THE CANCER LETTER

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NCAB, PANEL MAY LOOK AT DISCREPANCIES, DEFICIENCIES IN STUDY SECTION EVALUATION OF GRANT APPLICATIONS

The National Cancer Advisory Board will join the President's Cancer Panel in taking a hard look at the evaluation of grant applications by NCI and NIH study sections, if the Board goes along with the recommendation of its Subcommittee on Board Activities and Agenda.

The subcommittee agreed last week to ask the full Board to participate in a formal review of study section evaluations, including disparities in priority scores, qualifications of study sections in particular areas of research, and consideration for new investigators and innovative ideas. The review also may include an attempt to establish policy on deviating from funding by priority scores to give NCI more flexi-

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In Brief

ACOS ANALYSIS FINDS CONCLUSIVE SHIFT TO MODIFIED RADICAL, EARLIER DETECTION, TREATMENT FOR BLACKS

MARKED SHIFT toward modified radical mastectomy, away from the Halsted radical, was shown conclusively in an analysis of 30,000 breast cancers, half of them diagnosed in 1972 and the remainder in 1977. The study was conducted by the Commission on Cancer of the American College of Surgeons and reported in the Aug. 15 issue of *Cancer*. The shift occurred at every level of patient age, disease stage and tumor size, and in hospitals of every size. The proportion treated by surgery with axillary dissection increased from 79.8 percent in 1972 to 85.8 percent in 1977. The study also shows that breast cancer in black women is being detected and treated earlier. The proportion of localized disease among blacks increased from 38.5 percent in 1972 to 45.2 percent in 1977, and the proportion of cases with distant metastases decreased from 12.4 percent to 9.6 percent. The article was authored by Josef Vana, Ramez Bedwani, Curtis Mettlin and Gerald Murphy. . . . **"THE MAJORITY** of historical milestones in cancer prevention have occurred 'through the astute observation of clinical practitioners rather than by laboratory investigation or epidemiological study,'" Gerald Murphy, director of Roswell Park Memorial Institute, wrote (quoting Irving Kessler) in a paper prepared for delivery last week at the First UICC Conference on Cancer Prevention in Developing Countries in Nagoya, Japan. "One of the fundamentals I wish to stress is the importance of the observant clinician. Robert Miller posed the question and answer, 'Who is at risk of discovering host factors that predispose to cancer? I claim it is the bedside etiologist—the person who thinks as much or more about etiology than he does about diagnosis or therapy. This category of physician is in short supply.'" Murphy was prevented by illness from attending the conference; his bedside etiologist was treating him for kidney stones.

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NCAB SUBCOMMITTEE TO RECOMMEND REVIEW OF STUDY SECTION EVALUATIONS

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bility in emphasizing particular program areas.

The subcommittee met last week to develop the agenda for the Board's October and November meetings and to consider various recommendations for future Board activities.

Rose Kushner brought up the subject of grant review. "I was very disturbed at the extreme variations in scores of grant proposals," she said. "Anything having to do with monoclonal antibodies and hybridomas was approved, while almost nothing in cancer control was approved. The Cancer Control Grant Review Committee has no people on it who are competent to evaluate behavioral medicine proposals."

"This is a very important problem," Subcommittee Chairman Harold Amos said. "The Panel (of which he is a member) has decided to take some action. The problem is so serious that we may want to spend four or five meetings on it, bringing in outside experts. This has to be approached formally, in detail."

Amos referred to "the unfortunate assignment of nutrition grants to 17 different study sections. Only three of 57 scored 200 or better. One problem is that study sections are deciding how much money each grant should get, and how it should be spent. . . . The Panel and Board should approach this jointly."

Amos also referred to a newly established practice of the National Institute of Neurological Diseases & Stroke setting aside 20 percent of its extramural budget for assignment on the basis of factors other than priority scores. "NCI has not been very imaginative about finding a solution to this problem," he said.

