THE CANCER LETTER

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DEVITA WILL ASK NTP TO RETURN SOME NCI FUNDS TO HELP COVER SHORTFALL IN CENTER CORE BUDGET

Acting Director Vincent DeVita has committed NCI to providing an additional $3 million for cancer center core grants and is asking the National Toxicology Program to help meet that commitment by returning

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In Brief

CONTRACTS VS. GRANTS A NON ISSUE, UPTON SAYS IN FAREWELL APPEARANCE; CONTE EYES CHAIRMANSHIP

NCI'S REORGANIZATION "struck directly at the issue of contracts vs. grants and made it a non issue," Arthur Upton said in his final appearance as NCI director at a meeting of the President's Cancer Panel. Upton's comments were a summation of the accomplishments during his two-and-a-half year term as head of the National Cancer Program: In addition to the reorganization, there were (1) elimination of the bioassay backlog, (2) creation of the National Toxicology Program "which has set the stage for much closer coordination and cooperation between research institutions and regulatory agencies," (3) William Shingleton's review of the Cancer Control Program which with the reorganization "set the stage for much more effective coordination of cancer control with related efforts," (4) review of various components of the operation at Frederick Cancer Research Center where "we've come a long way, review was favorable on the whole, recommended changes have been carried out and caliber of the staff is quite good." Upton thanked his colleagues at NCI "who have been very patient with me." . . .

SILVIO CONTE, Massachusetts Republican and one of the most outspoken supporters of the Cancer Program in Congress, said at a meeting of the Coalition for Cancer Issues, "I'm going to work like the dickens to make Bob Michel the next minority or majority leader. He would then move off the Labor-HEW Appropriations Subcommittee and I would be the ranking member." If the near impossible happens and Republicans capture control of the House, the new minority leader would actually be the speaker, and Conte would become chairman of the subcommittee, now headed by Democrat William Natcher. GOP minority leader John Rhodes of Arizona has said he will give up that position after this term, and Michel, of Illinois, is one of the candidates to succeed him. Conte said he would help lead the fight for increased funds for NCI. "We must continue the search for vaccines, new drugs, new methods of treatment such as neutron therapy and interferon. That takes money. Dissemination of information must move forward. Cancer Act amendments of 1980 will further address the problem of cancer information dessemination and public and professional education. That does not mean the federal government can be the sole supporter of the program. State and local agencies, private and volunteer organizations all will have to step up their efforts."

THE "50% SOLUTION" MAY BE FLEXIBLE; DCT TO SEEK CLINICAL RESEARCH GRANTS

(Continued from page 1)

some of the $44 million it is getting this year from NCI.

The budget for cancer center support grants, $63 million, is about $4.5 million short of being able to fund all approved competing renewals at the levels recommended by the review group, the Cancer Center Support Grant Review Committee. Former Director Arthur Upton had promised to try to find at least some additional money to help make up the difference.

NCI first proposed to handle the problem by limiting the renewals to their previous year's budgets plus a cost of living increase of seven percent. Later, when firmer figures on the size of the short fall became available, the plan was changed to funding the renewals at their previous year's levels plus 50 percent of the recommended increase. The "50 percent solution" will require an additional $3 million over the budget.

At this week's meeting of the Assn. of American Cancer Institutes, Acting Centers Program Director William Terry said DeVita had scraped up about $900,000 and that he had made the commitment of another $2 million. The source of the $900,000 has been determined but not yet for the $2 million.

DeVita told AACI members that "We have requested some funds be returned from the National Toxicology Program. You can imagine the response that will receive."

In the Administration's budget for the 1980 fiscal year, NCI was directed to give $21 million to support the Carcinogenesis Bioassay Program in NTP. The House HEW Appropriations Subcommittee added $23 million, although there is some question now that this is firm "earmark" since the Senate did not go along with it.

NCI provides the largest single component of NTP, which also includes programs from the Food & Drug Administration, National Institute of Occupational Safety & Health and National Institute of Environmental Health Sciences. It is headed by NIEHS Director David Rall.

