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NCI TO OFFER COMPROMISE ON INCLUDING "CHOP-LIKE ELEMENTS" IN CCOP, AGREES CONSORTIA "APPROPRIATE"

NCI has developed a compromise proposal on the issue of including some cancer control elements in the Community Clinical Oncology

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In Brief

O'BRIEN WILL LEAVE USC TO BECOME MEDICAL SCHOOL DEAN AT CREIGHTON; DRCCA ADDS NEW STAFF MEMBERS

RICHARD O'BRIEN, who has been interim director of the USC Comprehensive Cancer Center since Denman Hammond left that position last year, has accepted the deanship of his alma mater, Creighton Univ. School of Medicine, effective Nov. 1. O'Brien has been at USC for 16 years, at the cancer center for seven. He said he has agreed to stay on through the move into the center's new building, now scheduled for Sept. 1. "It was a very difficult decision to leave USC," O'Brien said. "The cancer program here is very strong, and I had an important role in helping build it. I feel a great sense of loyalty to Creighton, and the chance to give something back to it as dean of its medical school is a very strong attraction. But I'm not through dealing with cancer." Joseph Van Der Meulen, USC health affairs vice president, said a successor to O'Brien will be chosen by a search committee. . . . MORE NEW STAFF appointments in NCI's Div. of Resources, Centers & Community Activities were announced last week by Director Peter Greenwald. Leslie Ford, from the HHS Bureau of Quality Assurance, will work with Jerome Yates and Robert Frelick on the Community Clinical Oncology Program. Olga Joly has been assigned to the Clinical Manpower Branch and Neil Grunberg will work on smoking programs; both are on the staff at the Uniformed Univ. of Health Sciences. Demetrius Albanes and Kathy Helzlsouer, on two year assignment from the Center for Disease Control, will work on chemoprevention programs. . . . ROBERT McKENNA, Univ. of Southern California, was chosen president elect of the Society of Surgical Oncology at the recent annual meeting in Florida. Gerald Murphy, director of Roswell Park Memorial Institute, is the society's 1982 president. Other officers are Jerome DeCosse, Memorial Sloan-Kettering Cancer Center, executive committee chairman; Hiram Polk, Univ. of Louisville, vice president; Charles McBride, M.D. Anderson Hospital & Tumor Institute, secretary; and Robert Hutter, St. Barnabas Medical Center, treasurer. . . . JOHNS HOPKINS spokesman says the university will not form a separate, nonprofit corporation to administer the Frederick Cancer Research Facility contract, if the university wins the competition for the research operations (*The Cancer Letter*, April 16). The contract would be administered directly by the university and FCRF scientists would be university employees, he said.

NCI TO COMPROMISE ON CANCER CONTROL ELEMENTS IN CCOP; TO NCAB MAY 19

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Program which will be submitted to the National Cancer Advisory Board next week when the Board is scheduled to take one last look at the program before the request for applications is released.

Details of the compromise were not available this week. ***The Cancer Letter*** learned only that a compromise had been reached on including some "CHOP-like" elements in the program. CHOP is the Community Hospital Oncology Program the current program supporting development of cancer control activities in 23 communities.

NCAB member Gale Katterhagen presented the case for including some cancer control elements in CCOP, citing some of those carried on in CHOPs, when the Board discussed CCOP in February. He argued that these would foster participation of community physicians in CCOP and suggested it might be the only way to assure that an adequate number of patients would be entered into research protocols.

NCI Director Vincent DeVita has resisted including any additional cancer control activities in CCOP (insisting that encouraging community physicians to take part in clinical research is cancer control). DeVita fears that the additional cost would reduce the number of CCOPs that could be funded and that might make review of the proposals too difficult.

Katterhagen, Board member Rose Kushner and members of the Assn. of Community Cancer Centers have continued to argue for inclusion of cancer control at every opportunity. Apparently, they were convincing, and the compromise reportedly was included in a summary of the provisions which will be included in the RFA which was to have been sent to all NCAB members this week.

