THE CANCER LETTER

Vol. 6 No. 17

April 25, 1980

Subscription $125.00 per year

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

TREATMENT PROGRESS INCREASES FIVE YEAR SURVIVAL TO 41%; RATES COMPARED FOR 10 LEADING CANCERS

NCI's SEER Program is turning up solid evidence of progress in the treatment of cancer, including statistically significant improvements in five year survival for the more common adult tumors.

NCI Acting Director Vincent DeVita has referred to the new figures

(Continued to page 2)

In Brief

GARB RAPS "HOSTILITY OF EXECUTIVE BRANCH"; HEW CONSIDERS ALLOWING GRANTS FOR INDUSTRY

SOLOMON GARB, one of the organizers of the effort that led to the National Cancer Act of 1971, was outraged by the Carter Administration's alleged justification for the new big cuts in the Cancer Program budget, that "cancer has more money in applied research" than other biomedical programs. Garb, as cochairman (with Emerson Foote and Kay Mansolill) of the Citizens' Committee for the Conquest of Cancer, fired off a letter to key Congressmen: "Applied research of course means clinical studies. In other words, because the Cancer Program is trying to use research discoveries to help sick people, it is singled out for the biggest cuts. This is just one more example of the continuing hostility of parts of the Executive Branch to studies that try to bring to patients the benefits of research. . . . We appeal to you to protect the Cancer Program. It is making good progress, although it could do better if it had adequate funding. Last year, an extra 11,000 American lives were saved because of the Cancer Program." . . . **HEW IS CONSIDERING** dropping its ban on grant and cooperative agreement awards to profit making organizations. Comments are being sought. Send them to Theodore Roumel, Grants Management Branch, Div. of Grants & Contracts, Parklawn Bldg. Rm 18A-03, 5600 Fishers Lane, Rockville, Md. 20857. . . . **GILBERT OMENN**, who as assistant director for human resources in the White House Office of Science & Technology Policy has been an ex-officio member of the National Cancer Advisory Board, has transferred to the Office of Management & Budget. He replaces Sue Woolsey as deputy director for health and welfare and will have a lot to say about future NIH and NCI budgets. Denis Prager has been named acting assistant director for human resources in OSTP and probably will take Omenn's seat on the NCAB. . . . **DIAGNOSTIC RESEARCH** Advisory Group meeting scheduled April 24-25 has been postponed to June 23-24 at NIH Bldg 31 conference room 8. The group will discuss new areas for diagnostic research, including improved tumor antigens and markers. . . . **"CURRENT CONCEPTS** in Cancer Chemotherapy" is the subject of a symposium June 25 sponsored by Adria Laboratories and M.D. Anderson. Contact Kenneth McCredie, Program Director, MDA, 6723 Bertner Ave., Houston 77030.

SIGNIFICANT IMPROVEMENTS IN TREATING ADULT TUMORS SEEN IN SURVIVAL RATES

(Continued from page 1)

in testimony before congressional committees and more recently at the annual science writers seminar sponsored by the American Cancer Society. A few of the writers picked up on the significance of the figures, but for the most part the extent of progress has gone unrecognized.

The SEER (Surveillance, Epidemiology and End Results) figures are compiled through continuous monitoring of cancer incidence, mortality and survival in five metropolitan areas, five states and Puerto Rico. They show that five year survival now is 41 percent, compared with the generally accepted rate of about 33 percent in 1955.

DeVita presented the latest SEER figures on five year survival for 10 leading cancer sites in white Americans. The figures compared survival rates for cancer diagnosed from 1960 to 1963 with those diagnosed from 1970 to 1973:

	1960-63	1970-73
Endometrium	73%	81%
Breast	63	68
Cervix	58	64
Bladder	53	61
Prostate	50	63
Colon	43	49
Rectum	38	45
Stomach	11	13
Lung	8	10
Pancreas	1	1

Those are the major killers contributing to the 405,000 cancer deaths predicted for the U.S. in 1980. If the increase in percentages does not seem startling, consider this: Those diagnosed with one of the 10 cancers in 1980 will total 542,400, according to American Cancer Society estimates. If there had been no improvement in treatment of those 10 malignancies since the early 1960s, 216,602 could expect to live five years. With only those improvements initiated from 1963 to 1973, 247,457 would survive five years.

