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THE CANCER LETTER

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DRCCA BOARD APPROVES CCOP, LIMITED RECOMPETITION OF COOPERATIVE GROUP PROGRAM, NEW CONTROL EFFORTS

The new directions NCI is taking in supporting cancer control, cancer control research, and community participation in clinical trials were spelled out more clearly last week in a series of actions by the Board of Scientific Counselors of the Div. of Resources, Centers & Community Activities. The Board:

- Approved the concept of the Community Clinical Oncology Pro-

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In Brief

SOME CANCER CENTERS FUNDED AT "RECOMMENDED" LEVELS FOR FISCAL 1981, BUT THERE WAS A CATCH

CANCER CENTERS whose core grants were renewed in the 1981 fiscal year and who scored 199 or better in their reviews were not really funded at the full recommended levels (as reported by *The Cancer Letter* Oct. 16). By the time NCI found some extra money just before the fiscal year ended and decided to put some of it into the center core grants, only two months were left in the grant year, which ends Nov. 30. NCI decided that the salary portions of the core grants would be prorated and that the extra funds for salaries would be limited to the final two months of the grant year. "The vast majority of the deficit in our core grant funding was in unfunded faculty salaries," one center director said. "Obviously, the overall funding of our core grant falls far short of recommended levels for FY 1981." Said one NCI executive: "That was a business decision. We didn't feel it would be wise to put money into salaries which had already been paid." Other portions of the grants were funded at recommended levels for those with priority scores through 199, and on a sliding scale for the others. . . . **ELLIOTT STONEHILL** has rejoined NCI from the NIH Div. of Research Grants as assistant director with a variety of assignments: executive secretary of the President's Cancer Panel; coordinator of low level radiation activities; and coordinating some consensus development activities. . . .**ESTIMATED $3 BILLION** that cancer costs American industry could be reduced substantially by getting workers to adopt some simple preventive and early detection practices, according to a new American Cancer Society study, "The Economic Impact of Cancer and Cancer Control on Private Industry." Medical economist David Eddy of Stanford Univ. prepared the report which noted that 120,000 workers in private industry get cancer each year. This costs $1.2 billion in medical care, $10 billion in lost earnings. The report suggests these steps: Monthly breast self examinations, annual physical breast examinations and Pap tests at least every three years for women employees; a stool guaiac slide test slide test yearly for all employees 50-65; antismoking activities.

DRCCA BOARD OKAYS CONCEPT OF CCRUs, NEW CENTER CANCER CONTROL GUIDELINES

(Continued from page 1)

gram, intended eventually to support participation in clinical trials of 200 community hospitals around the U.S. with the twin goals of making available to all cancer patients the highest quality care while increasing the number of patients entered into clinical research. One critical issue remains to be resolved.

- Approved recompetition of the Cooperative Group Cancer Control Program, in which six existing groups are funded to extend their clinical trials into community hospitals. The recompetition will be for two years, with this program to be phased out as the CCOPs take over.
- Approved the concept of a new program for cancer control research through "Cancer Control Research Units" which will be limited to institutions which have access to "defined populations." An RFA (request for grant applications) will be developed which will set aside $5 million for developmental funds and core support for units (a term preferred over "centers") which will carry out a wide variety of cancer control research projects.
- Approved in principle the development of new guidelines which will replace existing ones for cancer control outreach grants. Existing grants, all to cancer centers, were due to expire this year. They will be extended administratively while the new guidelines are being written. The Board expects to see a draft of the new guidelines at its January meeting, with a program announcement to follow once the details have been agreed upon.

CCOP is designed to link community hospitals with "research bases"—cancer centers, national cooperative groups or regional cooperative groups—which will provide the coordination, data management, investigational drugs and other support for clinical trials. The hospitals will be obligated to enter a minimum number of patients into research protocols each year. Protocols may be either those developed jointly by the communities and research bases, or national protocols.

The Assn. of Community Cancer Centers, NCI staff and a DRCCA Board subcommittee headed by Charles Moertel jointly developed the outline of the program. They expect it to provide as many as 10,000 patients a year for clinical research, at a cost of about $10 million, when the program is fully implemented with 200 participating hospitals.

Actual number of hospitals involved in the program could be larger. The guidelines provide for satellite participation of smaller hospitals and clinics affiliated with larger community hospitals in their regions.

Funds for the program for the most part will be those redirected from other DRCCA activities, including the Cooperative Group Cancer Control Program. That effort now costs about $5 million a year. NCI staff and the DRCCA Board consider some of the programs carried on by the six groups as successful, others less so. For some of the groups, as many as one-third of the patients now entered into their protocols come from their community collaborators.

