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

NCAB VOTES DOWN EFFORT TO DELAY CCOP RFA, DIRECTS SUBCOMMITTEE TO LOOK AGAIN AT PROGRAM COMPONENTS

The National Cancer Advisory Board last week voted down an attempt to delay start of the Community Clinical Oncology Program until after the Board's May meeting. Instead, the Board directed its Cancer

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In Brief

REAGAN ASKS $955 MILLION FOR NCI IN FY 1983, UP $13 MILLION OVER CURRENT LEVEL; PDQ IS COMING

PRESIDENT REAGAN'S request for NCI's budget in the 1983 fiscal year, announced this week in his budget message to Congress, was $955 million, an increase of about $13 million over the current 1982 spending level under the continuing resolution. It is at least $25 million less than the total Congress approved for 1982 (higher if the Senate figure is considered) but then reduced by four percent in the continuing resolution which provides interim financing through March 31. The Administration's request does not include the National Toxicology Program budget, which is almost $49 million in FY 1982 and which now is in the budget for the National Institute of Environmental Health Sciences. NCI will start telling congressional appropriations committees how it plans to spend the $955 million Feb. 22 (Senate) and March 2 (House) . . . . PDQ—THAT STANDS for Protocol Data Query, as well as "pretty damn quick," NCI Director Vincent DeVita told the National Cancer Advisory Board last week. PDQ will be a new information system to be developed from converting the existing CLINPROT to a system more easily available to physicians, patients and anyone else with access to a home or office computer. CLINPROT is a compilation of current cancer clinical protocols operated by the International Cancer Research Data Base. It contains only detailed protocol data which DeVita said he thinks "is not very useful" to practicing physicians or the public. PDQ will include the protocols without quite so many details, but also "what is treatable, where it is available, where it is being done," DeVita said. References to publications will be included, permitting physicians to look up any details on treatment regimens they may need. PDQ will be available through one of the national computer communications systems and should be "cheap, popular and effective," DeVita said. The idea was suggested by Richard Block of the H & R Block income tax service. No additional NCI funds will be required, with the cost to come out of the ICRDB budget for CLINPROT. . . . **BARUJ BENACERRAF**, president of Sidney Farber Cancer Institute, has contributed his $72,000 share of the 1980 Nobel Prize to the institute. He won the award for his studies of the immune system, sharing it with George Snell of Jackson Laboratory and Jean Dausset of the Univ. of Paris.

NCAB GOES ALONG WITH CCOP, BUT SOME MEMBERS APPREHENSIVE OVER DETAILS

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Control Subcommittee to take one last look at the proposed components of the program before NCI issues a request for applications in early April.

The motion by Rose Kushner to delay the RFA until May was defeated by a 6-4 vote. William Powers, Sheldon Samuels and Philippe Shubik joined Kushner in voting for the delay. Opposing were Harold Amos, Maureen Henderson, Robert Hickey, Gale Katterhagen, Frederick Seitz, and Morris Schrier.

Katterhagen, chairman of the Cancer Control Subcommittee, said it would meet in Washington prior to the March 4-7 meeting of the Assn. of Community Cancer Centers.

Board members objected to the fact that a final draft of the RFA had not been presented to them. NCI Director Vincent DeVita pointed out that anyone who sees an RFA before it is published is not eligible to compete for an award through the program, and his institution is also barred from the competition.

NCI's practice is for staff to write the RFAs after the appropriate advisory groups have had the opportunity to discuss the proposed programs and offer suggestions for changes. No RFA can be issued until the appropriate Board of Scientific Counselors has given the program concept approval. In the case of CCOP, the Div. of Resources, Centers & Community Activities Board approved the concept.

The NCAB's role is advisory, but DeVita has said he will not proceed with any program or project which the NCAB disapproves.

CCOPs will be funded through cooperative agreements, in the same category as grants, and the NCAB by law must approve grants exceeding $50,000 before they may be awarded.

