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DCT BOARD APPROVES NEW TASK ORDERS FOR BRMP CLINICAL TRIALS, HOLDS UP ON ADDITIONAL GRANTS

The Board of Scientific Counselors for NCI's Div. of Cancer Treatment last week approved (but not without argument) the concept of new clinical trials task orders for the Biological Response Modifiers

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In Brief

BRANDT NAMED TO HEALTH POSITION; EVERETT KOOP WOULD BE SURGEON GENERAL IN HHS REORGANIZATION

ASSISTANT SECRETARY for health in the Dept. of Health & Human Services will be Edward Brandt Jr., vice chancellor for health affairs at the Univ. of Texas. His tenure in that position will be short, if a reorganization plan being drawn up by the Administration is approved. That would move Brandt up to undersecretary of health. The Administration has nominated C. Everett Koop, surgeon in chief at Children's Hospital of Philadelphia, as Brandt's deputy. If the reorganization is approved, Koop would become assistant secretary for health and surgeon general . . . . **STAFF CHANGES** in NCI's Div. of Cancer Treatment include: **BRUCE CHABNER's** appointment as director of the intramural Clinical Oncology Program and deputy clinical director of the institute has been made permanent. **JOHN MARTIN** was recruited from FDA's Bureau of Biologics to become chief of the Biological Resources Branch in the Biological Response Modifiers Program. **SUE HUBBARD** has been named chief of the Scientific Information Branch, a new unit in the DCT director's office which among other duties will include publication of *Cancer Treatment Reports.* **JOE MAYO** is the chief of the Animal Genetics & Production Branch in the Developmental Therapeutics Program. **MORESHWAR NADKARNI** is chief of the Extramural Research & Resources Branch in DTP. . . . **NCI'S AUTHORITY** to hire up to 200 experts for terms up to two years without being subject to civil service procedures was reaffirmed when the institute was granted exemption of that authority from the Administration's hiring freeze. That authority was spelled out in the National Cancer Act, and previous administrations have not attempted to bring it under hiring freezes; it appeared for a while that the Reagan Administration would try to do so. The present freeze probably will not apply to Senior Executive Service positions, although HHS Secretary Richard Schweiker is requiring that all those appointments have his approval. NCI Director Vincent DeVita is preparing to submit to Schweiker his selections for the four vacant division director positions and his own deputy. . . . **LAURENCE BAKER**, associate chairman and professor in the Wayne State Univ. Dept. of Oncology, has been named deputy director of the Comprehensive Cancer Center of Metropolitan Detroit.

DCT BOARD APPROVES CONCEPT OF NEW BRMP CONTRACTS—IF MONEY IS THERE

(Continued from page 1)

Program; withheld until June concept approval of RFAs for grants totaling $4.5 million; approved three program announcements for grants; and approved, with some modifications, BRMP staff proposals for $1.5 million in contract supported projects.

The proposed initiatives follow up recommendations of the Board's Biological Response Modifiers Subcommittee which in its 1979 report listed 38 high priority projects. Of the projects approved last week, only the clinical trials task orders are assured of funding, with an estimated total of $1.75million in 1981 fiscal year money. The grants which would be generated by the RFAs and program announcements would be supported with FY 1982 funding. The contracts are intended for 1981 funding but only if additional money can be found for them—they are not in the current DCT budget.

BRMP Director Robert Oldham presented the proposals to the Board. He immediately ran into objections over certain aspects of the task orders, which will be competed among the 27 institutions which competed successfully last year for master contracts for clinical evaluation of BRMs.

Those 27 institutions are UCLA, Univ. of California (San Diego), Univ. of Cincinnati, Dartmouth Univ., Duke Univ., Fox Chase Cancer Center, Fred Hutchinson Cancer Research Center, Georgetown Univ., George Washington Univ., Hahnemann Medical School, Illinois Cancer Council, Institute de Cancerologie (France), Mayo Clinic, Univ. of Minnesota, Northern California Cancer Program, Ohio State Univ., Ontario Cancer Institute, Univ. of Pittsburgh, Roswell Park Memorial Institute, Sidney Farber Cancer Institute, Sloan-Kettering Institute, Univ. of Southern California, Temple Univ. (Southeastern Study Group), Univ. of Texas (M.D. Anderson), Vanderbilt Univ., Wayne State Univ., and Wisconsin Univ.