The CCOP discussion is scheduled for Wednesday morning, May 19, at 8:30 a.m. The Board's Subcommittee on Cancer Control & the Community, chaired by Katterhagen, will meet Sunday evening, May 16, prior to the start of the three day meeting of the full Board May 17.

ACCC's position was stated in a letter to Katterhagen by David Johnson, president of the Association.

"From the outset of this program, the community physicians and administrators within the Association have understood that this new NCI program would include, in Dr. DeVita's words, a 'quid pro quo,' " Johnson wrote. "On the one hand, NCI will receive a new infusion of patients entered on clinical trials. On the other, participating communities will receive sufficient funding to establish and carry out a CHOP-like program, thus affecting a larger percentage of patients and their families, and providing the referral base for a program which intends to enter 50 or more patients on protocol each year.

"As you know, many of our current members are members of the clinical research outreach programs of the national cooperative groups. These members point out that there are limits to the number of patients which they, acting alone, can enter onto protocols. In general they state that the oncologist without the active support of physicians in their institutions cannot expect to put more than 30 or 40 eligible patients onto protocols in a single year. Moreover, the very patients which Dr. DeVita and NCI desire to have entered onto protocols (because of their scarcity) are those that are controlled by primary care physicians. If these physicians are not involved in the program, if they are not given some recognition of their role in cancer care, if they are not shown that some aspects of the program are intended to help all cancer patients at their institutions, they will actively work against CCOP.

"It is this realization that leads the Board of the Association to unanimously endorse the need for a cancer control component in CCOP," Johnson's letter continued. "For a very few dollars, a program can develop and maintain CHOP-like activities. They require the attention of a full time administrator (something that is likely to be necessary in any case if you have a clinical research effort involving three or four different research bases, with a concomitant number of forms for their protocols), an administrative secretary, a data system for patient management information, some active, functioning committees, and support staff for data collection. Since the clinical research component will also require staff support for data collection and some administrative coordination, we do not see the cancer control component as introducing an onerous burden on the program."

Johnson also expressed concern over some implications of the regional restrictions NCI has said will be imposed in the program, which would limit CCOP affiliations to research bases closest to them, although permitting exceptions when appropriate.

"Surely you cannot review the CCOPs on the basis of the research base involved," Johnson wrote. "All of the early versions of CCOP have limited the community's ability to select a research base, by geography and in other ways. One cannot then penalize those CCOPs in a region which must affiliate with a center that may have less interesting protocols.

"Either all research bases are created equal (and all of their protocols are considered of relative value) or NCI must review all the research bases and their selection of protocols and determine which are acceptable. Or, NCI must lift the regional restrictions. If NCI finds a community's capabilities to be excellent, and the research base to be inadequate, perhaps the CCOP can be approved and given a certain amount of time to realign with a satisfactory re-

search base.

"We believe that regionalization is a good idea. The review of specific protocols and/or centers is not. If this is done, the review will quickly become a review of the centers and cooperative groups, not the communities. Instead, given that NCI has stated that all research bases are created equal (for purposes of the CCOP), we believe what needs to be reviewed is the community's willingness to put patients on protocols that the community and the research base mutually agree are 'high priority protocols.' While it is unrealistic (and unnecessary) for all patients entered on clinical trials to be placed on 'high priority protocols,' it is important for a community to make a commitment to put a significant portion of patients on these types of protocols.

"In short, what we would find difficult for reviewers to consider is a larger number of applications from a large number of communities without discussion of community support and community administrative capability, with instructions to review and rate multiple protocols from multiple centers and groups demonstrating widely varying degrees of priority in the eyes of different reviewers. This type of review is likely to skew the selected CCOPs and research bases in several ways, effectively disenfranchising whole sections of the country while it limits the ability of the applicant to choose a competitive alternative.