Some members felt that the NCAB should have been more involved in developing guidelines for the program and objected to a "lack of specifics" in the presentation to them. DeVita responded that the program had been in development for a year, had been the subject of several meetings of a DRCCA Board subcommittee and an ACCC committee, and had been thoroughly discussed at two DRCCA Board meetings. Representatives of cooperative groups and centers took part in those meetings.

Powers pointed out that a preliminary draft of the proposed RFA had been discussed at the January DRCCA Board meeting (the draft appeared in ***The Cancer Letter*** Jan. 22). DeVita said that draft had not been intended as a final one and was subject to revision.

DRCCA Director Peter Greenwald presented what he said was the rationale for CCOP as a cancer control effort and described its cancer control objectives. By doing some significant portion of clinical research in communities, new treatment methods will be more quickly disseminated, Greenwald said.

A new treatment proven in part in the community becomes a part of community private practice faster than with the present system of dissemination through publication, meetings, continuing education, etc.

Greenwald noted that with the Cooperative Group Cancer Control Program, protocol compliance and treatment results are at least as good with the community affiliates as they are with the university based members.

CCOP objectives are, Greenwald said:

- To help set up and implement national cancer control priorities.
- To test the diffusion hypothesis, that when some patients in a hospital or in a physician's private practice are on research protocols, other patients in the same settings benefit.
- To establish a communications network for professional and public education.

Greenwald said that he expects CCOP members, once the program is up and going, to participate in cancer prevention efforts.

Samuels asked how the program would be evaluated. "Several ways," Greenwald answered. "I have separated program management staff from those involved with evaluation, and we have applied for (HHS) evaluation set aside funds. Also, this is a research program, with measurable objectives—mortality, the diffusion hypothesis, numbers of patients going onto national protocols."

"Do you intend to evaluate as you go?" Henderson asked. Greenwald said evaluation would be implemented when the program is implemented.

Hickey asked how CCOPs would seek out affiliations with research bases (centers and/or cooperative groups). Greenwald said many groups are already talking with each other.

"This process has brought about getting centers, groups and communities together," Katterhagen said. "It is a healthy process."

Kushner said she at first had been opposed to the program but has always felt that "people want to be treated at home" and "I learned an awful lot in California (where she attended presentations on CCOP at the AACI meeting and a workshop at St. Vincent Medical Center). This could be the greatest thing to come down the pike, if care is given to writing the guidelines. I think the first group (of CCOP awards) ought to be limited to 25. I would like to see some questions answered before the program gets any bigger than that. How much is it going to cost? One thousand dollars per patient? Five hundred or two thousand? I'm scared of the idea that five corner oncologists can get together a CCOP."

Greenwald said that most of the answers to questions being asked are already in the guidelines.

"There are some answers, but for some questions, there just aren't any answers yet," DeVita said. "There is no way of knowing until we try it. Five corner oncologists can't become a CCOP unless they have a hospital, can demonstrate that they treat a certain number of patients, and meet the other criteria we have established."

Board member Janet Rowley said she was concerned about the number of programs which may be established and the cost per patient.

Greenwald said the estimate of $1,000 per patient was based on existing costs of other clinical trials.

Rowley asked how diagnosis and staging would be confirmed.

William DeWys, chief of the Clinical Investigations Branch in the Div. of Cancer Treatment, said the research bases would provide those services. "They have the structure for that. They will review pathology and perform other services required to monitor and follow the progress of clinical trials."

Amos suggested that the goal of 200 CCOPs, a figure DeVita said was "soft," would "not begin to affect treatment results around the country."

"I don't agree," Greenwald said. "If we have geographical spread and set up a participatory process, I think that number is enough to have an impact."

Noting that CCOP, unlike previous cancer control demonstration efforts, would involve a long term commitment of NCI support, Henderson asked what the criteria would be for ending the program.

"That is linked to criteria for stopping our clinical trials program, and the answer is when there is no longer a need for clinical trials," DeVita said.

