THE CANCER LETTER

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NCAB SUBCOMMITTEE CALLS FOR REVIEW OF ORGAN SITE PROGRAM, CONSIDERATION OF ONE FOR LUNG CANCER

The National Cancer Advisory Board Subcommittee on Organ Site Programs has called for an in depth review of the four programs and will recommend that the NCAB reaffirm its support for the concept and consider establishing others, specifically one for lung and upper respiratory tract cancers.

(Continued to page 2)

In Brief

NCAB WILL CONSIDER HOLDING "CIRCUIT RIDER" MEETINGS; KAPLAN ASKED TO SPEAK ON HYBRIDOMAS

NATIONAL CANCER Advisory Board will consider scheduling a number of extra meetings to be held at various locations around the U.S. Purpose will be to give more individuals a chance to present new research ideas to the Board or to discuss with Board members problems they feel need special attention. Board member Sheldon Samuels made the suggestion of "circuit riding" meetings in response to increasing number of requests to appear at regular Board meetings. The NCAB Subcommittee on Activities & Agenda will consider the suggestion when it meets in August. . . . **NORMAN ANDERSON**, Argonne National Laboratory, will discuss his "human protein index" research at the NCAB meeting this month. He is scheduled for 1:30 p.m. May 18. Other items on the May 18-20 agenda include foreign research, by NCI Associate Director for International Affairs Gregory O'Conor; construction grants, by Donald Fox, chief of the Research Facilities Branch; a further presentation on NCI contracting procedures by Director Vincent DeVita; and various subcommittee reports. . . . **HENRY KAPLAN** will be invited by the NCAB to speak on human hybridomas at its October meeting. **RICHARD STECKEL**, president of the Assn. of American Cancer Institutes, and **HERBERT KERMAN**, president of the Assn. of Community Cancer Centers, will be invited to the Board's November meeting to participate in its program review. . . . **NEW FDA** commissioner will be Arthur Hayes Jr., chief of clinical pharmacology at Hershey Medical Center. His specialty is hypertension and heart disease. . . . **UCLA'S JONSSON** Comprehensive Cancer Center formally dedicated its new 86,475 square foot laboratory and clinic last month. Financed by an NCI construction grant and private donations, the facilities are located within the Louis Factor Health Sciences Building. They include two floors for the Bowyer and John Wayne Cancer Research Clinics, four additional floors for cancer research laboratories, and another floor housing core biocontainment labs. Cancer research beds are located within the adjacent UCLA Center for Health Sciences which can be reached through bridge connections.

SUBCOMMITTEE REAFFIRMS ORGAN SITE SUPPORT, ASKS FOR IN DEPTH REVIEW

(Continued from page 1)

Organ Site Program participants have felt they were under siege for the past year, since NCI Director Vincent DeVita suggested that the time may have arrived for phasing out some of the programs and then followed by trimming the program's budget.

The NCAB last year reaffirmed its support of the concept under which the four programs operate. The National Prostatic Cancer Task Force, National Bladder Cancer Project, National Large Bowel Cancer Project, and National Pancreatic Cancer Project each has its own headquarters at a university or research institution, headed by a chairman and supported by a headquarters grant. Each receives investigator initiated grant applications and reviews them with their own review committees, with subsequent review by the NCAB.

The FY 1980 budget for the four programs was $17.6 million, but that was cut to $15.8 million for 1981, and then again to $15.3 million when the rescision was applied.

The Breast Cancer Task Force is not part of the Organ Site Program but was also included in DeVita's suggestion that it is one which has succeeded in stimulating its field and therefore might be a candidate for termination.

William Powers, chairman of the NCAB Subcommittee on Organ Site Programs, asked DeVita what sort of advice he was seeking from the Board. DeVita's response, in a letter to Powers:

"After we knew the budget was flat in 1981, the whole debate on the future of the organ site program was based on the premise that if each project was initiated to stimulate research in a field, then the endpoint, stimulation, should be easy to recognize. Perhaps adequate stimulation could serve as the trigger for the phasing out of an organ site program. That's why I used the example of the Breast Cancer Task Force, a program which I regard as having been highly successful and, thus, having 'stimulated the field.' We pose the question that this program might be phased into the regular programs of the Institute.

