THE CANCER LETTER

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SOME NCI ADVISORS TELL GAO CONGRESS "JUMPED THE GUN" IN CREATING CANCER CONTROL PROGRAM

The General Accounting Office, the congressional investigative agency which has been probing NCI's Cancer Control Program, has been told by some members of the President's Cancer Panel and/or the Cancer Control & Rehabilitation Advisory Committee they feel Congress "jumped the gun" in authorizing the program.

William Terry, DCCR acting director, commented at the meeting this week of the advisory committee that GAO was asking questions based on the statement (quoting Terry), that "advisors to the Cancer Control Program, as yet unnamed, have commented they feel Congress jumped the gun in authorizing the Cancer Control Program before the technology was available to transfer. Congress had thought that there were research findings lying on the shelf waiting for transfer to health care de-

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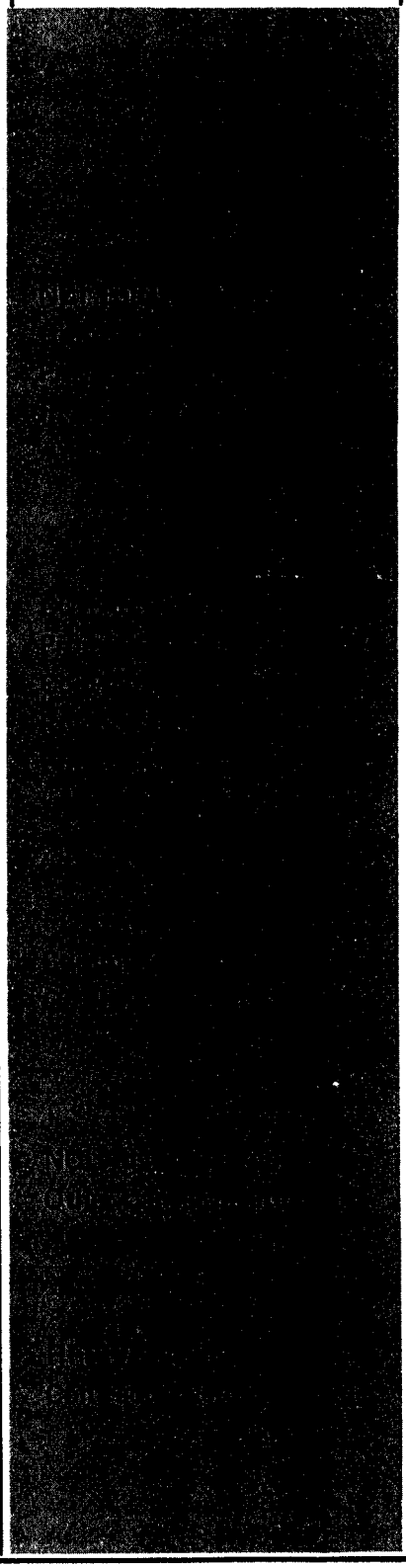
In Brief

INTERIM MONEY BILL PASSES; NCI CAN START AWARDING GRANTS, CONTRACTS WITH 1980 FUNDS, UNTIL NOV. 20

IT'S BUSINESS as usual at NCI, with approval of the continuing resolution providing interim funding for HEW while Congress continues to wrangle over the abortion issue. The resolution expires Nov. 20; until then, at least, NCI can proceed with awarding grants and contracts with FY 1980 money, at the rate approved by Congress of $1 billion for the year. If the appropriations bill has not been passed by Nov. 20, the continuing resolution will have to be extended. The House and Senate compromised in the resolution on language relating to Medicaid funding of abortions, but antiabortion forces plan a last ditch fight against the compromise in the regular bill. It's possible the interim funding could be stretched out for the entire year. . . . **NATIONAL CANCER** Advisory Board's Nov. 26-28 meeting, with emphasis on program review and no grants to consider, will hear from each of the division directors. Also on the agenda will be consideration again of the new guidelines for comprehensive cancer centers and a discussion of research training policies and guidelines. . . . **WORKSHOP ON POLYPEPTIDE** Hormone Receptors in Normal and Neoplastic Tissue will be held Nov. 13-14 at NIH, Bldg 31 Rm 10. Sponsored by the NCI Breast Cancer Program, the workshop will focus on prolactin and insulin and develop guidelines for the program in that area. . . . **ONCOLOGY NURSING** Society's Fifth Annual Congress will be held May 28-30 at the Sheraton Harbor Island Hotel in San Diego, overlapping the AACR-ASCO meetings which are also in San Diego at another hotel. The ONS meeting will include instructional sessions on nursing research, burnout, assessment tools, hospice and ethics. Original papers will be presented on research, practice, administration and education in oncology nursing.