The six groups are Childrens Cancer Study Group, Eastern Cooperative Oncology Group, Southwest Oncology Group, Radiation Therapy Oncology Group, National Surgical Adjuvant Breast and Bowel Project, and Northern California Oncology Group.

Harry Handelsman, DRCCA project officer for the program, asked for concept approval for recompetition of the cooperative group contracts (five, with one, to NSABP, a grant) for three more years.

Moertel argued that implementation of CCOP would replace the cooperative group program in less than three years and asked that it be extended only for one year. Board member Anthony Miller objected to the recompetition since that would open the prospect of other cooperative groups getting into the program just before it is to be phased out.

The Board first voted to extend the program for one year on a noncompetitive basis. However, Gary Kelley, chief of the Control & Rehabilitation Section of the Research Contracts Branch, advised the Board that a noncompetitive extension would require approval of the assistant secretary for health, which in the past has taken up to seven months.

Board members agreed to try anyway. Later, the members reconsidered when staff pointed out that CCOP full implementation could not possibly be accomplished within a year, and the two-year recompetition was approved.

NCI Director Vincent DeVita told the Board that CCOP was one of the institute's highest priorities. "We are anxious to get this program going. We have to move quickly to get it funded in the 1982 fiscal year. We may have trouble getting 1982 funding anyway," DeVita said, referring to the budget cut sought by the Administration.

DeVita cited several issues still to be decided, among them the funding mechanism. NCI probably would prefer cooperative agreements, which now are funding most clinical trials groups, including the cooperative groups, but DeVita suggested that either contracts or contracts with task orders might be appropriate.

DeVita also suggested that Moertel's committee remain active to work out details of CCOP, including refinement of the guidelines, advice on DRCCA staff running the program, and CCOP's relation to other programs.

One detail still to be worked out is a tough one and is crucial to the direction the program will take.

ACCC representatives have assumed from the start, since DeVita suggested the idea of an expanded com-

munity program to bring more community physicians and patients into clinical trials, that each program would be built around a community hospital. The community in each case would be the lead organization, probably with a community physician as the principal investigator. ACCC agreed on the necessity of allying each community with a research base, but NCI funds would go to the communities and not be filtered through centers or cooperative groups, in the ACCC view of the program.

Moertel has insisted that the research bases themselves have the opportunity to compete directly for the primary awards and thus be the lead organization in a program. Moertel has not argued for that arrangement in all cases, but only that centers and cooperative groups be allowed into the game on the same basis as community hospitals.

At issue is the section of the guidelines presented by Moertel to the Board which he said represented the compromise agreement reached at the last meeting of his committee (*The Cancer Letter*, Oct. 16). Board member Charles Cobau, one of three community representatives on Moertel's committee (the others are Edward Moorhead of Grand Rapids and Herman Kerman of Daytona Beach, current ACCC president) said he had not reached the same interpretation of the guidelines as had Moertel.

The Cancer Letter did not publish that portion of the guidelines in its report of the committee meeting because of space limitations. It follows here:

Research Bases for Community Clinical Oncology Program Activities

A. It is anticipated that the research bases for Community Clinical Oncology Program activities would be provided through comprehensive cancer centers, other university cancer centers, national cooperative groups or regional cooperative groups. It is hoped that the need of this program can be met by existing research bases currently funded by the Div. of Cancer Treatment or those to be funded under the current regional group RFA. If this does not prove to be the case funding would be provided for the establishment of additional research bases specifically oriented to this program.

B. The general function of a research base would be to stimulate, facilitate, coordinate, and evaluate the research and control activities of its associated CCOPs and other community affiliates.

C. The research base would have defined mechanisms for the community participants to have direct input to the administration and policy decisions of the respective research bases. It would be anticipated that approved and funded CCOPs would be voting research base members. It is also anticipated that community clinic members would have appropriate representation on governmental and operational committees of the research base.

D. Specific functions would include the following:

1. To assess the capabilities of community members and affiliates for participation in clinical research and cancer control activities.

2. To assist the community members and affiliates in any necessary upgrading of personnel and facilities and to provide training when indicated for supporting personnel, e.g. data handlers, study assistants, oncology nurses, etc.

3. To join with the community members and affiliates in developing and/or making available appropriate clinical research protocols.

4. To provide appropriate quality control procedures for data recording, protocol compliance, and reporting of adverse reactions.