"Instead, what is needed is a review of the administrative base created by a well organized community cancer control program, the community physician support engendered by a program that is inclusive rather than exclusive, the experience of one or more key investigators, and a demonstrated and documented interest in putting patients on clinical trials, including some percentage on protocols deemed high priority by the research base and community center in consultation.

"These aspects, in conjunction with the detailed agreement and technical aspects outlined in the original drafts of the RFA, are all we could expect a reviewer to consider."

Johnson said ACCC also was concerned about comments made by DeVita and other NCI staff regarding a preference, at least in the first round of CCOP competition, for single institutions rather than consortia.

NCI staff originally intended to encourage consortia applications, theorizing that this approach would bring in more community physicians as participants, make it easier to reach patient accrual goals, and help smooth local rivalries.

DeVita and his staff apparently had some second thoughts, and switched directions at a CCOP workshop in Florida. It was there that DeVita indicated single institution applications might be more welcome.

The issue came up at the St. Louis meeting of the American Society of Clinical Oncology. Jerome Yates, who heads the NCI office which will oversee CCOP, was asked to explain why single hospitals would be preferred.

"In dealing with a single hopsital, we would have a set administrative focus," Yates said. "But in the end it will depend on what reviewers think in evaluating the applications. It may be that some consortia will be just as efficient. Consortia will be fine, if they look efficient and feasible."

The final RFA will not state, as did an earlier draft, that consortia are "encouraged," but will say that they "may be appropriate."

"We don't want five institutions each putting in 10 patients," one NCI executive told ***The Cancer Letter.*** "But there may well be some areas where three or four institutions together present the most workable solutions. Our original intent was that it would be better to have all or most hospitals in a community working together. But we were seeing complicated consortia developing because one alone couldn't put in enough patients."

Johnson, in his letter to Katterhagen, cited "multiple benefits in the consortium approach:

"—Consortia will provide major economies of scale. More patients will be entered on more protocols, fewer staff will be necessary to manage and administer the program.

"—Consortia will be politically more viable. Single hospital CCOPs will be at the mercy of a single hospital medical staff. When consortia are formed the CCOP will be more stable, since competing medical staffs are unlikely to abandon a program that a competing hospital will maintain.

"—Competing single institutions in the same community will be drawing on the same population base. If NCI intends to use the CCOPs for the type of population based research it has discussed, it will desire only a single CCOP in a catchment area.

"—Multiple institution CCOPs fit the existing patterns of community practice. Many oncologists belong to groups that admit to multiple institutions. If one institution is given drugs and other hospitals are not, then only some members of the research team may be able to enter patients on protocol. The program, under these kinds of conditions, restricted to a single hospital could become a major source of community fragmentation of cancer care, rather than a catalyst for better cancer care."

Johnson suggested that consortia "be the preferred approach."

The RFA will require that letters of intent be submitted to NCI by institutions planning to compete for a CCOP award, prior to the writing of formal applications. NCI staff will screen the letters and attempt to discourage those clearly not capable of meeting the CCOP obligations from submitting applications.

DRCCA BOARD VOTES TO END SUPPORT FOR CCPDS EFFECTIVE JULY 31, 1983

The Cancer Center Patient Data System, a program for cancer centers funded by NCI at $3.3 million a year, will lose that support next year as the result of action by the Board of Scientific Counselors of the Div. of Resources, Centers & Community Activities.

The Board voted last week to accept the recommendation of a subcommittee which had conducted an evaluation of the program. The subcommitee recommended that grant funding of the CCPDS be discontinued as of July 31, 1983.

CCPDS was established to provide comprehensive cancer centers with a system to help carry out their various mandates, including collaborative research among the centers. It was felt that a common system would permit a greater degree of collaboration and exchange of information. It was coordinated through a Statistical Analysis and Quality Control Center, in Seattle.