"Any of the fuzzy business about program directors (skipping over study section scores to fund more desirable grants) does not apply to disapprovals," Kushner pointed out. "There is no court of appeal."

Barbara Bynum, director of the Div. of Extramural Activities, replied that an appeals process does exist. Applicants who are disapproved may appeal to the program director, NCI staff may take the issue to the NCAB, or an appeal can be made to William Raub, NIH associate director for extramural research and training.

"Those appeals are to the people who made the original decision," Amos said.

"Not when it goes to Dr. Raub," Bynum said. "He is the higher court."

"We really do have a formal appeals process," Board member Sheldon Samuels commented. "Few know about it." He suggested that a memo should be prepared describing the process for circulation to grant applicants. Bynum responded that it is included in instructions given to applicants.

"The vast majority of disapprovals, I suspect, are justified," NCAB Chairman Henry Pitot said. "But for a number of them, it's a case of someone reading it wrong and thus disapproving it. When those have been pointed out and are rereviewed, they frequently are approved."

"That can be handled administratively," Bynum said.

"If we do use a system such as NINDS plans, 20 percent is too much for NCI," Pitot said. "I think we should insist that half come from the grant pot, half from contracts, and all of it used for grants. That would really be directed research."

"I'm concerned about the trend of having rigid criteria of judgment," Samuels said. "The number of publications is an example. There are a lot of young scientists with no publications. We shouldn't push study sections to have rigid criteria of selection, or on the basis of who (the applicant) works for, but on the basis that it's one hell of a good idea."

"We need to take summary sheets, look at this, look at that, and say, 'You tell us why one was approved and one wasn't,'" Kushner said, after referring to examples of identical applications funded with high priority scores by one study section and disapproved by another.

Samuels, who previously had suggested that the NCAB hold regional meetings around the country, agreed to present such a plan to the Board in October. Other subcommittee members were not as enthusiastic as Samuels, however.

"There are people who want to talk to the Board," Samuels said. "Not only famous people, people with travel funds, but other citizens and scientists. Shouldn't the Board try to reach more people by making itself more available?"

"What would the objectives be?" Amos asked.

"To hear the suggestions of those who want to be heard," Samuels replied. "Take centers for an example. We hear from NCI staff and center directors about centers. We don't hear from the physicians, the scientists at centers, or the patients."

"Who would discuss those problems with these people?" Amos asked. "I wouldn't want to chair such a meeting in Boston (Amos is a Harvard professor). It would be a shambles. To send one of our members, or even half the Board, would be a difficult thing to do."

"I don't underestimate the difficulty," Samuels answered. "That's the price of our appointments. The regional meetings would not require a dialog. We would be trying to listen, to find out if there is something out there we ought to know."

"I'm still leery of this," Pitot said.

The subcommittee made no recommendation on the proposal, other than to ask Samuels to present some details of his plan to the full Board.

The subcommittee agreed with a recommendation

submitted by Board member Gale Katterhagen that a "Subcommittee on Cancer Control and the Community" be established.

Amos will suggest in his report to the Board that an ad hoc subcommittee be set up, to be converted to permanent status if the situation warrants after a year or two.

In a letter to Pitot, Katterhagen wrote:

"Throughout the past decade NCI has had an unusual congressional mandate, the development and maintenance of a cancer control program. The mandate can be considered unusual since it is unique among NIH institutes.

"Although only five percent of NCI's current budget is devoted to control projects, the control program has extremely high visibility. In the past it has gained NCI both applause and positive congressional attention, and, at times, negative comments. One index of the program's importance to Congress is the recent hearing by Sen. Paula Hawkins on community programs. Clearly the control program cannot be ignored.

"While it is generally recognized that 'control' was an amorphous idea in the early 1970s, the field appears to have matured over the past few years. Dr. Bill Shingleton conducted a review of ongoing control projects for the NCAB two years ago and generally concluded that many of the projects were reasonable.