GAO ASKS: "DO WE KILL CANCER CONTROL PROGRAM? OR PUT IT IN ANOTHER AGENCY?"

(Continued from page 1)

livery, but GAO has found that there is not a lot lying on the shelf.

"GAO is asking these questions," Terry continued. "Has Congress jumped the gun? Where do we go from here? Do we kill the Cancer Control Program and put that money into research? Or do we transfer it to another agency?"

Terry indicated he did not know who the advisors were. However, Matthew Solomon, who heads the GAO office at NIH, told *The Cancer Letter* his staff has talked with members of the President's Cancer Panel and CCRAC. They had not talked with members of the National Cancer Advisory Board, Solomon said.

NO CCRAC member at this week's meeting acknowledged talking with GAO investigators. The committee, now chaired by Joseph Painter, vice president for administration of the Univ. of Texas System Cancer Center, recently changed about one-third of its membership.

Solomon said that in addition to talking with members of the two advisory groups, "we are looking at selected cancer control projects, trying to assess their benefits and accomplishments." Investigators are reviewing project files and are talking with project officers and contract officers. They have not had any discussions with DCCR contractors or grantees, he said.

The investigation was requested by Congressman David Obey (D.-Wisc.). The report will be published by February, Solomon said.

Solomon declined to reveal the nature of the discussions with Panel and CCRAC members, whether the questions described by Terry had in fact been asked or the response received. "People are responding," he said.

CCRAC member Kenneth Casebeer said he was "concerned with the way the GAO questions were put. They seem to indicate the Cancer Control Program is only concerned with technology transfer. The program supports a number of programs which might be called cancer management and dissemination of information beyond health delivery people."

"Don't put too much emphasis on the narrowness of the questions," Terry said. "The GAO folks formulate their questions based on the kinds of questions asked by congressmen and congressional staff. It is important to point out that our activities go beyond technology transfer."

CCRAC member Harold Rusch commented that he had been on the Yarborough Panel "which fed information to Congress that led to the National Cancer Act of 1971. Some committee members did feel there was a lag, that there was a lot on the shelf to be transferred. My feeling was that there wasn't a lot that wasn't being transferred. When the Act was passed, I was surprised that a lot of it expanded what the American Cancer Society had been doing for years."

Rusch said he felt "not enough money is going into research that will help transfer faster the things on the shelf. An example would be research on selecting people at risk to cancer. Not a great deal is being done on such things as why some people who smoke get lung cancer while the majority does not. They may get emphysema or heart disease but not cancer."

"I'm distressed that frequently the community has little interest in cancer control problems," said Paul Engstrom, CCRAC liaison member with the cancer control review committees. "When programs are brought into the community, they are frequently looked upon as meddlesome, as things they don't want to deal with. The question is, are we trying to shake up health care delivery? Should we attempt to intervene early? Or wait until people have medical problems? All of us feel early intervention is better, but it is difficult to keep the momentum going for intervention efforts. We all believe that if you can prevent cancer or detect it early, you can save money. Most people reject that, and prefer to wait until they have a problem. Most physicians are up to date on prevention, detection or the social aspects. GAO is looking at the wrong end. The problem is getting people to accept cancer control technology."

"Some of the problem lies in the fact that Congress and DCCR have not had enough input from communities," CCRAC member Gale Katterhagen said. "The problem was not defined accurately at the start. You should define problems before offering solutions. Also, if you are going to transfer technology, you better have something permanent to transfer it to."

CCRAC consultant Anthony Mazzochi said he "perceives" cancer control as prevention, "although some in the scientific community see it differently. . . When looking at cures, scientists move into mythology." Commenting that the 1980s will see a major shift to emphasis on lifestyle in relation to health, Mazzochi said he was "appalled at discussions of lifestyle without discussing the way people live and work."

