THE CANCER LETTER

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DRCCA BOARD CHANGES CENTER CORE GRANT GUIDELINES TO PERMIT PAYMENT FOR CONTROL PROGRAM DIRECTORS

Guidelines for cancer center core grants will be modified to permit payment of salaries for cancer control program directors from core grants, the Board of Scientific Counselors of NCI's Div. of Resources, Centers & Community Activities has recommended.

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In Brief

FRIEDELL TO HEAD McDOWELL NETWORK, NEW KENTUCKY CANCER CENTER; NINE EXPIRING CORE GRANTS APPROVED

GILBERT FRIEDELL, medical director of St. Vincent Hospital in Worcester, Mass., and director of the National Bladder Cancer Project, has been appointed executive director of the McDowell Cancer Network of the Univ. of Kentucky. He also will serve as director of the new Lucille Parker Markey Cancer Center which will house both clinical and basic science activities related to cancer. Friedell is professor of pathology at the Univ. of Massachusetts Medical School and will hold a similar appointment at the UK College of Medicine. His appointment will be effective next July 1. If Congress forces NCI to keep the national organ site programs in place, rather than consolidate them as decided by the National Cancer Advisory Board, Friedell will have to decide on what to do about his position with the Bladder Cancer Project. . . . **NINE CANCER** center core grants expired this year; all were reviewed, and all were approved—Memorial Sloan-Kettering, Fels, NYU Institute of Environmental Medicine, Columbia, Duke, Georgetown, Mayo, Fred Hutchinson, and Mt. Sinai. Whether all scored high enough to be funded has not been disclosed. . . . **STAFF ADDITIONS** announced by Peter Greenwald, director of NIC's Div. of Resources, Centers & Community Activities, include: **JOHN HORTON**, head of oncology and professor of medicine at Albany Medical College, and current president of the American Assn. for Cancer Education, is "on loan" for a year from Albany to work on prevention programs; **THOMAS KEAN**, transferred from the Office of Cancer Communications to become assistant director of the Cancer Control Applications program, headed by DRCCA Deputy Director Joseph Cullen; **IVAN BAROFSKY**, joining NCI from the National Surgical Adjuvant Breast Project, will head rehabilitation studies and patient participation in the Centers & Community Oncology Program; **JOSEPH TANGREA**, chief of pharmacology at the NIH Clinical Center, will work in chemoprevention; **EDWARD LICHTENSTEIN** is assigned to the Behavioral Medicine Branch, **BRENDA EDWARDS** to the Biometrics & Operations Branch, and **JOHN DELL** to the Chemoprevention Branch. **ROBERT BURNIGHT**, who has been executive secretary of DRCCA's Board of Scientific Counselors, will head the new career development program.

DRCCA BOARD COMMITTEE REFUSES TO OK TRANSFER OF CONTROL FUNDS TO CENTERS

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The Board's Budget Committee later voted to lift the ceiling on core grants to accommodate those salaries. However, the committee rejected the suggestion that cancer control program directors be paid from DRCCA's line item cancer control money; funds for those salaries will have to be taken out of the budget for center core grants.

Jerome Yates, DRCCA associate director for the Centers & Community Oncology Program, told the Board that center executives have been concerned about how to support and coordinate their cancer control activities now that control support grants have been phased out. DRCCA ended that program, designed to help centers develop outreach and other control efforts, and is using the money instead to fund the new Cancer Control Research Units and Cancer Control Science Programs at centers.

Center core grant guidelines expressly prohibited use of core funds for cancer control, frustrating attempts to continue central cancer control administrative offices. DRCCA philosophy now, as developed by the Board of Scientific Counselors, is that the division will only support cancer control research, mostly through R01 and P01 grants. Under the old guidelines, and with the demise of control support grants, there was no way cancer control program directors could be supported with NCI funds.

"Center directors feel that (control administrative costs) should be dealt with as any other," Yates said. "If they have control research, they should be able to pay program directors. And they feel that should come out of the control line item. We're talking about $100,000 to $300,000 a year."

"Clearly, control has been one of the functions of centers from the beginning of the National Cancer Program," Board Chairman Lester Breslow said. "Some have not been carried out very well. They do support, out of core grants, program directors in a half dozen program areas. Here is a proposal by center directors to evade responsibility on the grounds that other money is available."