"The debate ended, it seems to me, on the note that stimulation of the field was not necessarily the endpoint; rather, a significant impact on the incidence and/or mortality from the disease might be a more appropriate endpoint. If this is the case, then the most successful organ site projects program should be preserved at the expense of those that are having more trouble either stimulating the field or just beginning. If, because of budget problems, no funds are available for growth of the organ site programs, one ought to decide whether there are programs at either end of the spectrum (those highly successful, those not so successful) which might be reduced or terminated to support growth of the rest of the program. That's one question that should be grappled with further by the committee.

"The second question is the issue of the review of the grants. If, in fact, organ site program grants were reviewed by the regular R01 mechanism, this would increase the dollars available to them in the competitive pool. In other words, if many grants came in as a result of announcements that emanated from organ site programs, and these grants received very good priority scores, the funding might exceed that now available to the organ site program. Of course, if this had been the case prior to the initiation of these programs, there would have been no need for them. There remains some concern that the peer review system is ready to handle specialized programs. Also, such an approach might be more successful for the more differentiated programs and not as applicable to programs that are just identifying areas to explore. Recommendations in this area would be helpful to us. The increased number of R01 grants would be useful to NCI to meet the NIH goal of 5,000 new grants/-year.

"Finally, the reason for examining these questions is that the Institute had to make priority decisions for application of its funds, and obviously the organ site program did not receive high priority for additional funds by staff or the NCAB budget subcommittee. Comments about other programs in the Institute that might be considered lower priority than the organ site programs or how to readjust the priority would be useful for us in our discussion with the subcommittee of the NCAB in May.

"These are the kinds of things that concern me when I think about the organ site program. I would be grateful for any advice the subcommittee can give to us."

The subcommittee, meeting last week, unanimously approved a set of recommendations it will make to the NCAB at its May 18-20 meeting. The recommendations were based on agreement that the rationale for the Organ Site Programs and their unique modus operandi is still as valid as when they were initiated. Recommendations were:

- The $500,000 in the rescision cut be restored.
- An in depth review be conducted by an independent ad hoc committee on the four programs to assure the NCAB of their quality and to facilitate future decisions regarding expansion or contraction of them.
- The feasibility of adding new programs be explored.

A key function of the review would be to assess the relative merits of the four programs in the event the Board decides that one or more must be reduced in scope or phased out. The subcommittee decided that one group should review all four programs to assure comparability. The ad hoc committee would

consist of six to 10 individuals, nongovernment, not associated with any of the programs, not members of the subcommittee or NCAB, half of them basic scientists. They would be appointed by NCI's Div. of Extramural Activities. Subcommittee members could attend meetings as observers but would not participate in or be present at executive sessions.

Subcommittee member Philippe Shubick questioned whether organ site funds would be kept intact if there are cutbacks among some of the programs and not distributed among other NCI programs.

"I can't answer that," Powers said.

"We've had pretty clear signals for over a year from the director that he would like to restrict if not phase out the Organ Site Programs," subcommittee member Harold Amos said. "We had a pretty good discussion, that we don't believe those programs can get into the R01 stream because of deficiencies in R01 review, and that we would like to have the programs at their old (higher) levels of funding."

Amos insisted that "feeling as we do about the Organ Site Programs, we ought to defend them strongly."

"And consider other sites," subcommittee member Robert Hickey said. "We're not doing so well in pulmonary cancer. We need to get something going there."

"We're told something has to give," Subcommittee member LaSalle Leffall commented. "Is it appropriate in this climate to talk about new programs?"

"We would be planning, not expanding. It would not be expansion to get something together, to coordinate what is already going on," Powers said.

"Organ Site Programs are a creation of and are kept alive by the Board," Amos said. "The director doesn't have to agree with us. Maybe we should come up with a statement on where the Organ Site Programs fit into the National Cancer Program, and whether any new ones exist which should be added."

Hickey asked whether the President's Cancer Panel, of which Amos is a member, could make a strong case for a budget increase to support the Organ Site Programs.

