THE CANCER LETTER

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CCOP LETTERS OF INTENT REACH 232; FRELICK EXPECTS 80-90 PERCENT OF THEM TO QUALIFY FOR APPLICATIONS

The count on letters of intent submitted for the Community Clinical Oncology Program stood at 232 on Monday, according to Program Director Robert Frelick. Eighty to 90 percent of them will be advised that they can submit applications, indicating that the total number will be about 200.

"The reviewers have their work cut out for them," Frelick said, not only because of the large number but also because some of them will be from large and somewhat complicated consortia.

Frelick intends to complete replies to all letters by Sept. 10, giving

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In Brief

ANGEL BRADLEY TO HEAD NCAB SUBCOMMITTEE; UCLA, USC JOIN IN CCRU GRANT APPLICATION

ANGEL BRADLEY, newly appointed lay member of the National Cancer Advisory Board, will be named chairman of the Board's Subcommittee on Activities & Agenda by Chairman Tim Lee Carter, ***The Cancer Letter*** has learned. A cancer patient herself, Bradley underwent mastectomy and adjuvant chemotherapy two years ago, has been involved in Miami cancer related activities. . . . **JOINT APPLICATION** for a Cancer Control Research Unit grant from NCI is being developed by the comprehensive cancer centers at UCLA and USC. Lester Breslow and Brian Henderson will be co-principal investigators. . . . **PAUL CARBONE**, director of the Wisconsin Clinical Cancer Center and chairman of the Dept. of Human Oncology at the Univ. of Wisconsin Medical School, has appointed Richard Steeves deputy director of the center. Steeves also was named head of the Div. of Radiation Oncology. New associate directors are Thomas Davis, clinical; Milton Yatvin, laboratory; and Richard Love, prevention and education. Love also was named head of the Div. of Prevention & Quantitative Oncology, and Yatvin will head the Laboratory Advisory Committee. David DeMets, formerly with the National Heart & Lung Institute at NIH, will join the university as professor of human oncology and statistics. . . . **BREAST CANCER** Task Force meeting Sept. 23-24 at the Linden Hill Hotel in Bethesda will include an overview of systemic adjuvant therapy for breast cancer. Craig Henderson, Sydney Farber Cancer Institute; Richard Margolese, National Surgical Adjuvant Breast Project; Jack Killen, NCI Clinical Investigations Branch; and David Byar and Donald Corle, biostatistical consultants to NCI's Breast Cancer Branch, will participate in the scientific session. . . . **ALISON EDENS** has been named associate administrator for nursing services at the USC Kenneth Norris Jr. Cancer Hospital and Research Institute. The Norris facility will be completed Oct. 1 and open to patients early in 1983.

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FRELICK EXPECTS 200 APPLICATIONS; RESPONSES TO LETTERS OUT BY SEPT. 10

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organizations almost two months to put together their applications by the Nov. 9 deadline.

NCI has compiled a list of questions and answers on CCOP which may give a clearer and more complete picture of the program than previous descriptions, including the information presented in the request for applications. To aid those preparing applications and offer some insight into the program for others who are interested, ***The Cancer Letter*** will publish the entire list.

QUESTIONS AND ANSWERS ON THE COMMUNITY CLINICAL ONCOLOGY PROGRAM

I. CCOP—Definition and Purpose

1. What is NCI's Community Clinical Oncology Program (CCOP)?

CCOP is a major long term NCI effort in cancer control to reduce cancer morbidity and mortality through technology transfer, by creating an opportunity for community physicians to participate in cancer treatment research by means of clinical trials. This will be accomplished by encouraging the affiliation of community physicians and their treatment facilities with clinical research resources. The CCOP establishes a system that provides for continuing interaction between the NCI clinical research effort (and its findings) and practicing community oncologists.

2. Why are CCOPs needed? Are their goals an integral part of cancer control?

CCOP is expected to accomplish a number of objectives of importance to the National Cancer Program including the dissemination of research results. The program will:

—Speed the transfer of advances in science to patterns of practice.