5. To join with radiation therapists of the community members and affiliates by assisting with treatment planning and in providing quality control both with regard to standardization of equipment and to dose and field.

6. To join with surgeons in the community members and affiliates to standardize operative reporting and, when feasible, operative procedures.

7. To join with pathologists of the community members and affiliates to standardize pathology reporting, to standardize pathology procedure, and in providing mechanisms for pathology review for appropriate protocols.

8. To provide an operations office which will provide regular and timely pertinent communication with affiliated community members and affiliates and establish logistics for data transmission.

9. To provide a statistical center for data management and to provide statistical assistance in the protocol design, protocol monitoring, data analysis, and manuscript preparation.

10. To monitor new drug procurement, to transmit new drug orders, and to monitor new drug use by affiliated community clinic members.

11. To organize regular meetings with its community members and affiliates for review of ongoing research activities, planning of future activities, and related professional education.

12. To join with its community members and affiliates in the planning and conduct of cancer control activities.

13. To assist community members and affiliates in evaluating the impact of their research and control activities.

14. To evaluate the quality of performance of its affiliated community members and affiliates. This evaluation will specifically include monitoring of patient accrual to research protocols.

15. To prepare at least once annually a comprehensive report of overall Community Clinical Oncology Programs.

E. For funding under this program it is anticipated that an existent or new research base will be affiliated with at least eight community units contributing at least 500 research protocol entries per annum.

F. It is anticipated that a research base meeting the minimum requirement as described in "D" would be funded for their activities in this program at a total cost of $150,000 per annum. Proportionately, greater funding would be allowed for a larger number of community protocol entries. Additional funds could be provided for appropriate and approved cancer control activities. Additional funds could also be added for subcontracting the activities of "satellite" community oncologists and clinics who do not have sufficient case entry potential to justify independent funding as a CCOP.

G. Allowable budget items for a research base would include professional (physician, statistician, nurse) staff salaries for administrative and advisory activities; paraprofessional salaries for administrators, data clerks, statistical assistants, secretaries; supplies, services, and equipment directly related to support services; computer charges; editorial, graphic, and photographic services; travel.

H. Awards would be made for five years for established groups. Developmental awards of two years would be made for groups with demonstrable potential but without established community productivity. These latter awards could be extended for an additional three years by NCI staff review if productivity is established during the initial two years.

Cobau particularly objected to the provisions under F. above which would permit funding through

the research bases of approved cancer control activities and of satellite community oncologists and clinics. Those activities especially should be the domain of the community hospital, Cobau argued.

"I will not back away from funding existing defensible satellite operations," Moertel said. "The approach of this concept includes that. You read it exactly right, Charlie."

Pressed by Board Chairman Stephen Carter to reach a decision on the overall concept, members agreed, leaving the unresolved issues to be worked out by the committee for presentation to the Board in January. No RFA will be issued until the Board has another look at the guidelines.

Although the Board approved the concept of supporting Cancer Control Research Units which would carry out cancer control research in defined populations, it rejected a staff proposal to get the program started through program project grants.

Carlos Caban, program director, said the grants, estimated at about $1 million each, would support several individual research projects and appropriate administrative components "that are tied together by a common theme." This program would be limited to research with defined populations, a provision insisted upon by the Board's epidemiologist members.

"This is a flip flop of emphasis," Carter said, insisting that deliberations of the Board's Cancer Control Subcommittee had reached the conclusion that the funding mechanism would be core grants. "The subcommittee felt CCRUs should be funded as a core, with individual projects coming under the core's umbrella. . . . Wedding this to program projects is a problem. Our concept was that CCRUs would begin as a core, out of which would come all sorts of cancer control research. With this, projects would be emphasized over the core."

Caban said staff felt the need was for discrete projects, which would permit the program to move ahead at a faster rate.

Moertel said, "We're talking about a core without the apple. You have to have an apple before you have the core," which was how cancer centers developed, he said.

"I like the Moertel model," Cobau said. "This program was designed as a semireplacement for the existing centers cancer control outreach grants. Epidemiologists here kept refining this, and limiting it to defined populations. We came to the conclusion that several institutions existed which could do research in defined populations, that they had the apple but no core. This is designed for the institutions with the apple."

The Board voted to approve the concept of funding CCRUs, but voted again to reject the program project approach, with only members Cobau, Harry Eagle and Alfred Knudson favoring it.

Carter said the Cancer Control Subcommittee would meet before the January meeting to draft guidelines for CCRU core grants.