Congress directed that NTP be given an additional 28 positions. The White House, however, has not released those positions, and there is some feeling at NCI that NTP will not be able to spend the entire extra $23 million if it does not get the extra people to help administer the program.

AACI members were not happy with the 50 percent solution, although DeVita said that without it, "we would have to stop paying at priority scores we all feel are excellent, in the 200 to 210 range. We will probably have to use this system more frequently." He pointed out that paying 50 percent of the recommended increases averages to about a 15 percent increase over the previous year.

Denman Hammond, director of the USC Comprehensive Cancer Center, commented that AACI had gone on record that "we would rather see funds allocated by merit, by priority score, rather than perpetuate those of less merit. The rub comes when you run out of money at a 214 priority score. That's tough."

Richard Steckel, director of the UCLA Jonnson Comprehensive Cancer Center, suggested that rather than award a flat 50 percent of the recommended increases to all renewals, NCI staff should be able to use discretion, awarding varying amounts in relation to priority scores.

"I don't think anyone should be surprised that core grant renewals have increased geometrically in size," said Steckel, who is a member of the Cancer Center Support Grant Review Committee. "After investing for a decade in development, faculty, facilities, we are close to the dream of reaching full operational status. Neither the seven percent solution nor the 50 percent solution is equitable. I'm not being critical of NCI staff. I probably would have done the same were I in their shoes."

The 50 percent solution does not take into account the varying needs and capabilities of the institutions, Steckel argued. "We should urge NCI to find the money to fund the renewals at 100 percent of the recommended amounts. If there is not enough to fund all, the descretionary funding should be related to priorities."

Terry said he would welcome the flexibility.

John Weisburger, vice president for research of the American Health Foundation and former member of the NCI bioassay staff, supported DeVita's attempt to recover some of NCI's contribution to NTP.

"I was one of the founders of the Bioassay Program," Weisburger said. "I am not proud of the way it has grown. NTP is getting $50 million (including other agencies' contributions), and I am certain that all of that can't be used well."

"That's a ticklish subject," DeVita said. "We're rapidly losing control of the NTP budget. It is not an NCI program. The argument for NTP was sound. It is only when one has to set priorities that you have a problem. . . . It is not possible to survive with a flat budget without terminating some programs."

Hammond argued that the budget for cancer center core support had declined from 9.6 percent of all NCI extramural awards except control in 1977 to 8.7 percent in the 1980 fiscal year. DeVita replied that the contribution to NTP distorted the percentages.

DeVita also noted that the seven percent increase still applies to program project competing renewals. "Centers are doing comparatively well. You've done well under the circumstances."

Other items mentioned by DeVita in his discussion with AACI members included:

• The Div. of Cancer Treatment will issue soon a program announcement suggesting that investigators resubmit applications for R01 grants in clinical research. The applications will be reviewed by a special ad hoc study section to be set up by the NIH Div. of Research Grants as an experiment in reviewing treatment research applications.

• He would like to see more clinical trials conducted regionally by cancer centers. "Every time I say something about regions I get into trouble (mostly with some members of the national cooperative groups who see development of regional groups as a threat to them). I'm a great believer in regionalization. I even think that people who are working on the same projects should have their offices on the same floor. I think we will see more regional clinical trials in some areas. There are some areas where it will not be necessary. The DCT Board of Scientific Counselors after our clinical trials review called for more regional cooperation around centers. Anyway, regionalization doesn't need my input. It is happening, and it is logical that it is happening around centers."

AACI TO SEEK CANCER ACT CHANGES, INCLUDING LINE ITEM FOR CENTERS

AACI members, after agonizing over the problem of an inadquate NCI centers budget, were ripe for the recommendation by the association's Policy & Programs Committee for a significant change in the National Cancer Act which would establish the cancer centers budget as a line item in NCI appropriations bills.

R. Lee Clark, president emeritus of the Univ. of Texas System Cancer Center, pointed out that the National Cancer Act of 1971 authorized cancer control and established a separate budget for it. NCI appropriations now come in two categories—"research," which includes everything except cancer control, and "cancer control," which includes funds for control and rehabilitation.

