THE CANCER LETTER

Vol. 7 No. 7

Feb. 13, 1981

Subscription $125.00 per year

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

IMPENDING REAGAN BUDGET CUTS FEARED BY CANCER PROGRAM ADVOCATES; DEVITA ASKS PARITY WITH NIH

NCI staff and Cancer Program advocates, like the rest of the federal establishment and its constituents, were watching warily this week the leaks dribbling from the White House and Office of Management &

(Continued to page 2)

In Brief

HOUSE FILLS SUBCOMMITTEE POSITIONS; SENATE SCHEDULES NCI APPROPRIATIONS HEARING FEB. 18

NEW LINEUPS on House subcommittees have been completed. Bernard Dwyer, New Jersey, is the new Democrat on the Labor-HHS-Education Appropriations Subcommittee. He was a businessman and state legislator before last November's election. New Republicans, both attorneys, are Robert Livingston, Louisiana, and John Porter, Illinois. William Natcher, Kentucky, remains as chairman. Other Democratic holdover members are Neal Smith, Iowa; David Obey, Wisconsin; Edward Roybal, California; Louis Stokes, Ohio; and Joseph Early, Massachusetts. Holdover Republicans are Silvio Conte, Massachusetts; George O'Brien, Illinois; and Carl Pursell, Michigan. Major changes on the Health Subcommittee of the Energy & Commerce Committee include addition of veteran New York Democrat James Scheuer (SHAW-yer) as second ranking majority member behind chairman Henry Waxman of California; and assumption of the top ranking GOP role by Edward Madigan of Illinois. Other new Democrats include veterans Toby Moffett of Connecticut and James Florio of New Jersey and freshman Ron Wyden of Oregon. New Republicans on the subcommittee are veterans Clarence Brown, Ohio; Robert Whittaker, Kansas; and Don Ritter, Pennsylvania; and freshmen Cleve Benedict, West Virginia; Thomas Bliley, Virginia; and Dan Coats, Indiana. Holdover members are Democrats Thomas Luken, Ohio; Doug Walgren, Pennsylvania; Barbara Mikulski, Maryland; Richard Shelby, Alabama; Phil Gramm, Texas; and Mickey Leland, Texas; and Republican William Dannemeyer, California. . . . **SENATE APPROPRIATIONS** Labor-HHS Subcommittee (see ***The Cancer Letter***, Jan. 23, for membership) has scheduled its hearing on the NCI 1982 fiscal year budget for Feb. 18. . . . **HAROLD AMOS**, chairman of the Div. of Medical Sciences at Harvard and a member of both the President's Cancer Panel and National Cancer Advisory Board, has been elected president of the American Cancer Society's Massachusetts Div. . . . **TIMOTHY TALBOT**, vice chairman of the board of Fox Chase Cancer Center, has been selected as winner of the award for distinguished service in support of cancer research made annually by the Papanicolaou Cancer Research Institute. **RAYMOND ERIKSON**, of the Univ. of Colorado Health Sciences Center, will receive the institute's award for scientific achievement in cancer research.

NCAB DECLINES SAMUELS' REQUEST TO TAKE STAND NOW ON BUDGET CUTS

(Continued from page 1)

Budget on the size and location of cuts President Reagan will attempt to make in both the 1981 and 1982 fiscal year budgets.

By press time, no leaks had developed which mentioned NIH or NCI budgets although massive cuts in various health services programs were included in proposals made in confidential memos to members of Congress. No one is predicting, however, that biomedical research is home free. The NIH budget represents 30 percent of discretionary funds for the entire HHS Dept.—money which can be cut without changes in authorization legislation. It does not seem logical to expect that Reagan would initiate pitched battles in Congress over changes in the entitlement programs without asking for substantial cuts in other areas.

The rumor circulating in Washington which seemed most likely of those including NIH is that the White House will propose a 10 percent reduction in the 1982 budget. For NCI, that would mean a cut of $104 million from the $1.042 billion requested by President Carter. The consequences of returning NCI to the 1979 level which that would bring about would be serious enough, even without considering the 30-40 percent inflation of the intervening three years.

NCI Director Vincent DeVita told the National Cancer Advisory Board and, later last week, the Coalition for Cancer Issues that he could live with a 10 percent reduction. "We can survive. We're flexible. I'm more concerned about our share of the NIH budget."