That translates into an additional 30,000 Americans who will survive the disease diagnosed this year—not counting the increased survival which most certainly will be attributed to progress made since 1973 but which will not be counted until five year survival data are available.

For instance, if 68 percent of breast cancer patients treated with 1973 techniques survived five years, what will the survival rate be for those whose disease was diagnosed after the Fisher and Bonadonna results became known, and adjuvant chemotherapy became standard treatment for all but stage one patients? If the 1980 figure is 75 percent, more than 81,000 of the 108,900 breast cancer victims will live five years, compared with 74,000 with 1973 therapy and 68,000 with 1963 treatment.

(Actual numbers of survivors for 1960-63 and 1970-73 would be less because the incidence was lower than the 1980 estimate.)

The improvements in treating childhood and young adult cancer have been recognized since the early 1970s, and have been reflected in the past two years in survival curves. The SEER data for 1960-63 and 1970-73 demonstrate the startling progress, and again much of the improvement still has not shown up in five year survival rates:

	1960-63	1970-73
Acute lymphocytic leukemia	4%	34%
Hodgkin's disease	40	67
Bone cancer	31	37
Wilm's tumor	33	70
Testis	63	72

Most pediatric oncologists are quoting far higher survival now, with the demonstrations in the 1970s of adjuvant chemotherapy in treating osteogenic sarcoma (50-80 percent survival being claimed); Wilm's tumor (80-90 percent); ALL (50 percent now seems to be the minimum rate quoted); Hodgkin's (in the 80 percent range); and testicular cancer, with new chemotherapy effective in treating recurrences, perhaps 90 percent.

It no doubt is easy to overstate the prospects, but it would seem that if the improvements in chemotherapy, in the increased availability of multidisciplinary treatment, improved supportive care, earlier diagnosis, all mean anything, the survival data SEER will be reporting each year now will add up to a smashing success story.

"I hope this will dispel some of the pessimism about the Cancer Program," DeVita told the writers. "We spent most of the 1960s trying to prove it was possible to cure cancer with drugs. In the 1970s we moved into adjuvant, multimodality therapy. The 1978 data will be even more emphatic, but we won't know how much until 1983. This is just the beginning."

DeVita prefers to include the 400,000 cases of skin cancer and in situ cancer of the cervix when he quotes survival figures. "Why should we exclude them just because we know how to cure them?" he asks. Also, if warnings about overexposure to sunlight are to mean anything, people should be made to realize skin cancer is lethal if untreated. Leaving it out of the statistics tends to diminish those concerns, DeVita points out.

With those cancers included, "fully 58 percent of the more than one million Americans who develop cancer this year can expect to be cured using currently available therapies," DeVita said. Subtracting those 400,000, he acknowledged, reduces that to the 41 percent (but again, 41 percent is the minimum figure, since it is based on the survival rates of those whose

treatment was started in 1973 or earlier).

Surgeons and radiotherapists, who are still responsible for a majority of cures presently being achieved in cancer, might claim some of the credit for the gains being reported. Survival in cases treated with surgery alone appeared to plateau in the 1950s, but some surgeons argue that a steady refinement of techniques and improved understanding of the disease have made important contributions. Radiotherapy, which leaped forward with more sophisticated and powerful equipment in the late 1950s, seems ready for another round of progress with the impending development of particle radiation.

"We often hear that cancer is the disease Americans fear most," DeVita said. "A surprising paradox is that cancer is one of the most curable chronic diseases in the country today."

The SEER program will publish a booklet with details on the five year survival data. It should be available within six weeks.

"DOG AND PONY" AGENDA AT FCRC OFF, NCAB GETS TIME FOR TALKS WITH STAFF

After Sheldon Samuels called the proposed agenda for the National Cancer Advisory Board's day long session at Frederick Cancer Research Center next month a "dog and pony show," the Board's Working Group on Board Activities & Agenda revised the schedule to give members more opportunity for discussion with FCRC staff.

The agenda prepared by NCI staff had most of the day (May 20, the second day of the meeting) taken up with presentations by division directors and FCRC senior staff, with tours of labs and animal facilities.

"If we want to learn something about Frederick, we will have to have access to the people working there under the contract (with Litton Bionetics)," Samuels said at last week's meeting of the working group. "I'm not against touring the facilities, but it is important that we have the opportunity to talk informally with the people who work there, and not necessarily the heads of the laboratories. We need at least an hour with real people."