Caban also presented a proposal for a program announcement for a revised program to support cancer control core grants for centers. No guidelines have yet been developed, although it would be necessary to do so before the January meeting.

Board members objected to issuing a program announcement (which differs from an RFA in that no dollar commitment would be included) soliciting grant applications until the guidelines have been written and approved. The existing cancer center outreach grants, involving about $10 million a year to 20 centers, do not permit cancer control research.

"This will do everything CCRUs can do but not in defined populations," Moertel said.

Miller, who has insisted that cancer control research can be done only in defined populations, said, "This is being put forward as a panacea. I will oppose it. I don't see how anything can be done. It can't be evaluated."

The Board agreed, with Miller objecting, to the concept of a new cancer control core grant program, and DRCCA Director Peter Greenwald said no program announcement would go out until after the next Board meeting.

HAMMER SAYS HE WILL PRESENT CASE FOR MORE NCI MONEY TO THE PRESIDENT

Armand Hammer assured his fellow members of the President's Cancer Panel that he would try to use his influence with Ronald Reagan to improve NCI's budget situation.

"I know first hand that President Reagan vigorously supports the National Cancer Program," Hammer said Tuesday at his first meeting as chairman of the Panel. "We will do all we can to encourage the Administration and Congress to give priority to the National Cancer Institute's budget."

Later in the meeting, John Potter, director of the Lombardi Cancer Center at Georgetown Univ., urged the Panel to take action against the proposed 12 percent cut in the 1982 budget. "A cut of that size would be highly deleterious to cancer research," Potter said.

Panel member Harold Amos agreed. "The number of issues have not shrunk, they have increased," he said. "We should not accept the decision to cut the Cancer Program along with everyone else. The needs have increased because of discoveries coming out of the Program. We should ask the President not only not to cut cancer funds, but to increase them."

"Very well said," Hammer added. "We have a duty to spearhead that action. I've already started it and will do more."

NCI Director Vincent DeVita told the Panel that a settlement had been reached with Eppley Institute

over the disputed amount arising out of charges that Eppley had performed unauthorized work under its carcinogenesis research contract. This had been an issue over which DeVita was severely criticized by members of the Seante for not pursuing it more vigorously.

DeVita said that from $500,000 to $800,000 had been in dispute, and that Eppley would repay $410,-000. More than $200,000 had already been recovered, DeVita said. Some of the disputed projects had been authorized after all, DeVita said. Also taken into into consideration in the settlement was the fact that one of the unauthorized projects had turned up the valuable finding that vitamin C blocked the carcinogenic action of nitrites, "and we had received our money's worth."

DeVita also reported on the status of the grant to Marc Straus, still under investigation by NIH and FDA for alleged irregularities while conducting clinical trials. Senators have insisted that Straus be stripped of his present grant. DeVita said that Straus' present institution, New York Medical College, had been asked to have Straus step down as principal investigator while the investigation was going on, but the college refused. The probe is 98 percent complete, DeVita said, and if it is not finished by the time the third year of the grant starts, it will not be funded.

"I think we did make a mistake in 1978 in not initiating an investigation then," DeVita said.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR NOV., DEC., FUTURE

Cancer and the Environment: Thresholds of Carcinogens—Nov. 2-4, New York Waldorf-Astoria. Sponsored by the International Study Center for Environmental Health Sciences. Topics will include concentration of harmful chemicals in the environment and in eventual biologic doses; absorption, distribution and interactions of potentially dangerous chemicals; multistep processes in human carcinogenesis, significance of risk declines after stopping smoking or changes in lifestyle; evidence for threshold concepts in humans. Cochairmen are Joseph Cimino, president of New York Medical College, and Harry Demopoulos, pathology professor at NYU School of Medicine.

Computer Tomography Scanning of the Brain—Nov. 4-6, NIH Clinical Center, Masur Auditorium, 9 a.m. each day. NIH consensus conference. Contact Dr. Michael Walker, director, stroke & trauma program, NINCDS, 7550 Wisconsin Ave. Rm. 8A08, Bethesda, Md. 20205, phone 301-496-2581.

Clinical Cancer Education Committee—Nov. 4, NIH Bldg. 31 Rm. 6, open 8:30–9:30 a.m.

21st Interscience Conference on Antimicrobial Agents and Chemotherapy—Nov. 4-6, Chicago. Contact R. Sarber, American Society for Microbiology, 1913 Eye St. NW, Washington DC 20006.

Pancreatic Cancer Review Committee—Nov. 4, Ambassador West Hotel, Chicago, open 8:30–10 a.m.