Some industries are moving toward three and four day work weeks of 12 or 10 hours a day, Mazzochi said. Few companies make provisions for serving hot meals, with most relying on vending machines as food sources for employees. "We (the unions) would like to discuss what goes into those machines, but we've been told we have no collective bargaining right to do so. No one is going to carry three meals a day with him to work. Any discussion of nutrition will have to take this into account."

Mazzochi took issue with the contention that Congress acted prematurely in authorizing the Cancer Control Program. "Our data shows we should be

concerned. Geographic areas (and cancer incidence) and the nature of the work should be looked at. We're criticized sometimes for quoting 'housewife epidemiology.' Well, I have faith in it. When workers have suspicions about a health problem, it always bears fruit."

CCRAC member Harold Mendelsohn said, "The problem is almost semantic. The business of technology transfer came from the aerospace program. It does not relate to our problems. Ours is not a 'how to' operation. It involves different kinds of processes, the dissemination of information, communication. There is very little technology transfer."

Terry, referring to Mazzochi's statement that cancer treatment involves mythology, said, "When you confront what we think we know about prevention, that abounds with mythologies. We know very little about nutrition and its relation to cancer. We have reasons to think nutrition is important, but when you get down to telling people what they ought to eat, be careful. We don't want to transfer technology that ought not be transferred."

George Omura, another CCRAC-review committee liaison member, noting that much research "falls through the cracks" because it can't get support although it has great relevance for cancer control, asked if projects could be supported as "joint ventures" with other NCI divisions and other government agencies.

"The reorganization (of DCCR) might be an opportunity to redefine which aspects of cancer control are appropriate for the division to support. The division should be supporting research in cancer control —how to get good works accomplished, rather than good work itself."

"Time is an important factor," said CCRAC member Sam Shapiro. "The challenge is not coming at the beginning of a program. It is important to select out what has been accomplished and find the direction to take for the future. We can concentrate on some issues, which can be targeted."

Terry presented the proposed makeup of the new division which will replace DCCR.

The new division's name will be (pending any decision otherwise when the reorganization package is presented to HEW) the Div. of Centers, Community Activities & Resources (DCCAR). It will include:

- All components, programs, personnel, responsibilities and activities of DCCR.
- The Cancer Centers Program, including the Research Facilities (Construction) Branch.
- The Training & Education Program, including the Research Manpower Branch and the Clinical Manpower Branch.
- The Organ Site Programs Branch, including the Bladder, Large Bowel, Prostate and Pancreas programs.

With NCI Director Arthur Upton's decision not to attempt to start a new Div. of Prevention, he has asked each of the other program divisions to review their programs with respect to ongoing activities, opportunities, needs, and proposed new initiatives in cancer prevention and to report to him by Jan. 1 on their plans and recommendations for steps to strengthen them.

DCCAR in addition to its other activities described above will be responsible for:

- Expediting the application of research findings through the development of practical measures for the prevention or early detection of cancer.
- Conducting appropriate studies to ensure the validity and timeliness of prospective interventions intended to prevent cancer.
- Evaluating and refining cancer prevention strategies to assure maximum benefit to the largest possible population with the least risk and cost.
- Developing close liaison with cancer centers, public and professional educational organizations, public health groups and agencies, labor organizations, trade and professional associations, and regulatory agencies "in order to foster communication, information exchange and cooperation."
- Collaborating closely with all NCI divisions and offices, the National Toxicology Program, other NIH institutes, and other national and international research organizations.

The responsibilities of the new division could be extended into cancer control related research, Shapiro said. (The program generally has not been permitted to fund research except for rehabilitation research.) "A great deal is required," Shapiro said. "Community relations, the Cancer Information System, require a good deal of research. Early detection. A prime example is the Breast Cancer Detection Demonstration Project. A research project before that was undertaken could have raised questions about what could be learned (from BCDDP), and could have led to modification of it."

"Of the 90,000 a year who die of lung cancer, 75,000 are related to smoking," Terry said. "This is a question of primary prevention. I don't think we know how to stop teenagers from starting to smoke, or how best to get people to stop. It's a problem for behavioral research. Would it be proper for this division?"

"No question of it," Shapiro said, "as the lead division of NCI in this area. It requires some broad investment in research."

Rusch said there is an opportunity for the study of "anticarcinogens in people. There has been quite a bit of work with animals and anticarcinogens. I think the time is right to test these anticarcinogenic chemicals in people. It will take a long time. Most study sections would turn it down."