"I'm enthusiastic about some, not at all about others," Shubick said. "In some, the quality leaves a lot to be desired. Some parts are extraordinarily good, some parts extraordinarily bad. I can't agree with a blanket statement that all are good. Our position should be that we will look into the programs and consider some redistribution. We should be prepared for redistribution within the overall program."

Elimination of one or more of the programs would not save any significant amount of money, one program director pointed out.

Gilbert Friedell, director of the National Bladder Cancer Project, noted in a letter to DeVita that the pay line for grants in his group is now at a priority score of 170. NCI's R01 payline currently is about 190, so if the bladder cancer grants are dumped into the R01 pool, most would be funded.

Powers told the subcommittee that administrative costs of the four programs—for planning, review, and communications—are less than 10 percent for each. "That's very efficient administration," Hickey said.

So efficient that eliminating the headquarters grants and transferring the administrative load to NIH probably would not save any money. Thus, eliminating the programs, at least those whose grantees are competing as well as the bladder project's, would not change NCI's budget picture and would result in elimination of the multidisciplinary coordination and planning features provided by the programs.

Friedell described his group's difficulties and suggested some alternatives:

"Over the past several years we have had difficulty funding applications which on review received high priorities. We have been reluctant to curtail the scope of the research program of the NBCP as the inclusion of all aspects of research on bladder cancer appears to be one of the real strengths of our project. Through successful competition with other segments of NCI for year-end funds and through deferral of high priority projects for payment in the next fiscal year, we have made such an approach work. However, this strategy has made us particularly vulnerable to budget reductions.

"With the budget level projected for this year (FY '81), we find ourselves currently unable to pay approved competing renewal applications (Type II) with a priority as high as 170. This situation will only be compounded by the March and June review meetings of the Bladder Cancer Subcommittee, at which time at least some Type II and Type I applications can be expected to receive high priority scores. Continuation of review activity by the NBCP without more probability of funding during this fiscal year does not seem to be justified when applicants receiving comparable priorities in the R01 program would probably be funded.

"There would appear to be the following administrative alternatives which could be considered:

"1. Sufficient additional funds could be given to the Project to permit the payment of applications which receive high priorities following review by the Bladder Cancer Subcommittee, i.e., funding to permit payment at priority levels comparable to those awarded by NCI in the R01 program.

"2. Sufficient funds could be given to the Project this fiscal year to permit the payment of applications in certain categories of bladder cancer research, thus reducing the scope of the Project. All other investigators would be encouraged to submit their applications to the regular (R01) grant program of NIH.

"3. Applications of high priority following review by the Bladder Cancer Subcommittee could be placed

in competition for payment with those of other NCI grant programs.

"4. All applications recieved by the Bladder Project could be reviewed through the R01 grant program of NIH.

"Of the available alternatives, review of applications by the R01 program of NIH would appear to be the least desirable. This might well prevent our continued implementation of a coordinated multidisciplinary program. Moreover, there would be minimal saving of money. The review process of the Bladder Cancer Subcommittee has been found by the Div. of Research Grants to be comparable to that of other study sections. Thus, grants which have been awarded through our review would presumably also be awarded through other review mechanisms.

"Unless you can provide some resolution for this problem, there would appear to be no alternative available to us except to advise all investigators to submit their applications directly to the Div. of Research Grants, NIH."

DeVita's response was noncommittal, noting that the Board subcommittee would be addressing the problem.

Gerald Murphy, director of the National Prostatic Cancer Task Force, described some of its achievements in written testimony prepared for the House Health Appropriations Subcommittee. Excerpts follow:

For the first time in the history of cancer research, scientists have produced what seem to be "blocking antibodies" in mammals which deter or prohibit prostate cancer growth.

This work would not be possible if it weren't for the availability of a laboratory animal which has a useful resemblance to human beings in its prostate cancer life experience.

And before the National Cancer Institute created a National Prostatic Cancer Project under the authority of the National Cancer Act of 1971, there were no such reliable animal models for human cancer.

