THE CANCER LETTER

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DEVITA APPOINTMENT NOW OFFICIAL; CALLS FOR NEW CHEMOPREVENTION PROGRAM, MORE APPLIED PREVENTION

President Carter made it unanimous this week.

Vincent T. DeVita Jr. was everyone else's choice to be director of the National Cancer Institute, and has been since Arthur Upton resigned last December. Jimmy Carter, whose opinion was the only one which really counted, affixed his signature to the appointment last week, making DeVita the ninth director of NCI.

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In Brief

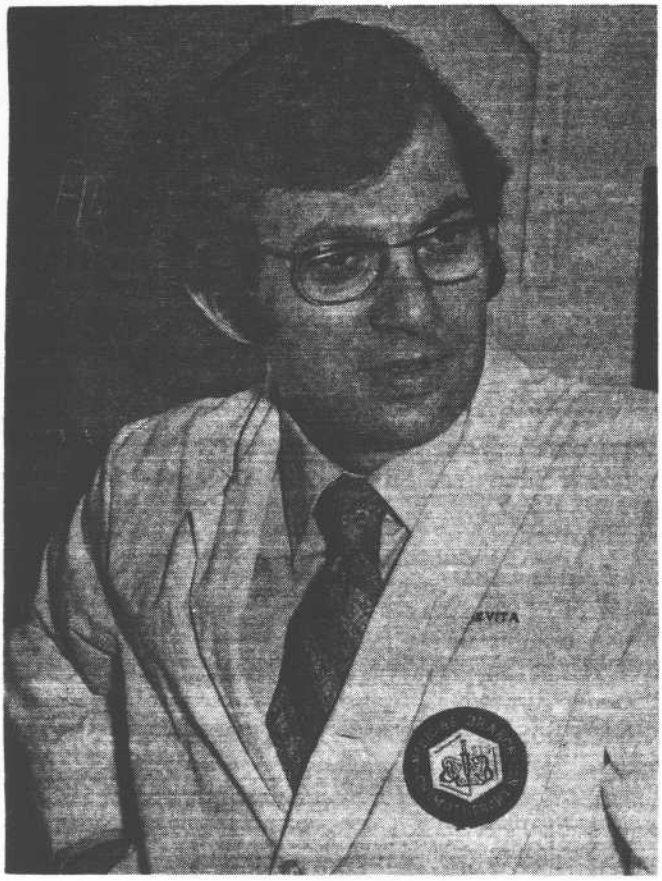
MARY LASKER TO BE NAMED TO NIH DIRECTOR'S ADVISORY COMMITTEE; AMOS APPOINTMENT OFFICIAL

MARY LASKER, who was not appointed to a third term on the National Cancer Advisory Board this year, has been nominated for a term on the NIH Director's Advisory Committee by HHS Secretary Patricia Harris. Apparently the Carter Administration, having forgiven Lasker's connection with Ted Kennedy's Presidential campaign, has decided her status and influence as the nation's top lay health expert should not be wasted. . . . **HAROLD AMOS'** appointment to the President's Cancer Panel was made official last week. He will join Chairman Joshua Lederberg and Bernard Fisher, replacing Elizabeth Miller. Amos' term will continue through February 1983, and he will continue as a member of the NCAB. . . . **GUY NEWELL,** director of cancer prevention at the Univ. of Texas System Cancer Center and former NCI deputy director, has been awarded an endowed professorship in cancer prevention by the Mesa Petroleum Co. of Amarillo. The company donated $300,000 to fund the endowment. . . . **BRISTOL-MYERS** has awarded more than $1 million for nutrition research at the Univ. of Alabama, Fred Hutchinson Cancer Center, Indiana Univ., Vanderbilt Univ., Columbia Univ., and institutions in Montreal, Toronto, Mexico City and Manila. Charles Butterworth at Alabama will direct research using nutritional support for patients with severe burns, trauma, cancer and other serious illnesses. Martha Hutchinson at the Hutchinson center will head studies of effects of high dose chemotherapy and radiation on the nutritional status of cancer patients with an effort to identify the level and type of nutritional support needed. The Vanderbilt study, under Harry Greene, will include studies of undernutrition in lung cancer and leukemia patients. The other grants are primarily for studies involving premature infants. . . . **SOCIAL WORK** Oncology Group at the Sidney Farber Cancer Institute is planning a national conference in July 1981 on psychosocial issues in cancer care, focusing on the social worker's role. Abstracts will be due Oct. 15, 1980. Contact the group at the Farber Institute, 44 Binney St., Boston 02115.