"There are several key reasons for the NCAB to develop a committee which will focus on the cancer control program and also on the role of the community in the National Cancer Program:

"• There is a need for an overall reassessment of the role of the control program within NCI. Should it be expanded? Diminished? Is it meeting the objectives Congress established for it? Are these objectives realistic? What is the value of the control program to NCI's other missions?

"• There is a need for an assessment of the role of the community within NCI. What is the community's role as national resource? What is its potential use in clinical trials? How do the community's needs and resources interface with the control concept? In what other ways should the community interface with NCI?

"• If the control program is to continue, what directions should it take? Is there a state of the art? What objectives is the program trying to meet? What future objectives should the program attempt to meet?

"• Given the above, what should NCAB's posture be on the control program and on the role of the community?

"The four major topics noted above would form the objectives of the proposed subcommittee. Addressing the questions described would constitute the subcommittee's specific tasks. I would propose that the subcommittee work closely with members and various committees or subcommittees of the Div. of Resources, Centers & Community Activities Board," Katterhagen's letter concluded.

Other matters considered by the subcommittee included:

—Policy on inviting speakers to Board meetings. Director Vincent DeVita and Pitot have received an increasing number of requests from persons wishing to address the Board. The members agreed to establish no policy or guidelines, and that all such requests be referred to the subcommittee which would decide whom to invite.

—Consideration of the proposal made by some at NIH that a ceiling be established on total funds a single principal investigator could receive.

"That would be a good subject for a regional meeting," Pitot said. "It would be mobbed."

The subcommittee agreed not to take up that issue at this time, and also to not sponsor a debate on the merits of program project vs. R01 grants, as had been suggested by some.

NIH PROBING "DOUBLE DIPPING" CHARGE INVOLVING TWO CANCER CENTER GRANTS

NIH is wrapping up an investigation, prompted by an anonymous letter, of a scientist accused of receiving pay from two cancer center core grants at the same time while claiming 100 percent effort for both.

The probe, by the NIH Div. of Management Survey & Review, has found that "double dipping" from two core grants probably did not occur. NIH hopes to complete the investigation by the end of September.

The scientist, Edward Modest, left Sidney Farber Cancer Institute last year to become associate director for experimental therapeutics at the Bowman Gray School of Medicine Cancer Center. The anonymous letter charged that Bowman Gray "worked out a deal permitting a substantial overlap" in pay in order to recruit Modest.

Charles Spurr, director of the center, denied the charge. "We were not aware of any arrangement he may have had at Boston," Spurr said. "Our understanding was that he was entitled to some terminal leave." Spurr said that Modest did not go on the Bowman Gray payroll until he took up his duties there. Even then, because the center's NCI core grant was in abeyance at that time, Modest was paid from other funds. When the grant was reinstated, Modest's salary was transferred to it.

Spurr said that the NIH investigator seemed satisfied that Bowman Gray had followed normal procedures and that there was no improper conduct on the part of the institution.

C. Nash Herndon, senior associate dean for research development at Bowman Gray, said that "several anonymous letters" were sent out, to NIH (and ***The Cancer Letter***) among others. A "dis-

gruntled former employee" is suspected of writing the letters, Herndon said.

Modest was on vacation and not available for comment.

NEW PUBLICATIONS

"Cancer Biology Reviews, Vol. 2," edited by John Marchalonis, Michael Hanna and Isaiah Fidler. Reviews aspects of the pathogenesis of metastasis. Contributors include Fidler, I.R. Hart, and Richard Roblin of the Frederick Cancer Research Center; Garth Nicolson, Univ. of California (Irvine); B.A. Warren, Univ. of Western Ontario; and Irving Zeidman, Univ. of Pennsylvania. Hanna is director of FCRC, Fidler is director of the FCRC Cancer Metastasis & Treatment Laboratory, and Marchalonis—the volume's editor in chief, is with the Dept. of Biochemistry at the Medical Univ. of South Carolina. Marcel Dekker Inc., 270 Madison Ave., New York 10016, $39.75.