—Bring to patients, no matter where they live, the benefits of medical care (for example, improving staging, new drugs and followup) that result from participation in clinical trials.

—Increase accrual of patients into high priority treatment protocols and thus reduce the time necessary to answer critical research questions.

—Develop a network for controlled distribution of experimental cancer agents.

—Establish a resource for implementing other cancer control and prevention research initiatives of the NCI.

3. What does NCI hope to achieve through CCOP?

It is hoped that two special goals will be achieved through this program: (1) patients will be able to receive the latest in cancer care through their own community physicians; and (2) a nationwide resource of community physicians and patients will be developed that can participate in both treatment and nontreatment NCI cancer control activities. The most practical way to begin this community involvement is to have community oncologists participate in ongoing clinical research trials.

4. Why is clinical treatment research considered cancer control?

Clinical trial protocols have the potential for improving patterns of care for many more patients than may be included in the protocols themselves. Thus the CCOP should have a beneficial effect on clinical cancer care and can serve as the basis of a more comprehensive cancer control program for optimal community cancer care. Other evidence of a community's interest in the cancer problem is involvement in other areas of cancer control, such as prevention, early detection, rehabilitation, continuing care, tumor registries or programs approved by the American College of Surgeons.

II. CCOP STRUCTURE

5. How are individual CCOPs structured?

An individual CCOP is a multidisciplinary entity developed to involve cancer patients within the community in clinical research. The CCOP may consist of a single clinic, a group of practicing physicians, a single hospital, or a consortium of physicians and/or clinics and/or hospitals. NCI funding goes to the CCOP through a fiscally responsible community hospital or a health care organization associated with the CCOP, but treatment of patients is under the direction of local physicians.

Each CCOP is to be formally affiliated with at least one research base—an NCI-funded clinical cancer center and/or a national or regional clinical trials group treating a number of different types of cancers plus, if desired, up to three clinical cooperative specialty groups such as the Radiotherapy Oncology Group (RTOG) and the National Surgical Adjuvant Breast Program (NSABP).

A CCOP should enter a minimum of 50 evaluable patients per year to approved clinical research protocols active in the center or group with which the community is affiliated. As one measure of performance it is anticipated that 10 percent or more of eigible patients in suitable disease categories, available for study to physicians listed as participating in a CCOP application, will be placed on protocols. The CCOP is intended for adult patients but pediatricians may apply if a majority of their eligible pediatric patients are placed on protocols. Credit towards the 50-patient minimum will be given for patients referred to a cancer center for protocol management.

Patient accrual, management and clinical recordkeeping are the responsibility of the CCOP. Development of new protocols in the future, evaluation of the eligibility of patients, management of data demonstrating treatment response, and documentation of

toxicity are joint responsibilities of the CCOP and its research base. The scientific analysis of the clinical trial rests primarily with interested investigators in the research base and the CCOP.

6. How does a CCOP differ from other community programs now supported by NCI?

NCI has not directly funded community physicians for participation in clinical trials. NCI is currently supporting clinical cooperative group outreach programs to community hospitals, as well as cancer center programs with outreach responsibilities. These programs emphasize methodology for developing opportunities for optimal care in the community, and focus less specifically on patient participation in research studies, although the cooperative group outreach studies do involve community patients in clinical trials.

The Clinical Oncology Program (COP) of 1976-1980 and the current Community Hospital Oncology Program (CHOP) were designed to improve community cancer care through direct support of activities such as patient data management, tumor boards that encourage physicians to share information, and other coordinated efforts. These programs do not have clinical trials as part of their cancer control efforts.

7. What is a protocol for a clinical research trial?

A protocol consists of precise guidelines for diagnosis, staging, treatment and followup, with very specific regimens and procedures.