Barbar Hulka chaired the subcommittee; she did not attend last week's meeting of the Board, and the report was given by David Eddy. The report stated:

"The subcommittee recommends that the grant funding of the CCPDS be discontinued as of July 31, 1983. Depending on their own assessment of the value of the CCPDS as a research resource, the comprehensive cancer centers may choose to support, from other sources, part or all of the activities currently funded by the CCPDS grant. If this is the case, NCI should consider contributing to the funding of the SAQC to help coordinate these activities and provide quality control.

"In its deliberations, the subcommittee recognizes the value to a cancer center of having a minimal data set such as the one developed in the CCPDS. The subcommittee also recognizes the importance of quality control and, to the extent that multiple centers collaborate on projects, uniformity of data sets. The subcommittee endores efforts to improve communications, to develop cooperative projects, and to make comparisons among the comprehensive cancer centers as well as among other centers that serve cancer patients.

"The subcommittee is impressed with the great effort made by the centers and SAQC to establish the CCPDS, and recognizes that its initial mission was not limited to serving as a resource for cancer control activities. We are also convinced that the SAQC accomplished its mission of helping to create the minimal data set and ensuring the quality and uniformity of data.

"A careful review of the progress to date, however, indicates that the CCPDS has not been well utilized as a resource for research on cancer etiology, diagnosis, treatment, or rehabilitation. Nor was the subcommittee convinced that the potential for future utilization was sufficient to justify continued funding. Of particular concern was the relative paucity of specific projects, proposals or ideas of how the CCPDS would serve as a unique data base resource. To the extent that the comprehensive cancer centers feel that the minimal data base is an essential tool for research planning and management, these activities could and should be supported by other means. The subcommittee felt that many of the projects that could potentially be done with CCPDS could also be done with other data bases, such as those provided through SEER and the clinical cooperative groups.

"In the past five years the CCPDS has performed a great service by developing a minimal data base, by implementing procedures for quality control, and by encouraging communication among the comprehensive cancer centers. The subcommittee feels that the value of these products should persist and serve as a starting point for future collaborations."

The subcommittee had been asked to evaluate the purposes, merit, organization, structure, operation and management of the system, paying special attention to the kinds and volume of use and to the effects upon the intra- and intercenter activities. Since it was funded with cancer control money, the subcommittee's charge included making an assessment of the value of CCPDS to control. A broad comparison with SEER was to be made, and it was pointed out that CCPDS and SEER overlap in three geographic areas.

"The main problem was underutilization," Eddy said. "No papers of important clinical significance have come out of the use of the system. There was reluctance by some centers to open their data for collaborative use.

"Is CCPDS necessary as a unique resource? There are things going on without it. Each center has its own data base. It is possible for collaboration to occur without CCPDS.

"Finally," Eddy continued, "if the system is judged useful, would be used and is unique, is it worth the money? We felt, based on the products we saw, both completed and in the pipeline, that the answer is no.

"This is not work down the drain. It has performed a valuable service, has forced communication, has created a uniform data set, and to the extent centers feel it is useful, there is no reason why it can't be continued."

Charles Moertel, Board member and director of the Mayo Comprehensive Cancer Center which has a CCPDS, said he had always "questioned the ability to get a whole bunch of data from different centers and trying to use it. There is so much difference between populations, I don't see how it would generate much in studies.

"On the other hand," Moertel continued, "perhaps

the value of maintaining a type of data set at centers has not been adequately stated, perhaps not adequately presented in the review. . . . There is merit, as service as a shared resource for research conducted within a center." Moertel said Mayo was carrying on 40 different research projects, supported by R01 and P01, peer reviewed grants, using the CCPDS.

"The fact is, this now exists and centers have adapted data sets to it. Some thought should be given before cutting off funds. I agree with the criticisms and that many aspects should be changed, but not precipitously cutting it off," Moertel said.

Board member Harry Eagle said, "There is an extraordinary disparity between money expended and results achieved to data. We (at Albert Einstein College of Medicine) don't have a CCPDS or a SEER, but we do have a data base and it's used effectively in contributing to many studies. CCPDS is not essential to a data base for use within a center."