Note: Cost estimates listed for the task orders and RFPs are staff estimates only and should not influence development of proposals. Those planning to participate in the competition should await announcement of the availability of the RFPs before formulating their proposals. Announcement of the availability of the RFPs will appear in *The Cancer Letter*. NCI staff descriptions of the projects and discussion of the concepts by the Board of Scientific Counselors are presented here to alert those interested in the impending announcements.

The proposed task orders for phase 1/2 clinical evaluation of biological response modifiers are:

Use of monoclonal anti T-cell antibody in T-cell malignancies. Immunoabsorbants for antigen and for antigen antibody complexes are to be considered for support under this task order. Cost estimate: $500,000.

"I'm not sure there are enough patients with T-cell malignancies at all the institutions (on the master contract list) for a $500,000 study," Board member Sydney Salmon commented.

"My impression is that there are enough patients with T-cell malignancies," Board member Paul Marks said. "Syd says there aren't. Who is right?"

"You are," Oldham responded.

"We're discussing the concept, not whether there are enough patients," Board Chairman Samuel Hellman said. "We'll find that out when the responses come in."

Oldham said the study would require at least 30 patients in each of two institutions. "We don't really know what this will cost. No one has ever advertised before for a monoclonal T-cell study."

"The principle is very important," Board member Sharon Murphy said. "We shouldn't focus on the cost."

The Board approved this task order unanimously, but limited the study to monoclonal antibodies.

Investigate lymphokines in the treatment of human cancer. Clinical trials to investigate the toxicity and dose of specific lymphokines are proposed. Cost estimate: $500,000.

Salmon suggested that "the probability is good someone will soon have a recombinant that will be a lot cheaper. The questions here are: Is it feasible? Is this the best way to expend our dollars?"

"That's the advantage of a task order," said Cancer Therapy Evaluation Program Director John MacDonald. "We can switch back and forth quickly."

Oldham noted that investigators participating in this study must have a lymphokine with an IND. "In fact, all of our trials must use agents which have an IND from (FDA's) Bureau of Biologics."

Salmon commented that standardization was necessary for agents used at several institutions, and the requirement for INDs "answers many of our concerns."

The project was approved with one abstention and one vote against, by Theodore Phillips.

Use of purified microbial adjuvants in the treatment of cancer. Proposals utilizing MDP, BCG cell wall skeleton and other purified components of BCG as well as other purified microbial adjuvants such as endotoxin and nocardia rubra cell wall skeleton for therapy will be considered. Selective delivery by liposomes will be considered as an option in this clinical trial. Cost estimate: $500,000.

Approved with little discussion and one abstention.

Study immunopharmacologic manipulation of suppressor cell function in patients with cancer. Cimetidine, prostaglandin inhibitors and/or antisera specific for suppressor cells can be considered as potential agents for a clinical trial as antisuppressor cell substances. Cost estimate: $250,000.

When Hellman first called for the vote on this project, he received only seven in favor, with six absten-

tions. "I'm unhappy with this," Hellman said. "I don't understand why there are so many abstaining. Why do you not exercise your mandate? I would feel more comfortable voting this down than with all the abstentions."

"We always have difficulty with some concepts," Salmon said.

"We have so little in depth information," Board member Walter Lawrence said. "Also, I don't think this followed the specific recommendation of the subcommittee."

Enrico Mihich, who chaired the BRMP Subcommittee, said he felt it was too soon for this test to be made with humans. "However, I can't vote against this because that would be interpreted as opposing a committee recommendation."

Board member Alexander Fefer suggested the problem for some members was that "we usually do concept reviews from something in a book (prepared by NCI staff). The subcommittee did not say, do this first, do that second. We felt that someone like Bob (Oldham) with his expertise would work out the details and sequence. I don't agree personally with this plan but would vote for it."

Board member Philip DiSaia said, "A phase 1 study in humans is worth while. The animal does not always tell us what works in humans."

"Phase 1 studies are for toxicity," Board member Gertrude Elion said. "You need phase 2 studies to know if it works."

DiSaia pointed out that the proposed study included phase 2.