"It ought to be possible to select items needing research," Shapiro said. "The role of the division is moving into those areas."

Demonstration projects have been the primary vehicle for the Cancer Control Program's technology transfer efforts. Casebeer asked if communities are picking up activities after the demonstration ends.

"The concept of demonstration was not carefully defined," Terry said. "Demonstrations are a form of research. As long as you build in evaluation, collect and analyze data, that's research. Were I to be the director of the division, I would think it terribly important to evaluate demonstrations. We would move away from demonstration without evaluation capability."

"One thing troublesome about demonstrations is that many were set up with the assumption that the demonstration would be successful. There is no accommodation for failure, and if it fails, it is dropped without an effort to use information gained. You can learn a lot from the failures."

Terry said that one of the problems in failure to follow up "is the high rate of turnover among the staff in this division. The corporate memory becomes deficient. There is a tendency to break new ground rather than continue working with existing projects. It is very important to recruit staff and get some stability."

Donald Buell, DCCR program director for medical oncology and community activities, said, "We have struggled with the problem of programs that fail. We need an administrative structure that looks at it specifically. Grants that don't get renewed just disappear from the scene. We need a mechanism to look at grants that do not get renewed."

Engstrom noted that some prevention efforts could be very costly. "I'm concerned whether NCI can pay the cost of studying prevention in the terms being presented. Those are 20 and 30 year programs."

"Because of that consideration, I've suggested they recruit a division director who is 15 years old," Terry cracked.

"It costs a lot of money not to deal with it," Mazzochi said. "The information you need isn't 30 years away. It's available now. The atlas (published by NCI's SEER Program showing cancer incidence county by county in the U.S.) has a lot of information on the cancer in particular places. No one addresses why. I can't understand it. It may be easier to get answers than you think."

CCRAC member Gussie Higgins, pediatric oncologist at Los Angeles Children's Hospital, disputed the contention that technology transfer has not played an important role in improving cancer treatment.

"There were successes in pediatric cancer before 1971," Higgins said. "Information was presented to Congress that children were dying of leukemia after nine months, when five year survival was possible with treatment available in some cancer centers. The question was asked, if this information is available in centers, why not in communities?

"We started, we had an effective treatment, and we demonstrated it. Now we are predicting that 60% will be long term survivors. We looked at what we already knew, and we dealt with it."

Engstrom argued that that "was a different modus operendi. Pediatricians assume that pediatric cancers are best handled in centers. Pediatric centers staked out their own territories, and referrals were almost automatic. As more pediatric oncologists are being trained, some are going into communities, but they are still satellites and refer to centers. We need to look at your lessons, but realize we're in a different ballgame."

"That was not rebuttal but support for what I said," Higgins responded. "We had effective therapy, something to work with."

Terry observed that "there seems to have been a large amount of distrust, or paranoia, between communities and centers. How can we deal with that?"

"It's often a town and gown relationship," Katterhagen said. "The town fears it will lose patients to the gown. We need to build mutual trust. Most patients need to remain in the town for treatment. We need staff at centers to include some from the town, so the centers will know the town's needs and problems."

"What can NCI do to assist?" Terry asked.

"By insisting that centers include people experienced in the town," Katterhagen answered. "Centers often hire a great deal of theory but little practical experience. The town feels that once cancer has been detected, treatment of the majority of adult tumors is no better at centers than in communities, and the outcome is the same. I don't know if that can be supported in the literature."

"The fear of taking away patients can be handled," Shapiro said. Referring to outreach efforts by Johns Hopkins Comprehensive Cancer Center, where Shapiro is director of health services research and development, he said that differences between the center and community physicians involve "what each feels is important. We thought that detection and prevention is important, they not at all. They wanted a directory of resources. What can NCI do? It is not easy. It takes a lot of nurturing, effort and time."

"How can comprehensive centers help?" commented Rusch, who founded and directed the Univ. of Wisconsin Comprehensive Cancer Center. "First, you have to have good will. Make sure that patients go back to the communities for treatment. Second, funnel small amounts of money to communities for record keeping, and some money to pay travel expenses. Community doctors come into our center about three times a year."