"In my view. . . if control is research, it is proper for core grants," Board member Alfred Knudson said.

"If you can defend control as research in peer review, then it is appropriate for core support," Board member Charles Moertel added.

The motion to change center core grant guidelines, to allow control to be treated as any other item and thus permit administrative support from the grant for control, was approved unanimously.

"Now you have to decide whether or not the money should come from the core budget or the cancer control line item, with a raise in the cap on the amount for which a center can apply," Yates said.

"The motion that was just passed said it should come out of the core budget, unless the issue is raised," DRCCA Director Peter Greenwald said.

"Consider it raised," Yates said. "The centers have raised it."

"I see no reason why we should rebudget control money," Breslow said. "Control program directors should be supported the same as others."

"In the past, yes, I could not apply for this amount," Moertel said. "Now, this motion has passed. In light of the level budget, I can put him on, but at the lower level with him out. We've arbitrarily thrown out the rule (prohibiting payment of the control director) but you're not putting back the money that was originally in there to support him."

"Some comprehensive centers have not taken cancer control seriously enough but still put full time persons on cancer control payrolls," DRCCA Deputy Director Joseph Cullen commented. "I think it is important that this come out of the core budget. Those that can't get R01 or P01 money and justify their interest in cancer control should not have a control program director at all."

"I would like to make it clear that what we're talking about is support for cancer control research," Board member Harry Eagle said. "That can't be emphasized enough. If only one or two people in a center are doing cancer control research, there is no need for a program director."

"If you say squeeze $50,000 to $100,000 in the existing budget without lifting the cap, you might as well not permit them in the first place," Moertel said.

When it appeared the Board would not take further action, Yates insisted, "I would like you to go on record one way or another. Center directors want an answer. It's a cop out if you don't. You can lift the cap, and say whether it should come out of the control line item."

The Board finally referred the issue to its Budget Committee, chaired by Eagle. The committee met following the Board meeting and decided to recommend lifting the cap, or ceiling on the amount for which centers may apply (the ceiling was laboriously worked out when the core grant guidelines were rewritten two years ago).

The committee also recommended that the money would have to come from the centers core grant budget and not the cancer control line item (earmarked) money.

Yates, after talking with cancer center personnel in Seattle last month, had indicated he might bring the question of phasing out NCI support for the Centralized Cancer Patient Data System back to the DRCCA Board (***The Cancer Letter,*** Sept. 17).

Yates told the Board that he is talking with CCPDS people about participating in the CCOP, to the extent of linking centers taking part as research bases to assure quality control of information collection.

"We're looking for some information from centers on what they plan to do with CCPDS," Yates said. "We hope they will try to use new approaches, and make it more productive."

No action was taken by the Board.

DRCCA BOARD OKs CONCEPT OF EVALUATION FOR THREE MAJOR COMMUNITY PROGRAMS

The DRCCA Board of Scientific Counselors gave concept approval to a community cancer care evaluation plan which would invite through a competitive RFP proposals to conduct an evaluation of the division's three major community efforts–the Cooperative Group Outreach Program, the Community Hospital Oncology Program, and the Community Clinical Oncology Program.

Jerome Yates, who heads the Centers & Community Oncology Program in DRCCA, estimated the evaluation would cost about $900,000 a year, probably for three years. NCI has applied to HHS for its share of the one percent set aside money the department collects from its agencies specifically for evaluation, and it is possible the entire cost could be retrieved from that source.

The decision to proceed with an integrated evaluation of all three programs sidetracks much of the proposal put together by 14 of the 17 CHOP contractors who had developed their own plan (***The Cancer Letter,*** Jan. 22). Under that proposal, the 14 CHOPs would have conducted an evaluation of their local programs as well as that of key national questions regarding the CHOP concept and community cancer care.

After reviewing the CHOP proposal with the help of outside consultants, NCI staff decided that it would not meet their needs and that an integrated evaluation of all three programs was required. Some portions of the CHOP local evaluation proposal still may be funded through the individual CHOP contracts.