When Hellman suggested that a more detailed presentation could be made to the Board at its June meeting and that "we're doing this now for a quick turnaround," the Board voted again, this time eight supporting the proposal, four abstaining and Elion against it.

Oldham did not ask for concept approval now for the RFAs but only for a general feeling of the Board toward them. They are:

Monoclonal antibody in the therapy of human cancer.
It is proposed that studies be initiated to evaluate the efficacy of monoclonal antibody alone or as a carrier of toxins, drugs, or isotopes in the treatment of specific human cancer where antigens or monoclonal antibodies have been identified or are in the process of being identified. $1.5 million.

Use of monoclonal antibody in cancer therapy.
Monoclonal antibody is proposed for use alone or as a carrier of toxins, drugs or isotopes in the treatment of experimental animals bearing cancer. Developmental studies into the localization, specificity and therapeutic activity of antibody or antibodies as carriers will be investigated in animal tumor models. $750,000.

Isolation, purification and characterization of tumor associated antigens with monoclonal antibody.
This RFA will support research in the use of monoclonal antibody as a specific reagent to isolate, purify and characterize specific human tumor associated antigens. $750,000.

Use of sensitized T-cell lines in adoptive immunotherapy.
Cultured T-cells grown as tissue culture lines with specificity for tumor associated antigens will be investigated as a therapeutic approach in the adoptive immunotherapy of experimental cancers in animal models. Attention to the identification of the effector cell subpopulation involved will be encouraged. $400,000.

Therapeutic approaches to lymphokine dependent lymphoid malignancies.
This RFA will support research on the effects of exogenously administered lymphokines or inhibitors of lymphokine production on in vivo and/or in vitro growth of lymphoid malignancies. Clinical and Experimental. $150,000.

Therapeutic efficacy of regulation of class of immune response by administering specific lymphokines, cells producing lymphokines or inhibitors of lymphokines.
This RFA will examine the influence on antitumor immunity regulation of the class of the immune response using various immune manipulations. $250,000.

Therapeutic efficacy of adoptively transferred lymphoid subpopulations in tumor bearing hosts.
This RFA will support research aimed at defining the capacity of T-cell subsets, NK cells and B cells, either alone or as mixtures, in the therapy of experimental tumors in normal mice or selectively immune impaired mice. $250,000.

Immunogenicity of macrophage processed tumor antigens.
This RFA will support studies on enhancing tumor immunogenicity by associating tumor antigens with cell surface constituents, especially H-2 and Ia antigens, present on macrophages. Various techniques including cell fusion will be considered. $150,000.

Therapeutic efficacy and mode of action of allioimmunization in tumor bearing hosts.
This RFA will support research based on in vivo and in vitro evidence that allioimmunization may either specifically or nonspecifically lead to in vivo and in vitro induction of an antitumor immune response. $150,000.

Definition of organ specific antigens expressed on tumors of nonvital organs, and development of autoimmune responses against these antigens.
This RFA will explore the therapeutic efficacy of induced autoimmunity specific for nonvital organs, e.g. thyroid, pancreas, breast, prostate and uterus in the immune elimination of tumors derived from these organs. $200,000.

The dollar figures assigned to RFAs are the amounts which would be set aside specifically to fund grants responding to the respective request for application. If a sufficient number of applications score well enough in peer review, the entire amount could be used to support those grants. NCI would not be committed to use that money for grants which do not "meet the payline" established for R01s; however, quality grants in areas deemed in need of stimulation probably would be funded even if they were above the payline.

Program announcements do not carry with them any dollar commitments, and applications responding to them must compete in the regular R01 pool.

Marks questioned the need for an RFA to stimulate work on the isolation and purification of tumor antigens. "That's already one of the hottest areas," he said. "This should be supported through R01s."

"Any of these could be program announcements," Oldham agreed. "We intended to create an emphasis

on those areas. If the Board feels there is enough R01 support, okay. But we want to look for an emphasis on therapy."

"No one in his right mind would think of this without an application to either detection or therapy," Marks said. "My impression is that it is an intensely competitive area, in academia and the private sector."

"There aren't many existing grants in these areas now, but there are a lot of applications in and being reviewed," Oldham said.