8. How will a CCOP decide which treatment study protocols to use?

The protocols in which a CCOP participates will be decided mutually between the CCOP and its research base(s). If protocols from several research bases are available for a particular type of cancer, a CCOP should select with its research base(s) only one protocol for a given eligible pool of patients.

The CCOP should have the appropriate medical disciplines represented in its group to match the selected protocols, and should have applied to the Institutional Review Board of the hospital where the patients will be treated for approval of the protocols to be used.

9. For the 50 evaluable patients required to be put on protocols by the CCOP each year, must a variety of cancer sites be represented, or, for example, could they all be breast cancer patients?

If a CCOP has enough breast cancer patients to meet its 50-patient requirement, these patients could satisfy that CCOPs obligation if the research base agrees, and if they represent 10 percent or more of eligible patients in suitable disease categories available for study to the CCOP physicians.

10. Will NCI funded cancer centers and funded members of a cooperative clinical trial group be eligible to become CCOPs?

The CCOP is designed to reach community physicians, especially those not now active in clinical trial programs so that funded members of cooperative groups or cancer centers would not be a target of this RFA.

11. Will individuals or institutions now participating in outreach programs of centers or cooperative groups be eligible to be CCOPs?

Yes, but if the organization or entity is funded by NCI for those outreach programs, it will either (1) give up those funds or, (2) if it wishes to continue its relationship with a center or speciality group for which it is already funded, it may, as a CCOP, not count cases accrued for the already established outreach purpose towards its CCOP total.

12. Will geographic distribution be an important factor in determining CCOP awards? Can there be more than one CCOP in a specific geographic area?

A major point of CCOP is to establish a national network. Therefore, geography will be considered when making awards. However, if two CCOP applicants within a specific geographic area have defined referral patterns and each can provide enough patients, each may be eligible for an award.

13. Can medically underserved areas, especially rural areas, apply for a CCOP?

While the 50 patient per year requirement may limit some less populated areas from submitting an individual CCOP proposal, consortium and satellite arrangements with larger hospitals in their referral area are possible.

14. Is there a limit to the number of physicians, clinics and hospitals that can be involved in a CCOP consortium?

No. While a large consortium may offer economies of size, it also may be administratively difficult to handle large amounts of data on individual patients from multiple sources.

15. Can clinical trials be primarily concerned with natural history or descriptive biology?

No. But such studies may be an add on to a treatment trial. For example, biological markers may be incorporated into clinical research either as a diagnostic technique in establishing trial eligibility or as an indicator of response.

16. What about clinical trials in the areas of analgesia, immunology and pharmacology?

Such studies may be carried out, providing they have been developed by the research base and approved in the usual manner.

17. What about phase 1 and phase 2 trials?

Phase 1 trials of NCI sponsored chemotherapeutic agents are conducted only at institutions specifically contracted to do these studies. Phase 2 trials will be up to the research base and CCOP. NCI credit may be limited for one patient entered into several phase 2 studies.

18. How much information must be provided by CCOP participants for eligible patients not put on

protocols?

Essential information for patients not put on protocols includes age, sex, site of cancer, stage, treatment disposition, and reasons for not going on the protocol (where appropriate), in order to determine whether patients who enter protocols differ from those who do not. Such data collection may be done in part through existing registries, but it may be more reliable and easier to develop a separate log of eligible new patients seen by CCOP physicians in the office and in hospital consultations even if they are not entered on research protocols.

19. Will the CCOP include other types of cancer control? If so, can these elements be a significant proportion of the program?

Control measures including the use of patient management guidelines are allowed in a CCOP. While a CCOP may be more effective with other control elements, they are not mandated in the RFA. Reviewers are being asked to consider such elements in their evaluation of the applications. Evidence of experience with cancer programs in a community suggests a commitment to cancer control which may signify promise for a prospective CCOP.

20. What is the role of the established radiological physics centers?

The six NCI supported radiological physics centers will provide without charge advice to any facilities used by the CCOPs concerning radiation calibration and dosimetry.