Yates' description of the evaluation plan:

While each of the three programs differs slightly in emphasis and essential elements, they all have the same primary objectives–to provide the highest quality, most up to date cancer management to patients in the community setting and establish a mechanism to facilitate the transfer of new technology to the community. The evaluation issues are the same–to what extent have these programs been successful in meeting these objectives; and which elements or combinations are most effective in upgrading the quality of cancer care for all patients in the community? To answer these questions, we are proposing an integrated evaluation of the three programs. This will allow us to not only evaluate the unique program components for each, but also their interactions over time to meet NCI program goals. (It will include) a descriptive analysis looking at the organizational arrangements of the programs, the level of community and physician participation in each program, the demographic variables of the communities, and the patient care practices that will be performed. Answers to questions relating to effective approaches to encourage community physicians to introduce the most advanced technology into their community practice, participate in clinical research activities, and provide the highest quality care to all their patients will be obtained.

The evaluation will be performed in phases. Phase 1 (first year) will concentrate on planning the integrated evaluation, collection of institutional characteristics and other baseline data, pilot testing the evaluation approach in CHOP and outreach institutions, and answering those questions peculiar to CHOPs. We are currently exploring alternatives for obtaining support for quality control and preliminary data analysis in phase 1. Also during phase 1, an RFP will be issued and a contract awarded to support phase 2 of the evaluation.

Phase 2 (second and third years) will be spent on full scale implementation of the integrated evaluation of the three programs. In this phase, the contractor will be responsible for data management, quality control, and analysis.

The integrated evaluation will concentrate on these areas: (1) organizational arrangements, (2) physician behavior, and (3) patient outcomes. We will gather descriptive information from participating institutions in order to characterize them for such factors as bed size, staff size, consultant mix, cancer center and/or cooperative group alliances, teaching programs (medical students and/or residents) and other local clinical research activities. The institutions will be divided for purposes of analysis into categories depending on the programs they participate in, taking into account overlaps. Comparison institutions, matched on geographical and other descriptive characteristics but not involved in these programs, will be used as controls to the extent feasible.

The organizational evaluation will examine (1) single institution and consortia CHOPs and CCOPs in an attempt to determine the optimal size for successful implementation of a subsequent program, i.e., were outreach hospitals more successful in competing for CHOP? Were guidelines already available? What effect did CHOP have on CCOP implementation? Does the development and use of guidelines influence protocol participation?

The physician behavior portion of the evaluation will be performed using the physician as the unit of analysis and selecting signal diseases to examine changes in patient care management. Initially, breast, oat cell lung, and colon cancer have been selected for study. We will look at the practice patterns of physicians both involved and not involved in the various programs, before and after implementation of the program to determine:

1. Changes in physician behavior, such as in the level of involvement in the program and the number of eligible patients registered on protocols;
2. Changes in the quality of patient care management (pretreatment evaluation, staging, and treatment), use of guidelines, and the extent to which new technology is introduced into practice, including whether patients not formally registered on protocols are treated according to protocol, the quality of care for patients treated by non-involved physicians, and other diffusion issues.

The outcome portion of the evaluation will use the patient as the unit of analysis. Adult acute myelocytic leukemia and testicular cancer will be used as the signal diseases (if adequate patient accrual is possible) in an attempt to determine changes in management outcome such as disease-free interval and mortality rates.

In addition to the characteristics of the institutions previously mentioned, the information for the integrated evaluation will be archival in nature. Critical elements of care (pretreatment evaluation, staging, treatment, and followup), which reflect the most recent technological advances, will be identified for the signal diseases. Data will be abstracted from medical records and other pertinent documents (lab and pathology reports, outpatient records, tumor registries) to deter-

mine whether or not the critical elements were met. A sample of patients will be followed for outcome data. No patient identifiers will be used. The samples will include protocol and non-protocol patients of both involved and non-involved physicians. Information pertaining to physician participation in the programs and registration of patients on protocols will be obtained from routine reports and protocol logs. Descriptive information will be collected at defined time intervals for a cross-sectional study. Also, both the outreach program and the CCOP offer quality assessment data related to participant performance which is routinely collected by their parent cooperative group or research base.

In addition to the integrated evaluation, there are areas unique to each program that will be evaluated. Briefly, these include:

1. Outreach Program—quality of affiliated hospital participation vis a vis full members, quality of data, protocol violations, and results. This evaluation is currently the responsibility of the Cooperative Group. Organizational arrangements will be examined.

2. CHOP—guideline development and revision process, procedures for use, guideline quality, guideline compliance. Information for guideline compliance will be collected by CHOPs. Guideline quality will be judged by expert panels.