DEVITA TOOK THE JOB AFTER WORKING OUT SYSTEM TO REMAIN IN RESEARCH

(Continued from page 1)

It was obvious almost from the moment Upton's decision to leave became known that DeVita would be the leading choice to replace him. The only question was whether he would accept the job. Although he readily accepted the acting director's role when NIH Director Donald Fredrickson asked him to, DeVita told colleagues he would prefer to remain as director of the Div. of Cancer Treatment rather than take the permanent job of running NCI. "I like what I'm doing and I'm not ready to give up active participation in research," he said.



VINCENT T. DEVITA JR.

. . . Will remain active in clinical research.

That sounded like a 1974 rerun, when Frank Rauscher, then NCI director, wanted to make DeVita director of DCT after Gordon Zubrod retired. DeVita was chief of DCT's Medicine Branch, had won worldwide acclaim for his clinical research including a major role in developing combination chemotherapy for Hodgkin's disease and other malignancies, and did not want to make the change. He accepted the promotion, however, when Rauscher agreed he could continue to spend some time in clinical research. When the position of clinical director became open shortly thereafter, Rauscher appointed DeVita to that job.

What changed his mind this time? DeVita was asked at a press conference Monday.

"It was a question of what I would be leaving behind," DeVita answered. "Being chief of the Medicine Branch was the best job I ever had. I was personally involved with research." Accepting the NCI directorship would involve a similar adjustment, "finding a way in which I could stay personally involved. I have more that I want to do in research. I don't want to atrophy."

DeVita said he has worked out a system which will permit him to spend 10 hours a week in clinical research, approximately the amount of time he had as DCT director. He will retain the position of clinical director.

DeVita revealed he plans to initiate a new Chemoprevention Program, including clinical trials with persons at high risk. NCI is spending $6 million a year on development of retinoids, "and we need to verify their effectiveness in large scale clinical trials."

Diet and nutrition "is a fascinating area. There are a number of important leads to pursue. The problem with nutrition is how do you field test an idea, such as whether fiber in the diet prevents colon cancer. Many people have the idea that we can't change dietary practice. I don't think that is correct. If we were to say that if you eat bran cereal every day it would prevent colon cancer, everyone in the country would soon be eating bran cereal."

"Are you going to say that?" a newsman asked.

"If we test that hypothesis and prove it, yes," DeVita answered.

DeVita said that NCI has neglected applied prevention. About 48 percent of the cancer control budget is in treatment, and that will be moved downward with a shift in emphasis to applied prevention. Smoking cessation and the epidemiology of smoking will be areas to be emphasized, he said.

DeVita said he hopes to increase the budget for applied prevention to about $30 million, without reducing the budget for prevention research.

Other items covered in the press conference:

* I'm facing a large recruiting job (for a new executive officer, three division directors and a deputy for himself). I'm looking forward to searching the scientific community for people to fill those positions. It will be the first time I will be looking for people other than those involved with treatment."

One of DeVita's strengths as an administrator has been the ability to recruit top people when he needs them. Although he did not mention it at the press conference, DeVita is emphasizing the need to bring in women and minority group members for senior staff positions.

* The impact of the National Cancer Program "is

reflected quite well in the latest survival figures. The fact that we can now cure 41 percent of serious cancers has been overlooked. We will not see the full impact (of progress from trials started in the early and mid 1970s) until 1985. There is no question survival has been improved in breast cancer. There are exciting new results coming in for colon and rectal cancer, and even lung cancer. If these results continue, by 1985 we will see a significant impact on survival in the upper age group."

* "When Dr. Upton was here, he once said that a rosy view of progress in cancer was unwarranted," a newsman commented. "Do you disagree?"