Samuels, a member of the NCAB, suggested that arrangements be made for Board members to mingle with FCRC staff at lunch. "I want to hear what they have to say, good or bad. A formal presentation is not a good way to make this kind of inquiry. We need to hear informal expressions. Some of the employees may be enraged by some of the things I have said and may want to say 'Samuels, you're wrong' . . . I would rather talk with people than watch animals propagate."

Samuels has been critical of administration aspects of the operation.

FCRC developed more or less along the lines demanded by the NCAB. President Nixon closed the Army's biological warfare facility there early in his first term and turned over most of the space to HEW, with instructions that it be used for cancer research. NCI executives envisioned it primarily as an animal, virus and chemical production facility, but Board members argued successfully that it should have a strong research component. That was built into the contract which was negotiated, after stiff competition, with Litton Bionetics.

The first five year contract expired in 1977, and although it was put up for recompetition, no other firm submitted a proposal. The present contract expires Sept. 25, 1982.

NCI Acting Director Vincent DeVita told the working group that "We will soon be discussing the Frederick contract. We will have to have it (the recompetition) framed by the end of the summer." The contract presently totals $23.7 million a year.

NCI is moving some intramural staff to FCRC. Two years ago, NCI and NIH executives considered changing the entire operation at Frederick into an extension of the NIH campus. That idea was shelved, but it is not entirely dead.

The NCI-Litton Bionetics contract has been the target of critics, although reviews have found the science to be of high quality.

The Board's May meeting will see the unveiling of the 1982 fiscal year budget proposal which NCI intends to submit to the White House in September, subject to modifications the Board may suggest.

David Rall, director of the National Toxicology Program will discuss the program, with presentations on Carcinogesesis Testing by Richard Griesemer; the National Institute of Environmental Health portion of the program by NTP Deputy Director John Moore; National Center for Toxicology Research (FDA) portion by Ronald Hart, NCTR director; and National Institute for Occupational Safety & Health portion by NIOSH Director Anthony Robbins.

The Board's grant review duties this time will be performed on the final day of the three day meeting, traditionally the least well attended (by Board members). NCAB Chairman Henry Pitot said members have been informed that they will be expected "to stay to the bitter end" this time.

The terms of six members have expired—lay members Mary Lasker and William Baker, and scientific members Denman Hammond, Joseph Ogura, William Powers and William Shingleton. They will be invited to the May meeting, even if their replacements have been appointed although they would not vote if the new members are present.

ACS SAYS FUND RAISING WILL BE HURT BY NEW POLICY IN FEDERAL INCOME TAX

The American Cancer Society's fund raising will be adversely affected by recent changes in federal income tax policy, Executive Vice President Lane Adams predicted in the Society's annual report.

Adams said that increasing the standard deduction "removes millions of taxpayers from long form filing and itemizing deductions," and that removal of a charitable gift tax incentive "will result in an (annual) estimated loss to charity of $5 billion."

Meanwhile, Adams said, the Society is confronted with expanding obligations of research, outreach to minority populations, and service and rehabilitation programs for cancer patients. "In spite of solid progress in prevention, such as our confirmation of the link between smoking and cancer, cancer will strike more people than ever. In the 1970s, 6.5 million Americans were afflicted with cancer. In the 1980s there will be at least 8.5 million."

Announcing that $142,138,732 raised by the Society in fiscal 1979 helped it to exceed $1 billion in contributions and legacies during the decade of the seventies, Adams asserted that "we must raise $3 billion in the eighties."

Advances in the detection and treatment of cancer will cause greater numbers of cancer patients to live longer lives, ACS reported. This will require more extensive patient service and rehabilitation programs, three of the Society's best known being (1) Reach to Recovery, for breast cancer patients, (2) the International Assn. of Laryngectomees, for persons who have lost their voice boxes to cancer, and (3) an ostomy program, for patients who have undergone various kinds of abdominal surgery.

ACS announced a budget of $164,188,000 for its current fiscal year (1980) which began Sept. 1. This includes $55,550,000 for research, $41,395,000 for programs of public and professional education aimed primarily at prevention, $32,191,000 for patient and community services, $15,267,000 for management and general expense, and $19,785,000 for fund raising.

The new budget will be supported in part from anticipated 1980 income. Normally the Society finances its programs with funds received during the immediately preceding year, in order to provide for even and uninterrupted program activity.

