THE CANCER LETTER

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THREE COMMUNITY BASED PROGRAMS SLATED FOR EARLY PHASEOUT, OTHERS MODIFIED, PROVIDED NCAB AGREES

NCI staff members, going along with recommendations of the merit review committee which has been reviewing the six Community Based Cancer Control Program contracts, agree that three of the six should be phased out—those in New Mexico, Rhode Island and Long Island.

(Continued to page 2)

In Brief

NCI'S REORGANIZATION PLAN PICKS UP SPEED IN HEW BUREAUCRACY, COULD BE APPROVED SOON

HEW APPROVAL of NCI's reorganization plan could come as early as March 6, as the department's bureaucracy has moved with uncommon speed. Asst. Secretary Julius Richmond signed off on the plan last week, and it is now in Secretary Patricia Harris' office. Her staff says it could be ready for her signature by March 6. . . . **RENEWAL OF BATTLE** over what actions the federal government should take on saccharin is shaping up as the law delaying implementation of the Delaney Amendment draws closer to expiration. The saccharin lobby, which included industry and representatives of diabetes and weight control groups, is getting ready to push for a permanent ban on action by the Food & Drug Administration. The NCI epidemiological study which looked into the relationship of saccharin and cyclamates to bladder cancer turned up data which demonstrated that the risk is increased by 60 percent among heavy users—those who consumed six or more servings a day of a sugar substitute or two or more eight ounce diet beverages a day. The risk was compounded when the heavy user also was a cigarette smoker. "I reiterate my concern about the consumption by so many Americans, especially young people, of large amounts of saccharin," said Jere Goyan, FDA commissioner. "We may have to wait 20 or 30 years to assess the possible effects on our young people of consuming large amounts of a weak carcinogen." By then, that risk could be translated into an additional 10-20,000 cases of bladder cancer a year, and we would have another cancer "epidemic" on our hands. FDA's regulatory proposals—banning the use of saccharin in processed foods, but permitting its sale as a table top sweetener for those who feel they require it for health reasons—seems reasonable. . . . **ROSWELL PARK** Memorial Institute and the American Cancer Society have scheduled an interdisciplinary conference on cancer in black populations May 5-6 in Buffalo. Contact Curtis Mettlin, Cancer Control Office, RPMI, 666 Elm St., Buffalo 14263, phone 716-845-4406. . . . **EORTC SYMPOSIUM** on Progress and Perspectives in the Treatment of Gastrointestinal Tumors is scheduled for May 22-23 in Brussels. Attendance will be limited to the first 200 registrations, at a fee of 3,000 Belgian francs. Contact D. Eeckhoudt, EORTC Data Center, Institut Jules Bordet, 1 rue Heger-Bordet, 1000 Brussels, Belgium.

EARLY CBCCP PHASEOUTS WOULD FREE UP MORE THAN $3 MILLION A YEAR FOR DCCR

(Continued from page 1)

Staff first recommended that the phaseout start immediately and be completed by July 31. However, NCI executives later decided that the National Cancer Advisory Board should be consulted, and no further actions on termination will be taken until the situation is presented to the NCAB at its meeting in May.

Bringing the NCAB into the picture now was justified by the fact that the CBCCP, a controversial program from its inception, was launched only after the Board had approved its concept. Also, the program "is so large and the issues so complex that we felt it should be reviewed by the Board," said William Terry, acting director of the Div. of Cancer Control & Rehabilitation.

Findings and comments of the reviewers will be presented to the Board in a closed session.

Reviewers and staff also have recommended that the three remaining contracts—in Los Angeles, Hawaii and Detroit—be continued with some partial terminations. Terry said those modifications would be "relatively minor."

Each of the contracts is funded at a level of about $1 million a year, so the total and partial terminations would free up somewhat more than $3 million a year. That would go a long way toward making up the $5 million proposed cut in the DCCR budget for the 1981 fiscal year.

The program was initiated in 1975 with the intent of demonstrating that an effective integration of the multiple cancer related activities and services in a community could have an impact on cancer morbidity and mortality. The request for proposals permitted responders either to go for a contract to support immediate implementation of a program, or for an 18-month planning contract designed to lead then to implementation.

