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AACI REMAINS SPLIT ON GUIDELINES; TERRY PROPOSES 25 PERCENT LIMIT ON STAFF INVESTIGATOR SALARIES

Assn. of American Cancer Institute members, agonizing perhaps for the last time over the proposed new guidelines for cancer center core grants, failed to reach clear cut agreement on the one issue still undecided—a limit on staff investigator salary support—at their semi-

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In Brief

CRCC, ONE OF THE 21 COMPREHENSIVE CENTERS, TO CLOSE UP; STECKEL NEW AACI PRESIDENT

COLORADO REGIONAL Cancer Center, one of the 21 NCI recognized comprehensive cancer centers, will close its doors and cease to exist April 30. CRCC is a consortium of institutions, has been in danger of losing its comprehensive status since failing to get its core grant renewed more than two years ago. The National Cancer Advisory Board's Subcommittee on Centers & Construction will consider a recommendation to withdraw comprehensive recognition at its meeting Feb. 2, realistically the only course left to NCI with the decision by CRCC's sponsors to put it out of business. Efforts are under way to put together a new cancer center, with the Univ. of Colorado playing a greater role than it did in CRCC. Brian O'Toole, CRCC acting director, is confident the new organization will be capable of securing comprehensive recognition. . . . **RICHARD STECKEL**, director of the UCLA Jonsson Comprehensive Cancer Center, assumed the presidency of the Assn. of American Cancer Institutes at the association's meeting this week. Retiring president is Alvin Mauer, director of St. Jude Children's Research Hospital. Timothy Talbot, vice chairman of the board of Fox Chase Cancer Center, was elected vice president and president-elect. Edwin Mirand, associate director of Roswell Park Memorial Institute, was reelected secretary treasurer. New members of the board of directors are Palmer Saunders, executive director of the Univ. of Texas Medical Branch Clinical Cancer Center (Galveston); Condict Moore, director of the Univ. of Louisville Cancer Center; and John Laszlo, director of clinical programs at Duke Comprehensive Cancer Center. . . . **PHILIP SCHEIN**, who has been chairman of FDA's Oncology Drugs Advisory Committee, has resigned from the committee due to increasing demands of other responsibilities. FDA does not plan to name a new chairman until after the committee's next meeting, in April or May. New members recently named to the committee are David Alberts, of the Univ. of Arizona Cancer Center; Walter Lawrence, of the Medical College of Virginia/Virginia Commonwealth Univ. Cancer Center; and Beth Strunk, a consumer representative from Coral Gables. One vacancy remains to be filled, and FDA is seeking an immunologist for the position.

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AACI SPLIT, BUT MAJORITY SEEMS TO SUPPORT NEW NCI PROPOSALS

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annual meeting this week in Bethesda.

AACI President Alvin Mauer did not call for a vote on the question when it became obvious no consensus was possible. "I think that reflects the diversity of institutions among our membership and reinforces the need for maximum flexibility in the guidelines," Mauer said.

After several hours of discussion (preceded by the more than three years of haggling with NCI), most of the members present reluctantly seemed to go along with the proposal for limiting support of staff investigator salaries from core grants. "I think a majority of us feel we can live with the limits, if there are assurances that the six or eight centers which are not now within the limit are not harmed," Mauer said.

William Terry, acting director of NCI's Div. of Resources, Centers & Community Activities, described the plan recommended by NCI staff following the last meeting of the DRCCA Board of Scientific Counselors Working Group on Guidelines:

—Salary support from core grants for staff investigators will be limited to 25 percent of the total grant direct costs. (***The Cancer Letter*** had reported that the Working Group recommended a 40 percent limit. That was merely a suggested figure, with the percentage to be determined by NCI staff after reviewing percentages of support in existing core grants. NCI found that the average percentage of core grant support for staff investigator salaries was about 25.)

—Centers which presently exceed the 25 percent limit will be held to the current level when they submit renewal applications and will be required to submit a plan for phasing down to 25 percent.

—Centers which use less than 25 percent of their grants for staff investigator salary support may in their renewal applications request up to the 25 percent level, although such increases are subject to certain limitations (see below).

