THE CANCER LETTER

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AACR, ASCO, ONS FLEX POLITICAL MUSCLES, SEEK CHANGES IN CANCER ACT, OTHER LEGISLATION, FUNDING OF GRANTS

Increasing pressures caused by the tightening federal budget, dissatisfactions with review and funding of grants, and a growing awareness of

(Continued to page 2)

In Brief

MUELLER, ROSENBERG HEAD AACR, ASCO; ELION, SCHEIN PRESIDENTS ELECT; PHS OFFERS EPIDEMIOLOGY TRAINING

GERTRUDE ELION, head of experimental therapeutics at Burroughs-Wellcome, was elected vice president and president elect of the American Assn. for Cancer Research at last week's annual meeting in St. Louis. PHILIP SCHEIN, chief of medical oncology and assistant director for clinical research at the Georgetown Univ. Vincent Lombardi Cancer Research Center, was named president elect of the American Society of Clinical Oncology. GERALD MUELLER, McArdle Laboratory, is the new AACR president, replacing SIDNEY WEINHOUSE. SAUL ROSENBERG, Stanford Univ., is the new ASCO president, taking over from JOHN ULTMANN. Other new AACR officers are ROBERT HANDSCHUMACHER, Yale Univ., secretary treasurer; and MARGARET FOTI, executive director. FREDERICK PHILLIPS, Memorial Sloan-Kettering, retired after five years as secretary treasurer, and the new office of executive director will assume the AACR housekeeping duties formerly handled by Phillips and his predecessors. New members of the AACR board of directors are ISAIAH FIDLER, ROBERT PARKS JR., ELLIOTT OSSERMAN, and Phillips. Other new ASCO officers are DAVID AHMANSON, secretary treasurer; ELI GLATSTEIN and SHARON MURPHY, new members of the board of directors; and GIANNI BONADONNA, JOAN BULL, DAVID FISCHER, DONALD MORTON, and FRANCO MUGGIA, members of the nominating committee, with Bonadonna chairman. . . . VINCENT DEVITA will receive an honorary doctor of science degree from his alma mater, William & Mary, at the college's commencement exercises this month. He received his bachelor's degree there in 1957. The NCI director received another honor last month, the James Ewing Award from the Society of Surgical Oncology. . . . EPIDEMIOLOGY TRAINING program supported by the Public Health Service is available for up to 12 persons a year who have an MD, a doctorate in an allied health profession, or PhD in a biomedical or behavioral science. Trainees attend a university at government expense to study epidemiology, biostatistics, and related subjects for one year, then work two years with senior epidemiologists at participating PHS agencies, including NIH. Salaries are $30,000 a year for physicians, $21,000 for others. Education and relocation expenses are provided. Contact Robert Gordon Jr., MD, Steering Committee, NIH Bldg 1 Rm 238, Bethesda, Md. 20205.

AACR ASKS FOR EMPHASIS ON R01s, CUTS IF NEEDED IN P01s, CENTERS

(Continued from page 1)

Their political clout resulted in a spate of actions directed at the National Cancer Program by members of the nation's three largest cancer societies at their annual meetings last week in St. Louis.

• Members of the American Assn. for Cancer Research approved a motion asking the organization's board of directors to formulate a policy statement opposing funding cutoffs based on arbitrary priority score paylines and asking that more money be made available for R01 grants, if necessary at the expense of program projects, centers and contracts.

• Members of the American Society of Clinical Oncology approved the report of their Public Issues Committee expressing opposition to some elements of legislation now making its way through Congress, and support for others. Members also went along with a call by outgoing ASCO President John Ultmann for a revision in the National Cancer Act to remove the requirement for appointment of special interest members of the National Cancer Advisory Board.

• Members of the Oncology Nursing Society—now, with nearly 4,500 members and thus the largest and potentially most politically powerful of the three societies—approved a resolution calling on Congress to amend the National Cancer Act to require appointment of a cancer nurse to the NCAB and calling on the President to appoint a nurse oncologist without waiting for congressional action.