The Univ. of New Mexico School of Medicine in Albuquerque and the Michigan Cancer Foundation in Detroit, as the lead agencies in their communities, were awarded immediate, five year implementation contracts. Nine planning contracts were awarded, but only four of them made it to implementation—Long Island, Rhode Island, Hawaii, Los Angeles.

The New Mexico and Detroit contracts are due to expire next year, with the former ending in June, 1981. Early termination thus would end federal funding of the New Mexico program only a year early. The Long Island contract was scheduled to end in March 1982, and Rhode Island in June 1982.

Two major problems were encountered by all six contractors, and the three recommended for early phaseout were not able to resolve them, in the opinion of the reviewers and NCI staff:

—Integration of the various cancer related activities in the respective communities.

—Evaluation of the impact of the program.

It was recognized from the start that integration would be difficult, with so many varied interests involved. Public, private, health provider, academic, professional and volunteer organizations, all with long histories of independent actions and directions, were required to coordinate those activities. A number of proposals were immediately rejected because they did not show sufficient evidence that coordination could be achieved. The five with planning contracts which did not receive implementation awards also failed to convince NCI that they could bring the multiple organizations together.

"If it could be made to work, it would be a powerful tool," Terry said. He acknowledged that the consequences of terminating the programs "are profound. The amount of effort involved in gearing up to participate in the program was very great. There will be a lot of disappointed people. The level of effort and community participation is not easily accounted for in the peer review system."

The six contractors will be permitted to argue against the early and partial terminations at the NCAB meeting, if they wish. There are indications, however, that some of them agree with the staff recommendations and will not oppose them.

Through much of the merit review process, tension and some bitter confrontations developed between site visitors and contractors. NCI staff also had to take a lot of heat from participants in the program who felt that members of the merit review teams were not qualified, and occasionally from members of Congress who were brought into the affair by angry constituents.

"It is an unusual program," Terry said. "Many of the people involved, including in some cases the principal investigators, have not had experience with the peer review system. The reviewers also were reviewing something very different from other NCI programs."

NCI staff now feels, however, that most of those in the program have accepted the review as a fair one.

Is the Cancer Program going to get anything for its money?

The three left in operation under the recommendations may yet be able to demonstrate that effective coordination can be achieved and that it can reduce morbidity and mortality from cancer in their communities. Other communities thus would be encouraged to follow their examples (but supported by funds other than from NCI).

Even those being phased out may have something to offer. Terry will soon have on his desk a staff recommendation for a study to analyze and evaluate what merit review consultants said was valuable information developed in those communities.

All the contractors were put on notice from the start that they would be expected to continue their programs with support from other sources at the end

of five years. It seems likely that at least one and perhaps all three of those being phased out will be able to continue some level of activity.

WAXMAN HEARING GENERATES STRONG SUPPORT FOR CANCER PROGRAM RENEWAL

Strong support for renewal of the National Cancer Program, with the special authorities granted to NCI by Congress since 1971, was expressed both by witnesses and congressional members of the House Health Subcommittee this week at the hearing on Subcommittee Chairman Henry Waxman's bill (H.R. 6522) that would reauthorize HEW's biomedical research programs.

Waxman's bill includes most of the improvements sought by the National Cancer Advisory Board and other Cancer Program advocates (***The Cancer Letter,*** Feb. 22) and renews NCI's budget bypass authority, the President's Cancer Panel, and presidential appointments of the NCI director and NCAB members. It establishes authorization levels which most supporters of the Cancer Program think are too low.

James Holland, chairman of the Dept. of Neoplastic Diseases at Mt. Sinai School of Medicine and also chairman of a major Cooperative Group, led off with a ringing description of progress in treating cancer. He also offered evidence that prevention of cancer will be advanced more through changes in lifestyle than in reducing exposure to carcinogens.

"It's apparent that cancer death rates vary widely in the 44 countries which have effective data," Holland said. "There are a number of theories why this is so. The principal differences are related to lifestyle, rather than to some particular exposure to carcinogens." He cited cancer incidences which vary drastically among countries with similar states of development, and other countries which are different industrially but which have similar incidences.