Commenting on the annual report, ACS President Saul Gusberg said that "over a period of a decade the Society's income has barely kept ahead of inflation. In spite of increased costs, however, the Society's programs and productivity have continued to grow largely because it has been blessed with the contributed labor of 2,300,000 volunteers."

NEW MEXICO CBCCP CHARGES CONTRACTS ENDED BY POLITICAL, ECONOMIC FACTORS

The New Mexico Community Based Cancer Control Program board of directors and staff have submitted to the National Cancer Advisory Board its response to NCI's decision to terminate the contract. A draft of the response contends that the New Mexico program "has fulfilled its contractual obligations."

NCI's Div. of Cancer Control & Rehabilitation, acting on recommendations of merit review committees, decided to terminate the New Mexico, Rhode Island and Long Island contracts in the Community Based Cancer Control Program, and to phase out certain portions of the other three contracts, in Detroit, Los Angeles and Hawaii.

The contractors were offered the opportunity to present rebuttals to the merit review findings at the May meeting of the National Cancer Advisory Board. All three of those being terminated indicated they would present their cases to the Board, which will consider them in closed session.

The Board has no statutory authority to overturn the staff decision, but the CBCCP was given concept approval by the Board when it was initiated. Any Board recommendation regarding the terminations probably would be carried out by NCI.

The New Mexico contract was originally due to expire in June, 1981. The termination order was to have been effective July 31, 1980.

The draft of the New Mexico rebuttal summarizes:

"New Mexico Community Based Cancer Control Program has fulfilled its contractual obligations to NCI. It has produced a coordinated cancer program in New Mexico and the Navajo Nation that are meritorious and evaluable by standard process. The program's board director and staff have chosen to reply before the National Cancer Advisory Board in a positive exposition of the program, its leadership, its evaluation and its viable and meritorious subcontracts. Its planned, orderly phase out into coordinated community programs by 1981 involved the state of New Mexico, the Dept. of Health and Environment, the Univ. of New Mexico, private industrial and professional groups and public hospitals and health groups.

"The premature and disorderly phase out instigated by political and economic circumstances, will result in a loss of proper transfer of the programs and the proper achievement of goals and objectives. It will destroy much of the evaluation of the impact of the programs and disrupt core activity including meritorious projects of professional education, Kayenta (Navajo) cancer control program, melanoma slide registry, core cancer prevention in stop smoking activity, cervical cancer followup, research in marijuana, and will be devastating to the legislative process of the Health and Environment Cancer Prevention and Control Program, as well as Southwest Health Care Corp. programs.

"The Board, director, and staff would not want to continue the destructive and repetitive rhetoric and the destructive and delaying relationships, suffered between DCCR and the community based programs, as well as this program, which begins to sound like 'boilerplate' semantics. . . .

"Lastly, our program has achieved professional recognition and fiscal integrity, as well as having the

services and participation of over 90 percent of the oncologists in New Mexico and the cooperation of the university, State Medical Society and citizens of New Mexico and the Navajo Nation.

"If, indeed, it is prematurely and destructively terminated, it is not due to its merits of leadership, evaluation or viable projects, but to more mundane considerations of priorities of political and fiscal factors. The greatest potential benefit in cancer prevention today is at a community level, changing behavior in an informed and motivated public."

CORRECTION: ***The Cancer Letter*** report on effect of the terminations on the three programs (March 21) said that Cancer Care Inc., a subcontractor with the Long Island CBCCP, was limited by its charter to offering its services only within a 50 mile radius of its office. The office it maintained in Long Island permitted it to serve all that area.

In fact, "no such restriction exists," Sam Allalouf, Cancer Care public relations director, said. "Anyone can call for assistance; we respond to requests from wherever they may originate. . . . While our office at Woodbury will soon complete its second year, we are not at all certain that we can continue to keep that office because of the precipitous withdrawal of support."

STUDY SHOWS SHORT TERM TESTS CAN PREDICT CARCINOGENICITY; NONE BEST

Frederick DeSerres, associate director for genetics of the National Institute of Environmental Health Sciences, has reported on a study which confirms that short term tests can predict carcinogenic activity but found that no single test could be determined as the best.

DeSerres, speaking at the American Cancer Society Science Writers Seminar, said:

The general acceptance of the somatic mutation of cancer has led to the development of mutational based tests for detecting those chemicals with the potential to produce mutations and cancer. This is not the only theory for the induction of cancer, and many other tests have been developed which are claimed to identify carcinogens and noncarcinogens with a high degree of accuracy.