"Yes and no. I'm an optimist, and I always take a rosy view of things. In 1965, we said we could improve treatment with the new methods we were developing then, and by 1975 we had done what we had said we could do. That was a long time, but it was progress. Dr. Upton was right, that progress is slow. There will be no immediate breakthroughs that will solve the whole problem."

* The early intereferon trials results "are interesting. If it were a drug, we would not be as excited. But it is a biological. Six to eight months ago we didn't know if it would have any antitumor effect. Now we can say it has, as good as a number of drugs were when they were entering into the field."

* "Could you achieve good results faster if you had more money? Is good research not being funded?" a newsman asked.

"We could always use more money. There are grants with good scores which aren't being funded. Whether they would result in important new discoveries, I can't say. Part of the reason for the massive new explosion of technology was due to increased funding for NCI, clinical trials included. We are pursuing all exciting leads, but we could pursue them faster if we had more money."

* On NCI's management of contracts, "We're being unfairly criticized. There are about 15 percent of our contracts which are problems, and that tarnishes the other 85 percent. I intend to clean up how we handle contracts."

That effort will include, *The Cancer Letter* learned, training project officers to watch more closely the projects for which they are responsible, insist on required reports, followup corrections of deficiencies, work more closely with contract officers to ensure required actions are taken, and increase the staff of the Research Contracts Branch.

For the record:

DeVita was born March 7, 1935, in the Bronx, N.Y., and grew up in Yonkers. He served in the Marine Corps, earned his bachelor of science degree at William & Mary in 1957 and was graduated with distinction from George Washington Univ. School of Medicine in 1961.

He served his internship at the Univ. of Michigan Medical Center and his residency at G.W. Univ. Medical service and District of Columbia General Hospital. He joined NCI in 1963 as a clinical associate in the Laboratory of Chemical Pharmacology, leaving in 1965 to complete his advanced training in medicine at Yale-New Haven Medical Center. He returned to NCI in 1966 as senior investigator in the Solid Tumor Service and later as head of that service. He became chief of the Medicine Branch in 1974.

Among DeVita's honors and awards are the Albert and Mary Lasker Medical Research Award, Annual Clowes Lecture, HEW Superior Service Award, Esther Langer Award, Alumni Medallion of William & Mary, Jeffrey Gottlieb Award, and Karnofsky Lecture.

Henry Pitot, chairman of the National Cancer Advisory Board, made the following statement:

"I think that this is an excellent appointment. Dr. DeVita is probably the one person who can move the Institute in the directions it should be moved at this time. He knows the Institute and the cancer problem intimately, which I believe to be very important.

"He has proven himself to be an able administrator as director of the Div. of Cancer Treatment and as acting director of the Institute. As acting director he made major moves to continue Arthur Upton's initiatives in prevention, and to assure that funding would continue to be available for the most important cancer programs in a period when the budget is expected to shrink.

"His appointment will be of enormous help to the oncological community in the United States and in the world. I look forward to a very bright and dynamic future for the National Cancer Institute under his leadership."

GAO REPORT NITPICKS ON FIVE CONTRACTS, IGNORES MOST CANCER CONTROL PROBLEMS

The long awaited General Accounting Office report of its investigation of NCI's Cancer Control Program was released last week. As has been the case with previous GAO probes of NCI operations, the congressional watchdog agency found a number of problems, many of which were relatively minor or easily explained, but managed to reach the conclusion that "NCI's administration of five cancer control contracts we reviewed was inadequate."

That was enough ammunition to give Congressman David Obey, who had requested the investigation, the excuse to issue a press release pointing out "serious deficiencies in the awarding and management of four of the five contracts."

Considering that two of the five contracts reviewed by GAO were selected by Obey and were known to have encountered serious problems from the start, the report was rather muted in its criticism. This is due in no small part to the strong reaction by

NCI staff to the first draft of the report, which included criticism based on misinformation and in some instances total ignorance of the facts. GAO rewrote the report and left out some of the offending sections; however, NCI executives pointed out that many of the misleading items were not removed.

Obey's news release also attempts objective and responsible criticism ("I can't be certain that the five contracts reviewed are representative of all contracts and consulting work being performed by the Cancer Control Program," he is quoted as saying). But the news release did focus on alleged deficiencies in the awarding of contracts, and on some real problems in administering them. Obey coupled the new GAO criticism with a previous GAO report (on the contract with the Eppley Institute), an HEW Inspector General's investigation and a probe by the House Appropriations Committee staff of the Frederick Cancer Research Center contract, "all finding much the same thing at NCI."