There are at least six and perhaps as many as eight centers which now support staff investigator salaries with more than 25 percent of their grants.

—Centers submitting renewal applications will be limited in their budget requests to their current levels plus 50 percent, direct costs. The limitation will be applied to the average for the grant period (three or five years, if five year awards can be made), and may vary from year to year as long as the average is the existing level plus 50 percent.

—The centers under the 25 percent limit for staff investigator salaries may request the current level plus 10 percent of the overall renewal ceiling, provided the amount requested for staff investigator salaries does not exceed 25 percent of the total amount requested.

—There will be no overall cap on new grant applications, but requests for staff investigator salary support in new applications may not exceed 25 percent of the total amount requested. The budgets of all grants, new and renewal, are subject to modification by peer review, as they have always been.

—Staff investigator salary support in core grants is the one item that cannot be reduced in peer review under the present guidelines. Those guidelines permit centers to request that a percentage of an investigator's salary be paid from the core grant as determined by the percentage of time he devotes to cancer related research. Peer review (the Cancer Center Support Grant Review Committee) may only verify the percentage, and if it is correct, approve the request.

This open ended aspect of the present guidelines prompted NCI to initiate the changes nearly four years ago.

When part or all of an investigator's salary is paid from the core grant, that amount is deducted from his R01 or P01 grant. There has been a feeling among scientists not affiliated with centers that this gives the center investigators a competitive advantage in being able to submit lower budgets in their grant applications.

NCI's early attempts to change the guidelines imposed a whole range of limitations on how center directors could use their grant funds. These included percentage limits on individual salaries, restrictions on the number of persons who could be paid from the grant (including some not in the staff investigator category), and a requirement that costs of shared resources be recouped from users.

AACI members and others objected to the drastic restrictions on how center directors could manage their organizations. They pointed out the difficulties of establishing rigid policies to be applied to more than 60 institutions with such diverse natures.

Their arguments prevailed, for the most part. Terry commented at the AACI meeting that "we hope to have a tradeoff—caps for maximum flexibility. Once you have the grant, we will do everything we can to make the use of funds flexibile." Other points Terry made included:

- Supplementary applications "will be severely discouraged. They will be a rare exception."
- New grants will be judged by the same criteria as competing renewals. "We assume some will compete well enough to be funded." Also assuming there will not be major increases in the Centers Program budget, that means there will be a turnover, with a few new centers being supported and a similar number of existing ones phased out.
- NCI, having failed again to get legislative approval for five year center grants, will seek an administrative remedy. That possibly could be accom-

might be due to variations in staging.

Board members in general were noncommittal on the entire program, although agreeing that the three contracts should be extended one year.

Peter Greenwald asked for an estimate on total number of patients required for all clinical trials (65-70,000 a year, Fisher said), and whether there is a crisis in meeting that need.

"There is more and more," Fisher said. "Most of the patients are in the communities."

Ernst Wynder suggested the groups might do a better job of aiding in cancer prevention by collecting data on their patients. Fisher noted that NSABP collects height and weight data on 8,000 breast cancer patients and is trying to correlate obesity with survival. "I believe in prevention. My goal in life is to put surgeons out of business."

Carbone said his group collects epidemiological data but that it has not been used effectively.

The proposed nutrition programs had been presented to the National Cancer Advisory Board (*The Cancer Letter,* Nov. 28). Although the NCAB took no action on the proposals, members did indicate support for them.

However, Diet, Nutrition & Cancer Program Director Diane Fink reported that the NCAB ad hoc nutrition subcommittee later had reservations about the clinical education supplements. That program was envisioned as an effort to teach medical students various aspects of nutrition as it relates to cancer. "The subcommittee had definite concerns about training physicians," Fink said.

"My feeling when I read this, is that I was not sure what would be achieved," commented Anthony Miller, DRCCA Board member. "Since we're going to take a look at the overall Clinical Education Program and with the limited funding now available, it is inappropriate to add supplements to it. Also, I'm not sure what knowledge should be imparted about nutrition."

Board member Barbara Hulka agreed. Wynder added, "If we teach anything, we have to know what to teach."

When Carter asked if anyone disagreed with those comments, there was no answer.