The only cancers increasing in incidence in the U.S. are those related to tobacco smoke, Holland said. Asbestos, vinyl chloride, DES, and radiation "together are responsible for an insignificant number of cancers. Mesothelioma, caused by asbestos, may be very significant in the future, but it occurs now too seldom to show up on the tumor registries."

Treatment of cancer has "made great strides since the 1960s," Holland continued. He displayed charts which showed that "not a single child with acute leukemia lived beyond 15 months in 1956. In 1974, 50 percent were alive without disease after five years." Ten year survival is now common, and "we are looking at children of children who had leukemia, and they are normal."

The figures he cited were taken from studies conducted by his Cooperative Group, Cancer and Leukemia Group B, supported with grants from NCI, Holland pointed out. He also referred to breast cancer studies, in which adjuvant chemotherapy has doubled survival.

This progress "represents tens of thousands of lives saved, many of them children and young adults in the fruit of life." It is progress, Holland pointed out, made possible by studies which were greatly strengthened and expanded through increased funds made available by the National Cancer Act.

Holland urged that the Cancer Program be continued, "with the suggestion that Congress address the tobacco problem."

Alvin Mauer, director of St. Jude Children's Research Hospital and president of the Assn. of American Cancer Institutes, presented AACI's position on the legislation:

"The Bill H.R. 6522 has been reviewed by us since the January meeting of AACI," Mauer said. "We wish to commend the authors of this bill for its sense of direction and content. All of us who have participated in the National Cancer Program are generally pleased with the current authority for its operation. We do not think there should be major changes at this time in a program which has worked well. Therefore, we were pleased to see that the director of the National Cancer Institute will continue to be appointed by the President under this bill, as will the members of the National Cancer Advisory Board. We were also pleased to see that under the provisions of this bill, the director of the National Cancer Institute shall prepare and submit an annual budget estimate directly to the President for review and transmittal to Congress, as was the case in the provisions of the original National Cancer Act.

"Two other provisions of this bill, which we feel are necessary and therefore would support strongly, is the increase of the NCI director's authority to approve grants without board review to $50,000. In view of recent inflation, this increase is needed to enhance the expedition of important and timely projects. We also strongly support the provision in which support of cancer centers may be for a period of up to five years. This provision will clearly enhance the stability of cancer centers and also reduce the administrative load.

"There are three items, however, for which we would request consideration of change in the bill," Mauer continued. "We feel that it would be advantageous to remove the appropriation language (authorization levels) for the National Cancer Institute. Research development and progress has occurred rapidly in the field of cancer as well as biomedical sciences generally during the past few years. In order to increase the flexibility for support of new research directions as they develop and provide the resource as necessary to take advantage of new advances, we would ask that an indefinite authorization for appropriations to the National Cancer Program be recommended.

"In our opinion, the cancer centers have provided a foundation for the National Cancer Program. During the period of the National Cancer Act, these

institutions have become increasingly important in both the basic and clinical research efforts. They have been major sources for both professional and lay education and have provided important contributions to improved patient care. In the last few years, the centers have been given an increasing load of responsibility for such programs as cancer control and prevention. In spite of the increasing responsibility the centers have carried, there has been no proportionate increase in funding support. Therefore, we would request a separate authorization for appropriations for support of cancer centers with a ceiling for the initial year of $150 million as indicated in our recommendations for National Cancer Act renewal. This separate authorization would assure the stability of the cancer centers program and would also assure the ability of the national cancer centers to carry out their increasing responsibilities.

"As one final request, we would recommend reconsideration of the appointment of a National Health Advisory Board. Such a function has already served the director of the National Institutes of Health and is in current effect. It is difficult for a board of that size and makeup to effectively oversee the diverse and numerous programs of the NIH. Furthermore, it has the potential of placing one more layer of administrative responsibility over the programs in current operation.