Hybridomas & Cellular Immortality—Nov. 5-6, Second Houston Symposium. Sponsored by the Univ. of Texas Medical School. Contact Sherry Smith, Office of Continuing Education, UTMS, 6431 Fannin, Houston 77030, phone 713-792-5436.

American Pancreatic Assn.-National Pancreatic Cancer Project Joint Meeting—Nov. 5-6, Chicago. Contact Dr. Isidore Cohn, NPCP, Louisiana State Univ. Medical Centerm 1542 Tulane Ave., New Orleans 70112.

Frontiers in Liposome Research: Targeted Chemotherapy—Nov. 5-7, San Francisco. Contact Dr. F. Szoka, School of Pharmacy, Univ. of California, San Francisco 94143.

International Symposium on Endocrinology of Cystic Breast Disease—Nov. 5-6, Turin. Sponsored by the Italian Society of Endocrinology. Contact Dr. A. Angeli or Dr. L. Dogliotti, Clinical Medica B, Universita di Turino, Via Genova 3, 10126 Turino, Italy.

Surgical Adjuvant Project for Breast & Bowel Cancers (NSABP)—Nov. 5-6, Toronto. Contact Dr. Bernard Fisher, Dept. of Surgery, Univ. of Pittsburgh School of Medicine, 3350 Terrace St., Pittsburgh 15261.

Fourth Annual San Antonio Breast Cancer Symposium—Nov. 6-7, La Mansion del Norte, San Antonio, Texas. Contact Marilyn Rennels, Office of Continuing Education, UTHSC, Floyd Curl Dr., San Antonio 78284, phone 512-691-6295.

Clinical Cancer Investigation Review Committee—Nov. 9-10, NIH Bldg 31 Rm 6, open Nov. 9, 8:30–9:30 a.m.

International Conference on Smoking and Youth—Nov. 9-11, Venice. Epidemiology, behavioral and social aspects, and prevention of smoking in young people. Contact P. Paccagnella, Universita degli Studi di Padova, Istituto di Igiene, Via Loredan 18, 35100, Padova, Italy.

Nutritional Management of the Seriously Ill Patient—Nov. 9-10, Mayflower Hotel, Washington DC. First Bristol-Myers Symposium on Nutrition Research. Program will include a presentation by Edward Copeland, Professor of surgery at the Univ. of Texas Medical School and M.D. Anderson Hospital, on the patient with malignancy. Contact Elizabeth Gerst, Director, Continuing Education Center, 630 W. 168th St., New York 10032, phone 212-694-3682.

Cancer 1981/Cancer 2001: An International Colloquium—Nov. 10-14, Shamrock Hilton Hotel, Houston. Sponsored by Univ. of Texas M.D. Anderson Hospital to mark the 10th anniversary of the National Cancer Program. Contact Dr. C. Stratton Hill Jr., UTMDA, 6723 Bertner Ave., Rm 115, Houston 77030, phone 713-792-2222.

New Needs in Cancer Education—Nov. 11-14, San Diego. American Assn. for Cancer Education. Contact Dr. Stephen Stave, Secretary, AACE, Childrens Hospital of Los Angeles, 4650 Sunset Blvd., Los Angeles 90027.

Breast Cancer: Controversies and New Directions—Nov. 11, St. Vincent Medical Center, Seton Hall Auditorium, 2131 W. Third St., Los Angeles. Topics include alternatives to mastectomy, adjuvant chemotherapy and its use in treatment of breast cancer, epidemiology, a detection demonstration followup, breast reconstruction, and the psychosocial impact of breast cancer. Sponsored by the medical center and the Community Hospital Oncology Program. Phone 213-484-7052.

Management of Advanced Cancer—Nov. 12-14, Amarillo. Inaugural Symposium of the Don and Sybil Harrington Cancer Center. Cosponsored by the Texas Tech Univ. Health Sciences Center. Contact Janie Brown, Office of the Medical Director, Harrington Cancer Center, 1500 Wallace Blvd., Amarillo 79106, phone 806-353-3571.

Controversies in the Management of Thyroid Cancer—Nov. 12, Roswell Park continuing education in oncology. Contact Gayle Bersani, RN, Cancer Control Office, RPMI, 666 Elm St., Buffalo, 14263, phone 716-845-4406.

Current Concepts on Cancer Management: Successful Treatment and Its Consequences—Nov. 13-14, Fairmont Hotel, San Francisco. Sponsored by Claire Zellerbach Saroni Tumor Institute of Mount Zion Hospital. Contact the Institute, PO Box 7921, San Francisco 94120, phone 415-567-6600 ext. 2125.