"We felt it is time to add a third authorization, for cancer centers," Clark said.

Clark presented the committee's proposals for changes in the Cancer Act, including the centers authorization. They were approved unanimously by the members for transmission to the Senate and House Health Subcommittees.

A few misgivings were expressed about the new line item. Playing the devel's advocate although not necessarily opposed to it, Mayo Comprehensive Cancer Center Director Charles Moertel suggested it "might trigger a series of line items for others with special interests." He suggested that community cancer centers might be one.

Albert Owens, director of the Johns Hopkins Oncology Center, said he had "mixed emotions. I'm becoming more depressed by the disparity between what is expected of centers and the resources necessary to meet those expectations."

Clark argued that the National Cancer Act of 1971 included language encouraging the development of cancer centers, as it did giving NCI authority for cancer control programs. "It's time now that we have some money authorized explicity for centers, just as control has," Clark said.

"I commend the concept," Hammond said. "We would have authorization for cancer research, cancer control, and cancer centers. Centers are a resource for both research and control. I don't see any reason to back away. Center support should not have to compete with research. Having a line item may be necessary in the 1980s. We just have to make damn sure it's big enough."

Marvin Rich, executive vice president of the Comprehensive Cancer Center of Metropolitan Detroit, commented that the proposed language of the addition to the Act does not limit it to comprehensive centers nor does it exclude community cancer centers.

Clark's committee proposed authorized levels for centers of $150 million for the 1981 fiscal year, $225 million for the 1982 year and $300 million in 1983.

The committee also recommended that the Act continue to carry the control and research authorized levels. This runs up against the American Cancer Society recommendation which has been accepted by the Senate Health Subcommittee to eliminate authorization figures. ACS feels those figures have now become ceilings rather than targets. AACI members suggested and Clark agreed that a cover letter will be sent with the proposals that the association is not adamant about including figures.

Clark said that "Starting in 1970, NCI's budget was $170 million. It took us 10 years to get to $1 billion. We hope to get to the second billion in half that time. I believe there is a consensus here that we could effectively and wisely use that amount."

AACI is recommending these dollar authorizations:

Research—$1,226,800,000 in 1981, $1,650,370,000 in 1982, and $2,062,907,000 for 1983.

Control—$123,200,000 for 1981, $124,630,000 for 1982, and $137,093,000 for 1983.

The totals including centers are $1.5 billion in 1981 (a half billion dollars over the actual appropriation in 1980), $2 billion in 1982 and $2.5 billion in 1983.

The rationale that will accompany the recommendations said that for research, the recommended amount is needed because "inflationary changes and increased costs of operation mandate increased funding levels to provide essential continuity and maintain momentum of the National Cancer Program as well as to support newly initiated and promising programs in nutrition, carcinogenesis, biomedical reactors (including interferon), and other developments in clinical cancer research."

The funds for cancer control are "needed to estab-

lish regional networks of cancer care facilities, improve the availability of the best possible cancer care, and promulgate prevention programs."

The centers money is "needed to stabilize core funding; there is a wide gap between the responsibilities imposed on centers by legislation and the resources allocated to them to accomplish their mandated activities."

Other recommendations for renewal of the Act which AACI approved were:

• Retain the present provision authorizing the NCI director to prepare and submit directly to the President for review and transmittal to Congress an annual budget estimate, and to receive from the President and OMB directly all funds appropriated to NCI.

"Required to continue proper program emphasis and assure that goals, priorities, progress and needs are brought directly to President and Congress; prior to passage of Act there were seven tiers of bureaucracy through which to submit budget and program requests. Direct control by director of appropriated funds necessary for flexibility in managing program."

• Change the authority of the NCI director to approve funding (without review by National Cancer Advisory Board) research and training grants not exceeding $50,000 (presently $35,000).

"Fundamental for innovative and exploratory investigations to be instituted without delays inherent in present review process; since '71 this authority has been used sparingly but effectively; increase is justified by rate of inflation since '71."

• Increase period of support for centers from three to five years.