The rapid proliferation of such short term tests has generated a problem of selecting the best and most useful tests for screening purposes. This problem has been tackled by various laboratories by carrying out validation studies to assess the effectiveness with which short term tests can detect known carcinogens and noncarcinogens. However, the problem remains of how to compare the performance of different test systems when the data describing the performance has been developed using studies with different protocols, different chemicals, different evaluation criteria, and in different laboratories.

In addition, when chemicals are tested for regulatory purposes this places particular demands on the test system and on the scientific evidence which is used to support the extrapolation of the data to man. The questions that need to be answered before such short term tests can be used with any confidence are as follows:

1. How good is the short term test in predicting carcinogenic and noncarcinogenic properties of chemicals?
2. What are the liminations of the particular test system in a routine testing situation?
3. Is there a need to provide a rigid standardization of test protocols in order to obtain reliable test data?
4. Is there a need to have a battery of test systems in order to detect all carcinogens? If this is the case, what penalty is paid by incorrectly classifying noncarcinogens?

The International Program for the Evaluation of Short-Term Tests for Carcinogenicity was specifically designed to examine the performance of various short term tests in detecting carcinogens and noncarcinogens. This international program started in 1977 in England under the auspices of the Health and Safety Executive and the Medical Research Council. A large number of test systems was under consideration with a variety of end points.

It was agreed that a useful method of assessing the performance of short term tests was to use pairs of structurally related chemicals (one of which was carcinogenic and the other noncarcinogenic) in a comparative study in which the investigators would not know the identity of the chemicals they were testing. A total of 42 compounds were selected for study including 25 carcinogens and 17 noncarcinogens which included 14 paired compounds. These chemicals were synthesized and prepared in 50 gram quantities and in a high state of purity.

Since this quantity was in excess of HSE/MRC program requirements, the study was expanded by the National Institute of Environmental Health Sciences to extend the collaboration to include a variety of test systems not included in the HSE/-MRC scheme. An international program resulted that involved 35 assay systems with 65 different investigators working in the United Kingdom, Europe, Canada, Mexico, Japan, the USSR, and the United States.

In the selection of the 42 test chemicals consideration was given to get as large a range of chemical types and chemical classes as possible in a group of 42 chemicals. In addition some carcinogens were selected because it was known that they gave a negative result in bacterial tests for mutagenicity. The inclusion of a number of such chemicals increased the chances of finding other assay systems which would detect their activity and give a positive test.

Chemicals were coded and sent to investigators who had knowledge of neither their identity, nor carcinogenicity. Chemicals were decoded only after the investigators had submitted their final data and conclusions regarding the positive, negative or inconclusive results with each chemical. All investigators were required to submit their final data and conclusions by Aug. 31, 1979, and the code was distributed to prepare reports of their results which were due at the Test Data Evaluation Workshop held on Oct. 17-22, 1979.

The main conclusions from this study to data are as follows:

1. This study confirms that there are short term tests that can be used to predict carcinogenic activity but no single assay or battery of assays was readily apparent as the best suited for this purpose.
2. Reliable data from any assay system is dependent upon the investigators' thorough understanding of the system, awareness of pitfalls, and careful conduct of experiments.
3. Nearly all assays produced both false negatives and false positives (those which did not were, for instance, particularly insensitive giving only a few positive responses for the 25 carcinogens tested). Therefore, to include any assay in a battery of tests will require a tradeoff between these two classes of errors.
4. Specific conclusions about test system performance and relative utility must await the outcome of more detailed analysis of the data base which is now underway.
5. Strong evidence for the use of a test battery was obtained (e.g. with HMPA, a rodent carcinogen, bacterial results

were largely negative in both repair and mutation assays and yet eukaryotic systems from yeast to whole animals were positive).

6. Recommendations on test batteries will have to await a clear definition of their application and the relative importance of false positive and negative results.

CONGRESS ASKED TO EQUALIZE BUDGET CUTS, ADD $20 MILLION FOR CENTERS

Timothy Talbot, president of Fox Chase Cancer Center, asked Congress to add $20 million to the FY 1981 budget request for cancer center core grants in testimony before the House HEW Appropriations Subcommittee.

Talbot also asked that any reductions in the 1980 and 1981 NIH budget be allocated equally among all the institutes, rather than require NCI to bear the major share of the burden as proposed in the Administration's budget cut requests.