The 96 institutions which have active clinical cancer education grants would have been eligible to compete for 10 supplements worth $40,000 each.

The proposed research training grants in nutrition fared better. This program would fund four or five grants, at $100,000 each. NIH had attempted to stimulate nutrition research with a program announcement a year ago. Only one application was submitted and it was disapproved, although another recently came in which Barney Lepovetsky, chief of DRCCA's Research Manpower Branch, said "looks pretty good."

NCI feels that lack of confidence in funding of training grants is responsible for the poor response. "We think that if we can assure the certain availability of about $400,000 for nutrition research training that we can stimulate a limited number of good applications relevant to cancer," Lepovetsky said.

After a brief discussion, Carter said, "I don't get a sense of undue negativism about this, nor is there any strong enthusiasm for it. Is anyone strongly against it?" There was no response, so Carter added, "I sense the Board is in favor of this program."

The proposed program announcement states:

"The National Cancer Institute intends to fund up to five meritorious research training grants in nutrition as it relates to cancer. The sum of $400,000 has been set aside for this purpose by NCI's Diet & Nutrition in Cancer Program. Proposed projects may encompass both predoctoral and postdoctoral research training, or may entail postdoctoral training only. Applications must be received by June 1, 1981. They will be reviewed by the Cancer Research Manpower Review Committee in September/October 1981, and by the Cancer Research Manpower Review Committee in February 1982. Qualifying applications will be considered for funding in March 1982."

NCAB APPROVES CALL FOR NEW EFFORTS ON CANCER IN BLACKS, HISPANICS

The National Cancer Advisory Board this week accepted the report of its ad hoc subcommittee on cancer in minorities, recommending various actions NCI should take in dealing with the problem of increasing cancer incidence and lower survival in cancer patients among black and hispanic Americans.

LaSalle Lefall, chairman of the subcommittee, told the Board that "with the exception of skin cancer, and with the exception of breast cancer, the incidence in blacks is greater for every major form of cancer."

Lefall reviewed the American Cancer Society conference in 1979 which drew national attention to the problem of cancer in blacks. Recommendations were made for various actions to be taken by ACS, including the recruiting and training of minority volunteers at the division and unit levels for the task of education.

Lefall said the subcommittee agreed that "NCI should join in deciding what information is needed and to add to the existing and planned ways of acquiring and presenting that information."

The subcommittee recommended these steps as the role NCI should play:

A. To establish a reliable data base for providing facts about cancer incidence, treatment and prognosis for minorities.

1) It is possible that differences in racial metabolism combined with life habits are significant factors.

We should find out.

B. To assist ACS in expanding ways to present data (This should be a secondary role of NCI).

C. Encourage training of minority oncologists among epidemiologists, practicing physicians, medical students, nurses and paramedical personnel.

D. Utilize control program funds to determine how minorities in selected communities are handled and should be handled by the cancer circuit.

E. Initiate a specific program to bring minorities into the practice sphere of the comprehensive and community cancer centers (minority patients).

F. NCI contribution need not be a high fund operation. Reorientation and, something we have not previously done, close cooperation with ACS are called for.

Research opportunities which could be explored by NCI include:

A. Why the greater increase in blacks c/w whites—less education effort re cancer, poor screening, delayed therapy (economic, social), increased occupational risk, exposure to farming chemicals, nutrition, alcohol, poorer followup, delayed diagnosis, stress (socio-economic, behavioral), difficulties in entering health care system.

B. Why poorer five-year survival (for the more common neoplasms)?

C. Cancer incidence in hispanic people (Puerto Rican, Cuban, Mexican)—migrant/P.R. comparison, nutrition, P.R. schools of medicine, training function, P.R. cancer center.

D. Lifestyle—residence (pollution), occupation, childhood illness/work, general health status, crisis orientation (threatened income), food differences, water supply in childhood, fungus, molds, housing, psychological reasons for delay in therapy, failure to use screening facilities (why?).

E. Evaluate statistical doubts—is this a black/hispanic problem or a socio-economic problem? Do statistics from "Harlem" and "Martland" obscure other data?