The AACR motion was approved only after a brisk floor fight, and a substantial minority voted against it. The discussion was initiated by George Mandel, George Washington Univ., who said similar action had been taken by the Assn. of Medical School Pharmacologists.

"We are concerned about medical research funding," Mandel said. "There is a crisis. Younger people have to rewrite grants which have been approved but not funded. There should be a broad base of scientific investigators. We need more of them, who prove they are good. We need stability. Obviously, we need more money for research. That is unlikely for the present, although that should be a long term goal. There is a need now for temporary adjustment.

"We are concerned over the all or none effect in awarding grants," Mandel continued. "A grant with a 150 priority score could be funded at as much as $1 million, while another at 151 would get nothing. There really is no difference in the quality of those two. One way of meeting that problem would be by funding grants on a sliding scale.

"Also, there should be careful review of all programs, contracts, and centers. The R01 grant is the best way to get the maximum amount of research. We agree that overhead must be reduced, although our administrators think differently. Also, we are suggesting that a limit be placed on the total amount of money going to an individual investigator."

Mandel pointed out that some NIH study section members, including the microbiology and pathology sections, have expressed support of similar positions (*The Cancer Letter,* April 16).

Enrico Mihich, Roswell Park, said he agreed with the proposal, with one note of caution. "The peculiar nature of our needs sometimes is best served by the program project, multidisciplinary approach. I would agree with the proposal if program projects were included."

A suggestion was offered from the floor that an individual investigator should be limited to no more than two awards from all federal agencies and that a total limit be placed on such awards of $200,000 in direct costs. "There may be special needs of our clinical colleagues and others in excess of that, but $1 million a year going to one investigator is a bit excessive."

James Holland, Mt. Sinai, said he had "great respect for George's view, but I take exception that this can be acted on by an assembly this large." Holland moved that the AACR board of directors consider the issues without a vote by the membership, but others objected and the discussion continued.

NCI Director Vincent DeVita said that the central issue is, "Do we pay grants as far as we can go, or do we spread the money out? The President's Cancer Panel [at its Boston meeting] found the sentiment is, spread it out. In fact, NCI has been trying to stretch available money over more grants. Also, the fixed payline is not arbitrary."

Another issue, DeVita said, "and a most important one, is the suggestion that we support career investigator awards." He said awards for five years to investigators with a track record, with five more years after review, is one approach being considered.

"We tried the sliding scale approach, and it was not very satisfactory," DeVita continued. "We have found that study sections already are using an informal sliding scale. A priority score of 100 gets 95 percent of its budget request, while those with lower scores get something less.

"We should think carefully about limiting the number of grants going to an individual. That causes concern whenever we bring that up. To deny a grant to someone who gets a priority score of 150 because he already has two would be very difficult."

Van Potter, McArdle Laboratory, offered the motion that "it is the sense of this body that we favor Dr. Mandel's suggestions."

Richard O'Brien, Univ. of Southern California, objected. "That subverts the intent of the recommendation to the board. An endorsement would tie the hands of the board."

"It would help to have some expression of principle," Mandel said. "Time is of the essence."

Paul Carbone, Univ. of Wisconsin, said he was "in favor of principle, but I'm not sure what the principle is. If it excludes program projects and collaborative clinical research, I would oppose it. I would accept the principle of opposing arbitrary priority score funding cutoffs."

Holland's attempt to table Potter's motion was defeated on a show of hands. AACR President Gerald Mueller then called for a vote on the motion, "That the membership favors the ideas put forth by Dr. Mandel and they should be carefully considered by the board." The motion carried by a majority of about 3-2.

Denman Hammond, chairman of ASCO's Public Issues Committee, reported on positions the committee has taken on legislation and on other issues:

–Small business set asides. Various bills in the House and Senate would require setting aside of one to 20 percent of research budgets for awards to small business. Hammond said ASCO opposed those bills and requested that, if any are adopted, biomedical research be excluded. He said that California Congressman Paul McCloskey had agreed to lead a floor fight for an amendment excluding biomedical research, if necessary.