That was a cheap shot. Most of the criticisms in those previous reports was of the same ilk as in the new one: Conclusions were based in misinterpretation of facts, ignoring other facts, concentrating on irrelevant matters. Most legitimate deficiencies turned up then have long since been corrected.

Obey acknowledged previously, and the new GAO report acknowledged again, that problems in administering contracts could be traced largely to the overburdening of NCI Research Contracts Branch staff and project officers. Obey has severely criticized Congress and the White House for position ceilings which have forced NCI to spread contract and project officers over the greatly increasing number of contracts.

Obey asked GAO to review the contracts with the Univ. of Louisville, to develop a model program for followup of workers exposed to polyvinyl chloride; and with the Texas Chest Foundation/East Texas Chest Hospital for followup of workers exposed to asbestos. GAO added the Univ. of Arizona's Breast Cancer Detection Demonstration Project, the Illinois Cancer Council contract for a demonstration project in head and neck cancer, and the New York State Dept. of Health contract for cervical cancer screening.

In his request for the investigation, Obey asked GAO to address these issues:

"1. What are the objectives of the Cancer Control Program and how are they being implemented?

"2. Have DCCR (Div. of Cancer Control & Rehabilitation) contracts resulted in the products called for? How frequently have contracts been discontinued before planned completion, and what are the reasons for this occurring?

"3. Are demonstration grants being continued by grantees after federal funds cease? If not, has any action been taken to determine why this is happening?

"4. What has been the rate of professional staff turnover? Is DCCR having a problem filling professional staff vacancies?"

GAO investigators discussed the issues with various NCI officials, including Acting DCCR Director William Terry, former Director Diane Fink, former President's Cancer Panel Chairman Benno Schmidt, National Cancer Advisory Board Chairman Henry Pitot, former Cancer Control & Rehabilitation Advisory Committee Chairman William Shingleton, and Donald Hayes, former chairman of the Cancer Control Merit Review Committee.

GAO and Obey used a statement by Hayes, whose committee reviewed ongoing contracts to determine how well they were being implemented (and recommended some for early termination) which perhaps is the most damaging aspect of the report. Hayes was quoted as saying that deficiencies GAO found in the five reviewed contracts probably could be found in at least 50 percent of all DCCR contracts.

GAO included in the report a history of the Cancer Control Program including what it said was the rationale behind its adoption into the National Cancer Act of 1971. The report quoted Hayes as saying that the "program had accomplished little that the medical community would not have done anyway and had not increased the body of knowledge needed to control cancer. He believed that the only part of the control program worth continuing was the community based programs, but these programs needed better NCI management."

The report included NCI's response to Hayes' alleged remarks. "NCI officials discussed the program's accomplishments with the chairman after our meeting with him. NCI officials told us that the chairman intended to convey that the program focused on procedures that were already being performed, and that the program helped disseminate them more rapidly, but that for some of them, dissemination would have happened sooner or later."

NCI executives submitted a list of 57 items they considered significant accomplishments of the Cancer Control Program and were infuriated when GAO included only four of them in the report.

The more rapid dissemination of research results to clinical use, of course, was the primary impetus behind congressional support of the Cancer Control Program. The view that clinicians will learn of and apply new techniques on their own is supportable, but it does not begin to cover the problems involved in technology transfer. Many DCCR programs have dealt effectively with shortages of key personnel, public education, development of multidisciplinary community programs, expansion of clinical trials

into communities, radiation quality control, and others.

Many of those who ardently support the concept of the Cancer Control Program are among its severest critics. Misplaced priorities, inadequate funding, lack of strong and consistent direction from NCI, and DCCR staff inadequacies are among the problems those critics complain about. The limited GAO investigation barely touched on those problems, concentrating instead on nitpicking over five contracts awarded four to five years ago.

NCI Director Vincent DeVita strongly disagrees with the implication that half of NCI's contracts have serious deficiencies (see previous article). Whatever deficiencies do exist, with cancer control and any other NCI contracts, will be among the first problems the new director will tackle.