III. NCI FUNDING

21. What is the NCI investment in the program?

Up to $10 million has been allocated for the CCOP in FY 83. The CCOP RFA will be reissued periodically as need arises.

22. What is the funding mechanism for this program?

A cooperative agreement. This is an instrument approved by Congress in 1978 for federal support of extramural research. Like a grant, it forms an assistance relationship and, like a contract, allows for substantial involvement by government staff. The terms of award form the basis of a partnership between the government and the recipient with the terms agreed upon before the award. Unlike the contract mechanism, which is used to "purchase" a well defined end product or service, the cooperative agreement allows for initiative on the part of the applicant.

23. When may first year funds be awarded to the individual CCOPs?

It is anticipated that the first awards will be made in July 1983. Proposals will be peer reviewed in January and February 1983, and approved proposals will be reviewed by the National Cancer Advisory Board May 16-18, 1983.

24. How are the CCOPs paid and what are some of their essential expenses?

The CCOP participants are paid directly by NCI through a responsible community fiscal agent, such as a hospital or other health care organization. Each CCOP will need a local office to handle administrative and fiscal matters, patient care data, quality review, compliance, and data on research findings. Data managers will be a necessary CCOP expense. (Cost-benefit is sometimes achieved with a nurse doing data management.) A rate for indirect costs, if not already available for the CCOP's fiscal agent institution, must be negotiated prior to award.

IV. RESEARCH BASES

25. What function does the research base perform?

In affiliation with the CCOP, the research base provides approved protocols, scientific guidance on the implementation of these protocols, management of data collected by its CCOPs, and procurement, distribution, and control of the investigational drugs supplied by NCI.

26. How many research bases may one CCOP have?

Providing the possible issue of overlapping protocols has been resolved, a CCOP may have up to five research bases.

27. How will the research base be reimbursed for expenses resulting from protocol participation by the CCOPs?

Once the CCOPs are reviewed and awarded, the number of CCOP affiliations with a specific research base will be known. If necessary the research base may then request supplemental funds to be provided to the research bases' existing NCI grants/cooperative agreements.

28. Can all cooperative groups, regional groups, or NCI supported clinical cancer centers quality as possible research bases?

A list of possible bases is included in the RFA. A CCOP and a "base" may agree to work together if protocols of mutual interest are available.

29. How much freedom will CCOPs have in selecting their research base? Must they select the research base that is closest geographically?

There is flexibility in the selection of research bases. Some areas of the country do not have NCI funded clinical cancer centers. Some centers may not have adequate or appropriate protocols for the community programs seeking CCOP participation. For the most part, however, research bases should be reasonably close geographically to their CCOP groups.

30. Does every CCOP affiliated with a particular research base have to participate in all of the studies sponsored by that base?

No. The research base and the CCOP will jointly select priority protocols that the CCOP can carry out and on which an appropriate number of patients can

be placed.

31. Whose responsibility is it to avoid competing protocols from two or more research bases?

It is the responsibility of the CCOP. (See response to question No. 8.) If new protocols are developed, they should be assessed for possible overlap. The matter of overlapping protocols should be resolved in the affiliation agreement between the CCOP and the research base.

32. Who writes the affiliation agreement between the CCOP and the research base?

The affiliation agreement is a necessary joint endeavor which should be acknowledged by both parties.

33. If the affiliation agreement between a CCOP and a research base proves unsatisfactory and either the CCOP or the research base wants out, will this be possible before the end of the three year period?

Unusual circumstances may require changes in research base affiliations, subject to NCI staff approval.

V. PLANNING, REVIEW AND EVALUATION

34. Will NCI provide a mechanism comparable to a planning grant for prospective CCOPs?

It is not planned to do so initially. However, if the first round of applications indicates that this would be helpful, reconsideration will be given to issuing planning grants. It is anticipated that some who may not qualify initially (because of, for example, some inadequacy in their proposed program) will be able to improve their organizational base to quality for subsequent RFAs.