–An amendment to Medicare legislation providing for hospice care. "That's a worthwhile objective," Hammond said. "Unfortunately, the bill provides that to be eligible for reimbursement, patients must be certified as terminal and must forfeit other Medicare benefits. It is not well written." Hammond recommended that ASCO members from states with members of key congressional committees contact them and urge clarification of the bill.

–The committee took stands supporting NCI and DeVita's leadership through last year's hearings, opposed cuts in NCI's budget and supported continuation of the bypass budget.

–The Community Clinical Oncology Program. "This is a matter of great importance to our members," Hammond said. "The committee recognizes the potential merits of the program, endorses it, but is concerned about some aspects and details of its implementation. ASCO includes in its membership a majority of oncology clinical investigators. The very persons responsible for development of CCOP and its outcome are in this room. Yet, this society was not involved in planning of CCOP, although other organizations have vigorously been involved. We urge that NCI involve the society more in planning and development of CCOP and other clinical programs."

At an earlier ASCO session, David Fischer, Yale Univ., reported on the current status of reimbursement for drugs by Medicare and other third party payers:

–Reimbursement for outpatient chemotherapy, while accepted by most third party payers when the drugs are administered in hospital clinics, has not been generally accepted when the treatment is performed in physicians' offices. An ASCO study has found, Fischer said, that outpatient chemotherapy is one third less expensive in offices than in hospitals, is equally effective, and that patients usually prefer going to their physicians' offices rather than hospitals. Some third party payers have agreed to reimbursement for office treatment, and others are considering it, Fischer said.

–Medicare reimburses for drugs only when purchased and administered by physicians and then billed to the patient. Payment is at the average Red Book wholesale price. "The problem is that often there has been a price increase between publications of the Red Book," Fischer said. "You have to be on your toes. The price may fluctuate monthly, while the Red Book is published yearly."

–Reimbursement for drugs not yet approved by FDA for marketing. Recent rulings have relaxed those restrictions, and Medicare is going along with paying for drugs as long as they are approved by hospital pharmacy or drug committees or their equivalent.

How about drugs approved by FDA for one indication when used for others? "FDA says that an approved drug can be used for any indication (deemed appropriate by qualified physicians), except those expressly disapproved." Medicare has agreed to reimburse in those instances.

Reimbursement for Group C drugs (not for the cost of the drugs, which are supplied free by NCI, but for their administration) also is being made, Fischer said.

Ultmann, in his presidential address, was critical of what he called "the governance of the cancer establishment" by the National Cancer Advisory Board.

"How can we improve the governance of the cancer establishment?" Ultmann asked. "In order to insure that budgetary decisions are made mainly on a scientific basis, we must stress the need to reverse the unwholesome politization of many aspects of the National Cancer Program and in particular, of the National Cancer Advisory Board. The NCAB consists of six basic scientists, six physicians, and six lay persons as well as a large number of ex officio members. They are responsible for overseeing the National Cancer Program and the manner in which the director of NCI and the division directors, advisory boards and review committees, etc., are carrying out the mandates of the National Cancer Program. The major function of the NCAB is peer review of science, that is, assurance of the integrity of the peer review process and broad advice to the Cancer Program. More

recently, Congress and certain lobby groups—certain lobby groups—have influenced the composition of the Board so that now it appears there are specific constituencies that either demand or have de facto representation on the Board.

"To compound the problem and to further confuse the main goal there is now contemplated a legislative mandate for the NCAB to review all contracts. From my own personal experience on the DCT Board of Scientific Counselors, where all DCT contracts were thoroughly and regularly reviewed, and from my knowledge of the other divisional advisory boards in NCI, such a charge to the NCAB is wholly unnecessary and will lead to the further creation of lobby or interest groups and to diversion from the main function of the Board. There is a need to return to the basic functions of this scientific review board. The review and advisory body should be the most ecumenical of all boards and its politization should be halted, and indeed, reversed.