"The National Cancer Program has been successful in achieving goals for which it was conceived. It is clear that the program is just hitting its stride and we look forward to accelerating progress which will directly affect the lives of cancer patients in the coming decade. Since 1970, cancer mortality has decreased in the young population, particularly for those under 30 years of age. The importance of this decrease in cancer mortality in the young people of our country can be appreciated when it is realized that the improvement in treatment of acute lymphocytic leukemia of childhood can be calculated to have added 50,000 person years of life annually to our population. Thus, the impact of cancer research and the National Cancer Program in this country is being felt and there is clear indication that this progress will continue."

Waxman asked Mauer for a rationale for continuing the President's Cancer Panel and for the Presidential appointments.

"It has provided a focus, a sense of purpose. It has been in place for a decade and has worked well. There is a saying where I came from that you 'don't try to fix nothin' that ain't already broke'."

When Waxman asked for a specific incidence of when the Panel intervened with the President to help the Cancer Program, Mauer referred to Benno Schmidt's success in getting President Nixon to salvage research training and to increase the NCI personnel ceiling.

Waxman said he was confused by the AACI position of, first, asking that no authorization levels be in the bill, and second, of listing figures for the next three years.

"AACI's figures are considerably above those in the bill," Mauer said. "We are offering the option—increase the amounts substantially, or leave them out completely."

Waxman asked why NCI needs separate construction authority from the rest of NIH. Mauer pointed out that "cancer facilities are considerably behind the need, particularly animal facilities. There is no question that construction is far behind what we need."

Congressman Tim Lee Carter (R.-Ky.), the ranking Republican on the subcommittee who plans to retire at the end of this term, expressed interest in interferon.

Holland said he has treated five patients with interferon, had obtained two remissions, and considers it an important, promising agent.

Carter asked if Holland felt NCI's budget of $13.5 million for interferon was sufficient.

"I don't know if that will be used for therapy," Holland answered. "If so, that is not enough. But if it is limited to investigation, it is probably as much as can effectively be spent this year."

Carter noted that some anticancer drugs are carcinogenic themselves.

"Rarely is that true," Holland said. "I've just looked at 1800 cases, and found eight new cancers. And we don't know if all of those were caused by the drugs."

Congressman Andrew Maguire (D.-N.J.) has been the subcommittee's leading advocate of increased emphasis on cancer prevention. It was his amendment to the Cancer Act renewal two years ago which required that at least six members of the NCAB be experts in environmental carcinogenesis. He has also criticized NCI for not spending more money on prevention.

"You say that the Cancer Program has been successful," Maguire said to Mauer and Holland. "My recollection is that the goal was a crash program to find cures for cancer. That has not happened, except for a small percentage of cancers."

"I'm not in disagreement with the goal, to find the cures and beyond that, prevention of cancer," Mauer said. "It is a question of time. There has been a tremendous acquisition of knowledge in the last decade. Those goals eventually will be achieved."

"I won't quarrel about achievements," Maguire said. "But it would be equally easy to say that the National Cancer Program has been unsuccessful in achieving most of its goals, at least as they were perceived 10 years ago."

Holland objected. Noting that he was a member of the Panel of Consultants which drew up the plans for the program which were incorporated into the National Cancer Act of 1971, Holland said, "There was

nothing in the Panel's documents which used the term 'crash program.' Second, I take exception to your statement that nothing has been accomplished that wouldn't have been achieved without the program." Going to his charts, Holland said, "Here are populations who owe their lives to the Cancer Program. The substantial decreases in numbers of deaths started with the beginning of the National Cancer Program. Those are not insignificant numbers."

"What I said was related to expectations of Americans 10 years ago," Maguire said. "Your graph is important, but there are still a lot of Americans dying of cancer."

Sheldon Samuels, director of Health, Safety & Environment in the Industrial Union Dept. of the AFL-CIO and a member of the NCAB, pointed out that his seat on the Board was one of those created by Maguire's amendment.

Samuels has been a critic of NCI's prevention activities, especially in the area of occupational exposures. It was evident that the subcommittee expected him to be an adverse witness, at least to some extent.