DeVita fears that a 10 percent total cut applied to NIH would be translated into something like 15 percent for NCI and less than 10 percent for everyone else. NCI increasingly has been tapped for more than its share of certain costs and for various projects undertaken by other agencies, along with getting lower percentage increases in budgets than the other institutes.

NCI's budget increased 4.4 percent from 1980 to 1982 while the other institutes went up from 13 to 34 percent. NCI has been required to pay almost half the entire cost of expanding the NIH Clinical Center, although it will get only 20 percent of the new space. NCI's share of the NIH budget a few years ago was 33 percent; it has dwindled now to 27 percent. "There may be a figure in someone's mind on what our percentage should be," DeVita said. "I have a feeling it is 25 percent.

"If in fact the Cancer Institute grew faster than the others in the 1970s because of the research opportunities and if in fact the Cancer Program is functioning well, we can defend our proportionate share of the NIH budget," DeVita told CCI representatives. "The research opportunities are extraordinary. I find it hard to believe we should be made proportionately smaller. When NCI was growing fast, the other institutes were not growing as fast but they were growing. The tendency now is to think that because we get a billion dollars, they can take pieces from us without hurting us.

"No one has ever told me any reason for the additional cuts. No one has said there are no research opportunities, or the institute is badly managed. If that can be proven, okay. I'm prepared to pay the price. But I'm arrogant enough to think that it would be very difficult to make that case."

NCI presently is operating on a 1981 budget which assumes that the $13.5 million rescission requested by the outgoing Carter Administration will be approved by Congress (and will not be altered by the new Administration). That would trim NCI's appropriation from the $1.001 billion voted by Congress to $987.5 million. NCI also is assuming that Congress will approve a supplemental request of about $9 million to help cover the cost of pay increases which went into effect last October, lifting the level back to $996.4 million.

Those two assumptions are in conflict: If Congress is in a mood to rescind $13.5 million it has already appropriated for the Cancer Program, it is not likely to approve the supplemental. It is entirely possible, therefore, that NCI will end up with less than $980 million for 1981, because the pay increase is in effect and the $9 million would have to be taken from the existing budget.

In the past, Cancer Program advocates could count on Congress rejecting Presidential rescission requests. That support no longer should be automatically assumed.

Sheldon Samuels, member of the NCAB Subcommittee on Planning & Budget, tried without success to stir up interest in a Board effort to head off budget cuts.

"It is the obligation of the Board to speak out against any cuts," Samuels said. "We should go on record as to what it means to the country, in terms of morbidity and mortality. That should be communicated loudly to the (HHS) secretary, in a public meeting."

Board member Rose Kushner agreed, but DeVita said, "Don't jump the gun." Board member Harold Amos suggested waiting until the Administration makes the cuts, "and then make a stand."

"That's just waiting to count the bodies," Samuels said. "We should say now that no cuts are tolerable."

DeVita argued that the value of NIH to the country will be evident in the appropriations hearings, and that neither the Administration nor Congress will take actions that would harm NIH. "What the Board

NATIONAL CANCER INSTITUTE'S PRESENT BUDGET STATUS
(In Thousands of Dollars)