CCRAC COOL TO THREE PSYCHOSOCIAL PROPOSALS, APPROVES ONE ON AGING

The Cancer Control & Rehabilitation Advisory Committee gave a lukewarm reception to DCCR staff requests for concept approval of new projects at the committee's meeting this week.

CCRAC approved the concept of studies related to elderly persons and cancer, and deferred decisions on:

- A state of the art workshop on stress among health professionals dealing with cancer patients.
- Evaluation of the effectiveness of self help groups, such as Reach for Recovery and Candlelighters.
- Determination of the incidence and prevalence of noncompliance with treatment, rehabilitation and continuing care regimens.

Rosemary Yancik, program director for social science projects, commented that with 75% of all cancer deaths occurring after age 60 and with the number of elderly persons increasing dramatically, "the burden of cancer falls heaviest on people who already have a lot of problems."

Yancik said the studies would address such issues as the interplay among nutrition, age and cancer; whether cancer presents differently in the elderly; contributions of age to the differences in cancer patients relative to other illnesses they may have; social aspects of cancer for older persons; and how practicing physicians deal with older patients.

The committee agreed unanimously that the subjects merited study and asked Yancik to come back with more details on specific proposals. Yancik said no decision had been reached on whether the studies would be supported through grants or contracts.

Casebeer asked if the National Institute of Aging had any similar projects under way which might overlap Yancik's proposals. "Are there any specific cancers showing up in the aging that are usually not seen in younger populations?" Yancik said NCI Director Arthur Upton and NIA Director Robert Butler had discussed collaboration on studies.

"There has to be a considerable body of information accumulated through the Cancer Control Program," Engstrom said. "We need to find out what information we already have."

"We have to find out what's known and what people know about what's known," Mazzochi commented.

Shapiro pointed out that NIA has identified 10 areas "they are intensely interested in. Cancer is not one of them."

Committee members showed little interest in Yancik's request for approval of a workshop on "personal stress on health professionals, how they cope, what anxieties they experience." Emphasis would be on physician stress. "There has been a lot of work with nurses in this area, but very little with physicians," Yancik said.

Engstrom said he has observed that morale among physicians and nurses increases when a hospital establishes an oncology unit. Katterhagen, who heads a community hospital cancer program in Tacoma, agreed.

"I haven't seen much stress among physicians," Katterhagen said. "Our nurses tend to be older and have been through the stress of marriage and children. Their biggest stress is with the administration and nursing service. The biggest stress on nurses in the hospice is with insurance problems, not with dying patients."

"This should have a low priority," Rusch said. "I don't feel there is any reason to get a body of information to convince people who aren't happy that they should stay in the field. Self selection is better. When people don't want to work with cancer patients, it's better to let them go elsewhere."

Sandra Levy, health science administrator in DCCR, presented the request for evaluation of self help groups. "There are a number of outcomes to measure—how to destigmatize a disorder, measure changes in attitudes, relate to other outcomes, develop normative criteria." She said patients would be randomly assigned to behavior modification groups, and "we would like to attract good behavorial scientists to these studies."

"There's some fuzziness here," Katterhagen said. "The average practitioner believes self help groups are good. The groups feel they do some good. How would this study influence the use of groups?"

"It's important to develop predictors, who can benefit and who not," Levy answered. "There are dropouts in groups, people who become disenchanted."

Committee members indicated they would vote against the concept if asked to do so at that time. Instead, they agreed to reconsider at a future meeting after more details are provided.

The noncompliance issue met the same fate, with committee members indicating they would need more reasons to support the proposed study before they would approve it.

FDA ACCEPTS ADVISORY COMMITTEE'S RECOMMENDATIONS ON NDA, LABELING

The Food & Drug Administration has accepted recommendations its Oncologic Drugs Advisory Committee made earlier this year. They were:

- Approval of the NDA for daunomycin HCL for treating adult AML and ANLL. The committee had voted unanimously that there is sufficient data showing complete remission rates for induction and noted the impact on survival with either daunomycin alone or in combination with cytosine arabinoside.

The committee said additional data were needed to make recommendations concerning adult ALL and requested the firm submit cata from CALGB studies 7221 and 7421. Those data were submitted,

reviewed and FDA accepted the recommendation to approve the indication of adult ALL.

• Approved labeling for dacarbazine (DTIC). FDA accepted the committee's recommendation to approve the supplemental application that provided labeling to include the indications for advanced Hodgkin's disease and metastatic sarcomas.