3. CCOP—quality of protocol participation, quality control of protocol data, protocol violations. This will be the responsibility of the research base. Effectiveness of single institution vs. consortia will also be examined.

The combination of the integrated evaluation plus the information unique to each program will provide an exceptional opportunity to answer critical questions regarding community cancer care and how it is best organized and delivered to provide the highest quality care to cancer patients in this country. Generalizability of the study results will be a major consideration during the analysis.

Board member Virgil Loeb asked why a disease such as Hodgkin's, in which improved results have been clearly demonstrated when properly managed, would not be included in the evaluation.

"Numbers," Yates said. "If we use these three (breast, oat cell lung, and colon), we can be assured that community hospitals will have enough patients so that we can get a flavor of what's going on."

DRCCA Director Peter Greenwald brought up the matter of controls, and suggested that NCI's SEER Program might be used. Loeb suggested that the American College of Surgeons approved hospitals could supply some data.

"We discussed at length the desirability of controls," Yates said. "I wouldn't rule out specifically looking at such factors as data from institutions not participating. We elected not to evaluate the world."

The Board gave concept approval for a request for applications to stimulate grants to study a project titled, "Patterns of Care for Elderly Cancer Patients: Implications for Cancer Control."

Rosemary Yancik, project director, estimated that four to six grants would be awarded, funded at a total of $400,000 to $600,000 per year for three years.

Yancik's description of the project:

DRCCA, under the program area of Centers and Community Oncology, and in cooperation with the National Institute on Aging, would like to issue an RFA to examine problems and needs unique to the elderly for the management of cancer. The intention is to direct a specific focus on persons 65 years of age or older as a target population to improve upon and strengthen practices in cancer control for the elderly. Knowledge is unavailable or ambiguous for an age group in which more than 50 percent of all cancers occur and 60 percent of all cancer deaths are observed.

The division, in consultation with NIA, is advancing the premise that a special research effort should be directed toward the interface of cancer and aging because optimal evaluation of elderly cancer patients requires an adequate information base on (1) assessment of interventions (i.e., diagnosis and staging of cancer) and (2) treatment (surgery, radiotherapy, and chemotherapy). Data need to be developed for specific management considerations for the elderly.

This project seeks to encourage phases 2, 3 and 4 cancer control studies which describe and examine patterns of cancer care for the elderly and how these patterns relate to differences in workup, staging, and treatment of older-aged persons. Topics of major interest to DRCCA include an examination of the problems unique to the elderly concerned with (1) sensitivity to older cancer patients to conventional forms of diagnosis and treatment (e.g., chemotherapy, radiotherapy, surgery); (2) interaction of multiple diseases with cancer; (3) decision making of physicians who must deal with the interplay of all factors inherent in old age and cancer; and (4) how and when older persons enter the health care system (e.g., actions taken by the aged in response to the signs and symptoms of cancer.

Well designed investigations which use descriptive and analytical methods, cohort analyses, and case control techniques may be pursued. Both observational and experimental studies are acceptable. Research studies which are conducted in defined population groups are highly desirable. A single activity or combination of activities from the broad spectrum of early detection, early diagnosis, pre-treatment evaluation, treatment, rehabilitation, and continuing care cancer control efforts may be addressed. Project investigators and their research teams should consist of persons having expertise in oncology, gerontology, geriatrics, and relevant disciplines and professions.

Cancer is primarily a disease of the elderly, but very little attention has been paid to the problems of the older adult who has cancer. Almost no site-specific data on the elderly are available. There is little information about the behavior of tumors as related to age. Whether the age of the host makes a difference in the behavior of the tumor is not known. Pharmacokinetics and pharmacodynamic information is scanty. Insofar as clinical trials are concerned, no definitive information can be determined from them about treatment of elderly cancer patients since the studies are not designed to look at older aged persons specifically. Selection bias factors prevail. Conditions of co-morbidity and the normal processes of aging further complicate the management of elderly cancer patients. For the most part, only anecdotal data exist on the multiple and complex issues that bear upon cancer in the elderly.