At Roswell Park Memorial Institute, the head office of the National Prostatic Cancer Project coordinates the research on prostate cancer that is being performed in 13 locations. These locations are Roswell Park, Tulane Univ. School of Medicine, Virginia Mason Research Center, Seattle, Univ. of Iowa Hospitals and Clinics, Walter Reed Army Medical Center, UCLA, Wayne State Univ. School of Medicine, Massachusetts General Hospital, Baylor College of Medicine, Univ. of California Medical Center, San Diego, Johns Hopkins Hospital, Univ. of Tennessee Center for Health Sciences, and Rush-Presybterian-St. Luke's Medical Center.

From the models developed in the live animals, in one called the F_1 Copenhagen x Fischer male rat, cellular immune responses have been detected, meaning that a substance is rejecting a tumor, providing protection against the surgically implanted tumor.

In test tubes, similar cellular responses have been noted. In both cases, the cells from a tissue culture called R3327, which invariably produces a tumor when put into selected live animals, have grown rapidly where there was no immunizing substance, but have grown slowly or not at all where there was an immunizing substance.

This is the beginning. The next step is to identify, purify, and test for consistency of action one or more substances which provide the detected immunity. These studies are underway. Once this is achieved in the rat, the information can be used to design parallel tests in humans.

The work is so far along that the National Prostatic Cancer Project is now distributing, on request, tumor-bearing animals to researchers all over the world, as well as the United States. The work has been refined so much that, using other animal models, researchers have come up with three tumor cell lines which produce predictable, consistent patterns of cancer metastatis. This is an important beginning to the understanding of how prostatic cancer spreads through the body.

While the work strongly indicates that there is an immunological agent, or agents, which will come out of laboratories to inhibit or reverse prostate cancer growth, the same animal models also create the possibility for finding what agents produce prostate cancer, or what processes in the human body lead to prostate cancer. Never before has there been a systematic way to test for agents causing prostate cancer even though soot was proven an agent causing cancer of the scrotum as long ago as 1750, and it has long been assumed that other substances might be causing specific cancers such as prostate cancer.

The establishment of certain genetic lines of rats useful in prostate research has also led to the important finding that the chemical, heparin, widely used as an anticoagulant, also speeds up the metastasis of cancer. If this and other factors responsible for cancer metastasis are explained, then the way would be opened for a two-phase attack on prostate cancer starting with detection, crisis treatment, then longer-term therapy to stop the spread of the disease.

A listing of the scientific papers which paved the way for these discoveries would total hundreds of items. The coordination of this research takes place at the National Prostatic Cancer Task Force meetings, through scientific journals and through study sections and other review mechanisms at the National Cancer Institute which take place because of the very existence of the task force.

Before the National Cancer Act of 1971, the coordination was loose, dependent upon which scientists happened to take part in cancer research meetings in any given year, and dependent on which scientists happened to read each other's papers. Little if any fiscal research support was available.

Now the work is focused, so that those investigators particularly interested in prostate problems are able to attend the periodic meetings of the task force, know the very latest developments will be discussed there, know that they can check their future study ideas against what is going on as reported in the task force's publications; or know they can get laboratory animals suitable for their purpose, compare specimens with a task force library of tissue samples, and can locate patients across the country who might fit into a study protocol they are engaged in or contemplating. It is no longer necessary for an investigator to rely on the patient flow through his own institution for the human material needed to explore his new ideas. He can take an experimental protocol to a task force meeting. The protocol is discussed and, possibly, approved by his colleagues who, after that, enroll patients of the right age, race, or condition into a panel of human subjects all grouped for a particular trial. The trial can take place at several different institutions simultaneously. The results can be aggregated faster than they could be at any one institution.

This is the value of a cancer organ site task force. In the time since the National Cancer Act was enacted, the recruiting for the prostatic task force has taken place as has the multi-institutional commitment to prostate cancer research, the recruitment of members of of the various scientific disciplines needed at the 13 cooperating institutions, the establishment of a statistics center, and the establishment of a pathology center. Since the National Cancer Act, all these things have

been accomplished. That is why research is moving so rapidly where, for over 40 years, no new therapy of prostate cancer in the opinion of some was discovered.

In fact, prior to the 1970s there were no systematic, controlled, prospective, randomized clinical trials to find which anticancer agents were useful in prostate cancer or which ones were superior.