"This Board is called upon to take a more serious view of this proposal," Amos said. "Not that it is not a good idea, but we may be opening Pandora's box. The closer we are linked to the community, the closer we will be to community problems. What's the rush? Why can't we see the RFA?"

"You can see it, but if you see it in advance of publication, you compromise your institution's ability to participate," DeVita said. "This is the only cancer control program we have had which was started one year ahead (of the decision to implement), with everyone having the opportunity to suggest ideas."

Powers insisted that if the RFA were to be discussed publicly at a public meeting, no one should be compromised. "There are a number of details that need to be worked out. There will be fantastic competition for these awards. Releasing publicly a draft of the RFA will not compromise this Board."

But Board Chairman Henry Pitot said he would not take the responsibility of possibly eliminating his institution from participation. He suggested that Katterhagen's subcommittee review the RFA.

DeVita pointed out that Katterhagen could not take part in reviewing the RFA without jeopardizing his institution's chance to compete for a CCOP award, and that his expertise as a community physician (the only one on the Board) would be needed in any further consideration of the program by the subcommittee or Board.

Amos, who had supported a delay on issuance of the RFA, said, "I've changed my mind. We've all heard all of the ideas. If we can't deal with the RFA, there is no reason to delay it."

Shubik said he favored a delay because "there seems to be lots of misgivings about it. This is a grant program, which the Board has ultimate responsibility for."

"The subcommittee can do it as well," Pitot said, "and any Board member can go to the subcommittee meeting."

After Kushner's motion was defeated, Pitot said the subcommittee would consider all the various components of the program without seeing the RFA itself and would report to Board members by letter. If any major issue should arise "we would still have the potentiality of changing the RFA."

Some members of the Assn. of American Cancer Institutes expressed concern over the impact CCOP will have on centers.

AACI President Timothy Talbot said at the organization's meeting at UCLA, "I'm confused and a little frightened. . . . I don't see that there are the tools for this."

Greenwald said he did not agree, that the tools which make CCOP possible are the increasing numbers of oncologists practicing in communities.

Denman Hammond, chairman of the Childrens Cancer Study Group which has one of the Cooperative Group Cancer Control Program contracts, said, "This proposal is intended to supplant the existing program. It won't increase participation, even if it is a better mechanism. There are hundreds of institutions and dozens of research bases. This hasn't been thought through."

"I have great concerns," Talbot said. "This new program is being dumped on us without testing."

CCOP recieved a friendlier reception at the St. Vincent workshop, when DeVita, Greenwald, and NCI Deputy Director Jane Henney described the program.

After outlining the program, DeVita said, "Ultimately, I see a large number of community hospitals involved in clinical research, with the spinoff that their patients will get better care."

Greenwald listed the qualifications for applying for a CCOP award:

1. It can be a single hospital, clinic, or a group of physicians, or a consortium of any of those.

2. It must have a multidisciplinary team—surgeons,

radiation oncologists, medical oncologists, nurse oncologist—"A critical mass required for good care."

3. It must define an administrative area. "Some spot in the hospital, some place to keep data together, for data management and quality control."

4. It must have a written agreement with a research base.

"You would be putting some of your patients into national protocol studies. You would participate in designing protocols. It's up to the community hospital groups to take the initiative and have something worked out in advance with the research base."

A CCOP will be expected to affiliate with only one research base unless there is a reason to have more than one, such as a disease or modality oriented cooperative group. Affiliations with distant cancer centers will be discouraged if it means leapfrogging a closer center. "If you are in Los Angeles and your research base is a cancer center, we would expect it would be one of the two comprehensive centers in Los Angeles," Greenwald said.

5. The CCOP applicant must describe its service area.

6. A CCOP will be expected to contribute a minimum of 50 patients a year to national protocol studies. "How it will be determined which of your patients that will be is something you will have to work out with the research base. It will not be dictated by NCI."

Questions from the audience and the answers:

What if you can supply a need to a research base outside your geographic area?