"I would like to quote from a summary by our ASCO Liaison Representative to the NCAB [Virgil Loeb]: 'The problems of wrestling with a restrictive budget are formidable and the National Cancer Advisory Board has simply got to come to grips with the establishment of funding priorities based upon long term goals and policies. Young investigators need to be attracted and supported; established centers need to be stripped of their nonessential fat; competing programs need to be coordinated, combined, and/or eliminated; basic and clinical centers of excellence deserve identification and support. The NCAB needs to assert its leadership role in order to assist the director in coping with and adjusting to the awful reality of a restrictive budget. At no time has it been more important for concerned individuals to cast aside their parochial interests and to share the awesome responsibility of assigning priorities to the support and implementation of the Cancer Program in the future.'

"This year the National Cancer Act is before the House and Senate for reconsideration. The NCAB must give reasoned arguments for the broad pursuit of research and the necessary legislation to continue the National Cancer Program. I cannot stress to each and everyone of you that you must take personal responsibility for pressing for the renewal of this Act. In view of the explosion of biologic knowledge, in view of the successes of the past, in view of the overall structure which we have in place to carry out cancer research, cancer prevention and cancer care, we must all take initiative for assuring continuation of this successful enterprise. I ask you and the officers of ASCO to help me achieve this. I ask the present NCAB to put narrow interests aside and to provide Congress the needed scientific advice for continuation of the National Cancer Act.

"I would like to turn to how we can improve the regulatory milieu. The regulatory mechanisms governing clinical research have grown so enormously, that some investigators have expressed concern regarding viability of the research process. The entire milieu of regulation is derived from an "expectation of evil" based on dismal experiences in World War II, on the present litigious climate, and on the errors of a minority. This milieu is not helpful to the process of investigation, to the investigator, and to the patient being studied because research is impeded and new data are not obtained. Clearly, the burden of unnecessary paperwork must be decreased and we will all welcome improvements in other aspects of regulation. Some of the paperwork is self inflicted by our own institutions, by many federal agencies other than NCI, and by NCI.

"I recommend that NCI examine its entire paper work requirement and streamline the entire process setting an example for all NIH. I further recommend that each of us continue and improve compliance with regulations in a spirit of constructive cooperation as we attempt to reduce the overall load of regulations.

"The impression from the recent congressional hearing that there is a tug of war between the NCI and the FDA is incorrect. There has been an evolving working relationship between the cancer research arm, the NCI, and the drug regulatory arm, the FDA. The relationship is working well. Differences are mainly in scientific interpretation, exposed to the public as scientific discrepancies should be. Much has been accomplished that has improved and simplified the flow of drugs. Obviously, more needs to be done and is being done."

Ultmann called on ASCO members to "take a strong stand" on antismoking efforts "and to labor vigorously on behalf of a number of initiatives to reduce smoking, including the newly proposed labeling bill of Representative Waxman and Senators Packwood and Hatch. This, together with your personal efforts at the local level, is certain to decrease cancer mortality with potentially over 150,000 lives saved annually, beginning five or 10 years from now. Let us start an 'epidemic of nonsmoking' throughout the country by setting the best example."

Among other problems facing cancer research and technology transfer, Ultmann said, is "Problem 1: We have a communication problem. The challenges we face today are largely the product of the magnitude of the cancer problem, the success and growth which have been achieved in the past decade, and the current, apparent crisis of confidence in science. If one listened to some congressional hearings, if one listened to the Washington press and to certain television programs which have less than 20/20 vision, one would get the impression that the public has become disenchanted with science and technology. It might appear that cancer research has become one of

its main targets. Nothing could be further from the truth.