Samuels may have surprised them all. His testimony for the most part turned out to be one of the strongest endorsements yet for continuing the Cancer Program. (It would not have surprised those who follow NCAB meetings. In less than a year on the Board, Samuels has been a knowledgeable, fair, and effective member.)

Samuels offered some rather drastic suggestions on the organization of NIH:

"The National Institutes of Health should receive the recognition and regulation that its size and importance warrants. This should be reflected in the organization of the department and cannot be adequately accomplished by legislation affecting NIH alone or a law which does not consider the function of NIH within the department.

"The director of NIH should be appointed by the President for a set term to eliminate both a purely patronage effect and institutional arthritis. A six-year term might be appropriate. That person should be at least a deputy assistant secretary. More, he or she ought to oversee all basic health research in the department. NIH, a research institution whose eminence and accomplishments are not exceeded by any scientific enterprise anywhere, nevertheless dilutes its efforts and accomplishments by dabbling in prevention and control. In this arena, its efforts are at best inept. Questioned about this, directors of scientific programs within NIH and within their supporting academic constituencies almost invariably tell me that they must control the 'practical' programs (and identify them with research) in order to 'sell' basic research to the Congress and the public regardless of the adverse effect on application! This callous disregard for the public interest must end. The identification of research and practice can and should occur in an honest manner.

"There ought to be a separate deputy assistant secretary for community disease prevention and control and a deputy assistant secretary for occupational health and safety.

"Establishment of cause and the mechanisms of effect require a different set of skills than prevention or control. Total separation is not possible or desirable, since often the opportunity for significant basic research or even discovery arises directly out of our efforts to prevent or control disease. But research is not translatable into action without the development of access to social structures and the use of political skills and tools.

"Disease is never prevented or controlled by the application of pure science, not even ideally in the most rational of worlds. Science is applied by other than scientific disciplines. Frequently an individual scientist is also an educator, or community worker, and a politician. To fulfill these other roles, the scientist is required to step out of the laboratory. When he does that, he no longer functions as a scientist. Politicians and community workers, to fulfill their function, need not be research scientists. But they need to understand science. The information developed by science needs to be translated and transmitted by the scientist to the applicators and interested publics. The information function within a scientific institution is, therefore, as important as the research function. But putting the information to work is a different kind of problem and ought not to be confused with the prior process of translation and transmission. . . .

"The independence and effectiveness of advisory bodies is related to the appointment process. All bodies should be appointed at a broader level of authority than the level of operation. Thus the National Cancer Advisory Board, which should advise the HEW Secretary, heads of other agencies and the director of NCI and should include their representatives (as is now the case), is appropriately appointed by the President. All NIH institute-wide boards should be appointed by the President (not now the case). Boards or committees that function at a divisional level, advising the directors of the NIH and the institutes, ought to have representation on institute level boards to facilitate the flow of information and policy consistency (not now the case).

"'Presidential panels' and 'budgetary bypass' structures and authorities—as you know—in real life amount to politically superficial affectations. Bypass occurs with or without a formal mechanism. Access to the President is not dependent upon congressionally conferred titles. Both are dependent on political or personal influence.

"More important, boards are not really independent if they lack the ability to function independently (not now the case). This requires a permanent secretariat, the selection of outside chairmen and com-

mittee assignments clearly separated from the agency. It requires the authority to review equally and with equal authority all phases of a program. Thus the authority to review the priority and distribution of all research and resource grants and contracts from concept to award to implementation is critical. The National Cancer Advisory Board, for example, has unequal powers in regard to grants and contracts (often half or more the budget)."

Waxman asked Samuels at what level of contracts should the NCAB and other NIH boards or councils become involved as secondary reviewers. "At $75,000 to $150,000," Samuels said. "I'm most concerned about the major contracts, such as the Litton contract for Frederick."

Samuels said that the scientific review which has been carried out by NCI boards of scientific counselors at Frederick Cancer Research Center "would, I think, be accepted by other Board members and by me. But not the administrative review. That is incredibly complicated."

Samuels said that the NIH peer review system, "while not perfect, has been very, very successful. We can take a great deal of pride in it. I just think we should have the same kind of review for contracts. There are committees of outside experts who review contracts, but they have problems. They are sometimes instructed to limit their review. For example, they can't question if an RFP should have been written in the first place."