"The Practical Regulatory Affairs Handbook," by Michael Furillo. A comprehensive look at eight key regulatory activities. Lifeline Institute of Medical Research, 1187 Coast Village Rd., Suite 8, Santa Barbara, Calif. 93108, $50 plus $2 shipping.

"Adjuvant Therapy of Cancer III," edited by Sydney Salmon and Stephen Jones. Proceedings of the Third International Conference on the Adjuvant Therapy of Cancer, Tucson, March 1981. Grune & Stratton Inc., Attn. Order Dept., 111 Fifth Ave., New York 10003, $29.50.

"Small Cell Lung Cancer," edited by F. Anthony Greco, Robert Oldham, and Paul Bunn Jr. A clinical oncology monograph, with chapters on etiologic and epidemiologic factors, pathology, tissue culture, and in vitro characteristics. Clinical staging procedures, immunologic aspects, extrapulmonary small cell carcinoma, clinical management of patients, and complications of therapy are covered. Grune & Stratton, address above, $39.50.

"Oncologic Emergencies," edited by John Yarbro and Richard Bornstein. Presents the common complications arising in the cancer patient that require prompt diagnosis and treatment. Emphasizes management, including medical, surgical and radiological emergencies. Grune & Stratton, $29.50.

"Cancer: Achievements, Challenges, and Prospects for the 1980s," edited by Joseph Burchenal and Herbert Oettgen. Proceedings of the 1980 International Symposium on Cancer presented by Memorial Sloan-Kettering Cancer Institute and cosponsored by NCI and ACS. Grune & Stratton. Vol. 1, $29.50, Vol. 2, $34.50.

"Cancer Research in the People's Republic of China and the USA," edited by Paul Marks. Proceedings of the First Bilateral Conference on Cancer Research in the People's Republic of China and the United States, Columbia Univ. Grune & Stratton, $24.50.

"Nutritional Therapy for the Cancer Patient," selected abstracts published by NCI's International Cancer Research Data Bank. National Technical Information Service, 5285 Port Royal Rd., Springfield, Va. 22161, $5.25.

"Clinical Immunology & Immunotherapy of Gynecologic Tumors," selected abstracts published by ICRDB. Order from same address above, $5.25.

"Biopsy Diagnosis of the Digestive Tract," by Heidrun Rotterdam and Gheldon Sommers. Raven Press, 1140 Avenue of the Americas, New York 10036, $45.

"Gastrointestinal Cancer (M.D. Anderson Clinical Conferences on Cancer)," edited by John Stroehlein and Marvin Romsdahl. Raven Press, address above, $45.

REQUEST FOR RESEARCH GRANT APPLICATIONS

RFA Number NIH-NCI-DCT-CTEP-81-4

Title: *Regional Cooperative Clinical Trials Groups*
Application Receipt Date: *Nov. 16, 1981*

NCI invites proposals for the establishment of regional cooperative clinical trials groups. At the present time, NCI's Div. of Cancer Treatment, through the Cancer Therapy Evaluation Program, supports clinical trials groups which cooperate together to conduct clinical research studies. These groups presently are of four major types: (1) groups that are specifically disease oriented; (2) groups that are designed to deal primarily with high technology, single modality studies; (3) groups in which the investigators have a particular expertise (such as pediatricians); and (4) multimodal national groups.

The purpose of this RFA is to encourage the establishment of groups which are geographically organized. These groups may have several advantages. For example, they may provide opportunities for practicing oncologists not currently involved in research clinical trials to have access to protocols conducted in their geographic vicinity. Creating regional groups may also forge bonds between the cancer centers program and research clinical trials. Some of these groups may be organized around cancer centers. The groups can also take advantage of community outreach programs, provide state of the art therapies to patients, and strengthen accrual to research protocols.