F. Commission a statistical review monograph—(by Hammond, Cutler, White, American Cancer Society), seek hypotheses.

G. Commission a geographic pathology monograph on cancer in blacks (Harrington).

Lefall said the studies of problem areas should be linked to training of minority oncologists and epidemiologists. Three to five field research units should be established, with a recognized epidemiologist-oncologist and his group to head each unit.

Research training teams would be established, each consisting of a hospital staff member and two postdoctoral or post-residency trainees. Each team would address a specific research problem. A special NCI study section should be established to review contract and/or grant proposals.

An NCI task force would be formed and would work with an ACS task force to oversee and coordinate the efforts of each.

NCAB Chairman Henry Pitot pointed out that if the Board accepted the report, "that implies the Board would follow the recommendations." He asked the subcommittee, which also includes Harold Amos and Irving Selikoff, to continue. He suggested the subcommittee work with Joseph Fraumini, director of NCI's Field Studies & Statistics Program, to develop a data base, "and work out something with ACS."

"Does that mean the Board authorizes us to cooperate with ACS?" Amos asked. Criticism of NCI-ACS collaboration has led both organizations to avoid formal contacts in recent years.

"It does if the Board accepts the report," Pitot said. The vote to accept was unanimous.

DRCCA BOARD ADOPTS STATEMENT DEFINING GOALS, APPROACHES OF CANCER CONTROL

The first task assigned the Cancer Control Subcommittee of the Div. of Resources, Centers & Community Activities Board of Scientific Counselors was to develop a statement on cancer control which would define its goals and approaches. Lester Breslow chaired that committee, and he presented the statement at last week's meeting of the Board:

The goal of a cancer control program is to reduce cancer incidence, morbidity, and/or mortality by: 1) identifying approaches that might accomplish this and performing research in defined populations to determine which are effective, 2) selective promotion and evaluation of these approaches, and 3) selective education and information dissemination for health professionals and/or the public. The scope of cancer control includes prevention, screening, diagnosis, pretreatment evaluation, treatment, rehabilitation, and continuing care activities.

The national cancer effort includes both research into and application of control methods. These are complementary and not antagonistic activities and are part of an ordered sequence, as indicated in the following statement from the report of the President's Biomedical Research Panel:

"The continuum from the discovery of new knowledge to the application of such knowledge in health care includes a number of steps:

"1. Discovery, through research, of new knowledge and the relating of new knowledge to the existing base.

"2. Translation of new knowledge, through applied research, into new technology and strategy for movement of discovery into health care.

"3. Validation of new technology through clinical trials (through clinical trials in defined populations, and in other ways).

"4. Determination of the safety and efficacy of new technology for widespread dissemination through demonstration projects.

"5. Education of the professional community in proper use of the new technology and of the lay community on the nature of these developments; and

"6. Skillful and balanced application of the new developments to the populations." (Words in parentheses added by the subcommittee)

Cancer control includes 2 through 5 although different

relative emphasis may be placed on each of those points depending on the specific cancer and whether prevention or treatment efforts are involved. Control and research must be mutually reinforcing and only the coordinated planning and implementation of research and control strategies will assure maximum yield from the dollars invested, maximum quality of the activities supported, and maximum probability that the research effort will continue to provide advances suitable for future application in the control of cancer.

Cancer control should support three types of activities in defined populations:

1. Research to determine whether and to what extent, actions proposed for a particular cancer are effective.
2. Research to determine the optimal strategies for promoting actions proven efficacious for particular cancers.
3. Selective implementation of those promotional strategies proven efficacious for particular cancers.

Cancer control efforts should give priority to cancers meeting one or both of the following criteria: 1) cancers causing the greatest mortality/morbidity in the United States; 2) cancers for which apparently effective actions are available. Highest priority should be given to cancers meeting both criteria.

Current "optimal" techniques for preventing or treating cancer must be considered as imperfect and as in a constant state of evolution. Despite this fact, great benefit could be derived if the entire population had access to current "optimal" techniques. One aspect of cancer control is, therefore, to determine, by expert consensus, the currently acceptable standard of management for all aspects of the health care continuum for particular cancers. Discrepancies between this baseline standard of management (BSM) and the actual management practiced in particular communities can be ascertained and appropriate steps taken to achieve the baseline. Attempts to do this must, however, be predicated on the understanding that the baseline is dynamic and that today's standard is tomorrow's outmoded technology.