"As I travel around the country and talk to cancer research workers and clinical oncologists, and to many representatives of the press, as I assess the pulse of my own patients and their families, I sense sympathy for the difficulty of our task. Cancer is still a major concern of the public. The public wishes to learn of all advances in cancer research, and the majority of the press at the national and local levels are reporting these developments in a responsible way.

"ASCO has a responsibility to provide the facts. ASCO cannot stay aloof from the struggles needed to support basic and clinical research and must help the public, Congress, and state agencies understand the critical role of biologic research, the need for cancer research and the special problems of the cancer care system. I think our profession needs to radiate reasoned optimism, because there are so many things which we can convey that attest to our success: the improved curability rates; the creating of 20 comprehensive cancer centers; the expansion of specialized cancer centers to number over 60; the major expansion of radiotherapy facilities and programs; the creation of dedicated cancer research facilities across the nation; the training of over 3,500 oncologists who deliver a caliber of care not available a decade ago; the creation of a surgical oncology training program; and many more."

Ultmann used the term "certain lobby groups" twice in referring to appointments to the NCAB, undoubtedly referring to the two which managed amendments to the National Cancer Act. One was the unorganized but effective coalition which demanded that five NCAB members be persons knowledgeable about environmental or occupational carcinogenesis or nutrition relating to cancer. The other was the Assn. of Community Cancer Centers, which succeeded in adding a requirement that two NCAB members be physicians primarily engaged in the treatment of cancer patients.

Ultmann might well have added a third "certain lobby group," because it is one that will be a major force from now on—the Oncology Nursing Society.

While ASCO and AACR, quite justifiably, have been congratulating themselves on the growth and development of their organizations, ONS has been quietly going about building its membership to where it far exceeds the other two. ASCO and AACR now list about 3,000 members each; ONS surpassed 4,000 before the St. Louis meeting, in only the seventh year of its existence (ASCO observed its 18th annual meeting, AACR its 75th anniversary).

ASCO members felt quite comfortable last week with the treasurer's report, that it had a surplus of $94,000 and that that would be increased by about $40,000 during the next year.

ONS members debated what to do with their quarter of a million dollar surplus, decided it would be prudent to maintain a reserve equal to an entire year's budget, and initiated plans to fund scholarships for oncology nursing masters degree students.

ONS members have observed that ACCC, with an individual membership total of about 500, has been very effective in lobbying Congress and key members of the federal Executive Branch. They already have done some low key lobbying and intend to step that up by a considerable margin. First on their agenda was a resolution diametrically in the opposite direction of Ultmann's demand—one more specialized appointment to the NCAB, of an oncology nurse.

The resolution noted that "Whereas, the partnership between research and community has been enhanced by the appointment of community physicians to the National Cancer Advisory Board; and whereas there are highly professional nurses who meet the eligibility criteria to serve on the National Cancer Advisory Board; and whereas the Oncology Nursing Society, over 4,000 strong, endorse and contribute to this progress; be it resolved that the Oncology Nursing Society urges the renewal of the National Cancer Act with increased funding for cancer research and programs; and resolved, that the Oncology Nursing Society supports an amendment to the National Cancer Act providing for the appointment of a cancer nurse to the National Cancer Advisory Board; and be it further resolved that the members of the Oncology Nursing Society strongly urge the President to immediately appoint a cancer nurse to serve on the National Cancer Advisory Board."

Sidney Weinhouse, wrapping up his leadership of AACR in its diamond anniversary year, said in his presidential address that the cancer researcher "is in the crossfire of this raging controversy" over ecological and health hazards perceived by the public.

"People are afflicted with a new neurosis we could call chemochondria or even chemophobia," Weinhouse said. "Seventy-five or even 50 years ago, cancer was perceived by the public as a Pandoran curse upon mankind, almost never discussed outside the clinic, and then only in anguished whispers. Today, cancer is headlined in the media; it is the subject of political debate in the halls of Congress and is in fact one of the 'raisons d'etre' of burgeoning regulatory agencies and a myriad of regulations that are perceived by conflicting polarized interests either as economic calamities or absolute necessities for human survival."