UICC Multidisciplinary Project on Breast Cancer—Nov. 17-20, Leeds Castle, Kent, UK. Contact UICC, 3 rue du Conseil-General, 1205 Geneva, Switzerland.
National Conference on Smoking and Health—Nov. 18-20, Waldorf Astoria Hotel, New York. Contact American Cancer Society, 4 West 35th St., New York 10001, phone 212-371-2900.
Cancer Center Support Grant Review Committee—Nov. 19-20, NIH Bldg 31 Rm 4, open Nov. 19, 8:30–10 a.m.
Seminar for Support Personnel Caring for Leukemia Patients—Nov. 20, Cornell Medical College. Contact Leukemia Society of America Inc., 215 Lexington Ave., New York 10017.
Clinical Oncology Society of Australia, Annual Meeting—Nov. 24-27, Univ. of Melbourne. Contact L. Wright, Executive Director, COSA, Box 4708, GPO Sydney, NSW 2001, Australia.
National Cancer Advisory Board—Nov. 30-Dec. 2, annual program review. NIH Bldg 1 Wilson Hall, 8:30 a.m. each day, all open.
NCAB Subcommittee on Planning & Budget—Nov. 30, NIH Bldg 31 Rm 11A10, 7:30 p.m., open.
NCAB Subcommittee on Board Activities & Agenda—Dec. 2, NIH Bldg 1 Wilson Hall, 1:30 p.m., open.
Tumor Cell Heterogeneity: Biologic & Clinical Implications—Dec. 3-4, Johns Hopkins Medical Institutions, Turner Auditorium, Baltimore. Fourth Annual Bristol-Myers Symposium on Cancer Research. Participants will review current findings that indicate cellular heterogeneity is a common characteristic of many cancers; analyze genetic and nongenetic causes of heterogeneity; and evaluate the impact of this research on clinical treatment of cancer patients. Contact Ellie Trowbridge, Symposium Coordinator, Rm 169, Johns Hopkins Oncology Center, 600 N. Wolfe St., Baltimore 21205, phone 301-955-2583.
Large Bowel Cancer Review Committee—Dec. 7, Eden Roc Hotel, Miami Beach, open 8:30–9 a.m.

Bladder Cancer Review Committee—Dec. 10-11, Logan Airport Hilton, Boston, open Dec. 10, 8:30 a.m.–noon.
Current Concepts in Cancer Therapy—Dec. 10-12, St. Louis. Sponsored by Washington Univ. and the American Cancer Society. Contact Office of Continuing Medical Education, Box 8063, 660 S. Euclid Ave., St. Louis 63110, phone 304-454-3873.
Clinical Cancer Program Project Review Committee—Dec. 14-16, Bethesda Marriott Hotel, open Dec. 14, 8:30–10 a.m.
Histocompatibility Antigens and Cancer—Dec. 14, Paris. Contact J. Levy, Hopital Cochin 27, rue Fg St. Jacques, 75014, Paris.

FUTURE MEETINGS

Gynecologic Oncology Group—Jan. 14-16, Omni Hotel, Miami. Business meeting. Contact John Kellner, Group Manager, GOG Headquarters, 1234 Market St. Suite 430, Philadelphia 19107, phone 215-854-0770.
Frontiers in Hematology/Oncology—Feb. 1-5, Sugarbush Inn, Warren, Vt. Cosponsored by Albany Medical College and St. Mary's Hospital Cancer Treatment Center of Troy, N.Y. Contact Linda Bonacquisti, Program Coordinator, Div. of Oncology, Albany Medical College, Albany, N.Y. 12208, phone 518-445-5361.
St. Jude Children's Research Hospital 16th Annual Clinical Symposium—Feb. 26-27, Memphis. Current results in treatment of children with cancer and leukemia. Emphasis will be given to diagnosis and treatment programs for primary disease as well as to the care of complications. Various aspects of supportive care as an essential adjunct to chemotherapy regimens will be covered. Open to the first 200 physicians who register (no fee required). Register by writing to Associate Director for Clinical Research, St. Jude Children's Research Hospital, Box 318, Memphis 38101.

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.