Waxman asked if he had any recommendations for achieving more public input into the policymaking process. "By not having all the old crowd making the appointments," Samuels responded. "There are forces in the White House that are different than the old boys at NIH," he commented, defending the Presidential appointment of NCAB members.

Samuels suggested that the NCI division boards of scientific counselors and the NCAB should have closer relationships.

"How effective is the NCAB review of grants?" Maguire asked.

"Very good," Samuels answered. "My experience is limited. We're not supposed to be replicating the work of the peer review committees, but to look at peer review itself, the process. People are interested in various areas, and pick up interesting things. It is not a rubber stamp. But it could be improved by having a full time secretariat."

Maguire asked about conflicts of interest on the part of Board members.

"That's a problem," Samuels said. "There is the old boy tie. But you can't get around it. You have to have people who are involved in the work to have competent review. You can get around it, if the kinds of people selected are high in caliber, in technical skill, and moral competence. There is no conspiracy to defraud. It is not a perfect system, but I can't think of anything better."

Samuels said he was "concerned about not providing a fair shake to the rest of NIH. I don't agree that the way is to downgrade NCI, but to upgrade the others, following the good pioneering work of NCI."

Maguire asked if the Board "is strong enough to follow congressional mandates on prevention?"

Samuels said he felt "NCI has done a good job of providing information to the regulators. Don't try to turn researchers into regulators. Scientists can't function as scientists if they have to be policemen and social workers."

Maguire asked if a line item in the budget for prevention would be useful.

"You would have a problem in defining prevention," Samuels answered.

Testimony of other witnesses, including NCI Acting Director Vincent DeVita, will appear next week in ***The Cancer Letter.***

PROGRAM ANNOUNCEMENT

Cancer Clinical Treatment Research

NCI's Div. of Cancer Treatment is seeking applications for research grants concerned with the clinical treatment of cancer. Appropriate studies include the elucidation of the effects of various treatments and related tissue responses, toxicology and the importance of host factors in disease occurrence, rate of progression and curability.

Improved experimental design, data management, statistical analysis, as well as specific experimental developments in supportive care methods and modalities are integral aspects of this program. Applications dealing with innovative approaches in surgical oncology are of particular interest.

In making this program announcement, it is not the intent of NCI to make or imply any delimitation related to cancer clinical treatment research, but rather to stimulate investigator-initiated research in clinical treatment.

Applications in response to this announcement will be reviewed on a nationwide basis in competition with each other, and in accord with the usual NIH peer review procedures. Applications will be accepted in accordance with the usual NIH receipt dates for new applications—July 1, Nov. 1 and March 1.

Applications should be submitted on form PHS 398, which is available in the business or grants and contracts office at most academic and research institutions or from the Div. of Research Grants, NIH. The phrase, "Prepared in Response to Program Announcement on Cancer Clinical Treatment Research" should be typed across the top of the first page of the application.

Additionally, a brief covering letter should accompany the application indicating it is being submitted in response to this program announcement.

The original and six copies of the application should be sent or delivered to: Application Receipt Office, Div. of Research Grants, NIH, Room 240

Westwood Bldg., Bethesda, Md. 20205.

For further information, investigators are encouraged to contact: William DeWys, Program Director for Clinical Treatment Grants, Room 8C17 Landow Bldg., Bethesda, Md. 20205, phone 301-496-4844.