"My colleagues who direct other cancer centers and I recognized the need for fiscal restraint," Talbot said. "We accept the necessity for budget restrictions, but we cannot agree with the proposal which asks the Cancer Program to absorb almost half of the proposed reduction in funding for the National Institutes of Health. Cancer's share of the NIH requested budget is 28 percent, but its share of the proposed reduction is 47 percent."

Talbot asked that the appropriations bill specifically designate funds for Cancer Center Support (core) grants. Those grants "make it possible for us to pay for research resources which can be shared by investigators whose individual grants would not permit this kind of help," Talbot said. "At our center we are able to give our investigators such tools as a protein sequencing laboratory, an organic synthesis lab to make compounds not commercially available, biostatistical laboratories, and many other services. In addition, Cancer Center Support Grants enable us to attract and keep first quality scientists, and the stability of continuing support is reflected in the productivity of our staff.

"Unfortunately, as our center has been encouraged to develop and expand over the past 18 years, so have the expectations of the communities and the people we serve. Until now, through our programs of professional training and public education we have been able to make a substantial impact on our area. Other centers are at a point where they are just about to begin fulfilling their promise. However, if there is inadequate funding, service to the public must inevitably be curtailed."

The proposed changes in the core grant guidelines also would damage the centers program, Talbot said.

Talbot asked the committee to direct NCI to allocate $85 million for Cancer Center Support Grants "from whatever appropriation is finally made" for 1981. The Administration budget requested $65 million for centers; if that is not increased, at least four centers and perhaps more would not be funded, and renewal awards would be held to a fraction of the recommended amounts.

The American Assn. of Cancer Institutes has scheduled a special meeting April 27-28 in Bethesda to consider the core grant guideline proposals. William Terry, acting director of the Centers Program, is scheduled to discuss the proposals with the National Cancer Advisory Board May 19.

No decision will be made at that time, however. NCAB Chairman Henry Pitot said at last week's meeting of the Board's Working Group on NCAB Activities & Agenda that discussion would be held to 30 minutes and the issue would be referred to the Subcommittee on Centers. The subcommittee will be asked to report at the Board's October meeting.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR MAY AND JUNE

Div. of Cancer Cause & Prevention Board of Scientific Counselors—May 1-2, NIH Bldg 31 Rm 9, open May 2, 9 a.m.–5 p.m. (closed May 1).

Hospice—May 2, Roswell Park continuing education in oncology.

International Conference on Cancer Among Blacks—May 5-6, Roswell Park, contact Curtis Mettlin.

Cancer Control & Rehabilitation Advisory Committee—May 5, Blair Bldg Rm 110, 9 a.m., open.

Third Lymphoma Panel—May 5-6, Turkish Society of Oncology, Istanbul.

Cancer Research Manpower Review Committee—May 8-10, Landow Bldg Rm A, open May 10, 9–10 a.m.

Recent Advances in the Diagnosis & Management of Breast Cancer—May 8, Roswell Park continuing education in oncology.

Fifth Symposium on Use of Radioisotopes in Gastroenterology—May 8-12, Cluj-Napoca, Romania.

Rehabilitation & Reintegration of Cured Cancer Patients—May 9-10, Besancon, France.

International Source on the Utilization of Non-Human Primates in Cancer Research—May 10-20, Sukhumi, Abkhazian SSR, USSR.

Joint Meeting of the Society of Surgical Oncology and Society of Head and Neck Surgeons—May 13-17, San Francisco.

Immunodynamics III: Immunoregulation and Autoimmunity—May 13-14, Cleveland Clinic Foundation.

Multidisciplinary Advances in Adolescent Oncology—May 16, Roswell Park continuing education in oncology.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors—May 16-17, NIH Bldg 31 Rm 7, open May 16, 9 a.m.–5 p.m.

National Cancer Advisory Board Subcommittee on Environmental Carcinogenesis—May 18, NIH Bldg 31 Rm 10, 7 p.m., open.

National Cancer Advisory Board—May 19-21, NIH Bldg 31 Rm 10 (except for May 20 which will be at Frederick Cancer Research Center), open May 19, 8:45 a.m.–3 p.m.; open May 20 at FCRC 9 a.m.–adjournment; closed May 21.

President's Cancer Panel—May 19, NIH Bldg 31 Rm 9, 5 p.m., open.