"Some of these are reasonable for RFAs but could be a little more targeted," Salmon said.

We don't know what applications are pending," Mihich said, "but the subcommittee looked at the field and concluded that the isolation, purification and characterization of tumor antigens should have top priority."

"By June, you will know how many grants have come on and may not need RFAs in all these areas," Salmon commented.

Hellman did not ask for a vote on the RFAs.

The three proposed program announcements were approved with little discussion. They are:

Genetically engineered cell products as biological response modifiers. This announcement will support diverse approaches into the use of genetic engineering to transpose genes coding for BRMs such as interferons, lymphokines, growth factors and other gene products into E. coli for a large scale production, isolation, purification and characterization of these factors as BRMs.

Development of cell lines producing lymphokines and cytokines with effects as BRMs. This announcement will encourage research in the development of such cell lines and the development of methods to isolate, purify and characterize the various products of these cell lines. These products may have a potential long-term usefulness in the treatment of cancer and/or in the alteration of biological responses important in the course of cancer.

The effect of growth factors and monoclonal antibody to growth factors on the growth and metastasis of cancer in animal tumor models.

Oldham asked for concept approval of the RFPs so that if money becomes available, "we can move quickly on them." They are:

Support services for review and evaluation of Biological Response Modifiers.

This contract is designed to provide for the efficient review and quality assurance of information submitted to the Biological Resources Branch of the BRMP. The contractor will be required to provide management services in the organization of peer review committees, workshops and site visits; to assess compliance with good laboratory and good manufacturing practices, institutional review, and adherence to protocol design; to provide knowledgeable reviews and summaries of activities of various BRMs; to provide secretarial and administrative support; and to work with the project officer in providing a consultative service to investigators regarding the rational development of safe and effective BRMs for clinical therapy. $250,000.

Support services for collection, storage and quality assurance and distribution of biological response modifiers.

In addition to supplying BRMs to interested investigators, this contract will provide laboratory support services for performing limited specific tasks relating to quality assurance, toxicity and biological activity of BRMs. Information derived from this contract will assist the Biological Resources Branch in its evaluation of BRMs for possible inclusion in the formal BRM screening program and in determining priorities in the distribution of various BRMs to qualified investigators according to specific areas of scientific expertise. $200,000.

Chemical coupling of cytotoxic agents to tumor reactive monoclonal antibody.

A contract is proposed to solicit contractors with the chemical expertise required to couple cytotoxic agents to monoclonal antibody. Examples of cytotoxic agents include ricin, diptheria toxin, chemotherapeutic drugs, and radioisotopes. The monoclonal antibody will be provided by the BRMP. This task order will enable comparisons of various proposed approaches at enhancing the in vivo efficacy of monoclonal tumor reactive antibody through chemical coupling to cytotoxic agents. It is anticipated that 2-3 monoclonal antibody preparations will be coupled with up to six types of cytotoxic agents during the first year. $250,000.

Production of human lymphokines and cytokines and assessment of purity and toxicity.

This contract will be used to obtain various lymphokines and cytokines of human origin, purification and partial characterization. Included in this contract will be immune interferon, interleukin I, interleukin II, T-cell derived suppressor factors and helper factors, lymphotoxin, migration inhibition factor, etc. Consideration will be given to factors produced by recombinant DNA technology. $500,000.

Efficacy and toxicity of in vivo administered monoclonal antibody reactive with human tumor xenografts in athymic nude mice.

This contract will study in vivo localization, half-life, therapeutic efficacy and toxicity of in vivo administered monoclonal antibody. Antibody preparations coupled to various cytotoxic agents will be used. $100,000.

Studies on the immunogenicity of human cytokines in the mouse and the production of hybridomas secreting antibodies reactive specifically with the cytokine.

This contract will provide for the production of antibodies specific for various cytokines, analysis of the cytokine function and efficient purification methods. $100,000.

Effect of monoclonal tumor reactive antibody on bone marrow stem cells.

This RFP will support studies capable of determining if various tumor reactive monoclonal antibodies can be used to eliminate contaminating tumor cells present in human bone marrow without impairing the regenerative capacity of the bone marrow using available clonogenic assays of stem cells and of tumor cells. $100,000.