"If you had a great source of breast cancer patients and there was no need for them in your area, there would be no restriction against affiliating with a national cooperative group," DeVita said. "The 50 patients is a minimum. We're looking for a percentage, something like 12 percent, per disease. That is something for you to negotiate with your research base. If you agree with the USC center that you will provide nothing but lung cancer patients, okay. But if USC needs some of your other patients, you will have to agree."

What would happen if a CCOP can't agree on the "tithe" with its research base?

"If you contribute 120 lung cancer patients and your research base doesn't want them, your support would be terminated," DeVita said.

Can a CCOP have a relationship with a cooperative group and with another research base?

"You can have a primary affiliation with a research base which has an array of multidisciplinary activities," Henney said. "You can have a secondary affiliation with other groups for nonconflicting protocols."

Will CCOPs participate in protocol design?

"There may be a lot of protocols coming from communities," DeVita said. "A lot of protocols have been developed in the past without any thought to their use in the community. Cancer centers will have to listen to what you need. I think you'll participate a great deal more than you have before. You'll have a lot more say so."

Hammond pointed out that 80 percent of pediatric patients are treated in major pediatric hospitals. "Fifty patients a year is a big number. I would suggest that some different number be established for pediatric patients, and also a higher proportion, maybe 50 percent."

"You hit on a very important point," DeVita said. "Drop the minimum, increase the tithe."

What will be the nature and amount of support?

"What we seem to have available is $10 million," DeVita said. "We don't know how many will apply. We don't know if the $1,000 per patient is realistic. Some institutions have told us that they may be willing to accept CCOPs without any cost, that they already have the systems in place for handling data, and adding patients will not increase their costs."

Will the day to day management of patients contributed to protocols still be in the community hospitals?

"Yes," Greenwald said. DeVita added, "There will always be a need for some patients to go to other institutions. Maybe there should be some weighted credit given for those patients. In the past when we have said patients have to go to centers, what we meant was, they had to go to persons with the expertise. Now that can be in community hospitals, and will be in most cases."

What can we do when a research base does not want to run concurrent controls? What can we do when a research base wants $500 a patient?

"If the research base presents demands not acceptable to you, don't go with them. Get another research base," DeVita said.

Will CCOPs obtain the grant money and then subcontract what is necessary to the research base?

"Direct funding will go to the communities," DeVita said. "If necessary, then some payments will be made to the research base. You will negotiate that."

If a CCOP estimates it will contribute 200 patients a year, and then puts in 350, will funding be adjusted?

"That's a good question," DeVita said. "I have no answer. It will depend on the funds available. The question is, if you gave enough, why give more?"

DeVita has said that group C drugs (those found effective against one or more tumors but which are not available commercially and which NCI now distributes free to qualified physicians) may, when the CCOPs are operating, be distributed through them.

Those will not be used (necessarily) in protocols. You've given CCOPs another job that can cause serious problems.

"You don't have to do it," DeVita said. "There will be doctors who don't want to belong to a CCOP but do want group C drugs."

A panel of Los Angeles area physicians expressed their thoughts on the program.

Robert McKenna, surgical oncologist, noted that the reaction of center representatives was "totally different than we see here. They're not sure they can do it or that they want to. . . . I think it will cost more to collect and handle data than you may think. But I encourage all of you to be involved. This is the reason ACCC exists. You all have wanted it. Here it is."

Philip Dreisbach, medical oncologist, said, "I feel like there's a gun at my head. If we don't get in, we'll be left by the wayside."

"This has a very positive side," DeVita said. "I hope it's not a have to do it or you're out kind of thing."

Ronald Koons, radiation oncologist, asked if the research base will be responsible for quality control.

"You must have quality control," Greenwald said. "That can be negotiated with the research base."

DeVita said that David Plotkin, medical oncologist and a member of the panel, "started bugging me about this a long time ago." Plotkin said that in a talk at an ASCO meeting about six years ago, he asked the question, "Can clinical investigation be done in private practice? The answer was, sure, if you'll let us."