"Experience has shown that three year period of support does not allow sufficient time for continuity and adequate long range planning (particularly by centers in mature stage), and produces wasteful expenditures of funds in terms of personnel and paperwork required. (For centers in formative stages of development and in need of surveillance, three-year period of support acceptable)."

• Retain presidential appointment of the NCI director and the NCAB.

"Assures consideration of the best; at a time when it is increasingly difficult to attract the best science administrators, the status of a presidential appointment is an inducement to attracting high quality appointees; maintains focus on the importance of the National Cancer Program."

• Require appointment of successor to fill an expired term or vacancy on the NCAB within 90 days.

"Prolonged delays lessen effectiveness; operating at full strength increases ability to stay in command."

• Delete present requirement for an NCAB report to the President and the Congress (via the Secretary).

"Report of NCI director and that of the Panel are sufficient; NCAB report is duplicative."

• Retain the President's Cancer Panel and the presidential appointment thereof.

"A useful mechanism for advising President and Congress on diverse needs of the cancer effort; Panel usually supportive of biomedical research in general; has been successful in focusing attention on important issues. Panel and Board serve different functions, yet liaison has always been close; added appointment restriction could slow action."

• Require the Panel to submit names for consideration for appointment as NCI director and members of the NCAB to the President.

"Panel members, selected on basis of knowledge and expertise, can perform nationwide review of qualified candidates; establishes planning mechanism for assuring orderly and timely consideration of appointments."

The original Act, which created the President's Cancer Panel, spelled out as one of the Panel's duties the task of recommending a director to the President. This was dropped in the 1978 renewal, and in fact was previously ignored when President Carter left it up to the HEW secretary to make a recommendation. The secretary relied on a search committee.

The President still could ignore the Panel, even if that charge is put back in. But if a President does try to follow the spirit of the Act, he would use the mechanism set up by Congress to bypass HEW in the selection of the director and NCAB members as well as in submission of the budget.

The AACI recommendations also included a statement opposing a section in the present draft of the bill S. 988 which will include the Cancer Act amendments and renewal authority along with other biomedical research authorities. AACI opposed creation of a President's Council for the Health Sciences. The rationale statement said, "We should support instead retention of the President's Cancer Panel and creation of similar bodies for other NIH institutes; an added layer of bureaucracy would hinder the productivity of the decision making process."

AACI also asked that the Act specify that programs evolved or carried out under the National Cancer Program be exempt from the provisions of the Health Planning Act. A general exemption for NIH was included in the planning act renewal last year, but Clark felt a more specific exemption would be helpful.

FRAUMENI APPOINTED FIELD STUDIES, STATISTICS CHIEF; HADSELL PROMOTED

Joseph Fraumeni, chief of the Environmental Epidemiology Branch in NCI's Div. of Cancer Cause & Prevention, has been named acting associate director of the division to head the Field Studies & Statistics Program, in which Fraumeni's branch is located.

The position has been vacant since last year, when Marvin Schneiderman was moved up to the NCI director's office as associate director for science policy.

Fraumeni will continue as chief of the Environmental Epidemiology Branch for the present.

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Richard Schweiker, addressing the Assn. of American Cancer Institutes this week, called for a more united approach by health organizations in support of health legislation.

CCI was put together largely by the efforts of Lee Mortenson, whose firm Elm Services provides management assistance to the Assn. of Community Cancer Centers and various other organizations and institutions. Other participants agreed to share with Mortenson the task of producing and mailing CCI announcements and information documents.

Mortenson distributed a draft statement describing the rationale for the organization, suggested missions and key principles. No one expressed disagreement with any portion of it. The draft:

Rationale:

Congress, NCI and regulatory agencies continue to promulgate laws, rules and budgetary authorities which affect research, education and treatment of

gram in clinical trials with the university, Salmon commented. But the effort has gone a long way toward reversing the trend that has seen fewer patients referred for clinical trials as the numbers and expertise of community physicians has increased.

Salmon told symposium participants that "initially, the university faculty members were viewed with suspicion by the community," when the university's cancer program was established in 1971.