35. Does NCI plan to assist the community physicians who may not be experienced in applying for government funding to do so?

NCI, as well as the research bases, will be available to give assistance. Regional workshops may be held if a defined need is identified.

36. Who will review the application for CCOP funding? Will review criteria be available?

Ad hoc review groups will be organized by NCI to include a number of community physicians, many of whom had experience in clinical research. Specialists in other clinical disciplines may also help in the review process. Review criteria are outlined in the RFA.

37. How many new cancer patients per year might serve as a potential resource for the CCOP's clinical trial activity?

The potential resource for a CCOP's clinical trial population is the number of patients available to the affiliated physicians with the type and stage of cancer that would make them eligible for the particular priority protocols agreed upon by the CCOP and the research base(s). This number will vary with the types of protocols. It could take as many as 800 to 1,000 new cancer patients per year in CCOP institutions to provide 50 protocol patients. One of the reasons for this situation is that for many of the common cancers, such as squamous cell lung or metastatic colorectal cancers, there may be few high priority protocols. Patients may not meet specific criteria for protocol entry.

38. Each CCOP is responsible for 50 evaluable patients on research protocols per year. What happens if the CCOP does not make the quota?

As one measure of performance, it is expected that 10 percent or more of eligible patients in suitable disease categories available for study to physicians listed as participating in a CCOP application will be placed on protocols. Annual performance review will determine if there are any extenuating circumstances.

39. How will NCI staff be involved with the CCOP participants?

Initial review of the agreements made between the CCOP members and their research base(s) will be by NCI staff who need to know that a system for data retrieval is in place. The NCI staff will periodically review data management in the CCOP program and may wish to check intermittently to determine that the program is operating well. External monitoring may be requested by NCI, however. FDA mandated requirements will be the responsibility of the research bases under NCI supervision. NCI staff will monitor progress on an annual basis and provide feedback to the CCOPs.

40. How can the CCOP experience be documented?

The research base(s) will analyze individual protocol data for the quantity and quality of case accrual. The organization of the CCOP and the development of its program will be evaluated by the NCI with the aid of the research base(s). NCI will also be interested in its impact on patients not on research protocols.

41. What is meant by the "diffusion hypothesis"?

The term "diffusion hypothesis" implies that patients of the CCOP physicians, and patients in the community as a whole, may benefit from the improved standards of care stimulated by the protocols used in the CCOP program. This effect has been demonstrated in a recent study from the current cooperative group outreach program, and will be further tested in the CCOP program.

VI. CCOP PHYSICIANS

42. Must physicians be board certified medical or surgical oncologists, radiotherapists, etc., in order to participate?

No, but CCOP physicians caring for patients on clinical trial protocols should have substantial experience with cancer patient managment.

43. As a member of a CCOP, will the community physician lose control of the patients he puts on research protocols?

The community physician will be responsible for day to day care of his/her patients including the ad-

ministration of the study regimens, and for data collection on the individual patient. He/she will receive data analysis feedback from the research base, and will direct the followup care of protocol patients after the studies are completed.

44. What would membership in a CCOP cost the community physician?

Time spent on CCOP matters depends on the number of patients the individual physician has on protocols. Much more detailed recordkeeping is essential for clinical trials than for non research treatment, but assistance with protocol management should be possible through the CCOP.

It also takes extra time to explain the clinical trial situation to the patient and his/her family with sufficient detail of the possible benefits and risks, since the patient must have enough information to give a truly informed consent.

The physician must obtain prior approval of protocols from a local Investigational Review Board (IRB). If such a Board does not exist in the hospital where the physician's patients will be treated he/she may need to help organize one.

IRB review is needed for approval of protocols even though they have already been approved by the research base and NCI.

45. Why should a community physician wish to become part of a CCOP?

The incentive to become a part of a CCOP involves scientific, professional, and humanitarian considerations. Participation in a CCOP provides an opportunity for community physicians to work with the latest research and treatment methods, and to expand contacts with clinical investigators. Being part of a CCOP enables community physicians to fulfill their responsibility not only to take care of cancer patients but to contribute to progress in the control of the disease.