The new trials have proven that cytoxan, 5-FU, methyl-CCNU CCNU, DTIC, hydroxyurea, procarbazine, streptozotocin, estracyt, vincristine, and Leo 1031 are active against prostatic cancer. Results to date indicate that on the basis of both objective and subjective criteria, chemotherapy has a demonstrated advantage over conventional therapy in hormonally resistant advanced Stage D disease. Moreover, patients who respond to chemotherapy survive significantly longer than nonresponders. Objective partial regressions were only observed in those patients treated with chemotherapy.

Over 1,700 patients have been enrolled in 13 chemotherapy studies in 13 participating institutions.

While this focus is on the kind of research which has been traditional in the National Cancer Institute before the 1971 act, even as far back as 1937, what is new is the strong focus, the ready teams, the base information gathered at pathology and statistical centers under the task force, and speeded interchange of outcome data on completed studies and ideas for new studies.

Further, the task force has joined others in cancer study in searching for better detection methods so that the new therapies can be used in time. And beyond detection, the National Prostatic Cancer Task Force is devoting some of its resources to preventive medicine, exploring vitamin A and its derivatives (retinoids) so that the possibility of heading off development of prostate cancer might become an actuality. This work includes the study of environmental, hormonal, and dietary factors related to the high rate of prostate cancer in the black population in the United States. At the same time, genetic and endocrine risk factors are being studied among Mormons where genealogical information going back to pioneer days is available for medical research.

An estimated 66,000 men in the U.S. will have been diagnosed to have prostate cancer in 1980. From these, and earlier diagnoses, an estimated 22,000 men will die this year. The chemotherapy trials of the National Prostatic Cancer Project can be expected to extend survival an average of about nine months in the patients with advanced, metastatic disease that respond to the agents under test. In earlier stages of the disease, hormones and chemotherapy are being administered in combinations in hope of extending survival even longer and chemotherapy is being used as adjuvants to potentially curative surgery or radiotherapy to increase cure rates. Life saving could begin when the results from the best clinical trials will have been duplicated, confirmed, and built into patient care regimens.

We think that the task force idea is a keystone of the National Cancer Program and urge the Committee to insure that NCI funds for organ site task forces continue to be allocated.

DECISION ON STATUS OF FREDRICKSON, DEVITA DUE IN MONTH, SCHWEIKER SAYS

Decisions on whether NIH Director Donald Fredrickson and NCI Director Vincent DeVita will be retained in those positions will not be made for at least another month, HHS Secretary Richard Schweiker told ***The Cancer Letter*** this week.

The delay is due to the necessity of first appointing and obtaining Senate confirmation of nominees for top level positions in the department, especially the various assistant secretaries including the assistant secretary for health/surgeon general, Schweiker said.

Schweiker intimated that the only reason a "reconfirmation" of the NIH and NCI directors is considered necessary is because they are Presidential appointees. Fredrickson was appointed by President Ford, DeVita by President Carter. Asked if there was any reason why a change of NCI directors was even being discussed, Schweiker said "because it is a Presidential appointment."

Outside pressures for a change in either position "have been minimal—very minimal," Schweiker said.

Schweiker was the keynote speaker at the cornerstone ceremony for the Vincent T. Lombardi Cancer Research Center at Georgetown Univ. The $11.5 million, 75,000 square foot pavillion will provide space for clinical and basic research laboratories, a modern outpatient department, lecture and conference rooms and administrative offices when it is completed in the spring of 1982. The project was aided with a $4.1 million construction grant from NCI, with private donations providing the balance.

Schweiker used the occasion to announce that he had given formal approval to NCI's Biological Response Modifiers Program. Part of the Div. of Cancer Treatment, the program has been operating unofficially since last fall, under the direction of Robert Oldham.

Schweiker said that "while not expected to replace other forms of cancer therapy, interferon and similar naturally occurring substances do offer challenge for the future. . . . (The BRMP) will support and contribute to the efforts surrounding interferon. It will allow for a cohesive approach and more accountability in this highly visible area of research. And when evidence of particular promise is discovered, the program's team will be able to respond quickly and begin careful testing and evaluation."

Schweiker praised the National Cancer Act, which he had a part in writing and funding as the ranking Republican member on both the Senate authorizing and appropriations health subcommittees. The Act made "the study of cancer causes and cures a top national priority," he said. "The program significantly raised our determination to combat cancer and made it first place on the country's health agenda."