The cancer researcher "has virtually been dragged from his ivory tower into the rough and tumble arena of political debate and political action," Weinhouse continued. "He or she now is in an unenviable spot—as 'the expert' expected by an anxious public to have 'answers' even to problems that have no easy answers; problems that involve potential risks to large popula-

tions, have exceeding economic consequences and impinge upon conflicting interests. At the same time, his modus operandi is not understood.

"Much of the general public, and this includes many of the vested interests, is either oblivious to or chooses to ignore the methodologic and statistical principles that govern the testing for carcinogenicity and also do not recognize the difficulties and pitfalls of the gathering and interpretation of experimental and epidemiologic data. The expert who has to conduct and interpret experiments in animals is up against a pervasive attitude of the lay public that such tests are meaningless; and this view is often fostered by vested interests whose chief weapon is ridicule.

"In the tempest of these conflicting views and public misconceptions, the cancer researcher...has to navigate cautiously. . . using as his compass the principles of ethics and sound science. Where the animal data are clear and statistically significant, he must state as an article of faith, on which our whole science of biology depends, that if a substance is carcinogenic to animals it is a potential carcinogenic hazard to some people. This viewpoint, though buttressed by a compelling body of sound scientific evidence, is the focus of great controversy and misunderstanding.

"As long as the cancer researcher stays within the bounds of his science he is fulfilling his role to society. He should have the courage of his convictions declare substances to be potential human carcinogens when the evidence is there; and it is then up to the public, through its official channels, to decide how to deal with such substances. However, at the same time he should not allow himself to be pressured, as he so often is, into putting numbers on risk estimations, particularly as sometimes happens, on the basis of dubious data and on uncertain mathematical models. It is very important, I believe as a general principle, to remember that in certain instances the most honest and accurate answer is, 'We don't know.' "

Weinhouse expressed concern over future funding of cancer research.

"One cannot reflect on the current state of cancer research today without some apprehension for the future. I need not dwell on the dismal prospects for research funding. Although we can take some comfort from the fact that cancer has, at least not yet, been hurt too badly, as have other federally funded programs, we cannot be altogether sanguine, facing what appears to be a widespread compression of the country's whole research enterprise. The golden age of generous support of science, which has made our country the model for the rest of the world, appears be in decline. While we are still outwardly healthy, it does not take special diagnostic insight to detect signs of serious illness.

"In the face of these dire prospects, our most pressing need is to maintain the momentum and the quality of cancer research. If funding declines, and if there is no way to stem this tide, where should the ax fall? What should go and what has to be retained? I would urge the National Cancer Advisory Board and other leaders and policy makers of the national cancer enterprise to spare the basic research effort. Let us remember that in our current state of knowledge the cancer problem is as broad as the whole field of biological science."

ECOG DEVELOPS GUIDELINES FOR CCOPs; NEW AFFILIATES CONDITIONAL FOR YEAR

The Eastern Cooperative Oncology Group, one of the national cooperative groups with which some of the organizations planning to compete for one of the Community Clinical Oncology Program awards hope to use as their "research base," has developed a set of guidelines for CCOP admission to the group. The guidelines were approved by ECOG's Cancer Control Committee.

ECOG separated CCOP admission into two categories—those institutions currently in the group's Cancer Control Program and those which are new to ECOG. The Cooperative Group Cancer Control Program supports through contracts with NCI's Div. of Resources, Centers & Community Activities extension of group clinical research protocols into community hospitals. Those hospitals may compete for CCOP awards but if successful, must give up their present contract support.

Under the ECOG guidelines, current ECOG cancer control institutions would be required to file information on resources, beds, radiotherapy units, other capabilities, and CVs for all professional personnel. Admission as a CCOP would require approval by the ECOG Executive Committee.