Vincent Guinan, president of St. Vincent Medical Center, was host for the workshop. Barry Sakulsky, principal investigator for the St. Vincent Community Hospital Oncology Program, and Joseph McKernan, PI for the California Hospital CHOP, were the moderators.

MINORITIES SUBCOMMITTEE SUGGESTS NINE "PROMISING" AREAS OF RESEARCH

The National Cancer Advisory Board's Subcommittee on Cancer in Minorities recommended nine of what it considered the most promising areas for research related to disturbing data which show black patients suffer cancer earlier, have a much smaller percentage localized when seen and have significantly less five year survival for such important cancers as colon, prostate, bladder, larynx, uterus, cervix and breast.

Subcommittee Chairman LaSalle Leffall, in presenting the subcommittee's report to the Board, said that American Cancer Society statistics show that 160 deaths a week would be prevented if blacks had the same rates as whites.

"Our committee believes its primary concern is how to decrease the burden of cancer among minorities, especially blacks, because the problem is greatest in this group," Leffall said. "Therefore we vigorously recommend consideration by the appropriate groups at NCI of measures to rapidly put in place at least some of the research efforts that seem most promising."

The report's recommendations:

1. "A major review be developed as rapidly as possible on geographical pathology of cancer in blacks. Dr. J.S. Harrington of South Africa was willing to come to the United States—and still is—to do this. This would statistically examine the various leads and suggestions, and would include the African observations, where they might be useful for comparative purposes. Only limited funds are needed, and, when Dr. Margaret Sloan discussed this with us, she felt it could be done by contract, very rapidly.

2. "There have been some misgivings concerning the validity of the statistical data regarding the incidence of cancer in blacks 1950-1980. This, too, could be undertaken very rapidly by Dr. Cuyler Hammond (with the assistance of one or two young people, who would then simultaneously be trained in this area).

3. "The influence and significance of migration. This is a straightforward problem and could be well studied in three institutions--Martland in Newark, Howard in Washington and Harlem in New York). Primarily, the essential in this research would be its design. The active involvement of Dr. Joseph Fraumeni and Dr. Peter Greenwald of NCI would be most helpful. Perhaps this could be done by contract. Here, Dr. Hammond's approach would be highly useful and again several young people should be involved, especially if they were to later be responsible for the field work.

4. "Comparison of factors in cancer incidence among blacks and whites, with attempt to minimize economic factors. This can only be done in an optimum way, prospectively. Following our discussions in March, Dr. Irving Selikoff reviewed the matter with the AFL-CIO which, in turn, reviewed it with the American Federation of State, Municipal & County Employees. It was found that they would be happy to cooperate with scientists.

5. "Detailed investigation for the poorer five year survival. This, again, could be undertaken in several large centers in the country and, again, collaboration with Dr. Greenwald and Dr. Fraumeni would be ideal. The cities that come to mind would include Los Angeles (Jose Vargas, Helene Brown, Charles Drew School of Medicine); Houston (Robert Hickey), New Orleans, Washington-Baltimore, Miami, Puerto Rico (Marcial), San Francisco, New York, Detroit.

6. "Industrial differences. Here the Workers Institute for Safety & Health (Sheldon Samuels) would be able to make important contributions.

7. "Specific pointed research projects with regard to some of the suggestions for the greater increase of cancer in blacks (less educational effort concerning cancer, poor screening, delayed diagnosis, stress, difficulties in entering the health care system.

8. "Life style factors (residence, pollution, occupation, childhood illness, age at onset of work, general health status, crisis orientation, food, water supply in childhood, fungus and molds, housing, etc.).

9. "Immediate and urgent research on the major cancers killing black people; why the lung cancer increase in the last 20 years? What multifactorial factors?"