SOURCES SOUGHT

Title: *Computerized literature surveillance of natural products*
Deadline for submission of statement of qualifications: *Nov. 13*

NCI's Div. of Cancer Treatment is seeking small business sources (500 employees or less) to perform a project that requires surveillance of chemical, biological, and biomedical literature for natural products or extracts of natural products which may be of interest to NCI as potential anticancer agents by virtue of their chemical structures or reported biological activities. The project will include both comprehensive surveillance of current literature and limited retrospective searches of past literature on compounds or organisms or plants of special interest to NCI. The current literature searches should give chemical taxonomic, geographic and pharmacological data. The address of the senior author is given.

Search capabilities must include the ability to:

A. Conduct substructure searches on a wide variety of natural products structures which entails access to a chemical data base which is searchable by chemical names and common names of compounds as well as structural fragments.

B. Identify biological sources of compounds of interest including nomenclatural synonyms of these sources, collection location, isolated yields and criteria of identity.

C. Search the literature for biological activities of natural products (both crude extracts and pure compounds) which may relate to anticancer activity.

D. Identify new natural product structures which appear in the literature and synthetic analogs of natural products.

E. Identify natural products of plant, microbial and animal origin.

All of the above data must be entered into a computer system for subsequent retrieval by any of the parameters involved including chemical structure or partial structure, biological activity, common and chemical names of compounds and sources organisms or synonyms thereof.

The principal investigator must be trained at the

PhD level in organic, medicinal, or natural products chemistry or a closely related discipline and must be familiar with natural products structures and chemical searches as well as having background and experience with biological activity preferably in the cancer area. The PI must also have at least two years experience in working with computerized literature surveillance and retrieval. The staff members to be used on the project must be trained at the bachelors level in either chemistry, library work, or computer programming. The mix of staff used on the project must encompass all of these areas.

Computer facilities must be adequate to perform searches as required by the scope of the work. Retrieval of data must be available based on input of chemical names and common names of compounds, chemical structure fragments, names of organisms, and types of biological activity. The availability of the computer to the contract must be clearly defined.

A large library with extensive holdings in the areas of biology, chemistry, microbiology, pharmacology, biochemistry, and medicine is required for the project. The quantity of the journals and abstracting services available will be a major factor in evaluation of the proposals.

This synopsis is not a request for proposal. Interested organizations qualifying as small businesses are invited to submit complete information indicating the methodology, personnel, facilities and experience that would be utilized in accomplishing the above described project.

Contracting Officer: John Palmieri
RCB, Blair Bldg. Rm. 228
301-427-8737

SOURCES SOUGHT Synopsis No. 45

Title: *Production and maintenance of specific-pathogen free animals for cancer research*

Deadline for submission of statements of qualification: *Approximately Nov. 20*

NCI has a requirement to carry out a project to provide for the production and maintenance of specific-pathogen-free (SPF) animals for cancer research. The Japanese quail and white leghorn chickens must be maintained under strict environmentally controlled conditions which preclude infestation by parasites and pathogenic microorganisms including viruses. The meaning of the term specific pathogen free here is that all of the birds, both white leghorn chickens and Japanese quail, are free of the following avian pathogens: Mycoplasma synoviae; mycoplasma gallispeticum; salmonella pullorum; Rous sarcoma virus; Marek's disease herpes virus; infectious bronchitis virus; chicken embryo lethal orphan virus.

In addition, the SPF chicken embryos must also be tested for their phenotype (C/O, C/A, C/AB, C/BE, etc.) and the animals must be tested for the presence of Rous accessary virus one and Rous accessory virus two. The contractor shall produce and characterize approximately: 10,000 C/E, 700 C/O, 50 C/AB fertile white leghorn chicken eggs, 3,000 embryonated eggs and 200 young chicks and approximately 19,200 fertile Japanese quail eggs, 1,600 embryonated eggs and 100 young quail. The contractor shall ship these materials as directed by NCI to various investigators.

This is not a request for proposal. Organizations' capabilities will be evaluated on their capability to provide the above services as evidenced by the following types of information which must be provided:

1. Facilities—The contractor must have immediately available upon initiation of the contract appropriate facilities and specialized equipment, adequately contained in the biohazard and environmental control sense, for large-scale production of these SPF animals under barrier conditions which will not compromise their defined status.

2. A listing of previous contracts or work performed in propagation of chickens and quail under SPF conditions including experience in quality control and shipping.

3. Capabilities of principal investigator—Provide a description of the individual's previous experience and capabilities for production and characterization of avian species maintained under SPF conditions and specifically address prior experience in monitoring these animals for bacteria, viruses and phenotypic expression of desired traits (C/E, C/O, etc.).