The Board disapproved the proposal to study monoclonal antibodies against human tumor xenografts in nude mice. "If it is worth doing, it is worth doing well," Mihich said, "and that is not enough money."

Salmon called the proposal redundant, in that the BRMP screening effort for potentially useful agents uses at least one similar model. Also, "you are going to be using it in clinical trials, which is one step beyond the proposal."

Mihich asked that the $100,000 earmarked for the rejected RFP be added to the bone marrow stem cell testing proposal, making that an estimated $200,000 project. The Board agreed, but with reservations.

"The last three bother me," Phillips said. "They are really research. They belong either with inhouse research or in RFAs. It's a bad way to use contracts. It is using contracts to support basic research."

"This could be considered a support contract for things coming into clinical trial," Salmon argued. "I view this as quality control."

"I tend to agree with Ted," Marks said. "This is an area being investigated in several laboratories, and $200,000 would moderately support one lab."

"This should be a task order," Salmon agreed. "There are a dozen places doing this kind of work. Let's give this contract to one of them."

The Board approved the RFP with the provision it be awarded as a task order.

In the discussion on the collection of BRMs and their distribution to investigators, Oldham said, "We can't get into the position that the Viral Oncology Program did in providing huge amounts to selected investigators on a long term basis." BRMs will be distributed in smaller amounts, on a broader basis, he said.

"I agree with that," Mihich said. "However, you should take into consideration peer review assessment of the request. It should be scientifically sound."

"I would rather see the request in a letter, from a grantee working in a relevant area, rather than a grant application for a small amount of biologicals," Salmon said.

"Some can be very dear," Mihich said.

"It should be on a case by case basis," Salmon answered.

"Bob has the message," Hellman said. "Distribution should be based on some evaluation."

Oldham reminded the Board that the $1.5 million needed to fund the RFPs is not yet available in the DCT budget. "I will take your approval of the concepts to the powers that be and say, 'This is what the Board has approved. We need the money.' "

"Lots of luck," Hellman said.

CROS FUNDING DEBATED AS DEVITA SUGGESTS ITS ROLE HAS DIMINISHED

The Committee for Radiation Oncology Studies was established in 1963 and funded by NCI as an advisory body to the institute, the radiation therapy community and various government agencies.

"We are a self governing, self appointed, self announted group," CROS Chairman William Powers said when he appeared at last week's meeting of the Div. of Cancer Treatment Board of Scientific Counselors to plea for continued support of the committee.

NCI Director Vincent DeVita had notified CROS that it would not be funded when its grant expires this year. "I regret that because of budget constrictions it is necessary to get into these kinds of discussions," DeVita said at the Board meeting. The issue is not one of eliminating bad programs "but a question of good, better and best," DeVita said. "There is no question of the value of CROS activities over the years."

The CROS grant amounts to $176,000 a year, and DeVita said that with indirect costs, the cost is $238,000. Powers disputed the higher figure, insisting the total is $176,000.

CROS consists of 15 "leading physicians and scientists, working together to improve radiation therapy, radiation biology, radiation therapy physics and oncology sciences concerned with oncology imaging," Powers said. It is presently operated through the Comprehensive Cancer Center of Metropolitan Detroit and the American College of Radiology. "It is dedicated to the improvement of the quality of radiation therapy practice and research, and the quality of cancer care throughout the country."

CROS initiates and, with other groups, plans and operates multidisciplinary workshops and state of the art meetings on appropriate topics. Workshops, publications and other activities of the group have played an important role in development of radiation therapy and in upgrading NCI's radiation oncology activities, DeVita acknowledged.

Current and past CROS members are a Who's Who of the field. Current members in addition to Powers are Luther Brady, G. Stephen Brown, James Cox, James Eltringham, Eric Hall, Samuel Hellman, David Hussey, C. Ronald Koons, Seymour Levitt, Carlos Perez, Philip Rubin, Herman Suit, Gordon Whitmore, and Peter Wootton. Past members are Malcolm Bagshaw, Fernando Bloedorn, Max Boone, Juan Del Regato, Gilbert Fletcher, Milton Friedman, Manuel Garcia, Frank Hendrickson, Henry Kaplan, Morton Kligerman, Simon Kramer, Isadore Lampe, Howard Latourette, Victor Marcial, Rodney Million, William Moss, Eslyrt Murphy, James Nickson, Robert Parker, Theodore Phillips, Robert Robbins, J. Robert Stewart, Norah Tapley, Jerome Vaeth, Richard Walton, Thomas Watson, and Rodney Withers.