Seventh International Congress of Cytology—May 18-22, Munich.

Plenary Meeting of the Organization of European Cancer Institutes–May 19-20, Rodos, Greece, closed.
First European Conference on Reach to Recovery–May 19-20, Copenhagen, sponsored by Danish Cancer Society, UICC, WHO.
Fourth Annual European Nuclear Medicine Society– May 19-23, Barcelona.
Cancer Questions and Answers– May 20, Marie Curie Memorial Foundation, London.
EORTC Symposium on Progress in Treatment of Gastrointestinal Tumors–May 22-23, Brussels.
Cancer Research Manpower Review Committee–May 24-25, Kings Inn, San Diego, open May 24, 9–10 a.m.
American Society of Clinical Oncology–May 26-27, 16th annual meeting, Town & Country Hotel, San Diego.
Interdisciplinary Aspects in Diseases of the Female Breast–May 27-31, Hamburg, International Society of Senology.
American Assn. for Cancer Research–May 28-31, 71st annual meeting, Town & Country Hotel, San Diego.
Oncology Nursing Society–May 28-30, 5th annual meeting, Sheraton Harbor Island, San Diego.

Prostatic Cancer Review Committee–June 2, Roswell Park, open 8:30–9 a.m.
Second World Congress for Bronchology–June 2-4, Dusseldorf.
Clinical Trials Committee–June 3-4, Bethesda Holiday Inn, open June 3, 9–9:30 a.m.
Fifth National Oncological Meeting–June 4-7, San Jose, Costa Rica.
Developmental Therapeutics Committee–June 5-6, Landow Bldg Rm A, open June 5, 9–9:30 a.m.
Large Bowel Cancer Review Committee–June 5-6, Prudential Bldg, Houston, open June 5, 7:30 p.m.–8 p.m.
Bladder Cancer Review Committee–June 5-6, Ramada Inn, Pittsburgh, open June 5, 8-9 a.m.
Pancreatic Cancer Review Committee–June 9-10, Tidewater Place, New Orleans, open June 9, 7 p.m.–8 p.m.
Cancer Control Grant Review Committee–June 9-10, NIH Bldg 31 Rm 7, open June 9, 8:30–9 a.m.
Second World Conference on Lung Cancer–June 9-13, Copenhagen.
Clinical Cancer Education Committee–June 11-12, Landow Bldg Rm A, open June 11, 8:30–9 a.m.
Conference on Biological Carcinogens–June 11-14, Michigan Cancer Foundation, Detroit.
Symposium on Recent Topics in Cancer Research–June 12-13, Osaka, sponsored by U.S.-Japanese Cooperative Cancer Research Program and the Japanese Cancer Assn.
Modern Trends in Human Leukemia–June 17-19, Wilsede, Germany.
UICC Pan American Conference on Public Education About Cancer–June 17-19, Bogota, Colombia.
Cause & Prevention Scientific Review Committee–June 19-20, NIH Bldg 31 Rm 9, open June 19, 9–9:30 a.m.
Third International Symposium on Cancer Therapy by Hyperthermia, Drugs and Radiation–June 22-26, Colorado State Univ., Fort Collins.
Cancer of the Colon-Rectum–June 21, Roswell Park continuing education in oncology.
Diagnostic Research Advisory Group–June 23-24, NIH Bldg 31 Rm 8, 9 a.m., open.
Clinical Cancer Investigation Review Committee–June 23-25, NIH Bldg 31 Rm 4, open June 23, 8:30–9:30 a.m.
Seventh International Conference of the International Assn. of Oral & Maxillofacial Surgery–June 24-26, Dublin.
Current Concepts in Cancer Chemotherapy–June 25, M.D. Anderson Auditorium, 8:30 a.m.
Fifth International Congress of Dentomaxillofacial Radiology–June 28-July 2, Portland, Ore.
International Symposium on Mouse Teratocarcinoma, Oncofetal Proteins and Human Testis Cancer–June 26-28, Minneapolis.
UICC Special Project on Breast Cancer Epidemiology & Prevention–June 26-29, Leeds Castle, Kent, UK.

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-CN-05520-04

Title: *Coordination program–Centers for Radiological Physics*
Deadline: *Approximately June 20*

The Div. of Cancer Control & Rehabilitation, NCI, is soliciting proposals from organizations who will provide a coordination program for six Centers for Radiological Physics (CRP), located throughout the country.