In order to alert DCT to the submission of proposals with primary thrust directed to clinical treatment research, a copy of the covering letter should be sent under separate cover to DeWys.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR MARCH, APRIL

Cancer Control Grant Review Committee–March 2-4, NIH Bldg 31 Rm 8, open March 2, 3–3:30 p.m.
Genes, Chromosomes & Neoplasia–March 4-7, 33rd Annual Symposium on Fundamental Cancer Research, Houston Shamrock Hilton.
Coalition on Cancer Issues–March 5, Georgetown Univ. Rm SE 202 conference room, Dept. of Anatomy, Medical/Dental School Bldg, 10 a.m.
Seminar on Bone and Soft Tissue Malignancy–March 7, Roswell Park continuing education in oncology.
Assn. of Community Cancer Centers Annual Meeting–March 7-9, Shoreham Hotel, Washington D.C.
Minimal Breast Cancer: Diagnostic & Prognostic Aspects–March 11-12, NIH Bldg 1 Wilson Hall, 8:30 a.m. both days, open.
Cancer Special Programs Advisory Committee–March 13-14, NIH Bldg 31 Rm 10, open March 13, 9–10 a.m.
Pharmaceutical Aspects of Cancer Care–March 15-16, San Francisco Hyatt on Union Square, West Coast Cancer Foundation 15th Annual San Francisco Cancer Symposium.
Cancer Centers Support Grant Review Committee–March 20-21, NIH Bldg 31 Rm 6, open March 20, 8:30–10 a.m.
Cancer Prevention & Detection: Update for the Community–March 20, Roswell Park continuing education in oncology.
Regulation of Cell Proliferation–March 20, Univ. of North Carolina School of Medicine, Chapel Hill.
Clinical Cancer Program Project Grant Review Committee–March 24-26, NIH Bldg 31 Rm 6, open March 24, 8:30–10 a.m., and later from 4–5 p.m. for a seminar on hyperthermia.
Div. of Cancer Treatment Board of Scientific Counselors–March 24-25, NIH Bldg 31 Rm 10, open 8:30 a.m.–5 p.m. both days.
Clinical Trials Review Committee–March 26-27, NIH Bldg 31 Rm 7, open March 26, 9–9:30 a.m.
Tumor Immunology Committee–March 28, Landow Rm A, open 9–9:30 a.m.
Management of Breast Carcinoma: Controversies and Current Concepts–March 28-29, Wayne State Univ., Detroit.
Cancer Research in the People's Republic of China and USA–March 28-29, Columbia Univ.
Management of Patients with Terminal Cancer–March 29-30, Shoreham Hotel, Washington D.C.
Clinical Cytopathology for Pathologists–April 14-25, Johns Hopkins Univ., postgraduate course.
Hormone Manipulation in the Therapy of Human Malignant Disease–April 15-16, Drake Hotel, Chicago, sponsored by Rush Cancer Center.
National Cancer Advisory Board Working Group on Board Activities and Agenda–April 17, NIH Bldg 31 Rm 9, 1 p.m., open.
Clearinghouse on Environmental Carcinogens Chemical Selection Subgroup–April 23, NIH Bldg 31 Rm 7, 9 a.m., open.
Endocrinology–April 24, Roswell Park continuing education in oncology.
Physiological, Psychological and Sociological Aspects of Cancer–April 25, Roswell Park, seminar for nurses.
Immunotherapy of Cancer: Present Status of Trials in Man–April 28-30, NIH Masur Auditorium, Second International Conference.
American Society of Clinical Oncology–May 26-27, Town & Country Hotel, San Diego, 16th annual meeting.
American Assn. for Cancer Research–May 28-31, Town & Country Hotel, San Diego, 71st annual meeting.
Oncology Nursing Society–May 28-30, Sheraton Harbor Island Hotel, San Diego, fifth annual congress.

NCI CONTRACT AWARDS

Title: Studies of environmental carcinogenesis research and bioassays (skin studies)
Contractor: Univ. of Nebraska, $184,870.

Title: Action of trytophan on the bladder
Contractor: Univ. of Nebraska, $20,016.

Title: Prenatal carcinogenicity of anti-fertility drugs: Enovide-G, ioestrin, micronor, oracon, and estradiol-B
Contractor: Univ. of Nebraska, $58,469.

Title: The possible influence of diet in carcinogenesis
Contractor: Univ. of Nebraska, $113,743.

Title: Studies on developing methods and/or causative factors in intestinal carcinogenesis
Contractor: Univ. of Nebraska, $68,090.

Title: The effect of oral contraceptive steroid treatment or carcinogen metabolism in rats and hamsters
Contractor: Univ. of Nebraska, $61,600.