Hellman is chairman of the DCT Board and Perez and Phillips are members.

Powers said that a majority of the former and current members he contacted support continuation of the committee.

Brady and Whitmore appeared at the Board meeting to defend renewal of the grant. "No other group or society can address directly the problems and needs as effectively as CROS," Brady said. "CROS activities have had a major and dramatic impact on improving the quality of radiation therapy."

Whitmore, a Canadian, acknowledged the "gener-

ous opportunities for collaboration in medicine and research which the United States offers to Canadians. It is something unique to the United States."

Whitmore then made a strategic error when he suggested that without CROS, NCI radiation oncology programs would be "centrally directed from Washington" and drew an analogy with the totalitarian governments of Eastern Europe.

DeVita was visibly angered. "I want to say to you, Dr. Whitmore, that your comments on centralization were unpleasant, unnecessary and untrue. The analogy to Eastern European governments is untrue. Your comments do not make it easier to discuss this situation."

DeVita noted that research supported by NCI and NIH is carried out entirely with the advice of advisory groups, review committees and boards of scientific counselors. Those advisors are broadly representative of the scientific community. "It was only through the intercession of this Board that we were able to support development of neutron generators, despite the fact that there were only four radiotherapists on the Board," DeVita said.

DeVita said that when DCT started building its radiotherapy staff, "we debated the role of CROS and agreed, I thought, that the need for CROS would diminish when we reached the point where we are now. Some CROS activities are not our direct responsibility. Some staff members felt at the last cycle that we do not need CROS. I interceded with Arthur Upton (then NCI director; DeVita was DCT director) and asked for one more cycle."

DeVita said he would take responsibility for the letter sent by NCI to CROS to the effect that it would not be necessary to apply for renewal, since NCI did not intend to continue funding.

Powers had suggested that not only should CROS be continued but that similar committees should be established for medical, surgical, and pediatric oncology.

"It is unnecessary and probably would not be useful to have committees for pediatrics, medical and surgical oncology beyond what we already have," DeVita said. "I submit again, Dr. Powers, that had this Board and staff been here 16 years ago, we would not have needed CROS."

Board member Sydney Salmon backed DeVita. "His comments seem reasonable. I have supported radiotherapy in the past, but I personally give my support to the NCI director on this. Dr. Whitmore's comments are absolutely incorrect. Our discussions the last two days make crystal clear this Board can criticize, can make overt decisions, can change directions of programs."

DeVita said that although he suggested the grant application not be submitted, "anyone can submit a grant. The issue would come to a head if it receives a priority score below the pay line. We would have to make the decision then, at which time I will make the recommendation that it not be funded despite the score."

Perez acknowledged that "I am not unbiased. But we're talking about different roles. CROS dealt with a number of issues we (the DCT Board) never will address. I urge the Board to consider the merits of CROS and support it."

"I second what Syd Salmon said," Board member Enrico Mihich commented. "With a Board like this . . . interacting with an intelligent, imaginative NCI staff, there may not be the need for continuing CROS." Mihich admitted that there might be an analogy for the Board's Subcommittee on Biological Response Modifiers, which he chairs. "I feel we could have a need for continuing that committee."

Board member Walter Lawrence said, "Having seen the Board committee and how it works, I am confused. I don't see the relationships between the Board Committee on Radiotherapy and CROS."

"The committees overlap," DeVita said. "CROS to this date does not have the access to (NCI's) budget that the Board subcommittee has. The time has come to merge, and there are ways to merge."

"CROS has made an important contribution," Phillips said. "As a radiotherapist, I would support going on with it. But as a Board member, I have some question. The meetings, guideline development, research planning—there are other ways to do it. It's the job of ASTR and ACR to develop practice guidelines."

"We're suggesting activities for other organizations to do what CROS does," Perez said. "They would have to request grant support, too."