The subcommittee met with a special ad hoc committee of ACS to consider how NCI and the Society could coordinate their efforts aimed at dealing with the problem. ACS representatives said they believed the Society's best role would be in educational programs which it would organize and sponsor. The following programs related to cancer and minorities have been scheduled:

—Workshop on Cancer in Hispanics, March 3-5, in Albuquerque.

—Workshop for Social Workers, April 28-30, in St. Louis.

—National Nurses Workshop on Cancer Education and Care for Black Americans, May 5-6, in New York.

—Second National Conference on Cancer in Minorities, April 28-30, 1983, in Memphis.

ACS also has developed new public education materials for minorities and three films have almost been completed. The Public Information Committee also has developed new TV spots for minorities.

Leffall's report pointed out that NCI is planning to initiate a study to explain black/white differences in survival, a three year project. The proposal will be submitted Feb. 26 to the Board of Scientific Counselors of the Div. of Cancer Cause & Prevention for concept approval. It would be a joint project with the Div. of Resources, Centers & Community Activities. Joint funding would include up to $150,000 a year from DCCP and $250,000 a year from DRCCA.

The proposed joint study would be a retrospective analysis of patient records to look at the possible role of prior medications, previous malignancies and treatment thereof, delay in seeking medical care, concurrent illnesses, indicators of socioeconomic status, extent of disease, cancer therapy and supportive care, and cause of death. Also, a longitudinal study of new cancer patients would be conducted, looking at behavioral and other factors.

The project would focus on both biological and behavioral/life style aspects of the black/white differential in patient survival. Four sites selected on the basis of the magnitude of survival differences and relative frequency of occurrence would be explored—endometrium, breast, colon/rectum, and urinary bladder.

The DRCCA Board of Scientific Counselors has already approved the concept of this project, including the $250,000 a year share of the cost.

Leffall also noted in his report that Congressman Mickey Leland (D.-Texas) is submitting a bill entitled the Minority Cancer Control & Prevention Act. It is still in the early stages of the legislative process.

SOLOMON GARB LOSES HIS FINAL BATTLE WITH CANCER; ARCHITECT OF CANCER ACT

Solomon Garb, one of the principal architects of the National Cancer Program, died Feb. 4 in Denver after a 15 month personal battle with cancer. He was 61.

Garb's death ended a career devoted to the fight against the disease in the clinic, in Congress, and anywhere he could find an audience of one or thousands, in person or by mail.

Garb was chairman of the Citizens Committee for the Conquest of Cancer, through which he directed letter writing campaigns to generate support for the Cancer Program. He was appointed in 1970 to the Senate Select Committee for the Conquest of Cancer, headed by Benno Schmidt and the late Sidney Farber. The committee presented its recommendations to the Senate in 1971, and that led to passage by Congress of the National Cancer Act of 1971. The Act brought about a four-fold increase in the level of federal support for cancer research, including a substantial increase in NCI's support of clinical trials.

Garb, a clinical pharmacologist, never stopped fighting for increased attention and money for clinical trials. "We need basic research, but we also need help for the patients we have right now," he said repeatedly in his pleas to NCI and Congress. As director of the American Medical Center at Denver, he developed numerous protocols with investigational drugs and claimed significant increases in survival for many of them.

Garb was one of the first to see the potential of THC in reducing nausea and vomiting induced by chemotherapy. When he became a patient himself, he used his THC protocol on himself, noted his reactions and developed a method for overcoming the hallucinogenic effects of the compound.

When Garb discovered he had stomach cancer in November, 1980, he underwent extensive and severe chemotherapy which ended last October. Soon after, there was widespread recurrence. Further surgery and treatment failed to halt the disease.

Garb is survived by his wife, Hildreth, and their three sons, James, Gordon, and Richard.

Interment was at the national cemetery in Fort Logan, Colo.

A fund for programs in medical fellowships to aid in the fight against cancer has been established. Contributions may be sent to the Solomon Garb Memorial Fund, Colorado Savings & Loan, 6631 S. University Blvd., Littleton, Colo. 80122.