In the portion of the continuum concerned with diagnosis and treatment, the baseline standard of management may be represented by well designed clinical research protocols. Another aspect of cancer control will, therefore, be the establishment of mechanisms that make it possible for community physicians to place patients on protocol studies, thus facilitating the implementation of current baseline standards of management.

In the portion of the continuum concerned with cancer prevention, it will be necessary to develop an understanding of human health behavior and to support research to identify strategies that effectively promote good health behaviors or effectively modify inappropriate health behaviors.

Another aspect of cancer control will be continuing assessment of the quality of important services and technologies, such as laboratory and x-ray. Standards for the quality of such services should be established as a part of the baseline standard of management and efforts made to ensure compliance with such standards through education of health professionals and the general public. These baseline standards are also in a state of evolution and will require revisions consistent with the advance of knowledge.

Social action for cancer control is another major channel that should be pursued. It includes such steps as reduction of occupational exposures to carcinogenic agents, a linking of institutional and community health agencies in the interest of cancer control, social and physical rehabilitation and supportive care of cancer patients, and the establishment of hospice programs for patients with terminal cancer.

The development of an effective national program for cancer control requires qualified personnel, particularly with training and experience in the disciplines of epidemiology, biostatistics, and disease control administration, and the placement of these individuals in responsible positions.

The Board approved the statement unanimously.

Referring to the General Accounting Office report on its investigation of the Cancer Control Program last year which contended that "there are few advances which are not put into medical practice," Breslow cited some examples refuting that nonsense.

"The Pap smear has been available since the 1940s. It should have been taken up and put into general use by the 1950s. If it had, deaths from cervical cancer would be approaching zero. In fact, in the 1960s there were still 10,000 deaths a year. In the 1970s there were between 5,000 and 10,000 a year. We still have around 5,000 a year. More than a quarter of a million women have died since we have had the technology to stop it.

"In breast cancer, the technology is available to reduce mortality in women over 50, where 80 percent of the deaths occur, by 40 percent. Lung cancer is even more dismal. There are 100,000 deaths a year, and it is rapidly increasing among women. In the 1980s, lung cancer deaths among women will exceed those from breast cancer, from a disease the cause of which we've understood a long time.

"The common notion that we are applying all we know is not true."

Board member Charles Cobau commented that subcommittee members felt that "the cancer control budget is a research budget." Referring to the cervical cancer problem, he said, "It may be appropriate for this division to learn why the Pap smear is not more widely used."

"One of our failures has been the mandate to separate research from control," Board member Charles Moertel said. "I feel they are one and the same. We should do research to develop better application. To eliminate discovery of new knowledge in cancer control is a great mistake. We need new knowledge on ways to control use of cigarettes, because the old ways certainly have not been adequate."

DRCCA BOARD, AACI AGREE ON NEW CORE GRANT GUIDELINES, ENDING LONG HASSLE

As Lyndon Johnson said (or was it William Polk?), "Reasonable men can reason together."

What may have been the most extended negotiations since those that ended the Korean War (or the Hundred Years War) finally were concluded last week when NCI's Div. of Resources, Centers & Community Activities Board of Scientific Counselors approved the changes in cancer center core grant guidelines.

Alvin Mauer and Timothy Talbot, representing the Assn. of American Cancer Institutes, told the Board they felt it was the consensus of AACI members that "we can live with these." Mauer said, "We feel confident with them."

The DRCCA Board still has not been formally constituted and thus was prevented from taking a formal vote on the guidelines. However, Chairman Stephen Carter asked, after some discussion and minor revisions by Board members, if there were any objections to approval and heard none.

Board member Charles Moertel, chairman of the working group which hammered out the compromise proposals, presented them point by point. Board members had these comments:

Lester Breslow: "It is remarkable that in all the years since cancer centers were proposed and implemented . . . there is no reference (in the guidelines) to prevention or epidemiological studies "

Moertel pointed out that the cancer center support (core) grants specifically excluded cancer control, and there is a separate mechanism for control grants. "I always felt it was a mistake to separate research core grants from control," Moertel said. "We can do something to get them together now (that control and centers are in the same division). But gosh, that's a big subject to open now in discussing these guidelines." The Board agreed, however, to add an epidemiology example to those in the guidelines used to help explain intended uses of core grants.