"Professional societies have the obligation to mandate professional standards," Board member Sharon Murphy said. "The radiotherapy community seems to be so well organized. I'm sure it can keep those activities going. I question the need for DCT to continue funding this."

DeVita suggested that workshops could be supported with conference grants. "There wouldn't be as abrupt a change as you might think."

DeVita backed down somewhat from his adamant stand against continued funding. "I will submit to whatever you advise," he told the Board. He added, "This is an appropriate issue to be discussed by the National Cancer Advisory Board."

Hellman did not call for a vote, and it is likely the issue will be referred to the NCAB.

NCI STILL FUNDING CONSTRUCTION GRANTS DESPITE DRASTIC BUDGET CUT

NCI's budget for construction grants is "only" $1 million in the 1981 fiscal year and also "only" $1 million in the 1982 budget request. Construction thus has suffered the most severe cutback of any NCI supported program—down more than 90 percent

from the $11 million the program received in 1980.

However, $1 million is still a lot of money, and Donald Fox, chief of NCI's Research Facilities Branch, points out that the program is still alive, if not as well as it once was. "We're still receiving, reviewing and awarding construction grants," Fox told *The Cancer Letter.*

Eight applications have been received and are being reviewed this year, with several requests in the $400-750,000 range. Considering that review will pare down those requests, Fox expects to be able to fund as many as four or five. Funding 50 percent or more of grants received is not a bad percentage, as things stand now with NCI and NIH budgets.

There is an outside chance that Fox might be able to do even better than that. Sometimes near the end of the fiscal year, when NCI has a few dollars still unexpended and stands to lose them if not committed prior to Sept. 30, institute executives look around for worthy projects which require only one year, one time funding, with no recurring obligation. That fits construction grants precisely, and Fox picked up an extra $500,000 that way in FY 1980.

The fact that only eight applications have been submitted in FY 1981 probably is due to the drastic cut in the construction budget. Feeling there was little chance of being funded, many institutions did not bother drawing up applications.

NCI is still accepting and reviewing applications for support of new construction as well as for renovation, although renovation grants might have a better chance of being funded because they usually are smaller. Not much new construction can be squeezed out of $1 million.

Grants for biohazard and chemical carcinogenesis containment construction, and for upgrading of animal facilities, probably will fare better in review than those for other types of construction, although other types are not being ruled out.

Applications are reviewed by an ad hoc construction grant review committee, chaired now by George Bryan of the Univ. of Wisconsin Comprehensive Cancer Center.

The history of NCI construction grant support has been a contentious one despite its brilliant record. Since the National Cancer Act of 1971 spelled out NCI's authority to award construction grants and stimulated a major surge in that support (NCI supported extramural construction before then), every President since has tried to kill or cut back on that activity. Construction of research facilities has never had much support from the White House.

Until about three years ago, construction grants were awarded on a 75-25 matching fund basis, with NCI putting up the largest share. The National Cancer Advisory Board cut that back to 50-50 when money started getting tight in an effort to spread it around. However, the matching portion was not really affected—local support in almost every case exceeded the required amount, and estimates have been made that for every dollar awarded by NCI, local sources have raised three dollars to support construction projects.

The NCAB two years ago conducted a survey of construction needs for the succeeding five years and found that estimates ranged upwards of $300 million. These were needs cited by center directors to upgrade animal facilities and improve biohazard and chemical carcinogenesis containment—to meet standards imposed by the federal government—as well as for improved or expanded clinical and lab research facilities. In some instances, improvements were badly needed to meet local and state building codes.

The NCAB Subcommittee on Construction took that figure, reduced it substantially on the assumption that that is what peer review would do, and then cut it in half again to represent NCI's share. The result: A total of $150 million would be required from NCI over the five years. The subcommittee proposed $50 million in the next fiscal year, and $25 million each year for four more years.

The full NCAB went along with only $25 million a year for five years, but directed that this be considered a program of the highest priority, and that if Congress did not put that amount into each appropriations bill for construction, the NCI director should reprogram money from other areas.

Neither former Director Arthur Upton nor present Director Vincent DeVita has even come close to that figure, however.

DeVita said recently that he has tried very hard to meet the NCAB mandate, and, in fact, his initial budget requests have included as much as $20 million for construction grants. The 1982 bypass budget, which goes directly to the White House without intervention by NIH or HHS headquarters, had $21 million for construction grants.