	1980 Actual		1981[1]		1982[2]	
RESEARCH GRANTS	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Research Projects						
Non-Competing	1,762	218,307	1,801	246,182	1,827	257,156
Administrative Supplementals		10,652		7,883		6,334
Competing						
Renewals	293	45,802	255	46,006	231	55,977
New	461	45,304	465	49,508	507	48,654
Supplementals	29	1,261	36	1,473	40	1,640
Sub-Total, Competing	783	92,367	756	96,987	778	106,271
Sub-Total, Research Projects	2,545	321,326	2,557	351,052	2,605	369,761
Research Centers						
Exploratory Grants	1	221	1	200	1	200
Core Grants	63	67,421	57	69,835	57	74,931
Sub-Total, Research Centers	64	67,642	58	70,035	58	75,131
Other Research						
Research Career Programs	125	4,720	112	4,493	109	4,493
Organ Site	187	17,554	135	15,300	122	15,300
Clinical Education Programs	98	10,906	64	8,000	48	6,000
Clinical Cooperative Groups	198	36,884	174	35,459	210	38,000
Other Research Related	24	4,492	14	3,510	9	3,386
Sub-Total, Other Research	632	74,446	499	66,762	498	67,179
Total, Research Grants	**3,241**	**463,524**	**3,114**	**487,849**	**3,161**	**512,071**
TRAINING						
Individual Awards						
Non-Competing	118	1,948	130	2,828	112	2,581
Administrative Supplementals		214				
Competing						
Renewals	7	133				
New	97	1,792	42	1,168	83	1,913
Sub-Total, Individual	222	4,087	172	3,996	195	4,494
Institutional Awards						
Non-Competing	95	11,640	132	19,829	135	21,274
Administrative Supplementals		1,934				
Competing						
Renewals	46	8,574	13	2,662	19	3,380
New	12	1,000	2	141	12	814
Supplementals		25				
Sub-Total, Institutional	153	23,173	147	22,632	166	25,468
Total, Training	**375**	**27,260**	**319**	**26,628**	**361**	**29,962**
RESEARCH & DEVELOPMENT CONTRACTS	820	231,346	687	205,130	645	205,130
INTRAMURAL RESEARCH		144,009		162,824		176,856
DIRECT OPERATIONS		38,868		42,248		44,096
PROGRAM MANAGEMENT		10,615		11,615		12,023
CANCER CONTROL		66,993		56,553		57,623
CONSTRUCTION		15,432		3,500		4,000
TOTAL, NCI		**998,047**		**996,347**		**1,041,761**

1 With the Rescission and Supplemental 2 As Requested by President Carter

does now won't have much impact, and it could hurt," DeVita said.

"I disagree," Samuels said. "Other people are making noises about other programs. We don't have to have cuts in this program. The people like the Cancer Program and support it. Forget what you read in the *Miami News* or *Newsweek*."

"We have a very good director and we ought to let him handle it," Subcommittee Chairman Fred Seitz commented.

Samuels pointed out that DeVita, as a member of the Administration, is obligated to defend the President's budget, whatever the cuts might be.

DeVita acknowledged that a 10 percent cut "would hurt, but we can tolerate it. Whatever NIH can tolerate, we can. My fear is being asked to take a bigger cut than NIH."

"Losing $100 million would be a bitter blow," Amos said, but he agreed that the Board should wait until the Reagan Administration makes its recommendation.

DeVita suggested that the cancer community "stick together. The worst thing we can do now is to pit one program against the other."

"None of what Mr. Samuels has said would pit one part of the Cancer Program against another," Board member William Powers said. "The question is at what point can the Board do its thing."

"I as an individual am going to fight for this budget," Samuels said. "I need help. . . . The Board represents the constituency working for the control of the disease. What I'm hearing here is don't make waves. The wave that's coming will drown you."

"You're saying we could alter the Congressional view by presenting our case for not lumping us in with the bulk of the budget cuts, and we should do it before the bulk of the cuts are made," Amos said. "There is some merit in that approach."

"I don't sense a mood on the Hill to cut the budget," Samuels said. "What's relevant right now is what's going on in the White House."

"There's not much chance of changing what's going on in the White House tonight," DeVita said.

"I know," Samuels said. "But when I go down, I want to go down fighting."

Seitz adjourned the subcommittee meeting without calling for a vote, and the issue was not raised when the subcommittee report was later presented to the full Board.

The 1982 budget may be the last in which the National Toxicology Program is shown as a component of NCI.

DeVita has proposed and NIH has agreed that the entire program be made a component of the National Institute of Environmental Health Sciences. NIEHS Director David Rall also is NTP director, and the program is operated out of NIEHS headquarters in North Carolina. However, NCI still makes a hefty contribution to fund the cancer related testing component of NTP.

NCI contributed $43.5 million to NTP in FY 1980, and is putting in $45.7 million this year. The original budget request for FY 1981 had NCI contributing $65 million, but DeVita was able to talk NIH Director Donald Fredrickson, HHS, and Rall out of $20 million of that. The FY 1982 Carter budget lists the NCI contribution at $49 million, but again DeVita is insisting that if the overall NCI budget is cut, NTP should bear a portion of the reduction.

If NTP does "disappear into the NIEHS budget," as DeVita described the proposed move, the NCI budget would be reduced accordingly.

