue, No. 50, in Volume 4.

The next issue will be published Jan. 5, 1979. The office of ***The Cancer Letter*** will be closed from Dec. 21 through Jan. 3.

Happy holidays and best wishes for the New Year.

CANCER PANEL MEMBERS NOT ENTHUSED ABOUT NEW TOXICITY TESTING PROGRAM

Members of the President's Cancer Panel are anything but optimistic about the prospects for success of the new National Toxicology Program, in which NCI's Carcinogenesis Testing Program resources have been removed from NCI control.

The Panel, meeting this week (yes, Benno Schmidt is still chairman, President Carter still not having appointed a successor), expressed doubt that the new organization can overcome bureaucratic deficiencies and diffusion of responsibility.

NTP is the arrangement in which the Food & Drug Administration, the National Institute for Occupational Safety & Health, the National Institute of Environmental Health Sciences and NCI are pooling money and staff in a combined toxicity testing effort, as previously reported in ***The Cancer Letter***. FDA, NIOSH and NIEHS have programs for testing various toxicities of suspected compounds; NCI is spending $21 million a year testing chemicals for carcinogenicity.

The new program is under the management of NIEHS Director David Rall. Richard Griesemer, director of the Carcinogenesis Testing Program, will report to Rall although remaining with his staff as NCI employees. Griesemer's $21 million budget will accompany him to the new program.

Schmidt said he was concerned about where the responsibility lay in such matters as selection of compounds for testing and design of tests. "If there are deficiencies in the total effort in carcinogenesis testing, NCI won't get off the hook because this is a joint agency kind of thing," Schmidt said. "If there are some major deficiencies, we better remedy them ourselves or we'll suffer the consequences.

"Historically, interagency arrangements have not been very effective operationally," Schmidt continued. "It's hard enough to get anything done out of one agency. When you increase the number, you increase the difficulty geometrically."

Schmidt said he views the program as one with two broad areas of activity—one to determine the carcinogenicity, and degree of carcinogenicity of compounds. "The other is the epidemiological area, to determine what the exposure levels are, where, who is exposed, how the public can be educated to protect against it, how the exposure can be eliminated by better public information or regulation. They really comprise one big area of activity, they are interrelated and involve different kinds of people. One of the unhappy byproducts of these efforts is that when a good board does as good a job as it can do in assessing an area of uncertainty, the uncertainty then becomes a certainty although there is a wide latitutde and no way to know precisely the degree of carcinogenicity."

NCI Director Arthur Upton said, "I don't see this as taking any responsibility away from us." But he did say there would be no epidemiology in the new program.

"Then who is going to make the list of compounds to be tested, find out who is exposed and to what degree?" Schmidt asked.

Upton pointed out that the program's executive committee would be made up of representatives of each of the four agencies involved plus the Environmental Protection Agency, Occupational Safety & Health Administration and Consumer Product Safety Commission. All will contribute the epidemiological data they generate to the decision making process.

Panel member Paul Marks said he still was not satisfied about who would be making the decisions on what to test. Upton said it has been agreed that the new executive committee will have the ultimate responsibility for chemical selection.

"But if Art really thinks something ought to be tested and the others don't agree, it still should be tested," Schmidt said. "He has $21 million of the $41 million that's going into the pot (including the contributions from the three other agencies)."

Marks said he felt that NCI's contribution will be forced to go up. "If NIOSH or EPA want to get something done but don't have the money for it, there will be a lot of pressure put on to get it tested anyway, with the money coming from NCI."

Upton reported briefly on the review of Frederick Cancer Research Center being conducted by an NCI group headed by John Moloney. "To date, the review shows that we have good quality science there," Upton said. He acknowledged that there has been a feeling among many outside the government that much of the work at Frederick could be done better elsewhere.

Upton confirmed the report (***The Cancer Letter***, Oct. 27) that there is strong sentiment among NCI and other NIH executives for phasing out the contract NCI has with Litton Bionetics for the operation of FCRC and staffing the facilities with intramural scientists. Consultations with NIH Director Donald Fredrickson "while still too early to report final conclusions, have identified two trends," Upton said.