Board member Alfred Knudson, Fox Chase Cancer Center, said, "No really significant research has emerged from CCPDS at our place, but that is not the fault of CCPDS as much as it is our getting our act together to do cancer control research. I see a lot of activities at our place in generating cancer control research. I see a potential increase in the use of CCPDS in the next year or so."

Board Chairman Stephen Carter called for a vote on accepting the report.

"Accepting the report means we recommend termination of CCPDS," Moertel noted. "That would move it into the category of shared resources which could be funded and defended under peer review."

Carter pointed out that the report's recommendation did specifically include Moertel's last point, "but that could be made into a recommendation, perhaps recommend that funding could be put into a core grant, as a shared resource."

The vote to accept the recommendation had no opposition, although Moertel and Knudson abstained.

DRCCA BOARD APPROVES CONCEPT OF NEW PROJECT FOR QUALITY ASSURANCE CENTER

The Board of Scientific Counselors of NCI's Div. of Resources, Centers & Community Activities gave concept approval to one new contract supported project and to the recompetition of two others at the Board's meeting last week.

The Board also approved the concept of extending for two more years the six Centers for Radiological Physics, and gave concept approval to two interagency agreements for epidemiology studies.

The new project will be to establish a clinical chemistry laboratory and quality assurance center, to support studies on natural and synthetic inhibitors of cancer. The project could result in the award of two contracts, although it could be performed by one contractor, and the total expenditure was not expected to exceed $500,000 a year.

The staff description of the project:

DRCCA is undertaking a number of studies to examine the role of several natural and synthetic inhibitors in reducing the incidence of site specific cancers. These studies will lead to a further understanding of the extent of action of various agents in the prevention of cancer in humans. The inhibitors of immediate concern in these investigations include, but are not limited to, beta carotene, vitamin A and its analogs, vitamin C and E, and selenium. The biological indicators either directly or indirectly relating to the compounds of interest in sera, plasma or whole blood; enzyme levels; serum markers; and/or biological tissues.

A major function of the clinical chemistry laboratory and quality assurance center will be to provide clinical laboratory services for the analysis of the substances of interest in various biological materials as required. In addition, the contractor will also be required to develop and provide a quality control and assurance program and to assist in standardizing analytical methodology for contractors and grantees participating in the chemoprevention program. The analytical support center will also provide advice and consultation to program participants concerning sampling, storage and analytical procedures. A quality assurance program is necessary to the chemoprevention program to insure comparability of analytical results from various participating laboratories.

Analysis of the substances of concern is not routinely conducted by the anticipated program participants. Numerous studies have found wide variations in both analytical precision and accuracy even for routine measurements. The difficulties, costs and complexities of conducting epidemiological and clinical investigations to study the possible inhibitory effect of chemoprevention agents argues for reducing or eliminating as many confounding factors as possible. Standardization of analytical procedures will increase the probability of discerning preventive actions of the agents by reducing analytical biases. The quality assurance program must include minimum requirements for reference and control sample distribution to participating laboratories. Results of quality assurance activities will be reported to both participating laboratories and NCI. Policies and procedures for sample collection, processing storage, and analysis require refinement, standardization and evaluation.

Presently, no mechanism exists for developing analytical methods or procedures, for conducting quality assurance activities, or for performing analytical determinations in support of the chemoprevention program.

This project is in support of the chemoprevention effort which has been designated as a high priority by NCI.

This project is expected to:

a. Develop and assess standard methods and procedures for the collection, storage, handling and analysis of biological samples.

b. Provide analysis of samples in support of division chemoprevention activities.

c. Provide assistance to investigators on the standardization of methods, protocols, reports and equipment calibration to insure that samples are collected, stored and analyzed in a similar manner to increase comparability and sensitivity of various investigations.

d. Develop and coordinate a quality assurance program which includes blind, duplicate and reference samples. Assistance will be offered to participating laboratories with the objective of improving the quality of analytical measurements.

e. Studies will be developed for evaluating various biological compounds, markers and enzymes as to their importance as endpoints or intermediaries of inhibition.