Moreover, since most cancer care occurs in the community and not in university medical centers or comprehensive cancer centers, treatment decisions made for elderly persons with cancer are not documented. Indeed, data from the Centralized Cancer Patient Data System covering patients admitted to comprehensive cancer centers from 7/77 to 12/80 indicate that only 35 percent of their patients are 65 or older. Thus, the numbers of older cancer patients treated in the centers are less than expected and probably not representative of the older segment of cancer patients in the general population.

There are also quality of life issues which are extremely relevant to cancer care for the elderly. Social support and

economic resources diminish in one's later years in life for most Americans, yet that is the most frequent time for onset of cancer, other chronic diseases, and deleterious effects of aging.

Coupled with these considerations is the burgeoning growth of the older population in the United States. There are approximately 22 million persons who are 65 years and older making up 11 percent of the population. In less than 50 years, the size of the older aged group will have more than doubled to about 55 million before the population expansion levels off. Cancer may more likely be an even greater health problem for older persons in the future.

Board member Barbara Hulka said she was "bothered by the definition of elderly as age 65. I would pick 80, or 70 to 75. What is elderly differs from one cancer to another." Ernst Wynder agreed that "65 is too young these days" to be considered elderly.

Yates, on the other hand, said that when chemotherapy is used, age 60 might be more appropriate.

Board members Jerome DeCosse and Leonard Derogatis suggested that some "fine tuning" be done on the proposal, and Breslow commented that the Board's Centers and Community Oncology Committee, chaired by Moertel, might be asked to look at it.

Moertel disagreed. "I don't think you can conclude that any of these things are right or wrong, that this age is the right one, or that one is. I prefer to have the investigator put together a hypothesis, which he defends in his research proposal, using his own particular criteria. Leave it wide open."

The Board passed the motion to approve the concept, with Hulka casting the only dissenting vote.

The Board gave concept approval to a new research training instrument, the "Physician Investigator Development Award."

Barney Lepovetsky, chief of the Career Development Branch, said this proposal is "a partial response to the problem" of a diminishing number of physicians entering research. He hopes to make eight to 10 awards. A program announcement describing the award will be published, probably in December.

Lepovetsky's description of the program:

This new award is intended to encourage recently trained highly qualified physicians to undertake careers in cancer research and to provide them an opportunity to develop into independent investigators. The initiation of this award is prompted by the chronic shortage of physician investigators. The physician investigator development award will facilitate a potential investigator's transition from clinician to independent basic or applied researcher. It differs from the research career development award in that it seeks to develop research ability in people who show research potential but who by reason of lengthy clinical training have not had an opportunity to demonstrate significant research achievement.

The physician investigator development awardee will be supported for a maximum of three years. All funds must be used to support the original awardee. No transfer of the award is permitted. Support is based on a fulltime, 12-month appointment. The awardee will be provided salary support of up to $25,000 in the first year with subsequent years up to a ceiling of $30,000, plus fringe benefits. The actual salary must be consistent with the established salary structure of the institution for persons of equivalent qualifications, experience and rank.

Up to a total of $10,000 annually may be provided for supplies, training, equipment, travel, etc., which are necessary for pursuit of the awardee's research program. An appropriate sponsor or sponsors must assume responsibility and provide guidance for the development of the candidate's program including his research.

Institutions may apply for awards on behalf of named individuals meeting the criteria for this award. Evidence of the commitment of the institution and sponsors to the candidate's research and career development is to be included in the application.

The grant will be made annually to the awardee's parent institution for each of the three annual budget periods. Costs allowed may include:

1. Equipment: Specialized research equipment essential to the proposed program. The available facilities should include most of the necessary equipment.
2. Supplies: Consumable supplies essential to the proposed program.
3. Travel: Domestic travel essential to the proposed program.
4. Tuition for training including courses: If essential to the awardee's individual research development program.
5. Other: Publication costs, patient costs, etc., necessary for the research program.

Funds will be provided for the reimbursement of actual indirect costs or an amount equal to eight percent of the total direct costs of each award, exclusive of tuition, fees, and expenditures for equipment. The lesser of the two amounts of money will be paid as indirect costs.

The award is designed to provide intensive, supervised research experience for clinicians. Thus, candidates are restricted to those holding health professional degrees in the clinical sciences (MD, DO). Candidates ordinarily will have completed their clinical experience by the time the award can be made. Ordinarily a candidate in the following categories will not qualify:

1. With more than six years of postdoctoral experience at the time of award.
2. With significant independent NIH research support or its equivalent.
3. With less than three years total postdoctoral clinical experience at the time of the award.