Leonard Derogatis: "Would it break the bank (if all centers increase staff investigator salary support to 25 percent of their total grants as the new guidelines provide)?"

DRCCA Acting Director William Terry said it would not, with the overall limit on budget requests in the new guidelines.

Moertel, on the provision which permits core grant funding for up to two years of salaries, limited to $60,000, of newly recruited investigators who do not bring their grants with them: "Is it fair to restrict this to zero grant support brought along? Let's say he has an easily transferrable American Cancer Society grant for $10,000. You tell him to get rid of that and you'll pay him $60,000. Why not offer him the difference between $60,000 and the smaller grant?"

Centers Program staff member Ray Morrison said that was an issue no one had thought of and that there was no reason Moertel's suggestion would not work. The Board approved the change.

Moertel, on interim salary support for investigators who lose their peer reviewed funding: "If this is used for something like keeping cronies on the payroll, I would hope peer review would take care of that. On the other hand, in today's budget climate, we have some awfully good people with approved, unfunded grants."

"The peer review system is not perfect," commented Board member Kaye Kilburn. "This will allow center directors to deal with inequities."

Moertel objected to the provision dealing with use of shared resources which limits that use to those holding peer reviewed grants or contracts. "I don't recall we came out this strongly. . . . If the institution pays the investigator's salary, it would be the most responsible use of the dollars (to permit that investigator to use a shared resource funded from the core grant)."

Terry agreed to add to the provision that "other users (than those with funded grants or contracts) should be shown on the log and be defended in peer review."

The National Cancer Advisory Board was scheduled to act on the guidelines this week, but approval seemed assured. NCAB Chairman Henry Pitot and NCAB Subcommittee on Centers & Construction Chairman Maureen Henderson told the DRCCA Board that they were satisfied with them.

Major changes in the guidelines, and those most in contention during the three and a half years they have been debated, follow. These are from the latest "draft" and still are subject to minor revision by staff and by the NCAB:

There must be an adequate base of established programs of high quality in laboratory and/or clinical cancer research. The high quality of the programs should be evident from the fact that they have been awarded support through national peer reviewed competition, such as in the form of NCI grants and contracts.

In order to apply for a CCSG, an institution must have a "base" of at least $750,000 direct costs in peer reviewed research and research training support. This requirement is not meant to imply that the center must "control" all of these supported programs.

The base is defined as including NCI awards with identifying numbers with the following prefixes: Research grants: R01, R10, R26, R23, P01; training: K04, T32, F32; and research contracts: N01-CB, N01-CP, and N01-CM, and NCI cancer control grants (R-18) with a major research component. Contracts that support primarily the production of materials in support of research (e.g. virus production, animal production) will not be included. The base may also include research grants and awards from the American Cancer Society and 25 percent of the research grant and research training support from other NIH institutes and the National Science Foundation. Contracts from sources other than NCI may not be included.

Limitation on the Amount Which May Be Requested in a CCSG Application

In no case may an application request more than $5 million in direct costs for one year, the limit prescribed by law.

Furthermore, because of budgetary constraints NCI has established ceilings or caps on the amounts which may be requested in renewal (Type 2) applications for CCSGs. Caps have been established both on the total direct costs and on staff investigator salaries.

The ceiling on total direct costs for renewal requests is as follows: The average annual direct costs requested may not exceed an amount 50 percent higher than the current level (the direct costs committed or provided by the NCI for the 12 months prior to the requested beginning date of the renewal application). The average is to be computed on the basis of constant dollars with the first renewal year as the base. Inflationary increases for personnel and supplies may be requested in future years. An example for clarification: For a grant with a current level of $1 million direct costs in the 06 year, a re-

newal request must average no more than $1.5 million per year using the 07 year as the base, i.e., inflationary increases for personnel and supplies may be added in years 08 through 11.