The primary objective of the CRPs is to ensure uniform high quality of radiological physics review services at clinical facilities where DCCR supports operations involving diagnostic and therapeutic radiology.

The coordination program will ensure uniformity of methods, standards and records. It will also review methods, protocols and guidelines. It will ensure utilization of accepted procedures, establish methods to evaluate the CRPs and evaluate the impact on cancer control. It will monitor existing linkage for communication to the radiological community and encourage on a national scale improvement in the quality of radiological physics. It will encourage the transfer of information on radiological health to professionals and the public.

The contract is anticipated to be a three-year, cost type level of effort contract.

Contract Specialist: Jacquelyn Carey
Control & Rehabilitation
301-427-8747

RFP NCI-CP-VO-01020-55

Title: *Large scale tissue culture virus production for cancer research*
Deadline: *Approximately June 6*

NCI is seeking support services for the production,

purification and distribution of large volumes of selected oncogenic and suspected oncogenic viruses and tissue culture cell lines.

The contractor will be reuqired to produce three to four different type-B, type-C or type-D retroviruses on a continuing but flexible basis at an overall level of approximately 200 liters of virus-containing tissue culture fluid per week. Prospective contractors must have adequate physical facilities. Appropriate government furnished equipment will be available to the successful offeror.

Contract Specialist: Elizabeth Osinski
Biological Carcinogenesis & Field Studies
301-496-1781

RFP NCI-CP-01032-77

Title: *Biomedical computing support services*
Deadline: *June 6*

NCI is seeking a contractor to provide computer-related support services to the Biometry Branch, Field Studies & Statistics Program.

Prospective contractors must have experience and expertise in all phases of software services, designing-programming and operating computer systems, integrating and handling large sets of medical data and requires the contractor to use sophisticated data handling and analytic techniques. The support required is 16 person years. The contractor should have offices located within one half hour's commuting distance of the Landow Bldg, 7910 Woodmont Ave., Bethesda, Md. 20205 to facilitate consultation and interaction with NCI staff.

In accordance with Section 15 of the Small Business Act, it is hereby determined that 100% of this procurement will be a Small Business Set Aside. In order to qualify as a small business for this procurement, responders must have less than 500 employees.

Contract Specialist: Patrick Williams
Biological Carcinogenesis & Field Studies
301-496-1781

RFP N01-CP-05672-56

Title: *Chemical services support for carcinogenesis bioassay testing*
Deadline: *June 12*

The Carcinogenesis Testing Program, NCI and National Toxicology Program, is interested in establsihing a contract to provide chemical procurement, analysis, storage, repackaging, and distribution services for approximately 25 chemicals per year in support of the activities of the Carcinogenesis Bioassay Testing Program.

A four-year cost-reimbursement contract is anticipated for effective pursuit of this project.

Contract Specialist: Ann Peale
Carcinogenesis
301-427-8764

RFP N01-CP-05673-73

Title: *Health and safety services support for carcinogenesis bioassay testing*
Deadline: *June 6*

The Carcinogenesis Testing Program is interested in establishing a contract to provide health and safety/industrial hygiene services in support of the program. A three year task order contract is anticipated for the effective pursuit of this project.

Contract Specialist: Rodolfo Reyes
Carcinogenesis
301-427-8764

NCI CONTRACT AWARDS

Title: Spontaneous and virus induced neoplastic transformation, continuation
Contractor: Meloy Laboratories, $83,350.

Title: Studies on the significance of experimental carcinogenesis data to man, continuation
Contractor: International Agency for Research on Cancer, Lyon, France, $263,769.

Title: Long term followup of the breast cancer screening project
Contractor: Stella & Charles Guttman Breast Diagnostic Institute, $376,044.

Title: Studies on the expression of the RNA tumor virus genome in animal and human malignant cells, continuation
Contractor: Duke Univ., $420,510.

Title: Acquisition of human tumor specimens for virus studies, continuation
Contractor: Memorial Hospital for Cancer and Allied Diseases, $175,000.

Title: San Francisco Bay Area resource for cancer epidemiology, continuation
Contractor: California State Dept. of Health, $270,405.

Title: Propagation and seroepidemiology of EB virus, continuation
Contractor: Children's Hospital of Philadelphia, $483,200.

The Cancer Letter _Editor Jerry D. Boyd

Published fifty times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.