NCAB DELAYS UNTIL MAY FINAL DECISION ON FATE OF FOUR ORGAN SITE PROGRAMS

The National Cancer Advisory Board put off until its May meeting any decision regarding the fate of the Organ Site Program as the result of the report from the Ad Hoc Review Committee (see the Feb. 5 issue of *The Cancer Letter* for the complete text of the report).

The NCAB's Subcommittee on Organ Site Programs had considered the report in its meeting prior to the meeting of the full Board last week. The subcommittee recommended that the report be accepted but was not ready to recommend acceptance of the report's recommendations (as was reported in *The Cancer Letter*). Chairman William Powers said the subcommittee needed more time to consider the report and would meet for two days, March 31-April 1, in open session, to further review it and develop a set of recommendations.

Powers asked the Board to accept the report without any reference to the recommendations. Board member Janet Rowley offered a motion which would have in effect eliminated the four projects in the Program as discrete, targeted efforts. That motion was defeated when Powers' motion to table was approved by a 7-4 vote.

The Ad Hoc Committee summarized the report and recommendations as follows:

"The reviewers: a) reaffirmed the value of conducting research targeted to a specific organ site; b) believed there were advantages in decentralization if government regulations could be kept at a minimum; c) recommended that headquarters costs be significantly reduced by 1) elimination of excess personnel, and 2) combining many services, including review, for all of the projects; d) strongly recommended increased emphasis on basic science and discontinuing support of large scale clinical trials; and e) recommended improved communication, especially among project directors."

Rowley said it was clear that attention focused on the four organ sites by the program has led to increased research on them. "But we need to reexamine the changing science and realities. It seems to me there is substantial support for these outside the program. The major strength of the program has been increasing dialogue among investigators. I therefore offer the following motion:

"1. That the Organ Site Program be reorganized so that some of the planning and management functions continue to be carried out by leadership groups located outside of NCI. These groups should be responsible for organizing the various scientific activities such as symposia and workshops that pertain to focused organ site programs. These programs should include all relevant investigators regardless of the source of their support.

"2. That as suggested in recommendation 8C [of the report], all grants be reviewed under the aegis of the Div. of Research Grants of NIH." [Grants awarded through the program now are reviewed by separate groups of "working cadre" for each of the four projects—bowel, bladder, prostate, pancreas. The report listed review by NIH study sections as only one possibility. Others were: form one review committee for all four projects, with representatives expert in each of the sites; or consolidate the review into bladder-prostate and bowel-pancreas groups.]

"3. That the Organ Site Subcommittee meet as planned to clarify the scope and role of the leadership group; to determine the most appropriate method for selecting each leadership group; to assist in the orderly transfer of research grants from the current review system to DRG; to inform the Board at its next meeting of the recommendations."

Rowley said acceptance of the committee report "would imply willingness of the Board to accept the Organ Site Program in some respects as it is constituted—continuing the working cadre, reviewing grants by the program. The thrust of my motion is that that is not acceptable."

Powers said that acceptance of the report is not an endorsement of the recommendations. "The subcommittee felt we couldn't act now."

"The Organ Site Program clearly needs modification," Philippe Shubik said. "The subcommittee should be given time to report back. The subcommittee merely stated that it wants time to look over the report and make recommendations.

Powers said that in addition to the two day meeting, the subcommittee should schedule another meeting on the Sunday prior to the May Board meeting.

"We've had a couple of years to think about it," Maureen Henderson said. "Dr. Rowley's motion puts limits on the subcommittee's discussion, and focuses it. It would save a great deal of time, if we make the basic decision now to return all grants to DRG."

Powers' motion to table was supported by Rose Kushner, Sheldon Samuels, Robert Hickey, Frederick Seitz, Morris Schrier, and Henry Pitot. Opposed were Rowley, Gale Katterhagen, Harold Amos and Henderson.