"We thought at the outset that the university could potentially work effectively with the community as long as we all recognized that the university had major expertise in clinical research and the community expertise in health care delivery. This program proved sufficiently successful that by 1976 our cancer center was formally created and we received an NCI cancer center core support grant."

One of the key moves in creating harmony with the community was the "Tucson Hematology-Onco-

logy Club," founded in 1972. "We reached agreement to initiate a trial period of cooperation," Salmon said. "That trial is still ongoing at the present time. While there were initially only four medical oncologists in town plus four at the university, our number has more than doubled and club members include radiotherapists, pathologists, and our clinical fellows. The club meets monthly, either at one of the hospitals or at the home of one of the university or community oncologist members. It always includes one or two short scientific presentations, occasional case presentations plus a summary of new clinical research protocols, new drugs, and a status report on one or more of our major clinical trials. Virtually every visiting professor of oncology (be he or she a surgeon, medical or pediatric oncologist, radiotherapist, pathologist, etc.) whom we invite to the university also speaks to the club. This club is run without dues or budget with each member taking turns arranging the meeting. Attendance is generally excellent."

The university carries out both local and cooperative group clinical investigations. "Hematologist/oncologists in Tucson were welcome to participate in our very first clinical protocols with the proviso that they had to be adhered to closely and the data be of excellent quality. At that time, most of the community specialists had received training only in hematology and were not experienced in clinical trials. To facilitate data collection, we obtained their permission to have one of our data managers visit their offices on a regular basis to review their office files on patients and to add any details that may have been lacking from flow sheets.

"In return for this cooperation, we have provided new drugs to all participants and include major contributors as co-authors in our papers. Additionally, we have done our best to have the local news media, which frequently looks in on our activities, clearly mention the active participation of practicing oncologists in the same breath along with identification of the university program.

"Our first real test of citywide clinical trials began in 1973 with a local trial of adriamycin and cyclophosphamide in women with metastatic breast cancer who had received no prior chemotherapy. Through the mechanism of the Hem/Onc Club, we reviewed existing data on single agents and combinations then available and opted as a group to combine the active and then new experimental drug adriamycin with cyclophosphamide using a dose schedule we had already pretested and found to be excellent for outpatient management.

"Formulative discussions with all participants are clearly critical to successfully launching such an effort," Salmon continued. "While Tucson practitioners were willing eagerly to participate, those in Phoenix (125 miles away) who had not been party to the original development declined to participate because in 1973 they felt that 'all patients should first have the benefit of 5-FU,' and indeed in those days that was the accepted view in our country. The results of this trial which involved 55 women proved exciting and showed a greater than 70 percent partial plus complete response rate with 20 percent of the patients achieving complete remission.

"Of importance in our analysis was the finding that fully one half of the patients were treated by community oncologists, and the overall response rate was identical among those patients to that which we observed among our patients at the university hospital.

"Such findings suggested that similar results could likely also be attained in other communities. In the course of this work, our community colleagues arranged to set up a satellite research pharmacy activity at the major community hospital and also have our informed consent forms for this study accepted by the various hospitals as well as using them in their offices.

"However, after completion of the A-C trial, as we moved on to new regimens adding other drugs to A-C for metastatic breast cancer (e.g., vincristine or hormones), many of our community colleagues tended to continue using A-C for their patients even though we had moved beyond that regimen in our own research priorities. However, because of the activity of A-C in breast cancer, we also wanted to initiate an A-C surgical adjuvant study.

"Therefore, in late 1973, after reaching agreement in the Hem/Onc Club, Dr. Stephen Jones and I began meeting with the Tucson Surgical Society, the Tucson Assn. of Pathologists and other interested parties and reviewed the then available data upon which we thought it rational to initiate an adjuvant A-C trial. The Pima County Medical Society, of which we are members, agreed to distribute information on this trial to all county physicians, and over 70 Tucson surgeons signed a mailback card indicating willingness to participate.