The task of providing analytical support services for the Cancer Centers Program, a contract presently held by CDP Associates, will be recompeted for three years. The present contract totaled $495,987 for the three years. The staff description:

The objectives of the contract would be to provide the Cancer Centers Program with analytical support services such as:

a. Assisting the centers program in developing and implementing specific projects in planning and evaluation which will help to assess and continually update the specific activities and objectives of the program and individual centers.

b. Assisting the centers program in undertaking both short and long term analytical projects for support of program administration and management.

c. Providing short term turnaround technical assistance to the centers program staff to insure timely responses to requests from the NCAB, NIH, HHS, and OMB, as well as other cancer related organizations.

Another contract being recompeted is the one providing support services for the Smoking, Cancer & Health Program. Prospect Associates is the present contractor, on a one year award made for the 1982 fiscal year at a total of $174,000. The new contract will be awarded for three years. Staff description:

NCI requires contract support to assist its staff in the logistics and management of the SCHP. The SCHP involves a number of organizational units within NCI. The program utilizes grants, contracts and intramural activities with central coordination provided by the coordinator, SCHP, located within DRCCA. The program is concerned with research and demonstration activities in toxicology, epidemiology, prevention, biobehavior, pharmacology, education, information training, communication, and other areas appropriate to cancer and health. This single centralized support contract exists to assist the various units in technical and administrative support. It is essential that such a single centralized support contract be available to serve SCHP.

Objectives of the contract would be to provide conference, workshop and seminar support; technical document development; data processing and computation support; liaison between and among other federal agencies, and preparation of informational materials.

The six Centers for Radiological Physics being extended for two years are located at Memorial Hospital, New York; Allegheny Singer Research, Pittsburgh; Univ. of Wisconsin, Madison; M.D. Anderson Hospital, Houston; Univ. of Washington, Seattle; and West Coast Cancer Foundation, San Francisco.

The present contracts will expire in January, 1983.

The CRPs were established to ensure a uniformly high quality of radiological physics at clinical facilities where DRCCA supports activities in diagnostic or therapeutic radiology; to ensure the accuracy of radiotherapy dosimetry at DRCCA supported clinical facilities affiliated with the cooperative groups; to work toward optimum patient dose/image quality factors at clinical facilities where DRCCA supports activities in the radiological detection and diagnosis of cancer; and to act as a focus for technology transfer of state of the art radiological physics to the radiological community.

"The review of radiological procedures at clinical facilities involved in DRCCA projects is important because these facilities are, for the most part, community hospitals rather than the larger medical institutions," the staff report said. "Most community hospitals employ only one physicist to oversee x-ray generator calibration and radiotherapy patient dosimetry and, in many instances, this is a part time employee or a consultant who visits the hospital periodically. There are, therefore, not the checks on accuracy and completeness of work which exist when two or more persons share radiological physics responsibilities."

The CRP reviews have resulted in uniformly high quality of physics services and have contributed significantly to the quality of cancer detection and diagnosis through radiological modalities and the care of cancer patients undergoing radiotherapy, the staff report said. Through technology transfer, the quality of radiological physics has been improved nationally.

NCI decided not to recompete the contracts now because the initiation of the Community Clinical Oncology Program and addition of two new regional cooperative groups will result in bringing from 100 to 200 and possibly more clinical facilities into the program.

"In this period of rapid transition, it will be important to have a stable physics program of experienced CRPs rather than the phaseout of some and startup of new CRPs with the associated staffing, staff training, and equipment procurement problems. In addition, NCI is requesting permission to institute a consolidated radiation program within the office of the director. When approved, this program will look at total NCI activities in radiation. A meeting in late May will consider the current status and future needs of radiological physics research, support services, and technology transfer. Etiher of these events could impact on future activities of the CRPs"

NCI plans to recompete the contracts when the two year extension ends in 1985.