This ceiling of 50 percent over current level will apply for the first renewal application submitted by all centers subsequent to the issuance of these guidelines. Thereafter, the ceiling will depend on the number of years since the last renewal. If a renewal is submitted after three years, the ceiling will be 30 percent over current level; if after five years, 50 percent over current level.

Professional Personnel Salaries

For all of the categories of personnel listed below, the requested percentage of an individual's salary may not exceed the percentage of effort devoted specifically to the center. Information substantiating this level of effort must be included in the application.

1. Senior leadership personnel: This category includes the individuals who have responsibility for the overall direction of the entire center. Specific titles that qualify as senior leadership personnel include center director, deputy director, and associate directors for laboratory and clinical research.

2. Major program directors: Many centers are organized into various identified programs, either along disciplinary lines (such as medical oncology, pharmacology, virology, epidemiology, etc.) or according to organ site (e.g. leukemia, lung cancer, prostate cancer etc.). Such "programs" include research projects conducted by a number of investigators and have designated leaders or program directors.

Staff Investigators

Scientists who are members of or closely identified with the cancer center and who have peer reviewed research support may receive salary as center staff investigators. To qualify, an individual must either be the designated principal investigator on a research grant or contract or the director of a peer reviewed sub-project of a program-project grant (P01). These grants or contracts must have been awarded as a result of creditable external peer review such as by an NIH study section. A major purpose of this partial support is to provide some of the necessary stability for a "core" of investigators with proven records. The salary support from the CCSG is reimbursement for effort devoted to the peer review project(s).

The percentage of salary supported by the CCSG may not exceed the percent of unfunded effort approved by peer review(s) of the individual grant(s) and contract(s).

It should be noted that a staff investigator may provide other services to the center, such as supervising a shared resource or service or serving as a major program director. Additional salary support for the time devoted to these activities may be requested under the appropriate category. For example, if a staff investigator is also designated as a major program director, an additional portion of his or her salary could be charged to the CCSG if the activities he/she carries out as program director justify the additional percentage of salary.

Salary support under this section may be used only for the individuals named in the application and approved.

If a center staff investigator loses his or her peer reviewed support during the approved project period of the CCSG the center director may provide interim salary support from developmental funds.

Ceilings on requests for staff investigator salaries:

The specific nature of this type of salary support and budgetary constraints require that the amounts requested be limited.

For renewal applications:

1. If current staff investigator salary support exceeds 25 percent of the direct costs of the present grant, the renewal application may request no more than the current level and must include a plan to phase down to the 25 percent level. The amounts requested should conform to that plan. The details of this plan will be negotiated with NCI.

2. If current staff investigator salary support is less than 25 percent of the current grant, the center may request up to either (a) 25 percent of the current grant, or (b) the current level of staff investigator salary support plus an increase of no more than 10 percent of the ceiling for the renewal application, whichever is less.

New Applications

No more than 10 percent of the requested funds may be designated for staff investigator salary support. (*The Cancer Letter* last week incorrectly listed that figure as 25 percent.)

The complete guidelines include more details on salary categories, detailed instructions on grant applications, on submissions of letters of intent, and various other items. With NCAB approval, the complete guidelines will be published by NCI.

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 Contracting Officer or Contract Specialist named, Research Contracts Branch, National Cancer Institute, Blair Building, 8300 Colesville Rd., 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-17481

Title: *Intraoperative radiotherapy*
Deadline: *Approximately April 3*

Task A: Investigate role of intraoperative radiotherapy in the treatment of intra-abdominal malignancies. Each of the contractors shall conduct research into the role of intraoperative radiotherapy, in accordance with the capabilities and interests of its institution in the treatment of tumors in at least 3 intra-abdominal sites, such as the stomach, pancreas or rectum in accordance with the following guidelines:

1. Carefully define surgical and pathological criteria and techniques for each tumor site to include the extent of surgery, the amount of residual tumor and the pathological stage.

2. Carefully define radiotherapy criteria and techniques to include, as a minimum, the type of radiation, total dose and isodose distribution in relation to the treatment volume for the intraoperative radiation as well as time, dose, fractionation and volume considerations for any preoperative or postoperative external beam radiotherapy.