Following here and in subsequent issues, The Cancer Letter *will publish major portions of the GAO report, Obey's comments on it, and NCI's response.*

GAO REPORT ON CANCER CONTROL PROGRAM

The origin of NCI's Cancer Control Program began with the 1937 National Cancer Institute Act. However, a specific authorization for a Cancer Control Program did not occur until the National Cancer Act of 1971 was enacted, authorizing NCI to establish cancer control programs in cooperation with states and health agencies to rapidly transfer research results into general medical application. The 1971 act did not specify the activities NCI was to undertake to implement the Cancer Control Program, although the act's legislative history provided guidance in this area. Legislation enacted in 1974 and 1978 specified activities for NCI to include in the program.

The objectives of cancer control are different than those of cancer research. Cancer research seeks to find the means for combating cancer, whereas cancer control seeks to identify, test, evaluate, and promote the means that are found.

Legislative Background of the Cancer Control Program – 1937 to 1971

The origin of NCI's Cancer Control Program began with the National Cancer Institute Act of 1937 which gave NCI responsibility for conducting research to prevent, diagnose, treat, and control cancer in humans. The 1937 act did not specify the activities NCI was to undertake to implement its control program. However, the act's legislative history shows that NCI was to purchase radium for use in the study and treatment of cancer; make grants to schools, clinics, hospitals, laboratories, institutions and scientific investigators for cancer research; and cooperate with state health departments and boards for the prevention, control, and eradication of cancer within the states. Subsequent amendments to NCI's legislation contained no discussion of Cancer Control Program activities until the Congress enacted the National Cancer Act of 1971.

In July 1971, the Senate passed S. 1828. A compromise version of this bill ultimately became the National Cancer Act of 1971. Regarding cancer control, the Senate bill authorized NCI to cooperate with state health agencies in the prevention, control, and eradication of cancer, but did not authorize NCI to establish a separate cancer control program to accomplish this.

In November 1971, the House passed its version of the National Cancer Act (H.R. 11302). In a report by the House Committee on Interstate & Foregin Commerce, the committee stated that it was very disturbed to find in its study of the cancer problem that identifiable funding for cancer control programs ended with fiscal year 1970 and that a number of activities (the committee did not specify the activities), previously supported through these programs, have in one way or another been terminated or allowed to lapse. The committee further stated:

"Disease control programs in cancer and other areas have long been a part of the public health scene, and their importance is incontrovertible, for they are a means of bringing into general medical applications the most practical fruits of research in terms of improved methods of treatment and control."

For states and other public or nonprofit organizations to once again receive funding for cancer control activities, the House committee included in its bill the authority for NCI to establish programs in cooperation with state and other health agencies for the prevention, control, and eradication of cancer. H.R. 11302 authorized NCI to establish a Cancer Control Program. According to the committee, the purpose for this specific authorization was to ensure that "funds intended to help in the attack on cancer are not diverted."

In December 1971, House and Senate conferees agreed to a compromise. This version closely followed the text of H.R. 11302, including a specific authorization for NCI's Cancer Control Program. On Dec. 23, 1971, the President signed into law S. 1828, which became Public Law 92-218, "The National Cancer Act of 1971." Section 409 of the act contained an authorization for NCI's cancer control program and states:

". . . (a) The director of the National Cancer Institute shall establish programs as necessary for cooperation with state and other health agencies in the diagnosis, prevention, and treatment of cancer."

Section 409 also authorized funds to carry out the program.

Program Intent, Goals, and Activities

The 1971 act did not discuss the intent of the Congress in authorizing the Cancer Control Program or the activities NCI was to undertake in implementing it. The Senate did not address the issue, and we determined congressional intent from from the 1971 report by the House Committee. According to the section of the report which discussed cancer control, the committee saw an important role for NCI in "bridging the gap" between research and general medical application. The report stated that, once the effectiveness of research findings could be demonstrated to the satisfaction of the scientific community, these results should be communicated to medical practitioners quickly. NCI was to develop an aggressive and coordinated Cancer Control Program to demonstrate the application of recent research discoveries as rapidly as possible, using whatever community resources were available, and communicate these findings to practitioners, who could apply these findings. According to the House report, the following activities were to be included in NCI's Cancer Control Program:

–Collecting, analyzing, and disseminating all data useful in the prevention, diagnosis, and treatment of cancer.