The Board approved the concept of an interagency agreement with the National Center for Health Statistics, costing $400,000, to participate in the National Health & Nutrition Examination Survey Epidemiologic Follow Up. It will investigate the relationships between nutritional, physiological, environmental, social, and demographical factors and the incidence and mortality of cancer.

The Board approved the concept of another interagency agreement, with the Center for Disease Control, to participate in the Aspirin Myocardial Infarction Study, to look at the histories of the 118 study subjects who reported some form of cancer during the study. It will cost from $30,000 to $50,000.

NEW PUBLICATIONS

"Pharmacologic Principles of Cancer Treatment," by Bruce Chabner, acting director of NCI's Div. of

Cancer Treatment. A comprehensive examination of the experimental and clinical properties of antineoplastic agents in a form understandable to both experimentalists and clinicians. W.B. Saunders Company (price not established by publisher at press time).

"Why Me?", Rose Kushner's book, "newly rewritten for the '80s. . . . What every woman needs to know about breast cancer to save her life." This version stresses importance of aspiration biopsies, estrogen receptor assay, staging before surgery, along with discussions of fibrocystic disease, mammography, other imaging systems, vitamins, high risk groups, conservative surgical procedures, chemotherapy, radiation. Breast Cancer Advisory Center, Box 224, Kensington, Md. 20795, $7.95 plus $1.25 for postage and handling. Half price for orders of 24 or more.

"Issues in Cancer Screening and Communications," edited by Curtis Mettlin and Gerald Murphy. Discusses programs and methods utilized by cancer control programs around the world. Analyzes many aspects of screening and addresses problem of how public health practitioners can reach those at risk and promote behavior changes. Alan R. Liss Inc., 150 Fifth Ave., New York 10011, $56.

"Cancer Epidemiology and Prevention," edited by David Schottenfeld and Joseph Fraumeni. Combines insights of epidemiology, genetics, carcinogenesis, and clinical and preventive oncology to provide a comprehensive survey of the causes of cancer and development of preventive measures. W.B. Saunders, West Washington Square, Philadelphia 19105, $98.

"Patient and Professional Educational Materials for Ostomates," new bibliography compiled by the Cancer Information Clearinghouse, a service of the Office of Cancer Communications of NCI. Free. Contact OCC, NCI, Bldg. 31 Rm. 10A18, Bethesda, Md. 20205.

"Second Annual Report on Carcinogens," compiled by the National Toxicology Program. Provides detailed information on 88 substances either known or reasonably anticipated to be carcinogens. Free from NTP Public Information Office, MD B2-04, P.O. Box 12233, Research Triangle Park, N.C. 27709.

"Biology of Skin Cancer," UICC publication edited by O.D. Laerum and O.H. Iversen. Workshop report, providing a critical evaluation of current knowledge of the biological basis of carcinogenesis and neoplastic growth in the mammalian skin. Hans Huber Publishers, Laenggassstrasse 76, CH 3000 Bern 9, Switzerland. 44 Swiss francs ($22 U.S.).

"Carcinogenesis and Biological Effects of Tumor Promoters," edited by Erich Hecker, W. Kunz, F. Marks, N.E. Fusenig, and H.W. Thielmann. $69.

"Hybridomas in Cancer Diagnosis and Treatment," edited by Malcolm Mitchell and Herbert Oettgen. $30.

"Expression of Differentiated Cancer Cells," edited by Roberto Revoltella. $57.50.

"Genes and Tumor Genes," edited by Ernst Winnacker and Hans Schone. $22.

"Toxicology of the Liver," edited by Gabrel Plaa and William Hewitt. $41.

"Maturation Factors and Cancer," edited by Malcolm Moore. $52.

Above six were published by Raven Press, 1140 Ave. of the Americas, New York 10036.