4. The government will make the SPF flocks of Japanese quail and white leghorn chickens available at the current contract site. Any prospective contractor will be responsible to move these animals and maintain their specific pathogen free status to their prospective contract site. Offerors must describe in their response to this announcement specifically how they plan to carry out the move of these animals.

Responses should reference Synopsis No. 45 and should be submitted in 20 copies to:

Elizabeth Osinski
RCB, Blair Bldg. Rm. 114
301-427-8888

RFP N01-CP-11021-76

Title: *Preparation of antisera to oncogenic or potentially oncogenic viruses*

Deadline: *Approximately Dec. 18*

In Part A the offeror will inventory, maintain and distribute existing government owned antisera and replenish supplies of these reagents, including purification of the necessary antigens. It is estimated that no more than 10 liters of antisera to these agents or their subviral proteins will be needed per year, and the necessary virus will be supplied by the government until supplies are exhausted (note, no spleen

cell focus forming virus is available from the government).

In part B the offeror will prepare the hybridomas producing monoclonal antibodies directed against a) The src gene product of Rous sarcoma virus transformed cells; b) Spleen cell focus forming virus glycoprotein; c) The active sites of murine virus polymerases and d) Antigens unique to chemically transformed cells, including DNA adducts.

It is estimated that 50 ml per year of each of these antisera will be sufficient to satisfy program needs. Provision of the antigens for production of these hybridomas will be the responsibility of the offeror.

In part C the offeror will, from time to time, be directed to produced ascites derived monoclonal antibodies utilizing hybridomas provided by NCI. It is estimated that no more than 100 hybridomas per year will be submitted for this procedures, and approximately 300 ml of antibody containing ascites fluid will be required in each case.

Contract Specialist: J. Steve Metcalf
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RFP NCI-CP-21006-54

Title: *Seroepidemiology of Epstein-Barr virus*
Deadline: *Dec. 14*

The Biological Carcinogenesis Branch, NCI, has a requirement to continue for three additional years ongoing studies on the seroepidemiology of Epstein-Barr virus (EBV). The following specific investigations will be performed:

1. Participate in ongoing collaborative studies and initiate new collaborative studies with research and clinical investigators in different parts of the world. It is estimated that about 12 well chosen collaborative studies should provide significant information on EBV association or implications in a spectrum of diseases.

2. Determine the EBV serological patterns and the presence of EBNA in biopsy touch preparations and evaluate the significance of these findings with the clinical picture and cellular immune responses for subjects in the collaborative studies. The serological tests include, for three classes of immunoglobulins, EBV viral capsid antigen (VCA), EBV early antigen both the D and R types (EA-D, EA-R) and heterophil antibody, PBD type.

3. Maintain and operate a serum bank containing about 40,000 serum samples from patients (and controls) with Burkitt's lymphoma (BL), nasopharyngeal carcinoma (NPC), infectious mononucleosis (IM), B -cell lymphomas, cancers possibly associated with EBV, immune deficiency diseases, and from immunocompromised patients.

The collection will contain sera standardized for EBV serology and useful as reference antisera. Operation of the serum bank will include shipment reference sera to requesting investigators and institutions in the US and other parts of the world. Data pertinent to the sera shipped and information on specific methods for EBV serological analyses will be provided by the successful offeror. The successful offeror is also expected to acquire about 3,500 serum samples annually through the collaborative studies and other sources.

Contracting Officer: J. Thomas Lewin
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NCI-CM-27534

Title: *Operation of a salmonella/pseudomonas diagnostic laboratory*
Deadline: *Jan. 8, 1982*

The Animal Genetics and Production Branch, Developmental Therapeutics Program, Div. of Cancer Treatment, NCI, is seeking proposals from qualified organizations having the capabilities, resources and facilities for the operation of salmonella/pseudomonas diagnostic laboratory. The scope of this effort will be directed toward the bacteriological monitoring of all rodent colonies under contract to the section, and the research animals used for compound evaluation studies.

Emphasis will be placed upon the examination of fecal specimens for the presence or absence of salmonella spp. and pseudomonas spp. It is expected that approximately 9,000 fecal samples will be assayed for salmonella and pseudomonas per year.

It is anticipated that the award will be a negotiated fixed price contract for a period of one year with an option to extend the contract on a yearly basis for four additional years. The principal investigator's expertise and experience in the areas of microbiology directly concerned with the diagnosis of salmonella and pseudomonas infection in laboratory animals must be presented.

An important factor in the selection process will be the demonstration of an understanding of the significance of infection in small laboratory animals (mice) with various species of salmonella and pseudomonas.

Contract Specialist: Marlene Haywood
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