NCAB RECOMMENDS RECOGNITION OF CRCC COMPREHENSIVE STATUS BE WITHDRAWN

The National Cancer Advisory Board has recommended that recognition of the Colorado Regional Cancer Center as a comprehensive cancer center be withdrawn. The recommendation is an advisory one to NCI Director Vincent DeVita; there is little doubt he will accept it and notify CRCC that it is no longer a comprehensive cancer center.

CRCC thus becomes the first center to lose its comprehensive status since the practice of NCI recognition was initiated following passage of the National Cancer Act of 1971. Twenty-one centers, including CRCC, had been deemed by NCI directors as having met the criteria for comprehensiveness as drawn up by the NCAB.

When the NCAB conducted its review of the compresentive centers a few years ago to determine how well they were living up to those criteria or "characteristics," Board members and NCI staff realized the time would come when recognition of some centers might have to be withdrawn. It was a prospect which dismayed NCI directors, who dreaded the task of initiating withdrawal and facing the wrath of a center's administrators and scientists as well as that of governors, congressmen, senators, etc.

The NCAB followed up its review by developing a scenario which takes some of the pressure off the NCI director. The Board decreed that loss of a center's core grant would be an indication based on peer review that a center might not be meeting the requirements for comprehensiveness. If failure to get a core grant renewed and funded is not followed with a successful renewal within two years, the Board decided, an NCAB review would be held to determine if the center were still comprehensive. The Board then would make its recommendation to the NCI director.

By the time that policy was adopted, CRCC had lost its core grant. A subsequent application also was disapproved. CRCC asked for postponement of the Board site visit scheduled for last July, and it was rescheduled to October. The center than asked that the site visit be switched from an evaluation of the center to a review of a restructuring of CRCC. NCI staff balked at that request.

"Under the rules, staff recommends that recognition of Colorado Regional Cancer Center as a comprehensive center be withdrawn," Ray Morrison, member of the Centers Program staff, said to the NCAB Subcommittee on Centers & Construction, meeting to consider the matter prior to last week's Board meeting.

Subcommittee member Robert Hickey offered the motion recommending withdrawal but added that the Univ. of Colorado, one of CRCC's consortium members, be "urged to continue efforts to develop a comprehensive center."

"That bothers me enormously," commented subcommittee Chairman Maureen Henderson. "It is implying that they will get funded."

"Not at all," Hickey answered. "We are only encouraging them to continue their efforts."

Board member LaSalle Leffall supported Hickey, but Henderson persisted. "Should we be encouraging them to continue in the face of a lack of funds to support the centers we have?"

"I think it is important to encourage them to continue," Hickey said.

"The language of withdrawal of recognition should

be straightforward," Board member Gale Katterhagen said. "The encouragement could be offered in a separate letter."

"Encouragement is not appropriate coming from the National Cancer Advisory Board," Henderson insisted. "We can ask the Board to take action on withdrawal of recognition, and also suggest to the division director that he discuss continuation of their efforts with the university."

"The onus to continue those efforts shouldn't be on NCI staff but on Denver," Katterhagen said.

The subcommittee approved without dissent the withdrawal recommendation. When Henderson presented her report to the full Board, "encouragement to continue" was not mentioned.

"Colorado has not met the criteria for comprehensiveness," Henderson told the Board. "Or put another way, the center has met the criteria for removing its recognition as comprehensive."

The Board unanimously accepted her report without discussion.

CRCC probably was doomed from the start by its flawed design as a consortium.

The Univ. of Colorado School of Medicine was a member of the consortium but was not in charge. Its role was never clearly defined. In the opinion of reviewers and NCI staff, failure to get the medical school more involved in the center was the primary cause for disapproval of the core grant.

The university is very strong in basic science and is on the upswing in clinical research. NCI staff and Cancer Center Support Grant Review Committee members agree that there is the potential for a good center in Denver. A solid commitment from the university is absolutely necessary, and the university appears ready now to make that commitment.

NCAB OKAYS GUIDELINES, PROHIBITS REBUDGETING STAFF SALARY REDUCTIONS

The National Cancer Advisory Board last week put the final touches on the new guidelines for cancer center core grants.

The Board's Subcommittee on Centers & Construction made one revision in the draft approved previously by the Div. of Resources, Centers & Community Activities Board of Scientific Counselors.

The new guidelines reuqire that centers which presently use more than 25 percent of their grants (direct costs) for staff investigator salaries must phase down to that level eventually. Their renewal applications must include a plan to reach the 25 percent maximum over a period of years.