"One, there is little question that the science is good. Not all of it, but in balance. Some of the laboratories have come a long way.

"Also, it has been recognized that the existence of FCRC represents a unique resource for NIH. With the overcrowding on the campus here, we may need to re-examine how the facilities at Frederick can house intramural programs. Some are already there, and it appears likely we may want to put more intramural scientists out there. If so, it will be a gradual transition. There has been no decision to make a drastic change."

CCRAC SHOOTS DOWN TWO STAFF PROPOSALS FOR NEW PROJECTS, APPROVES OTHERS

The Div. of Cancer Control & Rehabilitation Advisory Committee (CCRAC) gave its blessing (NCI prefers the term "concept approval") to almost every proposal for new projects submitted to it by DCCR staff this fall. Most have been described in previous articles and RFP and RFA announcements in ***The Cancer Letter.***

Two proposals, however, were discouraged by CCRAC and may be dead, although DCCR Director Diane Fink said her staff would revise them and bring them back to the committee's meeting in February.

One of the rejected proposals was for a study of the "psychological sequallae to notification of exposure to carcinogens," as Fink described it. She said these concerns grew out of the experiences in notifying workers and communities of their exposures to asbestos. "We've seen a high rate of depression, family disruption, an epidemic of suicides," Fink said. There have been indications of similar troubles among DES exposed families, although Fink said it was mostly anecdotal information.

Larry Burke, program director for rehabilitation control, said that the study might help develop ways to "minimize by more effective or different ways of notification" the adverse effects of notification. The study would cost from $100,000 to $150,000 a year, to be supported by a contract, Burke said.

CCRAC member Sam Shapiro objected. "This would be an extremely difficult area to get into. There will be problems in comparing, with self selection, the issue of proximity to information."

Committee consultant Anthony Mazzochi, a labor union executive, said, "I have problems with this proposal. I don't have problems with workers knowing something. There is a body of thought that we should inform people of risks involved with their jobs and if they accept the risks, then that's the nature of the job. We don't accept that attitude, which this proposal tends to support. My feeling is that NCI is responsible to get out the information that is known, to people who have the right to know."

Mazzochi said he did not believe suicides are consequence of industrial exposure "except where the chemical in question induces suicide. I want to emphasize that what we want is that which is known, must be told. If you want to study some psychological problem, study the scientists who don't want to tell anyone about occupational exposures."

CCRAC Chairman William Shingleton suggested that the proposal be deferred, and the committee agreed.

The other rejected proposal was for a contract to cost $100,000 a year for five years to develop continuing education courses in preventive medicine for physicians and other health professionals.

CCRAC member J. Gale Katterhagen said, "There's a plethora of continuing education programs and recertification programs. I'm not sure we wouldn't be trying to teach physicians something they don't already know."

Andrew Hegyeli, DCCR program director for carcinogenesis, argued that courses in preventive medicine would be a new concept in physician education.

"I beg to differ," said Katterhagen, who is a medical oncologist in Tacoma and former president of the Assn. of Community Cancer Centers. "I think most primary physicians know about these things. What I would like to know is why he isn't using them."

CCRAC member Oliver Beahrs said, "In the last several years there has been a rapid proliferation of these subjects in continuing medical education programs."

"Doctors know the value of doing a rectal," commented CCRAC member Maurice Reizen. "But do they do them?"

Fink suggested the proposal be deferred, and the committee agreed.