PROGRAMS EXPIRING OR UP FOR RENEWAL OFFER BUDGET FLEXIBILITY, CARTER SAYS

Realization that existing cancer control programs which either are expiring or are up for renewal concept approval could affect a significant portion of the cancer control budget grew at the recent meeting of the Div. of Resources, Centers & Community Activities Board of Scientific Counselors (*The Cancer Letter*, Jan. 29).

Board Chairman Stephen Carter made a few calculations and came up with the observation that the Breast Cancer Detection Demonstration Project,

Centralized Cancer Patient Data System, OSHA pass through funds, Cancer Communications Network, the Community Hospital Oncology Program (not to be confused with the new Community Clinical Oncology Program) and the Cooperative Group Cancer Control Program are costing a total of about $14 million a year; and that (2) cancer center outreach grants are costing $10.7 million a year. All are either up for concept approval, have already been marked for phaseout, or were originally intended to terminate within the next two years.

"That's one half of the cancer control budget," Carter said. "The potential for flexibility is phenomenal. It is enough to fund the Cancer Control Research Units, and the CCOPs, with a lot left over for chemoprevention. We may have up to 50 percent of the budget to play with."

SHUBIK APPLAUDED FOR NCAB SERVICE "UNDER DIFFICULT CIRCUMSTANCES"

Last week's meeting of the National Cancer Advisory Board was the final one (barring reappointment) for Chairman Henry Pitot, Bruce Ames, Harold Amos, Marie Lombardi, Frederick Seitz, and Philippe Shubik.

For Shubik, it ends a 20-year period of service as one of NCI's principal advisors. He joined the National Advisory Cancer Council in 1962, went off for four years, and then was a member when the Council was upgraded to the NCAB in 1972. One of the world's foremost scientists in carcinogenesis, Shubik was sometimes the target of strong criticism from those who did not agree with his views in that field. Criticism mounted when the Eppley Institute, which he headed, became the target of various investigations. Although the probes cleared Shubik of all charges, Eppley's role as a major carcinogenesis research center was severely diminished, and Shubik left to return to research at Oxford.

Board members applauded and agreed unanimously to the following statement:

"The National Cancer Advisory Board in acknowledging the contribution of members whose terms end with this meeting wishes to express its recognition of a special debt to Dr. Philippe Shubik. Dr. Shubik has served the Board with distinction at times under unusually difficult circumstances. The members of the Board wish to affirm for the public record their support of Dr. Shubik whose integrity and high standards have proved invaluable to the deliberations of this body."

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 N01-CP-25613-59

Title: *Tumor promotion in cynomolgus monkeys (macaca fascicularis)*

Deadline: *April 15*

The scientific objective of this project is to establish support to the Div. of Cancer Cause & Prevention of NCI utilizing cynomolgus monkeys (macaca fascicularis). These animals will be maintained under conditions which permit close observation, frequent manipulations and an optimum environment. Chemical carcinogens and tumor promoting agents will be furnished by NCI and the contractor will administer to the test animals under specific protocols in an attempt to demonstrate tumor promotion in this species.

Chemicals may be administered by one or more parenteral (intraperitoneal, intravenous or subcutaneous), or by the oral route (as a dietary component, in water, or by gavage), according to specific protocols. This project will require close collaboration as well as the exchange of unstable chemical solutions. Biological specimens, such as blood, serum, plasma, secretions, and/or excretions, will be collated and processed for testing or storage as required by the NCI.

A three year and six month effort is anticipated in the effective pursuit of this project.

Contract Specialist: J. Roland Castle
RCB, Blair Bldg. Rm. 2A07
301-427-8764

NCI CONTRACT AWARDS

Title: Cancer Communications Network

Contractors: Univ. of Wisconsin, $682,812; Sidney Farber Cancer Institute, $649,342; Fox Chase Cancer Center, $671,452; Memorial Hospital for Cancer & Allied Diseases, $834,838.

Title: NTP computer support

Contractor: Enviro Control Inc., $3,002,490.

The Cancer Letter _Editor Jerry D. Boyd

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