Subcommittee members suggested that the guidelines as written might permit center directors to rebudget money saved by cutting staff investigator salary support. "That was not our intention," said DRCCA Acting Director William Terry.

Subcommittee Chairman Maureen Henderson suggested adding the phrase "and may not be rebudgeted" to the section requiring the phase down, and other members agreed.

NCAB Chairman Henry Pitot asked what the situation would be with a grant for which the study section reduced the budget, bringing the percentage of staff investigator salary support over 25. "At the next renewal, would the salary support have to be reduced to bring it under 25 percent of the new level?"

"That's the interpretation by staff of the intent of the guidelines," Centers Program staff member Ray Morrison said.

The full Board approved the guidelines unanimously with no further changes.

U.S., FRANCE CARCINOGENESIS PROGRAM

NCI and the French Institut Nationale de la Sante et de la Recherche Medicale (INSERM) have an agreement to promote cooperation in basic research in carcinogenesis. Limited funds are available through this program to provide travel expenses and subsistence allowance of U.S. scientists to work in France for periods of up to a few months on appropriate collaborative research projects with French colleagues. Similarly, limited funds are available to pay for living expenses of French scientists to work in the United States on appropriate collaborative projects with American colleagues. Each request for support will be reviewed for scientific merit by the American and French Program Committees.

Contact: Dr. Louis R. Sibal, Div. of Cancer Cause & Prevention, NCI, Bldg 31 Rm 11A03, Bethesda, Md. 20205.

NCI CONTRACT AWARDS

Title: Long-term followup of the Breast Cancer Screening Project participants

Contractor: Univ. of Arizona Medical Center, $772,500.

REVISED PROGRAM ANNOUNCEMENT

Cancer Clinical Treatment Research

The Div. of Cancer Treatment of NCI desires to expand its support of clinical treatment research. The program is seeking applications for research grants concerned with clinical cancer treatment. Appropriate studies include:

1. The evaluation of toxicity, disease response and patient survival associated with various treatment programs;

2. The evaluation of methods of improved experimental design, data management and statistical analysis;

3. The experimental development of new methods and modalities of supportive care.

Applications dealing with innovative approaches

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

Applications in response to this announcement will be reviewed on a nationwide basis in competition with each other, and in accord with the usual NIH peer review procedures.

Deadline: Applications will be accepted in accordance with the usual NIH receipt dates for new applications: July 1, Nov. 1, March 1.

Applications should be submitted on form PHS 398, which is available in the business or grants and contracts office at most academic and research institutions or from the Div. of Research Grants, NIH. The phrase, "Prepared in Response to Program Announcement on Cancer Clinical Treatment Research" should be typed across the top of the first page of the application. Additionally, a brief covering letter should accompany the application indicating that it is being submitted in response to this program announcement.

The original and six copies of the application should be sent or delivered to: Application Receipt Office, Div. of Research Grants, NIH, Westwood Bldg., Room 240, Bethesda, Md. 20205.

For further information, investigators are encouraged to contact: Dr. John Y. Killen Jr., program director for clinical treatment grants, Landow Bldg., Room A416, Bethesda, Md. 20205; telephone 301-496-2522.

In order to alert the Div. of Cancer Treatment to the submission of proposal with primary thrust directed to clinical treatment research, a copy of the covering letter should be sent under separate cover to Killen.

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 NO1-CM-15745-57

Title: *Production and isolation of type II (immune) human interferon*

Deadline: *April 17*

The Biological Modifiers Program, Div. of Cancer Treatment, NCI, intends to investigate the basic mechanisms by which human interferons produce an antitumor effect to increase the therapeutic effectiveness of these agents in humans. Investigations relating to interferon action will be carried out at the tissue, cellular and molecular level as well as preliminary clinical studies.

These investigations will require the acquisition of substantial quantities of type II (immune) human interferon at a high degree of purity. The BRMP seeks a contractor who can produce and isolate 5 billion units of type II human interferon at a minimum specific activity of 2 x 107 units per mg of protein. Because of the need for a large quantity of highly pure interferon and program's intention to stress the cost effectiveness of procedure employed, proposals are anticipated from organizations qualified to produce type II human interferon by established animal cell culture technology and/or procedures relying on recent advances in recombinant DNA techniques. Offerors may propose to produce interferon by either or both of the indicated procedures.