–Prevention (the elimination from the external and internal environment of chemical and other agents that cause or promote cancer).

–Pap tests for cervical cancer.

–Breast checks and oral examinations.

–Training for personnel in cancer.

–Gathering of cancer statistics.

–Cancer treatment (limited to demonstrations of new techniques or methods).

–Diagnosis.

According to the acting and the former directors of DCCR,

the chairman of the President's Cancer Panel, and the chairmen of the National Cancer Advisory Board, the Cancer Control & Rehabilitation Advisory Committee and the Cancer Control Merit Review Committee, at the time the National Cancer Act of 1971 was enacted, the scientific community and the Congress thought (1) that many research advances existed that could impact on cancer and (2) these advances were not being disseminated to the medical community to use on cancer victims and, as a result, were "on the shelf." NCI's Cancer Control Program was to bridge this gap between research advances and application of the research by the medical community.

However, according to the acting and former directors of DCCR and the chairmen of the Panel, Board, CCRAC and Merit Review Committee, the assumption that a significant number of cancer research advances existed that were not being used proved to be incorrect. These officials told us that, in reality, very few cancer advances existed which the medical community was not using. We asked NCI to provide a list of cancer research advances that were not widely used before the Cancer Control Program was established, but NCI did not furnish such a list.

In commenting on our draft report, NCI said that there were research advances that required dissemination in 1971, that there were research advances that require dissemination in 1980, and NCI anticipated additional research advances as long as there is a National Cancer Program. NCI provided two examples of advances that needed to be disseminated or put into practice–the identification of smoking as a major cause of lung cancer and the development of exfoliative cytology.

The 1971 act, as it pertains to NCI's Cancer Control Program, was amended in 1974 by the National Cancer Act Amendments of 1974 and 1978. The 1971 act required the director of NCI to conduct control programs with state and other health agencies in the diagnosis, prevention, and treatment of cancer. The 1974 amendments continued this requirement, but added a requirement that NCI conduct trial programs to diagnose uterine cancer (i.e., Pap tests). The 1978 amendments contained the current authorization for the Cancer Control Program. The first of these directives called for locally initiated education and demonstration programs to transmit research results and to disseminate information. The second directive required specific education and demonstration programs for health professionals in methods of early cancer detection, for identifying individuals with a high risk of developing cancer, and for improving patient referral for early diagnosis and treatment. The third directive called for the demonstration of methods for the efficient dissemination of information to the public concerning the early detection and treatment of cancer and information concerning unapproved and ineffective methods, drugs, and devices for the diagnosis, prevention, treatment, and control of cancer.

Goals of the Cancer Control Program

Before implementing the National Cancer Program, NCI held a series of planning conferences in 1971 and 1972 attended by 250 scientists. The scientists formed a group–Working Group 8– to establish the goals and objectives of the Cancer Control Program. In June 1975, the group issued its report proposing that the Cancer Control Program be a distinct entity, separate from cancer research because, in the group's opinion, cancer research seeks to find the means for combating cancer, whereas cancer control seeks to reduce the incidence, mortality, and morbidity from cancer by identifying, testing, evaluating, and promoting the means that are found. The group said that the following activities were appropriate to implement this goal–prevention, screening and detection, diagnosis and pretreatment evaluation, treatment, rehabilitation, and continuing care. The Cancer Control Program has emphasized these areas. In fiscal year 1979 NCI said it was conducting a multifaceted cancer control program focused on:

–Identifying, evaluating, and planning the application of innovative, practical methods of cancer control.

–Developing demonstration programs to promote the use of effective cancer control methods by the nation's health professionals.

–Developing training resources for educating health professionals in the use of cancer control interventions.

–Developing methods of encouraging beneficial attitudes and life styles as they relate to the control of cancer with emphasis on hard-to-reach populations, such as minority groups and blue collar workers.

–Providing mechanisms for organizing the nation's resources for an effective, coordinated attack on specific cancer control problems.