Citing progress in the last 10 years, Schweiker said that "cancer is now one of the most treatable of chronic diseases" with at least 41 percent cured through early detection and prompt treatment. Falling cancer death rates for Americans under age 45, improved five year survival in seven of 10 major forms of cancer in whites and six of 10 in blacks, and increase in survival from 10 percent to more than 50 percent in childhood cancer are statistics "which tell a tremendously encouraging story," he said. "Years of research and perseverance are at last paying off,

and it's largely because we're learning more about the disease itself and perfecting the successful experimental therapies of the 60s.

"We should recognize this progress for what it is: a national achievement. We are doubly indebted to the community of researchers and practitioners, including those at Georgetown Univ. Medical Center, who have made it their life's work. But we must also be mindful that our progress has come in small, painstaking steps, for cancer is not just one disease but many complex diseases whose solutions demand our time and energies."

Schweiker said his department is committed to continuing the Cancer Program. "I think that is reflected in the budget we've submitted to Congress. We had to make some very difficult decisions in revising the department's budget for fiscal year 1982. Some programs were cut as much as 25 percent, others eliminated altogether.

"But for the National Cancer Institute, we have asked for a modest increase in funding. Considering the severity of some other cuts that we had to make, this increase is significant—it is a statement of our great concern for cancer research and our strong belief in its goals."

[The budget request for FY 1982 was $1.025 billion, $25 million more than Congress voted NCI for 1981, $50 million more than it will get if the rescision is approved, and $16 million less than former President Carter requested in his 1982 budget. It is the smallest percentage increase of any institute at NIH.]

Schweiker noted that NCI will begin this year "a major new initiative in applied prevention" and that Americans are increasingly becoming "prevention-oriented, but we still have a long way to go. This is why research and its direct application to prevention programs remains so important in the fight against cancer and all other forms of disease. . . .

"Where we stand today in our knowledge of the causes, treatment, control and prevention of cancer is extraordinary compared to what we knew just a decade ago. A longer journey is still ahead of us."

The university conferred an honorary doctor of science degree on Schweiker during the ceremonies.

John Potter, director of the center, said that the "achievements of the Lombardi center illustrate the importance of comprehensive cancer centers, and attest to the wisdom of the National Cancer Institute in establishing these programs. The comprehensive cancer center allows the creation of a critical mass of people and facilities which establishes a chain reaction of research discovery and improved patient care. The comprehensive center attains a level of identity and visibility which is essential for effective operation. Thus, by attracting community support, the effects of federal funding are magnified and become highly cost effective."

The Lombardi center, with the Howard Univ. Cancer Center, is one of the 20 recognized comprehensive cancer centers.

The center was named for the famed football coach who died of colon cancer at the university hospital in 1970. His son, Vincent, speaking during the ceremonies, said that his father "was a man with a concern for humanity. When all the films, quotes, and winning scores have dimmed in our memories, the Lombardi Cancer Center will be a lasting memorial to the man whose name it bears."

INTERNATIONAL CONGRESS ADVANCE PROGRAM ANNOUNCEMENT AVAILABLE

The Advance Program Announcement for the 13th International Cancer Congress Sept. 8-15, 1982, in Seattle, is now available. Copies may be obtained by writing to Edwin Mirand, Secretary-General, 13th International Cancer Congress, Roswell Park Memorial Institute, 666 Elm St., Buffalo, N.Y. 14263.

William Hutchinson is president of the Congress and Enrico Mihich is chairman of the National Program Committee.

The Advance Program Announcement includes details on the preliminary scientific program proposed by Mirand's committee. Ten plenary lectures will cover the broad areas of clinical cancer research, chemotherapy, carcinogenesis, endocrinology, cell biology, molecular biology, epidemiology, immunology, and the role of volunteer agencies.

Nine general symposia are scheduled in each of the three major areas of the Congress: preclinical, clinical, and allied sciences. They will present broad overviews of selected areas of cancer research where significant progress has been achieved since the 12th Congress in 1978. The Advance Program Announcement lists each of those subjects.