The bypass budget is not the one which the Administration uses in determining NCI's share of the President's budget request. The real budget is worked over by the various levels, up to and including the White House Office of Management & Budget. All of those offices get in their licks against construction. Although DeVita would not be specific as to the real culprit, OMB is the most likely in that role.

Congress could alleviate the situation by setting forth in the appropriations committee reports certain amounts for construction. While that does not carry as much force as a line item, agencies usually try to follow directions expressed in the reports. In one of the Nixon years, a Senate report demanded that a certain amount of money be available for construction. OMB ignored that and ordered NCI not to spend that much, but backed down in the face of severe pressure.

Until Congress changes the situation or until the

Administration develops a friendlier attitude toward construction, the construction backlog will grow larger. Meanwhile, Fox urges those with construction needs to submit applications. Some of them will be funded. He may be contacted at:

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Blair Bldg Rm 3A07
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LIVELY ARIZONA CONFERENCE MATCHES FREIREICH VS. MOERTEL ONCE AGAIN

The biennial International Conference on the Adjuvant Therapy of Cancer sponsored by the Univ. of Arizona Cancer Center was initiated only four years ago but has already developed into one of the liveliest and most important meetings of its kind.

Cochairmen Sydney Salmon and Stephen Jones have lined up another top flight program for the conference March 18-21 in Tucson. Once again, it will feature head to head confrontations between Emil (Jay) Freireich and Charles Moertel, whose battles over the issues of randomization and historical vs. concurrent controls have been classics.

Moertel will deliver a special lecture in the first session of the meeting, titled "How to Succeed in Adjuvant Trials Without Really Trying." His lecture will follow a discussion by Freireich on "Informed Consent vs. Pre-Randomization." The two are included in a final panel discussion on the last day of the conference along with Salmon, Jones, Donald Morton, Lawrence Einhorn, Eli Glatstein, Vincent DeVita, and Trevor Powles.

DeVita will chair the opening session, on biology and therapeutic approaches to adjuvant therapy of cancer. Other sessions will be chaired by Saul Rosenberg, on hematologic malignancies; Einhorn, on gynecological cancer and genitourinary tumors; David Alberts, on head and neck cancer; Bernard Fisher, Powles, and Gianni Bonadonna on breast cancer (three sessions); and Moertel, on gastrointestinal tumors.

For registration information, contact Cancer Center, Arizona Health Sciences Center, Tucson 85724.

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-17389-26

Title: *Therapy of patients with early stage colon & rectal cancer*

Deadline: *April 13*

The Cancer Therapy Evaluation Program, Div. of Cancer Treatment, NCI, by means of a group of clinical contracts, desires to continue its studies of early stage colon and rectal cancer. Successful offerors shall engage in the development and validation of therapies of early stage colon and rectal cancer.

Studies shall at a minimum examine the role of multimodality therapy treatment of early stages of disease. Investigators may participate in pilot studies which may contribute to the formulation of group-wide studies. Upon completion of current studies, contracting parties shall participate in the scientific analyses of the terminated studies, and, in addition, shall participate in the formulation of subsequent trials consistent with the prescribed goals of the group.

Successful competitors who intend to utilize satellite institutions (other organizations affiliated with contracting institutions) shall demonstrate that these have close and continuing scientific exchange with the contracting institution, and that there shall exist adequate facilities for diagnosis, treatment, followup and data retrieval.

A minimum number of 32 fully resected Duke's B and C stage disease patients shall be accrued during each of the first three years of the anticipated five years of these contracts. Twenty of the required 32 patients during each year shall be patients with colon cancer and 12 of the required 32 patients during each year shall be patients with rectal cancer.

It is anticipated that multiple awards will be made as a result of this RFP and that incrementally funded contracts will be awarded for a period of five years, one month. This RFP represents a recompetition of the program, "Therapy of patients with large bowel carcinoma."

Contract Specialist: Carolyn Swift
Cancer Treatment
301-427-8737

NCI CONTRACT AWARDS

Title: Iso antigenic typing of mouse strains
Contractor: Northwestern Univ., $108,320.

The Cancer Letter _Editor Jerry D. Boyd

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