"A list of all Tucson oncologists (both university and community) was distributed to all of these surgeons and they were advised that they could consult anyone on the list and their patients could be a part of the trial. The adjuvant program was formally launched in mid-1974 and case accrual of both pre- and postmenopausal women has been steady since that time.

"In view of this development, we were able to successfully incorporate this trial as a component of a program project grant that we obtained from NCI in 1975. . . . It is of interest that we have accrued postmenopausal women into this trial at a constant rate despite national publicity resulting from scientific publications which prematurely proclaimed that adjuvant chemotherapy was of no value in postmenopausal women. Obviously, we discussed these articles

among our group, decided they were premature conclusions and so informed all members of the medical society by letter at the same time we provided updating of case entry and results to all physicians.

"Such communications have been invaluable and we continue to write such open letters annually and continue to get good case accrual to this trial. However, we have noted that community oncologists are reluctant to randomize their private patients to A-C with respect to radiotherapy, even though we are willing to randomize our private patients.

"A second program that has developed smoothly has related to white cell transfusions. We began a program in this area in 1972 after Dr. Douglas Heustis, professor of pathology and head of the blood bank, asked, 'How can I help?' We responded, 'White cells' and Dr. Heustis responded. Initially this was a research program during which Dr. Heustis perfected a technique to use the predecessor of the hemanetics blood processor (which was then designed for platelets) to also serve for white cell collection. Once the system proved to work, we began to investigate the therapeutic efficacy of white cell transfusions and made white cells available also to our community oncologists free of charge for use in other hospitals.

The research phase was completed in 1978 and the service has continued to be offered by the university on a cost reimbursement basis and thus remains as a community service arising from our earlier research effort.

"I would be remiss if I implied that all such efforts are successful. In fact, they are not.

"As Tucson has grown, the number of cancer specialists has increased. To be candid, not all practitioners care to participate in clinical research, and, even in Tucson, a few of them do not. Some who think they would like to participate, nonetheless fail to follow the protocol closely or record the required data. Obviously, we don't continue to provide investigational drugs under such circumstances unless the problem can be corrected.

"Similarly, while general surgeons are usually cooperative in relation to adjuvant trials on breast or GI cancer, it has not always been feasible to organize community surgical subspecialists to participate in clinical trials in ovarian, bladder or head and neck cancer. This has been a national problem in which surgical subspecialists have unfortunately often impeded case accrual onto multimodal trials.

"This problem now faces cancer centers and cooperative groups alike, and is widespread in the U.S. as well as in England. Additionally, we have clearly become a scapegoat for some of the newer oncologists in town who feel that we are draining their patients. To the contrary, our referral level while good is static, and only the rest of the patient pie is being cut smaller by the increasing number of private oncologists.

"While thus far our trainees who go into practice in medical oncology have moved to other cities, this is not the case with other cancer centers. There is now a major concern that cancer centers are doing themselves a major disservice by training too many specialists in medical oncology who remain in the larger cities, and yet decline to participate in clinical trials, and thereby slow the pace of research in precisely that specialty in which they hope to apply the 'latest treatment' to their practice.

"Thus, the critical problems of the future may well be too many specialists and not enough new clinical cancer research. Cancer patients constitute a rare and valuable resource and their participation is clearly needed if we are to define new and effective treatment. I hope that community oncologists can come to realize that their active participation is crucial to advances in cancer treatment."

NEW PUBLICATIONS

"Hormonal Biology of Endometrial Cancer," from a series of workshops on the biology of human cancer. Edited by G.S. Richardson and D.T. MacLaughlin. 17 Swiss Francs plus postage and packaging. UICC, 3 rue du Conseil-General, CH 1205 Geneva, Switzerland.

"Cancer Education in Schools," a guidebook for teachers. 12 Swiss Francs plus 4 Francs for postage and packaging. UICC, same address as above.

"Screening in Cancer," edited by A.B. Miller. 20 Swiss Francs plus 5 Francs for postage and packaging. UICC.

"Innovations in Cancer Risk Assessment," symposium proceedings. Edited by Jeffrey Staffa and Myron Mehlman. $29, plus $2,80 postage for countries outside continental USA. Pathotox Publishers, 2405 Bond St., Park Forest South, Ill. 60466.