3. Obtain detailed followup information on all patients with regard to local control, regional control, development of distant metastases and both acute and late complications of surgery and/or radiotherapy, if any.

Perform an analysis of and prepare guidelines for the intraoperative radiotherapy technique(s) used to treat each tumor site to include, as a minimum, the following:

1. The surgical and pathological criteria and techniques.
2. The radiotherapy criteria and techniques.
3. Normal tissue tolerance to large single doses with or without supplemental external beam therapy.
4. Tumor response to large single doses, alone or with supplemental external beam therapy, in terms of local and regional control.
5. The safety of the combined surgical and radiotherapy procedures and any hazards which require special precautions.
6. The advantages and disadvantages of alternate techniques used at the individual institutions.

Development of "consensus guidelines" for intraoperative irradiation of intra-abdominal malignancies.

Task B (optional): Investigate the use of radiation modifiers in conjunction with intraoperative radiotherapy in the treatment of intra-abdominal malignancies. The contractor shall conduct research into the use of one or more radiation modifiers (chemical sensitizers, radiosensitizers, radiotherapy for the treatment of tumors in at least three intra-abdominal sites (stomach, pancreas and rectum) to include, as a minimum, the following:

1. All the requirements for intraoperative radiotherapy specified in Task A.
2. Pharmacokinetic studies if radiation modifying drugs are studied.
3. Detailed characterization of hyperthermia treatment if used in conjunction with intraoperative radiotherapy to include, as a minimum, details of heat generation, thermometry, thermal profiles achieved, normal tissue tolerance.

Offerors shall be capable of accruing not less than 15 patients per year per task proposed upon. All offerors shall propose on Task A and may also propose on Task B. The offeror shall propose either a device capable of producing an electron beam or one producing kilovoltage x-rays.

Contracting Officer: Harold Thiessen
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RFP NCI-CM-17401

Title: *Shelf life evaluation of clinical drugs*
Deadline: *Approximately March 31*

The Pharmaceutical Resources Branch of the Developmental Therapeutics Program, Div. of Cancer Treatment, NCI, is seeking a contractor to properly store, adequately test, and evaluate shelf life samples of investigational clinical drug formulations, including both injectable products and oral dosage forms; and report the results of such testing to the PRB.

The project will involve the storage of samples from approximately 30 to 40 lots of clinical drugs per year under freezer storage (-10°C), refrigeration, (4°C), controlled room temperature (25°C), and elevated temperature (50°C) conditions. Further, performance of this project will require analytical and pharmaceutical testing of each of the samples to adequately evaluate the shelf life of each of the clinical products. Testing requirements and protocols will be determined by NCI in accordance with FDA Current Good Manufacturing Practices (CGMPs). Testing intervals will normally be 0, 3, 6, 9, 12, 18, 24, 36, 48 and 60 months of storage.

In addition, the project will require storage and inspection of reserve samples as defined by the FDA CGMPs. Each of the reserve samples (40 vials or ampules or two bottles of tablets or capsules) will be stored at the labeled condition for one year past the expiration date and will be visually inspected for apparent changes annually. At present, about 150 reserve samples are in storage. In addition, it is estimated that approximately 100 lots of injectable products and 15 lots of oral products each year will require reserve sample storage and inspection.

All work performed under this contract must be in accordance with FDA promulgated CGMPs. The contractor selected must meet at least the following minimum requirements:

1. Must be experienced in analytical and pharmaceutical evaluation of clinical drug products and shall be required to have in-house operational equipment and capabilities at the time of contract award.
2. One high performance liquid chromatograph, one ultraviolet spectrophotometer and one pH meter shall be dedicated for exclusive use on this contract.
3. Must provide the following minimum storage space for the shelf life and reserve samples: 50°C–16 cu. ft.; 25°C–400 cu. ft.; 4°C–360 cu. ft.; -10°C–45 cu. ft.

A five year period of performance is projected with the following level of effort for each of the years: Year 1–4.00 staff years; Year 2–3.80; Year 3–3.60; Year 4–3.40; Year 5–3.2.

Contract Specialist: Maria Decker
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The Cancer Letter _Editor Jerry D. Boyd

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