Proposals that were approved included:

- Followup on the breast cancer and head and neck cancer networks, to evaluate the concept of networks and look at morbidity and mortality. These probably will be sole source contracts to the centers in the networks.
- Study of 11,000 screenees in a program supported by the National Heart, Lung & Blood Institute. The NHLBI study was established to assess benefits of treating hypertension with reserpine. There is a control group, and the screenees include large numbers of women and various races who have been followed for five years or more. DCCR sees it as an opportunity to "look for just about anything" related to cancer. CCRAC member Harold Rusch noted, "At my institution (Univ. of Wisconsin) we wouldn't give reserpine because we felt it might cause breast cancer." The study might offer some evidence one way or another, he suggested.
- Contracts for development of programs of instruction in oncology nurse rehabilitation. One would be a subspecialty program in oncology nursing, the other in continuing education for public health nurses.
- A new RFP for contracts at four or five institu-

tions for training maxillofacial prosthedontists. A similar program now completed which was started in 1974 trained 36 prosthedontists and 40 technicians. There are only 96 working full time in the U.S., and the need is for at least 25 more.

- A support contract for DCCR, to develop materials for professional education, prepare documents for state of the art conferences, physicians advisories, other meetings. It will be a single contract, two years, at about $300,000 a year.
- A contract not to exceed $120,000 a year to develop methods for rapid and effective dissemination of new health care techniques to health professionals and the public. The main product would be a conveniently organized handbook of principles and guidelines, based on theory and practice and written in lay terms that would assist policymakers and communicators in planning and implementing effective cancer control promotion strategies.

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.

SOURCES SOUGHT

RFP NCI-CP-VO-91020-54

Title: *Investigations into induction and control of MuMTV expression in mouse mammary preneoplastic tissues as a model system for developing techniques, reagents and concepts which can be applied to the search for a putative breast cancer virus in precancerous human mammary tissues*

Deadline: *Dec. 29 (for submission of resumes)*

NCI is seeking organizations capable of performing investigations into the induction and control of Mu-MTV expression in mouse mammary preneoplastic tissues as a model system for developing techniques, reagents and concepts which can be applied to the search for a putative breast cancer virus in precancerous human mammary tissues. Interested organizations must have these capabilities:

1. Conduct virological investigations to propagate sufficient quantities of hyperplastic alveolar nodule tissues (or outgrowth lines) in selected MTV positive and MTV-negative mouse strains other than BALB/c by traditional in vivo serial transplantation procedures.

2. Using standard or newly developed biochemical and immunological methods (e.g., nucleic acid hybridization, immunoperoxidase techniques; EM), the contractor shall detect and quantitate levels of Mu-MTV expression as proteins, nucleic acid and complete virion in HAN tissues of varying tumorigenicities in the selected mouse strains.

3. To alter virus expression in HAN tissue with immunologic reagents, chemicals and/or hormones in efforts to define regulatory controls which may determine functions of viral components during mammary tumorigenesis.

4. To apply developed technology and reagents in the mouse model for the detection of oncornavirus expression in human mammary tissues and tumors.

Responses should not include cost or pricing information. Concise responses to the points mentioned above are requested. Respondents should indicate their facilities, experience and capabilities for carrying out this research and should include descriptions of availability and qualifications of professional and technical personnel to work on the project.

Ten copies of the resume of experience and capabilities must be submitted.

Contracting Officer: J. Thomas Lewin
Viral Oncology & Field Studies
301-496-1781

SOLICITATION NO. SS-79-2

Title: *Collection of data pertinent to the incidence of cancer of the breast, endometrium and ovary in a large population base*

Deadline: *Jan. 5 (for submission of responses)*

Case-control study on the incidence of cancer of the breast, endometrium and ovary with emphasis on the effects of oral contraceptive use on the risk of these types of cancer. The study is divided into two phases—a pilot study and a full scale study. The pilot phase will test the effectiveness of data collection instruments and procedures over a two or three month period beginning approximately May or June 79. The full scale study will begin approximately April-June 1980 and last for two or three years.

To collect the data necessary for conduct of the study, a prospective contractor must be able to identify in a defined geographic area all women ages 20-54 who are newly diagnosed as having cancer of the breast, endometrium or ovary. The minimum number of cases of these types of cancer would be 150 in a one year period.