"Radiation Biology in Cancer Research," M.D. Anderson symposium on fundamental cancer research. Edited by Raymond Meyn and Rodney Withers. $49.50. Raven Press, 1140 Ave. of the Americas, NYC 10036.

"Treatment of Primary Breast Cancer," video tape summary of NIH consensus conference. Sponsored by Stuart Pharmaceuticals, with no commercial mention of a product. Available free to professional audiences from Ted Klein & Co., 118 E. 61st St., NYC 10021, phone 212-935-1290.

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.

DEADLINE CHANGE

The due date for proposals has been extended to the close of business on Friday, Feb. 15, for RFP NCI-CP-FS-01011-77 entitled "Support services for radiation studies.

RFP NCI-CM-07362

Title: *Operation of genetic production center for rodents in biocontainment environments*

Deadline: *Approximately March 15*

Develop and maintain colonies of inbred and outbred rodents of required genetic characteristics, and with defined microflora. Some of the tasks include substitutions and additions of strains and stocks, and the production of large numbers of rodents in barrier environments.

Successful offerors must have an existing facility with, as a minimum, an absolute filtration system, mechanical cage washing machines, auxiliary generators, autoclaves (stem sterilizers) with sufficient capacity for large numbers of caging equipment, and large volumes of animal food and bedding. Offerors must have a minimum of three years experience in pedigreeing procedures with inbred rodents. Respondents must be capable of demonstrating a minimum of two years experience in the maintenance of barrier type facilities. Evidence for this experience shall include a minimum continuous experience of two years in the production and distribution of laboratory rodents for biomedical research; and a minimum two years in maintenance of barrier enclosed production colonies.

To accomplish the needs of the program as described, the following task levels are required. The isolator cage levels of each task are those that allow the maximum production efficiency for the rat and mouse strains needed. The listed ratios of isolator to barrier cages are the only ones which will be considered at this time.

Task 1: Approximately 1,225 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 2,000 mouse cages maintained under strict barrier conditions as pedigreed expansion colonies.

Task 2: Approximately 1,250 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 4,000 mouse cages maintained under strict barrier conditions as pedigreed expansion colonies.

Task 3: Approximately 2,200 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 8,000 mouse cages maintained under strict barrier conditions as pedigreed expansion colonies.

Task 4: Approximately 850 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 4,000 mouse cage equivalents maintained under strict barrier conditions as foundation and expansion colonies.

Task 5: Approximately 3,550 mouse cage equivalents maintained as foundation colonies in associated flora isolators. Approximately 13,500 mouse cage equivalents maintained under strict barrier conditions as foundation and expansion colonies.

Due to the size of this effort and special requirements, it will be necessary that barrier production be performed on at least three facility sites which are located at least 50 miles apart. Only one task will be awarded to any one contractor location. It is expected that full and true competition will occur only at the Task 1 level.

In order to avoid disrupting the movement of inbred animals from the centers to the program, competition at the Task 2 – Task 5 level will be restricted to those contractors who are presently performing in the program at the genetic center level. It is anticipated that awards will be for three year incrementally funded periods of performance.

Contracting Officer: Daniel Abbott
Cancer Treatment
301-427-8737

RFP NCI-CP-VO-01005-55

Title: *Support services for clinical studies section laboratory of viral carcinogenesis*

Deadline: *Approximately Feb. 25*

NCI is seeking support services for the preparation of antigens, performance of assays and the worldwide collection, storage and distribution of specimens for a variety of different projects within the Clinical Studies Section. Prospective contractors must have adequate facilities and demonstrate knowledge and expertise in the above. Prospective contractors must be located within approximately one hour driving time to NIH, Bethesda, Md.

This effort will be successor to current contract No. N01 CP 4333, being performed by Litton Bionetics Inc.

Contracting Officer: Fred Shaw
Biological Carcinogenesis
301-496-1781

The Cancer Letter _Editor Jerry D. Boyd

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