Examples of the types of projects NCI supports in the cancer control program are hospices, and studies on pain management, psychosocial impact of cancer, and radiotherapy practices.

Publication of portions of the report will continue next week.

ACS TO OFFER 10 NEW TWO YEAR ONCOLOGY NURSE SCHOLARSHIPS OF $8,000 EACH

The American Cancer Society announced that it has established a national scholarship program for nurses who intend to teach cancer nursing or to become clinical specialists in cancer nursing.

Saul Gusberg, the Society's national president, said that the new program will become effective in 1981. Each scholarship will cover annual subsistence and tuition costs of $8,000 for a maximum of two years of full time study in a graduate school of nursing. The awards will be issued for only one year at a time, but qualified applicants are expected to be renewed for a second year. Up to 10 new scholarships will be awarded each year.

The purpose of the scholarship program, Gusberg said, "is to strengthen nursing services to cancer patients by providing opportunities for advanced nursing education and clinical experience."

Although ACS has long offered a variety of fellowships for cancer researchers, this is its first national scholarship program of any kind.

Award winners will be required to attend institutions accredited by the National League for Nursing and to complete a course leading to a master's degree in cancer nursing.

The program will be administered by the office of Nicholas Bottiglieri, ACS vice president for professional education.

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 contract 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 N01-CO-04347-41

Title: *Budget formulation and fiscal projection model*

Deadline: *Approximately Sept. 5*

Provide ADP support to NCI for one year in the enhancement, maintenance and operation of a fiscal projection model used in preparing and analyzing institute budgets. This research effort is to be performed in close collaboration with NCI staff. The contractor's facility must be within a 25-mile radius of the NIH headquarters, Bethesda, Md.

RFP N01-CO-04343-41

Title: *Evaluation of the impact of strategic planning on biomedical research (phase I)*

Deadline: *Approximately Sept. 5*

Perform a feasibility study to define optional approaches to evaluation of the impact of the National Cancer Program Plan.

Contracting Officer for above 2 RFPs: Hugh Mahanes
Biology & Diagnosis
301-496-5565

RFP NCI-CM-07383-17

Title: *Operation of an animal disease diagnostic laboratory*

Deadline: *Approximately Sept. 15*

The Mammalian Genetics and Animal Production Section, Drug Evaluation Branch, Div. of Cancer Treatment, NCI, is interested in organizations with the capabilities to develop, maintain and operate an animal disease diagnostic laboratory.

Successful offerors must have an existing facility with, as a minimum, facilities for the complete physical and pathological examination of laboratory animals (rodents) utilizing pathological lesions together with supportive clinical information to diagnose animal diseases.

Experience must include the capability to perform: A. Physical examination including initial observations, microscopic examination for parasites; B. viral serological testing; C. histopathological examination of all major organs and organ systems; D. bacterial culturing and examination for pathogenic microbes; E. examination for ectoparasites, and F. examination for endoparasites. The above includes the monitoring of all areas of the animal production and utilization program as designated by government representatives.

A second area will be concerned with emergency performance when clinical disease outbreaks occur within the program. While animal disease problems are expected to occur with decreasing frequency throughout the general program, certain areas will remain of critical importance, e.g., nude mouse production and testing lifetime bioassay experiments and biological modifier program mice.

The third area of performance will be that of assisting the project officer in interpreting data from other monitoring services which will include serological, microbiological, histological, parasitological data supplied by other contractors.

A degree of flexibility will be expected between the project officer and the successful bidder regarding both the exact procedures utilized and the number and frequency of animals that should be tested in order to build a profile. However, it is estimated that approximately 1500 rodents will be processed per year and that approximately 15,000 viral serodiagnostic titrations will be performed. Animals will be furnished by the government at no charge to the contractor.

It is expected that there will be flexibility between the project officer and principal investigator regarding procedures to be followed in making rodent disease diagnoses. For example, new pathogenic viruses and/or microbes may be uncovered which are more sensitive and/or less costly.

It is anticipated that awards will be for a five year incrementally funded period of performance.

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

NCI CONTRACT AWARDS

Title: Evaluation of levamisole as a therapeutic adjunct in squamous cell carcinoma of the head and neck

Contractor: Sloan-Kettering Institute, $252,569.