For CCOPs with no previous ECOG affiliation, the same requirements would apply, plus:

—The application would be reviewed by the ECOG Cancer Control Steering Committee which would make a recommendation to the Executive Committee.

—New CCOPs would be on conditional status the first year. After the first year they will automatically be on full status if their participation is evaluated as satisfactory by the ECOG Executive Committee. Ordinarily this would mean entering a minimum number of patients into ECOG protocols as specified in the CCOP application to ECOG with satisfactory and timely data quality.

For those CCOPs which are consortia of institutions, ECOG would require a statement of rules and governance which outlines how the principal investigator is selected, term of office, policy and administrative committees, how CCOP funds are allocated, etc.

These general conditions would apply to all CCOPs

joining ECOG:

- All CCOP investigators are entitled to participate in all ECOG activities, including protocol design, steering committees, Executive Committee, etc.
- All CCOPs would be governed by the existing constitution and bylaws of ECOG.
- One condition of CCOP acceptance into ECOG would be formation of an institutional review board in each participating institution which has received a special or general assurance from NIH to participate in the ECOG program.
- In addition to the practical activities, all CCOPs must participate in the scientific activities of ECOG as they relate to community hospital activities. In the past this has required responding to surveys, questionnaires, and taking part in case studies.
- All CCOPs would automatically be entitled to two representatives on the ECOG Cancer Control Committee. This representation is the same as any other ECOG member institition. Since membership on the ECOG Cancer Control Steering Committee is either by election or representing an ECOG committee, the Steering Committee will be enlarged by the group chairman appointing one member from the entire CCOP to the Steering Committee. The intent is to guarantee at least one CCOP representative on this committee. This does not preclude other CCOP investigators serving on this committee by virtue of election or being a representative from another ECOG standing committee.
- A CCOP as a total unit is responsible for following all patients entered on ECOG protocols. Serious infractions by one or more CCOP institutions may result in penalties (freezing of randomization, probation, termination of ECOG affiliation). In order to minimize the administrative problems in obtaining followup information, each CCOP investigator must submit a statement agreeing to follow all ECOG patients in which he/she is listed as the physician of record. In the event such followup cannot be carried out, each CCOP investigator gives permission in advance for a CCOP or designated ECOG representative to have access to all hospital and patient records for the purpose of obtaining followup and other information needed to evaluate the ECOG studies. Also permission is given to contact (if necessary) the patient, family, or other individuals, who can supply the missing information. All costs to obtain the missing followup information will be borne by the institution credited with the initial patient entry. The permission to access the patient records must be signed by an authorized institutional official and approved by the Institutional Review Board.
- The ECOG Cancer Control Steering Committee will be prepared to advise and review potential CCOPs in preparing any applications for funding which relate to ECOG participation.

ECOG Chairman Paul Carbone said that the guidelines are not "hard and fast. . . . We felt we needed some uniform way of approaching negotiations with CCOPs. These will provide the basis for negotiation."

Jerome Yates, associate director for centers and community programs in DRCCA, said the ECOG guidelines were not in conflict with NCI's plans for implementing CCOP.

NCI CONTRACT AWARDS

Title: Services in support of the primary drug screening program, continuation
Contractor: IIT Research Institute, $259,994.

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-CB-23907-34

Title: *Bank for human breast cancer*
Deadline: *July 19*

NCI wishes to contract to obtain, prepare and bank breast tissue, histologic sections and serum in a frozen state and to make such specimens and their associated clinico-pathologic data accessible to other investigators who are developing new markers for use as diagnostic or prognostic tests in breast cancer.

Contract Specialist: Elizabeth Abbott
RCB, Blair Bldg. Rm. 332
301-427-8877

RFP NCI-CM-37554

Title: *Quick reaction work order contracts*
Deadline: *Approximately June 7*

The Drug Synthesis & Chemistry Branch of the Div. of Cancer Treatment, NCI, is seeking organizations for the synthesis of a variety of organic/inorganic compounds. The primary focus will be on the synthesis of organic compounds. It is the intent of DS&CB to establish these with laboratories as quick reaction work order contracts.