Forty-eight symposia dealing with a variety of important topics of timely interest are scheduled, and they are listed in the Advance Program Announcement. Post graduate courses, at 2½ hours each and intended as continuing education, are scheduled, and each is listed in the announcement.

Twenty-one seminars are planned, designed to discuss topics of current importance, including some controversial ones. Thirty-one topics are planned for round table discussions, with intensive debate on provocative subjects.

The National Program Committee invites individuals to submit abstracts of papers intended for presentation at the Congress. The committee will schedule them either for proffered sessions or poster sessions, or they may be placed in panel sessions. The advance announcement includes instructions on abstract submissions and describes formats.

Dec. 1, 1981, is the deadline for receipt of official abstract forms. Jan. 29, 1982 is the deadline for advance registration, and July 31, 1982, the deadline

for guaranteed housing accommodations. The advance announcement includes registration and housing accommodation forms.

Scientific exhibits that present research oriented results from noncommercial sources may be accepted. The scientific content must be summarized in the official abstract form. Additional supporting documents may be included.

Commercial exhibits presenting a product or service from a manufacturer or company are invited. Complete details on commercial exhibits can be obtained from the Congress Operations Office, 13th International Cancer Congress, Fourth & Blanchard Bldg., Suite 1800, Seattle, Wash. 98121, phone toll free 800-426-9920.

BRISTOL-MYERS ADDS MSK, GEORGETOWN TO GRANTS PROGRAM WITH $1 MILLION

Bristol-Myers announced grants totaling $1 million to two cancer centers, bringing the company's commitment to unrestricted cancer research to $3.86 million.

The new recipients—Memorial Sloan-Kettering Cancer Center and Georgetown Univ School of Medicine will receive the grants over a five-year period.

These institutions are the eighth and ninth to participate in the program, which also includes Stanford, Yale, Johns Hopkins, Baylor, Univ. of Chicago, Royal Marsden Hospital of London and the National Cancer Institute in Milan.

"When we established our cancer grant program four years ago, we wanted to demonstrate that private enterprise as well as government should contribute to this important humanitarian effort," said Richard Gelb, chairman and chief executive officer.

"We believe more firmly than ever in what we are doing," Gelb continued. "We intend to stick with it."

Administering the grants will be Paul Marks, president of Memorial Sloan-Kettering, and Philip Schein, professor of medicine and pharmacology and chief of Georgetown's Div. of Medical Oncology. Schein is also assistant director for clinical research at Georgetown's Vincent T. Lombardi Cancer Research Center.

Marks said that the Memorial Sloan-Kettering grant will support a broad spectrum of ongoing and new investigations into the role that genes play in carcinogenesis. These studies will encompass clinical research among people who are at high risk for cancer and basic research to understand the cellular and molecular events that lead to cancer.

The Georgetown grant will be used primarily for basic research. "Our ultimate goal," said Schein, "is to gain an in depth understanding of how anticancer drugs act against malignant cells and to devise drugs with unique chemical structures that will be effective without harming normal tissues."

NCI CONTRACT AWARDS

Title: In vitro evaluation of chemical candidates for in vivo testing
Contractors: EG&G Mason Research Institute, Rockville, $953,101 (task II); and Research Triangle Institute, $322,998 (task I).

Title: Long term followup of the Breast Cancer Screening Project participants
Contractor: Univ. of Michigan, $909,725.

Title: Support of activities of the USA National Committee for the UICC
Contractor: National Academy of Sciences, $89,940.

Title: Add operation and maintenance of the human stem cell cloning assay subsystem to the biological data processing system
Contractor: VSE Corp., Alexandria, Va., $119,768.

Title: Data management for collaborative cancer pain study
Contractor: National Institutes for Advanced Studies, Washington, D.C., $194,869.

Title: Biomedical computing software services in support of Breast Cancer Treatment Program
Contractor: Information Management Services, Bethesda, $643,732.

Title: Analytical services in support of the Div. of Extramural Activities of NCI
Contractor: Capital Systems Group, $288,739.

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. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs to the individual named, the Blair Building room number shown, National Cancer Institute, 8300 Colesville Rd., Silver Spring, Md. 20910. RFP announcements from other agencies reported here will include the complete mailing address at the end of each.