It is anticipated that multiple basic ordering agreements (BOAs) will be awarded. As requirements arise, RFPs will be issued to all BOA recipients eligible for the particular effort. The ensuing awards will be designated as task orders. Only these organizations who have received BOAs will be eligible to compete for task order awards.

Contracting Officer: Damian Crane
Cancer Treatment
301-427-8737

RFP NCI-CM-17482

Title: *Evaluation of treatment planning for particle beam radiotherapy*

Deadline: *Approximately April 14*

The Div. of Cancer Treatment, NCI, requires organizations possessing the facilities and capabilities to perform the following:

1. Task A: Treatment planning for particle beam radiotherapy.

a. The contractor shall develop treatment plans for representative patients with tumors in each major anatomic site (brain, head & neck, lung mediastinum, upper abdomen, pelvis, trunk, extremities, superficial and deep lymph nodes). Not less than one patient per contract shall be accrued for each site. Treatment plans shall be developed in accordance with the following minimum guidelines. Each tumor shall be treated in accordance with each guideline:

1) Perform a sufficient number of CT scan sections to fully characterize the tissue density inhomogeneities within the target volume and in all surrounding normal tissues through which the beams will pass

and to provide precise tumor and normal organ localization.

2) Perform additional tumor and normal organ localization procedures if appropriate.

3) Incorporate tissue inhomogeneities corrections into the treatment planning calculations.

4) Determine the optimum dose distribution to include the most uniform high linear energy transfer (LET) dose distribution, accounting for the variable LET distribution throughout the broadened Bragg peak of beams of helium ions, pions and heavy ions and for the change in LET distribution with depth of penetration of neutron beams.

5) Fully consider limitations on total dose by the tolerance of critical normal tissues.

6) Consider the physical limitations of radiation delivery inherent in each particle beam therapy system.

7) Incorporate into the treatment planning procedure the use of existing (or soon to be available) ancillary treatment equipment such as patient immobilization and positioning devices, beam energy modulation devices and bolus materials.

b. The contractor shall conduct a program of dosimetric and microdosimetric measurements for each particle beam during the actual treatments of patients with representative tumors in each major anatomic site, if feasible, and during simulated treatment of tumors in phantoms in accordance with the following minimum guidelines:

1) The objective of measurements made in patients shall be to confirm, in as many locations within the irradiated volume as possible, the dose distributions (total and biologically equivalent doses) calculated for the optimum treatment plan specifically for a different patient.

2) The objective of the measurements during the simulated treatments of phantoms shall be to gather considerably more data than is possible in humans on dose and LET spectrum distributions to verify the execution of the simulated treatment plan.

3) The patient or phantom irradiation shall strictly adhere to the optimum treatment plan to include the use of positioning devices, bolus, and other conditions specified by the plan.

2. Task B: Evaluation of particle beam capabilities

a. The principal investigator (or his representative) from each institution shall serve on a working group which will help design and coordinate the activities required to carry out the work specified in Task A, parts a and b, to include, as a minimum, the following:

1) Defining RBE's for normal tissues and maximum allowable doses to critical organs for each particle beam.

2) Defining standard procedure for dosimetry and microdosimetry measurements in patients and in phantoms.

3) Defining common criteria for calculating biologically equivalent doses.

4) Defining common criteria for tissue density inhomogeneity corrections.

3. Equipment

The offeror shall propose the use of:

a. A recent generation of body and head CT scanner(s).

b. One of the following particle beam radiotherapy systems: isocentric DT neutron generator; isocentric 42-48 MeV neutron generator; proton beam therapy system; helium and heavy ion therapy system; single vertical pion beam therapy system; multiport pion beam therapy system.

c. A radiotherapy treatment planning system capable of incorporating images and tissue density information from CT scanners.

Each contractor shall enter a minimum of 25 eligible patients per year for a four year period.

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

RFP NCI-CM-17395

Title: *Synthesis of natural product analogs and other novel heterocycles as potential anticancer agents*

Deadline: *Approximately April 3*

The Drug Synthesis & Chemistry Branch of the Developmental Therapeutics Program, NCI, is seeking contractors with chemical synthesis expertise to synthesize analogs, partial structures, and novel heterocycles based on natural products which have shown antitumor activity.