It is intended that regional groups will be able to support clinical trials which take advantage of the scientific strengths of the communities in which they are organized. If, for example, a neutron generator is available, then a regional group could be established to accrue patients for neutron therapy trials in the

geographic vicinity of that facility.

The Div. of Cancer Treatment intends to support these groups through the funding of institutions capable of serving as group operations and statistical offices. These offices would function as the centers of operation for consortia with reasonable geographic bases and unique patient resources and/or treatment capabilities. It is intended that these new cooperative groups will demonstrate the functional capability of regional consortia to perform innovative and meaningful cancer clinical research trials.

RESEARCH GOALS AND SCOPE

Institutions or organizations seeking funding as regional operations offices must meet the following minimum requirements:

1. They must possess expertise in the design and conduct of cancer clinical trials. Current cancer center status, possession of grant or contract support for clinical trials, possession of clinical program project support, active current cooperative group participation (including substantial scientific input into the group's activities) or record of substantial pertinent publications are some of the ways in which this expertise may be demonstrated. Groups possessing established special expertise with a particular treatment modality or having other unique resources are likewise eligible.

2. They must demonstrate an ability to provide data management and statistical support which will ensure the development of accurate conclusions in an efficient manner. They must also demonstrate an ability to continuously monitor ongoing studies for patient safety.

3. They must demonstrate that each member of the potential group has available the facilities and professional personnel to permit the conduct of cooperative clinical trials. This includes, where appropriate, the resources required for accurate diagnosis and pathological review as well as high quality surgical, medical, and radiation oncology therapy. They must demonstrate the commitment of each proposed member to participate actively in the studies of the group.

4. They must demonstrate the availability at each member institution of support personnel to ensure timely and accurate data retrieval and reporting.

5. They must demonstrate the availability of adequate patient resources—especially of previously untreated patients—to permit the completion of meaningful clinical trials, through the cooperation of qualified members located within reasonable geographic proximity. In addition, they must demonstrate the ability to commit these patients to group studies. The size and geographical area encompassed by regional groups will be judged on an individual basis; this is an issue to be decided by the proposer and to be judged by the peer review committee. The criteria will be adequate patient population and scientific expertise to perform valid clinical trials. Particularly important in this regard will be a clear statement documenting the rationale behind the geographic basis of the group.

6. They must demonstrate the availability of personnel and facilities capable of performing and supporting the administrative functions of a clinical trials group.

7. They must express a willingness to participate in NCI sponsored intergroup studies of certain less common diseases which cannot be accomplished by existing individual cooperative groups or institutions. Such studies may be proposed by either NCI staff or any outside investigators. The resources available to the individual group shall be taken into account in this regard.

MECHANISM OF SUPPORT

Awards will be made as cooperative agreements. These are assistance relationships entailing substantial collaboration and involvement with NCI staff. The terms of this involvement by NCI staff are included in this RFA. NCI anticipates making three to five awards as a result of this request. A total of $1.5 million has been set aside to fund the initial year's awards. Awards will be made for project periods of four years. Adjustments in the level of funding may be made yearly. Renewal of the initial award beyond four years will be contingent upon satisfactory review of a competing renewal application by a scientific peer committee as well as the National Cancer Advisory Board. These competing renewal applications will be paid from funds budgeted for NCI research clinical trials. All policies and requirements which govern the grant programs of the PHS apply, including the requirement for cost sharing. The following additional points apply:

1. The administrative and fiscal structure of the individual groups must be specified in the application. Currently NCI supports a variety of financial arrangements including: a) central operations office funding for all group activities; b) distribution of resources by subcontract to members through the central operations office; c) a mixture of member funding both through the operations office and by individual grants or cooperative agreements; and d) each member holding an individual grant. Awards under this announcement will be made only to institutions serving as the operations and statistical office for the group. Each applicant must submit a detailed plan specifying the administrative structure of the group and any plans for distribution of support funds to the various group members from the operations office cooperative agreement. If any proposed group member is supported by R10 grant or other cooperative agreement funds, the disposition of those funds must be included in this plan. Application for support of group activities by individual member institutions will be accepted in the future and will be sub-

ject to the same peer review process now in effect for research clinical trials.