VII. CCOP PATIENTS

46. What ways now exist for patients in the community to be put on NCI research studies?

Patients referred to NCI supported cancer centers may be entered in appropriate center research protocols. Patients who live in a community that has a hospital participating in an NCI cooperative group, either directly or as a satellite or affiliate institution, may be put on appropriate research studies by that hospital's physicians.

47. What will be the cost to a patient on a clinical research protocol?

As in all NCI sponsored clinical trials, treatment costs vary among facilities. NCI sponsored experimental drugs are provided free of charge.

48. Will patients who are not on clinical trials think they are being shortchanged?

If CCOP physicians make it known within their referral areas that eligibility for a particular clinical trial is the key factor in patient participation, and that eligibility criteria are determined not by the local physician but by the NCI approved research protocol, patients not eligible for clinical trials will more readily understand their exclusion. It may be that only 10 to 30 percent of the cancer patients of CCOP physicians will be eligible. However, many of those not eligible may benefit from some of the same regimens that their physicians have become familar with through the research protocols.

The rest of the NCI question and answer list on CCOPs will appear in next week's issue of ***The Cancer Letter.***

ONS FLEXES MUSCLES, SEEKS INDEPENDENT NURSING RESEARCH, SPLITS FROM ASCO

The Oncology Nursing Society, now the largest oncologic professional society in membership, struck out in its first attempt to transform that strength into political muscle when President Reagan did not appoint a cancer nurse to the National Cancer Advisory Board. That was not the total extent of ONS's effort to influence the National Cancer Program, however.

ONS resolutions adopted at the annual meeting in St. Louis included the one asking the President to appoint an oncology nurse to the NCAB, a request which probably came too late to be considered in this year's appointments.

The nurses approved other resolutions which probably will get more attention and which demonstrate members' growing feeling of independence and confidence in the society.

Two resolutions dealt with the issue of independent nursing research. One expressed support of "voluntary collaborative nursing and medical research. . . and nurses right to do nursing research independently. The other called on NCI to fund professional nurse principal investigators in cancer nursing research.

"There is a part of nursing practice that is autonomous from medical practice within all areas of health care," the first resolution stated. "Nursing research is the cornerstone of nursing practice and professional growth. Research collaboration in an atmosphere of mutual respect achieves optimum results. Collaboration between nursing research and medical research should be voluntary and mutually beneficial to all parties.

However, the resolution continues, "Institutions exist that require a physician name on all clinical nursing research, regardless of physician involvement. Institutional requirements of this type are repressive to nursing practice and professional growth."

Therefore, such collaboration should be voluntary and nurses should have the right to do independent nursing research, the resolution concluded.

The resolution directed to NCI further justified cancer nursing research support. "Clinical research efforts have been directed to provide optimum care for the patient diagnosed with cancer. Nurses often work in a collaborative effort with other clinical investigators to provide complex nursing interventions for cancer patients in a variety of practice settings. There is need for new knowledge to help persons in cancer prevention and detection as well as during all phases of the disease process. Increasing numbers of patients diagnosed with cancer are living longer with their disease. Increasing numbers of nurses have obtained advanced training in research and are involved in independent and collaborative research projects. Professional nurses have served as principal investigators on research grants funded by the National Cancer Institute."

In two other resolutions, ONS declared its independence in the matter of where it will hold its annual meetings and announced it would not have them in states which did not pass the Equal Rights Amendment.

The Society has held its annual meetings in conjunction with those of the American Society of Clinical Oncology. The resolution stated, "Independent planning of future congresses will enable greater geographic and calendar flexibility. A 1981 survey of congress participants revealed that 91.9 percent would attend future congresses not held in conjunction with ASCO. The Oncology Nursing Society is a solvent, independent, and professional society. Therefore, be it resolved that future ONS congresses for which contracts have not been signed be held in locations based primarily on ONS needs."