• The committee had recommended that the indication for hydroxyurea in treating head and neck cancer in combination with radiotherapy remain in the package insert. FDA accepted the recommendation.

• FDA went along with the committee's decision that high dose thymadine studies had demonstrated adequately the agent is safe and that clinical trials should be continued.

• FDA agreed with the committee's request that its advice be sought when a drug has been proposed for NCI's Group C distribution list (and available to physicians at no charge).

NCI TO OFFER NEW GRANTS IN PREVENTIVE ONCOLOGY-EPIDEMIOLOGY, BIOSTATISTICS

NCI plans to invite national competition for Preventive Oncology Academic Awards in epidemiology and biostatistics, a new grant program which will have the dual purpose of improving the quality of preventive oncology education and of fostering research and careers in epidemiology and biostatistics.

Schools of medicine, public health and NCI designated cancer centers in the U.S. and U.S. territories and possessions will be eligible to compete for one Preventive Oncology Academic Award for a project period not to exceed five years. The number of new awards made each year will depend on the availability of funds.

Donald Luecke, acting chief of the Special Programs Branch in the Div. of Cancer Cause & Prevention, described the new program at the recent meeting of the National Cancer Advisory Board. The Board took no formal action regarding it, but with comments from members generally favorable, NCI executives determined that they had at least tacit approval and plan to go ahead with it.

Luecke said individual awards would amount to $70-80,000 each and that as many as 10 awards would be made. An RFA (request for applications) will be published which will describe the program's requirements.

Objectives of the awards will be to:

—Encourage development of high quality preventive oncology education programs that will attract outstanding students to preventive oncology research, teaching and practice.

—Ensure superior learning opportunities in preventive oncology.

—Develop promising young faculty whose interest and training are in preventive oncology.

—Develop superior faculty who have a major commitment to, and possess educational skills for, teaching preventive oncology.

—Facilitate interchange of educational ideas and methods among awardees and institutions.

Competitive review of proposals will include assessment of both the sponsoring institution and the proposed awardee. To qualify, the institution must:

—Sponsor a candidate with competence in epidemiology, biostatistics, or one of the closely related biomedical sciences, and with major career interest in preventive oncology and in improving educational programs.

—Present plans to develop or improve the preventive oncology educational program.

—Identify the resources (patients, manpower, materials) necessary to implement the proposed program.

—Provide the awardee with time to acquire the educational skills necessary for personal development as a teacher, and for the development of the preventive oncology program.

—Have access to facilities for appropriate preventive oncology research and high quality patient care.

—Provide evidence of commitment by the administration and by the chairman of the sponsoring department to facilitate implementation of the proposed program.

—State the mechanism for continued institutional support of the preventive oncology program subsequent to the award.

The candidate must:

—Be a citizen or noncitizen national of the U.S., or have been lawfully admitted to the U.S. for permanent residence at the time of application.

—Hold an academic appointment at a school of medicine (including osteopathic medicine), or public health in the U.S., its territories or possessions at the time of application.

—Have sufficient research training or clinical experience in oncology to be effective in developing and actively implementing a high quality research and education program in preventive oncology.

—Present a program for developing or improving preventive oncology education in the grantee institution and for evaluating the outcome of this effort.

—Commit a substantial portion of his/her effort to developing, improving and implementing a preventive oncology program, including some research in preventive oncology.

—Specify a program for enhancing his/her educational skills; agree to report annually on the status of the program.

—Agree to meet annually with other recipients of Preventive Oncology Academic Awards to exchange ideas, methods and program evaluations.

Award funds may be used for support of the awardee, travel, equipment, supplies, consultant fees, stipends for a limited number of students to augment

their preventive oncology learning experiences, and indirect costs.

NCAB member Sheldon Samuels said he had "misgivings, which stem from the basic purpose of the award, to individuals, not institutions. Awards should be made to stimulate excellence. Excellence in science comes from individuals, not institutions. There ought to be an award for younger scientists. Breakthroughs will not occur through providing more support for institutions."

NCI Director Arthur Upton said, "We've heard many reasons why people are not in this field. We need to address that. This award is not intended to support research. It is intended to create incentives in academic institutions to engage young scientists who will continue research and help the institution develop an effective training program."