2. Membership in an existing clinical trials group supported by R10 grant, cooperative agreement or contract, or participation in cancer control activities of another cooperative group, shall not preclude an institution or investigator from participation in a new regional clinical trials group. The institution or investigator must, however, express a written commitment to one group or the other for any study for which there is a competition for patient resources. This will be subject to NCI approval.

3. An institution currently holding an R10 grant or cooperative agreement supporting participation in a cooperative group may elect to terminate its participation in the existing cooperative group and become a member of a new regional group. The institution may then remain funded under the existing R10 grant or cooperative agreement funded separately from that of the operations office, or a portion or all of the separate grant or cooperative agreement may be transferred to the operations office. Such fiscal arrangements are flexible, but must be spelled out and are subject to NCI approval.

4. Any R10 grant or cooperative agreement effected by the preceeding point shall in general be subject to peer review under the timetable of the original award. This process will be consistent with existing PHS/NIH review requirements.

REVIEW PROCEDURES AND CRITERIA

1. Plan for Review: Applications will first be reviewed for responsiveness to this RFA. Those judged to be nonresponsive will be referred for review as part of the existing clinical trials program. Responsive applications will be evaluated by an NCI peer review group composed of non-federal scientific consultants familiar with cancer clinical trials. The application will subsequently undergo final review by the National Cancer Advisory Board.

2. Criteria for Review: All applications will be reviewed on the basis of the following criteria.

A. Unique Strengths of Proposed Group.

Each applicant should identify and document the strengths of the proposed group and should formulate specific goals and objectives relevant to these strengths. The achievement of these goals and objectives will serve as an important basis for annual review of progress and review of competitive renewal applications. A group need not conform to the multidisease, multidisciplinary mold of existing cooperative groups.

B. Experience in the Conduct of Cancer Clinical Trials.

As previously cited this may be shown by any of a number of methods and is not limited to those mentioned. Applicants should include at least two fully developed treatment protocols and present in outline form several other protocols likely to be initiated during the first four year funding period. It is possible that this requirement might be waived in the case of a disease or modality oriented group. It should be understood that the first annual review of progress will be heavily weighted toward evaluation of studies initiated as opposed to future protocol development.

C. Ability to Complete Clinical Trials of Substantial Scientific Merit.

It is anticipated that different groups will have varying patterns of patient referral accession, etc. Furthermore, the areas of special expertise may differ widely. Therefore, specific minimum requirements of patient accrual capability and geographic size cannot be stated. Applying groups must clearly show, however, that they have the potential to accomplish clinical trials of sound scientific quality in a reasonable period of time. Especially important will be studies involving patients with no previous therapy. The ability to accrue adequate patient numbers must be clearly documented, and it is in this context that geographic size will be judged. It should be understood that applications for renewal of funding following the initial four years will be judged on the basis of the group's ability to complete studies of scientific merit. Specifically patient accrual will be judged in the context of its contribution to the completion of these trials rather than in terms of total groupwide patient accession.

D. Availability of Professional and Support Personnel and of Appropriate Facilities to Ensure that the Group is Capable of Performing Innovative Cooperative Cancer Clinical Trials.

This criterion applies not only to the facilities and personnel of the operations office but also to those of affiliated member institutions.

E. Availability of Adequate Statistical and Data Management Support Services and Staff.

This should be clearly documented and should include a clear description of the experience of the proposed group's statistical office staff (statistician(s), programmers and data management staff) in the analysis of cooperative cancer clinical trials as well as the experience of the operations office data management and administrative staff.

F. Leadership Ability of Proposed Group Chairperson

Applicants should clearly document that the proposed group chairperson is experienced in dealing with the problems of cooperative clinical cancer research, and that he/she has appropriate experience to qualify him/her as the group's leader.