One of those needs, the subsequent resolution made clear, is for the meetings to be held in states which ratified ERA. The Society will "join with the 350 other organizations which have withheld economic support from non ERA ratified states," the resolution noted.

Those 350 do not include ASCO, which voted down a similar resolution a few years ago. ONS has agreed to go along with ASCO and the American Assn. for Cancer Research for the next four years, to San Diego, Toronto, Houston, and Los Angeles. But the other two will meet in Atlanta in 1987, and Georgia did not ratify ERA. Apparently, that is when the split will occur.

The resolution asking for an oncology nurse on the NCAB strongly supported renewal of the National Cancer Act and called for an amendment requiring that at least one member of the Board be an oncology nurse.

The resolution pointed out that a previous amendment requires appointment of community physicians (actually, that amendment does not mention "community" but requires that at least two members be primarily involved in the treatment of cancer patients). "Partnership between research and community care has been enhanced by the appointment of community physicians to the NCAB," the resolution said. "There are highly qualified professional nurses who meet the eligibility criteria to serve on the National Cancer Advisory Board."

Legislation renewing the National Cancer Act is still pending in both houses of Congress. So far, neither version includes the ONS amendment.

Other resolutions approved called for:

- ONS members to support antismoking efforts, "especially within our profession," acknowledging that nursing has a higher percentage of smokers than any other health profession.
- Members to support efforts, locally, nationally, and internationally, to stop the arms race.
- Acknowledgement of "one of the pioneer contributors, Eugenia Helma Waechter, for her excellence and contributions as a teacher, researcher, author, and leader in the field of pediatric oncology nursing."
- A study to evaluate development of an associate member category.

NCI OFFERS HYBRIDOMA CELL LINES TO COMMERCIAL ORGANIZATIONS

NCI this week released the following announcement on the availability of hybridoma cell lines:

In the interest of assuring an adequate supply of anti-H-2 and anti-Ia hybridoma antibodies to the scientific community, NCI is willing to supply to any legitimate commercial source a number of hybridoma cell lines. These hybridoma cell lines are:

Anti-H-2—3-83P, 12-2-2S, 15-1-5S, 15-3-1S, 15-5-5S, 16-1-2N, 16-1-11N, 16-3-1N, 16-3-22S, 20-8-4S, 23A-5-21S, 23B-10-1S, 27-11-13S, 28-8-6S, 28-11-5S, 28-13-3S, 28-14-8S, 30-5-7S, 31-3-4S, 34-1-2S, 34-2-12S, 34-4-10S, 34-4-21S, 34-5-8S, and 34-7-23S.

Anti-Ia—14-4-4S, 17-3-3S, 25-5-16S, 25-9-3S, 25-9-17S, 26-7-11S, 26-8-16S, 28-16-8S, 34-1-4S, and 34-5-3S.

Evidence of an organization's interest and capability to produce is a prerequisite; therefore, a brief resume of experience and capabilities must be sent with request for hybridoma cell lines within 90 days of this publication to Shelby Buford Sr., contracting officer, Research Contracts Branch, NCI, Blair Bldg. Rm. 2A07, Bethesda, Md. 20205. Make reference in the request to Contract No. N01-CB-25585.

The cells are provided as a service to the research community. They are provided without warranty of merchantability or fitness for a particular purpose or any other warranty, express or implied. In addition, the recipients of the cell lines agree to indemnify and hold harmless the United States from any claims, costs, damages, or expenses resulting from any injury

(including death), damage, or loss that may arise from the use of the cell lines.

References for further information on these hybridomas are:

1. Ozato, K., Mayer, N., and Sachs, D.H.: Hybridoma cell lines secreting monoclonal antibodies to mouse H-2 and Ia antigens. J. Immunol. 124: 533-540, 1980.