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR NOVEMBER, DECEMBER

Cancer Clinical Investigation Review Committee—Nov. 5-6, NIH Bldg 31 Rm 6, open Nov. 5, 8:30 a.m.—noon for a mini-symposium on biostatistics and their impact on clinical trials.
Clinical Cancer Education Committee—Nov. 7-8, NIH Bldg 31 Rm 10, open Nov. 7 8:30—9:30 a.m.
Cancer Special Programs Advisory Committee—Nov. 8-9, NIH Bldg 31 Rm 8, open Nov. 8, 9—10 a.m.
Molecular Actions & Targets for Cancer Chemotherapeutic Agents—Nov. 8-9, Sheraton Park Plaza Hotel, New Haven, Conn., Yale Univ. Comprehensive Cancer Center, 2nd annual Bristol-Myers symposium.
Tumors Involving the Skin—Nov. 8, Roswell Park continuing education in oncology.
Status of the Curability of Childhood Cancers—Nov. 8-9, Shamrock Hilton Hotel, Houston, M.D. Anderson 24th annual clinical conference.
Workshop on Polypeptide Hormone Receptors in Normal & Neoplastic Tissue—Nov. 13-14, NIH Bldg 31 Rm 10, 9 a.m., both days, open.
Cancer Center Support Review Committee—Nov. 15-16, NIH Bldg 31 Rm 6, open Nov. 15, 8:30—10 a.m.
Div. of Cancer Biology & Diagnosis Board of Scientific Counselors—Nov. 16-17, NIH Bldg 31 Rm 10, open Nov. 16, 9 a.m. —5 p.m. Review of the Laboratory of Pathophysiology.
Symposium on Diagnosis & Treatment of Bone Tumors—Nov. 17-18, Memorial Sloan-Kettering Cancer Center. Physicians only. Contact A.G. Huvos, Memorial Hospital, New York 10021.
National Cancer Advisory Board—Nov. 26-28, NIH Bldg 31 Rm 6, 9 a.m. each day, all open.
Clearinghouse Chemical Selection Subgroup—Dec. 3, NIH Bldg 31 Rm 4, 9 a.m., open.
4th Annual Asian Cancer Congress—Dec. 4-8, Bombay. Contact Charles Sherman, Dept. of Surgery, Univ. of Rochester Medical Center, Rochester, N.Y. 14642.
Pacific Endocurietherapy Society—Dec. 5-7, Mazatlan.
Critical Issues in Toxicology & Environmental Health—Dec. 5-7, Sheraton Park Hotel, Washington D.C., sponsored by the American College of Toxicology and Mt. Sinai School of Medicine.
Clinical Cancer Program Project Review Committee—Dec. 10-11, NIH Bldg 31 Rm 6, open Dec. 10, 8:30—10:30 a.m.
Clinical Cooperative Group Chairmen's Committee—Dec. 13, NIH (no room assigned yet), 1:30 p.m., open.
Cause & Prevention Scientific Review Committee—Dec. 14, NIH Bldg 31 Rm 6, open 9—9:30 a.m.
New Drug Seminar—L-Asparaginase and Daunorubicin—Dec. 17-18, NIH Masur Auditorium, 8:30 a.m. both days, open.
2nd Workshop on Cloning Human Tumor Stem Cells—Jan. 3-5, Univ. of Arizona. Contact Mary Humphrey, Cancer Center Div., UA, Tucson 85724, phone 602-626-6044.

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. Address requests to the contract officer or specialist named, NCI Research Contracts Branch, the appropriate section, as follows:
Biology & Diagnosis Section and Biological Carcinogenesis & Field Studies Section—Landow Building, Bethesda, Md. 20205; Control & Rehabilitation Section, Chemical & Physical Carcinogenesis Section, Treatment Section, Office of the Director Section—Blair Building, Silver Spring, Md. 20910. Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CB-64337-35

Title: *Characterization of HLA antigens of donors' lymphocytes by serotyping and cellular typing*
Deadline: *Jan. 9, 1980*

NCI is seeking the assistance of a laboratory to characterize, as fully as possible, HLA antigens on normal donors' lymphocytes supplied by the National Cancer Institute. Typing shall include serotyping, (for HLA-A, -B, -C, -DR and other B cell specificities) and cellular typing.