RFP 263-81 P(60) 0158

Title: *Growth of fibroblast B cell and hybridoma cloned cells*
Deadline: *June 1*

NCI is interested in establishing a contract with an organization having the capabilities to grow fibroblast B cells and hybridoma cloned cells. In this project recombinant DNA technology is used to identify the genes coding for immunoglobulin molecules and to define gene rearrangements associated with lymphocyte maturation.

These studies are directed toward the analysis of the early events of B lymphocyte maturation, to define the nature of defects in individuals with primary immunodeficiency diseases and to develop new approaches for the categorization of lymphatic leuke-

mias as being of B or T cell lineage. For each of these tasks the analysis of large numbers of cloned B lymphocytes and fibroblasts from specific patients are required.

The objective of this project is to have fibroblasts from specific B cells and hybridoma cell lines that are submitted to the contractor propagated in culture and expanded to the quantities of cells required for the analyses to be performed by NCI staff.

In view of the requirements of the proposed contract, it is essential that the offeror's facilities be readily accessible to the NIH headquarters in Bethesda. This support effort is to be performed in close collaboration with NCI staff. Therefore, offeror's facilities must be within an hour's drive of the NIH headquarters.

Contracting Officer: Elizabeth Abbott
RCB Blair Bldg Rm 332
301-427-8877

CORRECTION—
CHANGE RFP N01-CP-15770-50 to RFP N01-CP-15772-50 (*The Cancer Letter*, April 24)

Title: *Toxicology and Carcinogenesis Bioassays*
Deadline: *June 22*

The National Toxicology Program is interested in obtaining proposals from bioassay laboratories capable of performing toxicology and carcinogenesis bioassays in laboratory animals for the purpose of obtaining data, which would aid in the meaningful prediction of the toxicity/carcinogenicity potential of chemicals to man.

The experimental protocol will involve two major tasks: Task I-Prechronic tests and Task II-Chronic tests. A master agreement (basic ordering agreement) is to be used for this award. Requests for this solicitation should reference RFP N01-CP-15772-50.

Contract Specialist: Dave Monk
RCB Blair Bldg Rm 2A01
301-427-8774

RFP N01-CM-15757-58

Title: *Collection, storage and quality assurance and distribution of biological response modifiers*
Deadline: *June 22*

NCI is interested in establishing a contract to support the Biological Resources Branch (BRB), Div. of Cancer Treatment, in achieving its goals of producing high quality biological response modifiers and in ensuring the sterility, safety and potency of biological response modifiers for clinical and preclinical investigations.

This support project involves two parts—Task A and Task B. Offerors may propose on one or both tasks.

Task A—(1) Provide facilities and develop an inventory system for the receipt, storage and distribution of biological reagents and tumor cell lines. (2) Perform occasional assays as required by the project officer. These assays will include: (a) bacterial and fungal sterility; and (b) general safety, (as referenced in 21CFR 610).

Task B—Offerors will be requested to perform on an assigned basis and according to protocols designed by the project officer certain tests and assays designed to confirm stated biologic properties of BRM preparations.

Because of the need and value of frequent communication between the principal investigator and the project officer, the contractor's facilities must be located within a 35 mile radius of the office of the BRB, which is located in the Landow Building, 7910 Woodmont Ave., Bethesda, Md.

Contract Specialist: Mary Armstead
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RFP N01-CM-15755-58

Title: *Technical support for review and evaluation of biological response modifiers*
Deadline: *June 22*

NCI is interested in establishing a contract to support the Biological Resources Branch (BRB), Div. of Cancer Treatment, in its function of collecting, reviewing and compiling available information on biological agents.

Offerors will be required to (1) provide for the collection, storage, compilation and organization of available preclinical and clinical data on biological response modifiers considered of interest to the BRB; (2) provide adequate technical facilities and personnel for a computer based data center support function; and (3) provide technical support to the BRB for the completion of other specific tasks.

Because of the need to have staff attend meetings of the NIH and collect or deliver data and data files to the NIH within 24 hours of notice, the contractor's facilities must be located within a 50 miles radius of the office of the BRB, which is located in the Landow Building, 7910 Woodmont Ave., Bethesda, Md.

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