NATURE OF COLLABORATION WITH NCI STAFF: TERMS OF AWARD

It is the responsibility of the awardee to develop the details of the research design following the guidance given in this announcement. The awardees shall develop protocols for clinical cancer research in

accord with their own interests and the minimum requirements given in this announcement, and submit them to NCI staff for approval prior to their implementation.

1. Scientific Resources

NCI staff will serve as a resource to provide specific scientific information with respect to treatment regimen and clinical trial design. The staff will assist the groups in developing information concerning the scientific basis for the performance of specific trials and also will be responsible for informing the group of the nature and results of relevant trials being carried out nationally or internationally.

2. Protocol Design

NCI staff will have an active role in assisting the group in protocol design. The NCI program director will meet with the group's protocol design committee and advise with respect to: a) duplication of proposed study by other groups or institutions; b) scientific rationale; c) design and implementation; d) availability of necessary drugs and/or other treatment modalities, and e) statistical requirements.

3. Protocol Review

All protocols prepared by regional cooperative clinical trials groups supported by cooperative agreements will be reviewed by the NCI Cancer Therapy Evaluation Program (CTEP) protocol review committee. This committee will meet weekly and will consist of CTEP clinical and investigational drug staff. It will be chaired by the Associate Director, CTEP, or his designee. Ad hoc reviewers, independent of NCI, will be utilized when deemed appropriate by the committee chairperson.

If a protocol is disapproved by NCI, specific reasons for rejection will be furnished to the group chairperson. NCI staff will work with the group to develop a revised protocol compatible with the needs of the group and NCI.

NCI will not fund performance of, or provide investigational drugs for, a protocol disapproved within the context of the above guidelines. NCI will establish an appeals process for investigators who wish to appeal protocol disapproval. An arbitration panel composed of one group nominee, one NCI nominee, and a third member with clinical trials expertise chosen by the other two will be formed to review NCI decisions. The NCI appeals process in no way affects the right of a recipient to subsequently appeal an adverse determination using the NIH informal appeals system and the formal Dept. of Health & Human Services procedures.

4. Quality Control

NCI staff will approve, in cooperation with each clinical trials group, mechanisms developed for quality control. Quality control in clinical trials shall consist of: a) pathology review to verify pathologic diagnosis, b) review of clinical and laboratory data on patients to establish stage of disease and performance status and c) quality control of treatment. It is understood that mechanisms of pathologic quality control should retain considerable flexibility since the degree and sophistication of pathological review will vary with the disease under study and the clinical trials question being addressed. Treatment related quality control should consist of a review of patients' flow sheets for compliance in dosage and scheduling in chemotherapy trials and appropriate review of patient information and port films to establish compliance with radiotherapeutic or surgical protocol standards in radiation or surgery trials. It is understood that NCI staff may periodically review the group for compliance with quality control standards.

5. Data Management

NCI staff will approve mechanisms for data management and analysis in groups operating under the cooperative agreement mechanism. NCI staff will have access to all data and will periodically review data management by the group. Data must be available for external monitoring if required by NCI.

6. Protocol Termination

NCI staff may determine when a protocol study should be terminated. Protocol studies may be terminated for such reasons as insufficient accrual or when further accrual of patients on study will not add any information of scientific relevance. NCI will not fund performance of a protocol terminated within the context of the above guidelines. There will be an appeals process for investigators who wish to appeal protocol termination. An arbitration panel composed of one group nominee, one NCI nominee, and a third member with clinical trials expertise chosen by the other two will be formed to review such NCI decisions under the supervision of the DCT Board of Scientific Counselors.

7. Investigational Drug Management

A. NCI will have the option to cross file or independently file an IND on investigational drugs evaluated in trials supported under cooperative agreements. This would apply to drugs not developed in the NCI drug development program.