Title: Five additional alteration/renovation/maintenance/upgrading projects at Frederick Cancer Research Center, modification

Contractor: Litton Bionetics, $741,350.

Title: Long term followup of the breast cancer screening project participants

Contractor: Albert Einstein Medical Center, Philadelphia, $489,401.

Title: Data management center for breast cancer detection demonstration project, 14 month renewal

Contractor: University City Science Center, Philadelphia, $1,187,073.

Title: Computer support for cancer information dissemination
Contractor: IIT Research Institute, $2,270,567.

Title: Immunotherapy in outbred cat lymphoma and leukemia
Contractor: Harvard Univ., $64,970.

Title: Replication of oncogenic RNA viruses and its relation to human cancer, continuation
Contractor: Columbia Univ., $33,158.

Title: Immunological assays for DNA and RNA viruses, continuation
Contractor: Litton Bionetics, $82,224.

Title: Study and production of avian leucosis viruses, continuation
Contractor: Life Sciences Inc., $453,481.

Title: Evaluation of surgical adjuvant chemotherapy utilizing 5-FU, cytoxan and prednisone, continuation
Contractor: Mayo Foundation, $40,000.

Title: Studies and investigations on therapy of patients with stage 2 and 3 carcinoma of the breast, continuation
Contractor: Case Western Reserve Univ., $74,700.

Title: NCI immunodiagnostic reference center
Contractor: Meloy Laboratories, $260,247.

Title: Specific and nonspecific immunotherapy as an adjunct to chemotherapy in skeletal and soft tissue sarcoma
Contractor: UCLA, $317,394.

Title: San Francisco Bay Area resource for cancer epidemiology, continuation
Contractor: California Dept. of Health, $1,290,480.

Title: Research, process development and delivery of human leukocyte interferon
Contractor: Meloy Laboratories, $989,520.

Title: Screening and detailed evaluation of antitumor agents and combined chemotherapy and modality studies
Contractor: Arthur D. Little Inc., $1,371,581.

Title: Studies on therapy of patients with stage 2 and stage 3 carcinoma of the breast, continuation
Contractor: Evanston Hospital, $91,400.

Title: Molecular biologic studies of tumor viruses
Contractor: Meloy Laboratories, $781,525.

Title: Epidemiology of benign breast disease, continuation
Contractor: UCLA, $62,800.

Title: Central statistical group for collaborative studies in lung cancer, pancreatic cancer, and EMI scanner evaluation (brain cancer), continuation
Contractor: Univ. of Cincinnati, $401,725.

Title: Case-control study of lung, pancreas, and stomach cancer in southern Louisiana, continuation
Contractor: Louisiana State Univ. Medical Center, $46,125.

Title: Replication of Oncogenic RNA viruses and its relation to human cancer, continuation
Contractor: Columbia Univ., $554,970.

Title: Biochemistry and cell culture resource
Contractor: Microbiological Associates, $1,303,032.

Title: Support services for the Laboratory of Viral Carcinogenesis
Contractor: Hazleton Laboratories, $3,467,302.

Title: Estrogen replacement after premenopausal oophorectomy and the risk of breast cancer, continuation
Contractor: Boston Univ., $41,190.

Title: Carcinogenicity studies in rodents
Contractor: EG&G Mason Research Institute, $1,501,214.

Title: Large scale isolation of antitumor agents from natural sources
Contractor: Polysciences Inc., Warrington, Pa., $850,743.

Title: Cancer control program for Clinical Cooperative Groups—Eastern Cooperative Oncology Group, 22 month extension
Contractor: Frontier Science & Technology Research Foundation, $2,619,148.

Title: Support services for radiation studies
Contractor: Westat Inc., $1,693,504.

Title: National survey of public attitudes, knowledge and practices related to breast cancer, modification
Contractor: Opinion Research Corp., Princeton, N.J., $16,128.

Title: Processing lab for virus containing fluids, continuation
Contractor: Electro-Nucleonics Laboratories, $200,000.

Title: Biomedical computing software services
Contractor: Information Management Services Inc., $992,171.

The Cancer Letter _Editor Jerry D. Boyd

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