Quick reaction contracts are master contracts negotiated and awarded to more than one contractor. These contracts are designed to accomplish a specific task as rapidly as possible.

The objectives of this project are: (a) the resynthesis of known compounds of varying degrees of complexity for confirmatory testing; (b) the resynthesis of a limited number of compounds in large quantities sufficient for extensive biological evalua-

tion; (c) the synthesis of unique compounds with reported biological activity; (d) the synthesis of potential radiosensitizer/radioprotectors; (e) the synthesis of unique compounds in support of the intramural program.

Approximately 300 compounds will be synthesized during each contract year and these will comprise roughly 40 individual work orders. It is expected that individual work orders will be issued quarterly. It is anticipated that 10-12 master contracts will be awarded.

Twenty percent of these contracts will be set aside for award to small businesses. A small business for the purposes of this procurement is 750 employees or less. The SIC number is 2833.

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

RFP N01-CM-25612-58

Title: *Technical support for the review and evaluation of biological response modifiers*

Deadline: *June 21*

The Biological Response Modifiers Program of NCI seeks a contractor to provide for the collection, storage, compilation and organization of available preclinical and clinical data on biological response modifiers. The function will include literature review and development of a relevant bibliography and a brief one page synopsis, sending requests for published information to investigators.

Information concerning the nature, biological activity, source and availability, manufacturing process, standards of purity and potency, consistency, stability, and toxicity should be included in the information gathering process and in the data files.

The contractor will be required to abstract data on each BRM from the paper files and place the information in a machine readable form as specified by the project officer. In this capacity the BRMP contractor will interface with an in place NCI computer contractor who will transcribe the information into searchable computer files. The BRMP contractor shall provide updated BRM information additions in a machine readable form to the NCI computer contractor for expansion of the data base. The BRMP contractor will have no direct role in the automated data processing and rapid data retrieval functions related to BRM agents.

The contractor will also be responsible for the adequate security and safekeeping of all data files and protecting the confidentiality of all privileged information contained in any data file.

An estimation of time commitment to the project would be PI 400 hours, staff scientist 2,500 hours, assistant scientist 1,500 hours, and 2,000 hours for typing/editing service per year. The contractor will deliver 6,400 hours during year one; 5,700 hours for year two, and 5,200 hours for year three. Any award resulting from this solicitation will be restricted to organizations located in the U.S.

Contracting Officer: Damian Crane
RCB, Blair Bldg. Rm. 212A
301-427-8737

RFP NCI-CM-37552-24

Title: *Screening of congeners and detailed evaluation of antitumor agents*

Deadline: *July 21*

The Drug Evaluation Branch of the Developmental Therapeutics Program, Div. of Cancer Treatment, NCI, is seeking organizations with resources, facilities and the expertise to examine drugs for anticancer activity in murine leukemic and solid tumor systems.

The objective of the studies is to provide DCT with a resource for comparative evaluations of 300-400 congeners and prodrugs in tumor-bearing mice. The contractor also will be expected to devise appropriate laboratory experiments in response to questions that might arise during the preclinical development, toxicological evaluation or clinical trial of specific agents, or in the response to questions raised by the Food & Drug Administration in the course of reviewing investigational new drug applications. Experimental results will be transmitted to DCT via a computer terminal.

Minimum requirements for the proposed effort are the following:

1. The principal investigator must have an MD degree, a DMV (or VDM) degree, or a PhD degree in pharmacology, tumor biology, biochemistry, or immunology.

2. The contractor must provide facilities/equipment to maintain a conventional rodent colony to hold a minimum of 8,000 mice in holding and quarantine per week.

The offeror may not be a pharmaceutical or chemical firm as compounds of a discreet nature may be evaluated.

It is anticipated that one incrementally funded contract will be awarded for a period of three years.

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