The objective of the project is to develop, via chemical synthesis, compounds related to products of natural origin with improved antitumor activity and decreased toxicity. Synthetic modifications include partial structures, structural analogs and novel heterocycles. Areas of current interest include the development of isoxazoline antibiotic analogs, anthramycins and other novel heterocycles. A three year period of performance is projected with the following level of effort required for each of the years: Year 1, 4.00 staff years; year 2, 3.75 staff years; year 3, 3.50 staff years.

Contract Specialist: Maria Decker
Cancer Treatment
301-427-8737

RFP NCI-CM-17480

Title: *Phase 1 evaluation of equipment for hyperthermic treatment of cancer*

Deadline: *Approximately April 4*

The Div. of Cancer Treatment, NCI, requires organizations possessing the facilities and capabilities

to perform the following:

1. Task A. Assess the performance of heat generating and thermometry systems in the major anatomic sites

a. Each of the contractors shall evaluate the ability to heat tumors in each major anatomic site(brain, head and neck, lung, mediastinum, upper abdomen, pelvis, superficial and deep lymph nodes, trunk and extremities) with his equipment and that provided by the government in accordance with the following guidelines:

1) Plan and execute heat treatments in three or more patients with tumors in each of the major anatomic sites using each of the available heat generating devices available to him and appropriate for heating that site.

2) Measure temperatures in as many locations as possible within the treatment volume using each available type of thermometry device appropriate for the site being heated.

b. Each of the contractors shall prepare an analysis of the efficacy of each heat generating system for heating tumors in each major anatomic site and of the corresponding thermometry systems. The analysis should include but need not be limited to the following:

1) Physical description of the equipment.

2) Physical characteristics of the heating process (frequency, surface area or volume heated, power density).

3) Accuracy of temperature measuring devices.

4) Adequacy of temperature feedback control system, if any.

5) Heating dynamics (time and power to reach desired temperature, power required for steady state heating, temperature profile (isotherms) throughout the treatment volume).

6) Safety of equipment with respect to the patient and other personnel (leakage radiation, etc.).

7) Advantages and disadvantages of each heat generating and heat monitoring system for each site.

8) Recommended guidelines for the use of each system in each site, as appropriate.

9) Adverse effects on normal tissues.

2. Task B: Development of "consensus guidelines" for heating tumors in different anatomic sites

a. Determine the information that should be obtained for each item of equipment and for its use in each anatomic site.

b. Design data collection and reporting forms.

c. Recommend and establish (implementing) quality control procedures.

3. Equipment

a. The offeror shall propose the use of not less than two different types of heat generating systems and not less than two different thermometry systems suitable for use with each heat generating system.

b. The offeror shall have one heat and thermometry system on site and operational by Sept. 30, 1981. The offeror shall have additional heat and thermometry systems on site and operational by March 31, 1982.

c. Heat generating systems shall be capable of heating effectively to 45°C at midplane body depth.

4. Patient requirement

The contractor shall accrue a minimum of 40 eligible patients per year for a five year period.

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

RFP 200-81-0612 (P)

Title: *Benign breast disease review for the Cancer & Steroid Hormone (CASH) Study*

Deadline: *March 13*

The Center for Disease Control proposes to negotiate a contract for a CASH study on the effect of oral contraceptive use on the risk of breast cancer. The purpose of the proposed contract is to obtain a panel of three expert pathologists to perform a histologic review of benign breast disease.

RFP 200-81-0615 (P)

Title: *Endometrial cancer review for the Cancer & Steroid Hormone (CASH) Study*

Deadline: *March 18*

The Center for Disease Control proposes to negotiate a contract for a CASH study for endometrial cancer review. The purpose of the proposed contract is to obtain a panel of three expert pathologists to perform a histologic review of endometrial cancer.

RFP 200-81-0614 (P)

Title: *Ovarian cancer review for the Cancer & Steroid Hormone (CASH) Study*

Deadline: *March 16*

The Center for Disease Control proposes to negotiate a contract for a CASH study for ovarian cancer review. The purpose of the proposed contract is to obtain a panel of three expert pathologists to perform a histologic review of ovarian cancer.

For above 3 RFPs: Contracting Officer, PGO
Center for Disease Control
255 E. Paces Ferry Rd. NE
Atlanta, Ga. 30305

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.