WYNGAARDEN TAKES OVER AT NIH, SAYS NCI AUTHORITIES ALL RIGHT WITH HIM

James Wyngaarden, sworn in last week as the 12th director of the National Institutes of Health, met the press this week. Wyngaarden's response to a wide range of questions included:

- The special authorities granted NCI by the National Cancer Act (bypass budget, President's Cancer Panel, Presidential appointment of the NCI director and National Cancer Advisory Board, authority to support centers, construction, and cancer control, among others) "have worked well, have not been destructive," and he has no objection to their continuation.
- He does not favor, however, extending the same privileges to the other institutes.
- Despite the Administration's opposition to continuing NCI's bypass budget, "I don't care one way or another, although it is a little awkward to have to develop two budgets each year."
- The peer review system is a "brilliant creation of the Shannon era (former NIH Director James Shannon). . . but it operates more comforably in times of affluence." He acknowledged the unfairness of funding one grant at a 160 priority score and not funding another at 162, since "there is no difference between the two." But authority of the institute directors to skip over scores in selecting which grants to fund helps alleviate that problem.
- Most institute directors are uncomfortable unless they can pay 45 to 50 percent of approved grants (they'll be lucky to pay 30 percent this year), because they know that some very good research is going unfunded unless they do.
- Funding grants on a sliding scale—fully funding those on the higher end, partially funding others with lesser priority scores—is one way of dealing with the current budget restrictions which have resulted in study sections competing for funding by giving increasingly better scores. A return to normalization of scores is another. Those measures are under consideration by the NIH Director's Advisory Council.

James Wyngaarden

. . . First priority: stability

• The most important problem facing NIH is maintaining stability in support of investigator initiated grants in the face of budget restrictions. That's the first priority. Second is stabilization in training new investigators. The 50 percent of NIH's budget going into basic research is the appropriate amount, now that contracts, centers and clinical trials have been cut back somewhat to make that possible.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP, citing the RFP number. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs to the individual named, the Blair Building room number shown, National Cancer Institute, 8300 Colesville Rd., Silver Spring, Md. 20910. RFP announcements from other agencies reported here will include the complete mailing address at the end of each.

RFP NCI-CP-31002-8

Title: *Hybridoma assays and related laboratory tests*
Deadline: *Approximately June 29*

NCI has a requirement for the performance of hybridoma assays and related laboratory tests. The place of performance for this requirement must be within a 35 mile radius of the NIH Campus, 9000 Rockville Pike, Bethesda, Md.

The contractor shall perform the following tasks:

1. Routine immunoperoxidase assays which include cutting of tissue sections and immunoperoxidase staining of tissue sections.
2. Cell fusions and cloning of hybridomas.
3. Routine assays for monoclonal antibodies. The contractor shall also deliver samples and records to investigators.

Contracting Officer: Elizabeth Osinski
RCB, Blair Bldg. Rm. 117
301-427-8764

RFP N01-CP-25611-35

Title: *Smoker compensation and cigarette smoke yield*
Deadline: *Approximately June 20*

NCI has a need to determine whether there is compensation by cigarette smokers when changing to a lower tar/nicotine cigarette. Specifically, the purpose of this investigation is to document changes quantitatively in several physical and biological parameters in man over a period of time during a change of cigarette type. This is not a study to modify the smoking habits or patterns of human smokers.

Contracting Officer: Robert Townsend
RCB, Blair Bldg. Rm. 332
301-427-8764

RFP NCI-CM-37538-24

Title: *Iso-antigenic typing of mouse strains*
Deadline: *July 23*

The Animal Genetics & Production Branch, Developmental Therapeutics Program, Div. of Cancer Treatment, NCI, is seeking proposals from qualified organizations having the capabilities, resources, and facilities for the iso-antigenic typing of mouse strains.

To accomplish this effort, reciprocal skin grafts will be exchanged between NIH reference mice and corresponding sublines. An estimated 5,300 animals will be tested annually. Mice will be observed for 90 days.

Shipment of all animals for skin grafting purposes will be scheduled by the government project officer and will be sent prepaid.

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

Contract Specialist: Marlene Haywood
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301-427-8737

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