B. NCI staff will advise investigators of specific requirements and changes in requirements concerning investigational drug management that the Food & Drug Administration may mandate. Investigators performing trials under R10 grants or cooperative agreements will be expected, in cooperation with NCI, to comply with all FDA monitoring and reporting requirements for investigational agents.

C. Investigators performing NCI funded clinical trials will be advised by NCI staff of potential studies which will be relevant to new avenues of cancer therapy. When this involves investigational drugs, the clinical information should be acceptable to the FDA for inclusion in a new drug application. In cooperation with NCI staff, the research clinical trials groups will develop protocols to obtain such information,

METHOD OF APPLYING

1. As soon as it is determined that an application may be filed, a letter of intent should be sent to Dr. John Killen at the address shown below.

2. Applications should be submitted on Form PHS-398, which is available in the business or grants and contracts office at most academic institutions and research institutions, or from the Div. of Research Grants, NIH. The phrase, "Prepared in Response to RFA No. NIH-NCI-DCT-CTEP-81-4" should be typed across the top of the face page of the application. Additionally, a brief covering letter should accompany the application indicating that it is being submitted in response to this request. The original and six copies of the application should be submitted to the Div. of Research Grants, NIH, as directed in the grant application instructions. An additional copy should be sent to Dr. Killen. All curricula vitae should be limited to three pages each.

Investigators interested in submitting applications in response to this announcement are encouraged to contact the following:

Regarding program/scientific matters: John Y. Killen Jr., MD, Head, Medicine Section, Clinical Investigations Branch, CTEP, DCT, National Cancer Institute, Rm. 4A14, Landow Bldg., 7910 Woodmont Ave., Bethesda, Md. 20205, 301-496-2522.

Regarding administrative policy: Leo F. Buscher, Grants Management Office, NCI, Westwood Bldg., Rm. 8A18, 5333 Westbard Ave., Bethesda, Md. 20205, 301-496-7227.

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 NCI-CB-15000-07

Title: *Transplantation, induction and preservation of plasma cell tumors in mice and the maintenance of special strains of mice*

Deadline: *Oct. 23*

The Div. of Cancer Biology & Diagnosis, NCI, is seeking proposals for provision of a support facility for studies on the genetic basis of susceptibility to develop cancer. This contract will provide for a closed (quarantine protected) conventional mouse colony in which mice can be observed for plasmacytoma development and in which various congenic strains of mice can be developed and bred for induction studies.

Specific tasks under this contract will be: (1) the induction of plasma cell tumors in mice, that includes a conventional mouse colony containing inbred and congenic strains of mice; (2) the transplantation, preservation and distribution of plasma cell, lymphocytic macrophage and mast cell tumors in a frozen tumor bank; (3) characterization of myeloma proteins; (4) the development of congenic strains of mice, using biochemical, serological and karyological markers; and (5) the maintenance of a wild mice colony as a resource for new genetic markers and a facility for observing wild mice for the development of leukemia and mammary tumors.

Helen Kelly
Contracting Officer Representative
RCB, Blair Bldg. Rm 105
301-427-8877

RFP NCI-CO-14349-14

Title: *Cancer Communications Program support*

Deadline: *Oct. 15*

NCI is soliciting proposals for a small business firm to provide communications services to support the Office of Cancer Communications. This proposed procurement listed herein is a total set-aside for small business concerns.

Small business size standard—Services: Any concern bidding on a contract for services (including but not limited to services set for th in Div. I, Services of the Standard Classification Manual) not elsewhere defined in this section and its average annual receipts for its preceding three fiscal years do not exceed $2 million (see FPR 1-1.701.11 for size standard differentials which are applicable to specified non-foreign areas).

This project is for a three year period. Offerors will be limited to those firms having operating facilities within a 50 mile radius of Bethesda, Md.

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301-427-8745

CANCELLATION

Bioassay Report, RFP N01-CP-15786-71, (***The Cancer Letter,*** Aug. 7) is hereby canceled until further notice.

The Cancer Letter _Editor Jerry D. Boyd

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