Offerors must be able to meet the above requirements and have the following qualifications: (1) have established mechanisms for reporting cases and reviewing (abstracting) medical records and patholo-

gists' reports; and (2) experience in organizing, conducting and managing large scale case-control interview studies. The only known sources possessing the above qualifications are the participants in the Surveillance, Epidemiology and End Results (SEER) Program established by the National Cancer Institute.

Organizations, other than the SEER participants, who have demonstrated capabilities, qualifications and experience to perform this work and who desire to receive consideration for an RFP for the pilot study phase are invited to submit a concise resume describing in detail: (1) Data base to be utilized including letter(s) of agreement to participate if the original data source is other than the offeror; (2) Evidence that the data base is geographically based, reports all cases, and meets the 150 cases per year minimum; (3) Organizational background and experience in organizing, conducting and managing large scale case-control interview studies.

Note: A resume should be submitted only if an organization desires to receive an RFP for the pilot study. Another Sources Sought synopsis will be announced for the full scale study.) Unnecessarily elaborate brochures are neither required nor desired. Responses must be submitted in five copies.

Contracting Officer: Ken Williams
Center for Disease Control
255 E. Paces Ferry Rd. N.E.
Atlanta, Ga. 30305
404-262-6541

RFP NCI-CM-97264

Title: *Study of the distribution, disposition and metabolism of antineoplastic agents*

Deadline: *Approximately Feb. 15*

Establish and operate a research unit for studies on the clinical pharmacology of new antitumor agents under development by the Div. of Cancer Treatment. Information of potential clinical usefulness is to be obtained on the absorption, plasma clearance, distirubtion, plasma protein binding, metabolism and urinary and biliary excretion of such agents in human subjects. Comprehensive pharmacokinetic studies with potential predictive value are to be stressed. Where indicated, pilot studies are to be carried out in experimental animals (rats, mice or dogs) prior to initiating studies in man. Analytical methodology is to be developed where not previously available.

The laboratory must have close affiliation with a comprehensive cancer treatment unit within the same parent institution to permit integration of the studies with ongoing phase I and phase II clinical trials of antitumor agents in man. One or two new agents will be submitted by the project officer for study per year.

While this contract does not support phase I and II clinical studies per se, its purpose is to generate data of immediate utility in the conduct of such studies within the same or a closely affiliated institution. The contractor will therefore establish close liaison with clinical oncologists conducting such studies, for the purpose of furnishing them with data concerning assay methodology, plasma clearance, drug metabolism and other pharmacological information which may be of value in the design and conduct of phase I and II clinical trials.

When appropriate, the contractor will carry out analyses of drug and drug metabolite levels in biological samples generated in the course of such studies. It is anticipated that one award will be made for a three year period.

Contract Specialist: Otis Parham
Cancer Treatment
301-427-8125

NCI CONTRACT AWARDS

Title: Breast Cancer Detection Demonstration Project, renewals
Contractors: St. Joseph Hospital, Houston, $321,300; College of Medicine & Dentistry of New Jersey, $322,050.

Title: Standard protocol for evaluation of imaging techniques in cancer diagnosis, continuation
Contractor: Bolt, Beranek & Newman Inc., Cambridge, Mass, $73,715.

Title: Operation of facility to provide and maintain subhuman primates for cancer research, continuation
Contractor: Litton Bionetics, $82,997.

Title: Research on spontaneous and virus induced neoplastic transformation, continuation
Contractor: Meloy Laboratories, $83,335.

Title: Immunoprevention of cancer in cats
Contractor: Cornell Univ., $346,234.

Title: Support services for studies on the role of viruses and experimental oncogenesis and human cancer, continuation
Contractor: Hazelton Laboratories, $73,274.

Title: Support services for molecular studies of human and animal cancer, continuation
Contractor: Meloy Laboratories, $57,143.

Title: Identification of cell surface receptor for oncornavirus gp^{70} on murine fibroblasts
Contractor: UCLA, $243,590.

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