Title: Activation and transport of N-nitrosamines and their metabolites
Contractor: Univ. of Nebraska, $53,723.

Title: Establishment of mouse urinary epithelial cells in culture
Contractor: Univ. of Nebraska, $26,704.

Title: Breast Cancer Detection Demonstration Project, long term followup
Contractor: Medical College of Wisconsin, $456,399.

Title: Large scale production of oncogenic or potentially oncogenic viruses, continuation
Contractor: Electro-Nucleonics Laboratories Inc., $68,437.

Title: Operation of a facility to provide and maintain nonhuman primates for cancer research, continuation
Contractor: Litton Bionetics, $88,498.

Title: Mouse typing and diagnostic reagents, continuation
Contractor: Microbiological Associates, $43,400.

Title: Fibroblast repository for patients at high risk for cancer, continuation
Contractor: Meloy Laboratories, $127,562.

Title: Spontaneous and virus induced neoplastic transformation, continuation
Contractor: Meloy Laboratories, $288,183.

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-CM-07364-18

Title: *Preclinical pharmacology studies of antitumor agents*
Deadline: *May 12*

The purpose of these studies is to provide a pharmacologic profile in animals of newly developed antitumor agents so that their introduction into clinical trial will be based on definite knowledge of their probable pharmacologic behavior. To this end, tissue localization, pharmacokinetic behavior (including distribution and execretion kinetics), biotransformation pathways, and metabolic identification will be investigated as appropriate. The contractor should also be able to apply the latest sophisticated technology to the development of highly sensitive and specific assays for antitumor agents in biological materials.

Whenever possible these methods should be sufficiently sensitive for eventual application to clinical studies, although these will not be required under this RFP. The government will provide necessary drugs and small laboratory animals for the required studies.

It is anticipated that two awards will be made under this RFP at two different levels of effort (approximately 14 and six technical man years for each) for a period of three years. The contract will be incrementally funded on a yearly basis. Only one award will be made to a successful organization under this RFP.

Contract Specialist: Helen Lee
Cancer Treatment
301-427-8737

RFP NCI-CM-97238-18

Title: *Hematology support care*
Deadline: *March 31*

The Pediatric Oncology Branch, Div. of Cancer Treatment, is seeking proposals from qualified sources for the serum repository services involving over 30,000 samples and some in vitro assays including leukoagglutination, lymphocytoxocity, and platelet migration inhibition tests.

This proposed project represents a recompetition of an ongoing project. Microbiological Associates is the incumbent contractor. Because of the nature of the specimens involved, the successful offeror must be within a 50 mile radius of the NIH reservation so that daily pickups and delivery of samples are possible. The contractor is also required to provide a computer program for sample retrieval for identification, volume, and localization. In addition, the computer capabilities must provide data verification and updating routines.

It is anticipated that the contract will be awarded incrementally for three years and should provide for the accommodation of 20,000 additional samples.

Contract Specialist: Otis Parham
Cancer Treatment
301-427-8737

RFP NCI-CM-07340-22

Title: *Chemoprevention of cervical cancer and/or associated pathology reference center*
Deadline: *April 9*

Perform either of the following:

Task 1—Clinical trials in the chemoprevention of cervical cancer. Offerors shall demonstrate knowledge of and accomplishments in the development of topical retinoid preparations. Also, offerors shall demonstrate the ability to develop and obtain such materials in conjunction with members of the pharmaceutical community. NCI will not supply these materials. Contractors shall perform phase 1, 2 and 3 clinical studies.

Task 2—Operation of the pathology reference center. The contractor will receive from the clinical trials contractors all pertinent material upon which the initial diagnosis of early stage cancer of the cervix was based. In addition, all slides related to patient followup will be submitted to the Pathology Reference Center. This may include, but is not limited to, one or more of the following:

1. Cytology slides; 2. Slides of needle biopsies, core or aspiration, from any site; 3. Slides from any other pertinent biopsies. The award of Task 2 may be made independently of the clinical trials task.

Contracting Officer: Harold Thiessen
Cancer Treatment
301-427-8737

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