2. Ozato, K., Hansen, T.H., and Sachs, D.H.: Monoclonal antibodies to mouse MHC antigens. II. Antibodies to the H-2L^d antigen, the products of a third polymorphic locus of the mouse major histocompatibility complex. J. Immunol. 125: 2473-2477, 1980.

3. Ozato, K., and Sachs, D.H.: Monoclonal antibodies to mouse MHC antigens. III. Hubridoma antibodies reacting to antigens of the H-2^b haplotype reveal genetic control of isotype expression. J. Immunol. 126: 317-321, 1981.

4. Sachs, D.H., Mayer, N., and Ozato, K.: Hybridoma antibodies directed toward murine H-2 and Ia antigens. In Hammerling, G.J., Hammerling, U., and Kearney, J.F. (Eds.): Monoclonal Antibodies and T Cell Hybridomas. Amsterdam, Elsevier/North Holland Biomedical Press 1981, pp. 110-113.

These cell lines are already available to noncommercial sources through the American Type Culture Collection, c/o Dr. John G. Ray Jr., IAIDP, NIAID, NIH, 7A07 Westwood Bldg., Bethesda, Md. 20205.

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-CO-33855-38 CORRECTION

Title: *Screening, indexing and abstracting (SIA) of cancer related literature for input to the ICRDB Program databases*

Deadline: *Oct. 25*

The NCI synopsis for this procurement, published in the Aug. 27 issue of ***The Cancer Letter,*** is corrected to: 1. Delete the requirement that "Proposals must include statements which document that the offeror has prepared indexed abstracts of biomedical literature and bibliographic records on magnetic tapes/discs which are suitable for use in online databases at the level of at least 5,000 abstracts per year within the past two years." 2. Amend the RFP issuance date from Sept. 10 to Sept. 13, 1982. 3. Add the following: The preproposal conference for this RFP will be held at 8:30 a.m. Sept. 24, 1982, in Conference Room 11A10, Bldg. 31, NIH, 9000 Rockville Pike, Bethesda, Md. 20205.

RFP NCI-CO-33856-38 CORRECTION

Title: *Screening, indexing and keying (SIK) of cancer related literature for input to the ICRDB Program databases*

Deadline: *Oct. 27*

The NCI synopsis for this procurement published in the Aug. 27 issue of ***The Cancer Letter*** is corrected to: 1. Delete the requirement that "Proposals must include statements which document that the offeror has prepared indexed abstracts of biomedical literature and bibliographic records on magnetic tapes/discs which are suitable for use in online databases at the level of at least 5,000 abstracts per year within the past two years." 2. Amend the RFP issuance date from Sept. 10 to Sept. 13, 1982. 3. Add the following: The preproposal conference for this RFP will be held at 11 a.m. Sept. 24, 1982, in Conference Room 11A10, Bldg. 31, NIH, 9000 Rockville Pike, Bethesda, Md. 20205.

Contract Specialist for the above two RFPs: Barbara Mercer
RCB, Blair Bldg. Rm. 332
301-427-8877

NCI CONTRACT AWARDS

Title: Additional alteration/renovation/maintenance/upgrading projects at Frederick Cancer Research Facility, modification
Contractor: Litton Bionetics Inc., $536,021.

Title: Operation of a salmonella/pseudomonas laboratory
Contractor: Univ. of Missouri/Columbia, $63,124.

Title: Intraoperative radiotherapy
Contractor: Howard University, $338,622.

Title: NSABP cancer control network
Contractor: Univ. of Pittsburgh, $490,608.

Title: Operation of a virological diagnostic laboratory
Contractor: Microbiological Associates, $1,898,732.

Title: Develop a course on prevention focusing on cancer
Contractors: Wayne State Univ., $404,843; Research Foundation, State Univ. of New York, $91,902; Baylor College of Medicine, $165,-333; Univ. of Washington, $191,076; Memorial Hospital for Cancer & Allied Diseases, $167,582.

The Cancer Letter Editor Jerry D. Boyd

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