Contract Specialist: Elizabeth Rexroad
Biology & Diagnosis
301-496-5565

NCI CONTRACT AWARDS

Title: Clinical data retrieval services, renewal
Contractor: EG&G Mason Research Institute, $681,086.

Title: Pulmonary adenoma induction in strain A mouse
Contractor: Univ. of California (San Diego), $494,754.

Title: Provide rodent disease diagnostic laboratory support for monitoring health status of animals used by the NCI Carcinogenesis Testing Program
Contractor: Univ. of Alabama, $663,861.

Title: Development of protocols for worker notification and information programs
Contractor: Western Institute for Occupational/Environmental Services, Berkeley, Calif., $228,572.

Title: Biology of neoplastic liver lesions in mice
Contractors: Univ. of Texas System Cancer Center, $30,777; Univ. of Maryland, $93,189; and Univ. of California (Davis), $38,707.

Title: Development of ultrasonic endoscopic probes to be inserted through endoscopes for use in cancer diagnosis, continuation
Contractor: SRI International, Menlo Park, Calif., $69,233.

Title: National survey of public attitudes, knowledge and practices related to breast cancer, extension
Contractor: Opinion Research Corp., Princeton, N.J., $38,394.

Title: Development of an informational data base for public health strategies in cancer prevention
Contractor: Midwest Research Institute, $499,160.

Title: Followup fluoroscopically examined tuberculosis patients in relation to incidence of cancer, continuation
Contractor: Harvard Univ., $394,920.

Title: Biomedical computing: Designing and implementation of computer programs and systems
Contractors: Geomet Inc., $885,154; and ORI Inc., $623,187.

Title: Support services for National Nonmelanoma Skin Cancer Study, continuation
Contractor: Pacific Consultants, Boston, $28,375.

Title: Support services for field studies, continuation
Contractor: Westat Inc., $248,591.

Title: Detroit SSMA population-based cancer registry, continuation
Contractor: Michigan Cancer Foundation, $244,265

Title: Nonmelanoma skin cancer study in New Hampshire-Vermont
Contractor: Dartmouth College, $127,601.

Title: Etiologic study of respiratory cancer in coastal Texas
Contractor: Univ. of Texas Health Science Center, Houston, $733,667.

Title: Support services for occupational studies
Contractor: Westat Inc., $1,371,217.

Title: Animal morbidity/mortality survey of colleges of veterinary medicine in North America
Contractor: Assn. of Veterinary Medical Data Program participants, $133,950.

Title: Operation of a virological diagnostic laboratory
Contractor: Microbiological Associates, $688,125.

Title: Short training course on principles and techniques for the safe handling of chemical carcinogens
Contractor: IIT Research Institute, $179,709.

Title: Processing of clinical patient research data
Contractor: Control Data Corp., Rockville, Md., $60,000.

Title: Therapy of patients with colo-rectal cancer, modifications
Contractor: Univ. of Pittsburgh, $150,000 and $500,000.

Title: Primary breast cancer therapy group study, modification
Contractor: Univ. of Pittsburgh, $802,000.

Title: Support for BCRP medical and laboratory programs, modification
Contractor: Univ. of Maryland, $3,204,798.

Title: Gastrointestinal Cancer Research Program, continuations
Contractor: Georgetown Univ., $42,825, $52,030.

Title: Phase II studies in gastrointestinal cancer
Contractors: Mayo Foundation, $649,136, and Georgetown Univ., $385,077.

Title: Storage and distribution of chemicals and drugs used in cancer chemotherapy, modification
Contractor: Microbiological Associates, $46,350.

Title: Hematology support care project, 10 month renewal
Contractor: Microbiological Associates, $111,882.

Title: Primary and detailed in vivo screening for anticancer activity, modification
Contractor: Mason Research Institute, $119,279.

Title: Statistical support for the gastrointestinal tumor study group
Contractor: EMMES Corp., Potomac, Md., $79,924.

Title: Hyperalimentation studies, continuation
Contractor: Univ. of Texas System Cancer Center, $58,750.

Title: In vivo screening program
Contractors: Battelle Memorial Institute, Columbus, Ohio, $4,988,245; and IIT Research Institute, $5,276,562.

Title: Health effects of carcinogenic exposure, community demonstration project
Contractor: Western Institute for Occupational/Environmental Services, Berkeley, Calif., $878,200.

The Cancer Letter _Editor Jerry D. Boyd

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