Eagle noted that other strong programs aimed at encouraging physicians to go into research have been successful, that 90 percent of the physicians going through them have remained in research.

The proposal submitted to the Board would have emphasized the need for surgical oncologists, radiation oncologists, and preventive oncologists. Moertel said that "bugged" him, and suggested there were other specialties in equal need, mentioning clinical immunology, nutrition and metabolism, pediatric oncology, gerontology, and gastrointerology. Board members agreed to remove the language emphasizing the three specialties.

Eagle said, "This is a magnificent program, that fills an urgent need. I'm dismayed at the disparity between the number of awards projected and the need. Eight to 10 nationally is totally inadequate."

Lepovetsky said that more might be awarded if more money becomes available.

The Board gave concept approval to a three year,

randomized double blind clinical trial to evaluate the efficacy of 13 cis retinoic acid as a chemopreventive agent for basal cell carcinoma. The study will be conducted cooperatively with military clinical centers serving retired military personnel and their dependents, and possibly at some VA hospitals.

George Schreiber, project director, said he expected about six institutions to participate, all of them in the sun belt areas where skin cancer is more prevalent. He estimated the study would cost about $2 million total over six years, including three years of followup. It will be supported through interagency agreements.

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

Cancer Nursing: Today and Tomorrow—Nov. 1-2, Johns Hopkins Medical Institutions, Baltimore. Contact Program Coordinator, Turner 22, 720 Rutland Ave., Baltimore, Md. 21205, phone 301-955-6046.

Cancer Clinical Investigation Review Committee—Nov. 1-2, NIH Bldg 31 Rm 6. Open Nov. 1, 8:30-9 a.m.

Annual Course in Pediatric Radiology—Nov. 1-3, Cambridge, Mass. Contact Educational Resources Associates, P.O. Box 369, Brookline, Mass. 02146, phone 617-738-8859.

3rd Annual International Congress for Interferon Research—Nov. 1-3, Miami. Contact E.R. Ruffing, Scherago Associates, 1515 Broadway, New York 10036, phone 212-730-1050.

International Symposium on Gynecologic Oncology—Nov. 1-9, Amsterdam. Contact Erwin Witkin, SCME, 6609 Reisterstown Rd., Baltimore Md. 21215, phone 301-358-1541.

Current Controversies in Breast Cancer—Nov. 3-5, Shamrock Hilton Hotel, Houston. Contact Cochairmen Drs. George Blumenschein, Eleanor Montague, or Frederick Ames, M.D. Anderson Hospital, 6723 Bertner Ave., Houston, Tex. 77030.

Double Contrast Techniques in Gastrointestinal Radiology—Nov. 3-6, Vienna. Contact Prof. Dr. H. Pokieser, Secretariat, Zentrales Institut fur Radiodiagnostik der Universitat Wien, Allgemeines Krankenhaus, A-1090 Wien, Alserstrasse 4, Austria.

Lung Cancer: Diagnosis & Therapy—Nov. 4, Roswell Park continuing education in oncology. Contact Gayle Bersani, Cancer Control Coordinator.

American Pancreatic Assn. and National Pancreatic Cancer Project—Nov. 4-5, Chicago. Contact Dr. Isidore Cohn, NPCP, Louisiana State Univ. Medical Center, 1542 Tulane Ave., New Orleans 70112.

International Symposium on Radioimmunoimaging: A State of the Science Update—Nov. 4-5, Albuquerque. Contact Dr. Buck Rhodes, Nuc-Med Inc., P.O. Box 13329, Albuquerque, N.M. 87192, phone 505-294-5197.

5th Annual San Antonio Breast Cancer Symposium—Nov. 5-6, San Antonio, Texas. Contact Terri McDaniel, Cancer Therapy & Research Center, 4450 Medical Dr., San Antonio 78229, phone 512-690-0655.

Cincinnati Conference on Cancer Therapy: Breast Cancer—Nov. 5-6. Contact Thomas O'Connor, Cancer Treatment Center, Bethesda Hospital, 619 Oak St., Cincinnati, Ohio 45206, phone 513-559-6337.

EORTC Symposium on Paraneoplasia Basic Concepts and Clinical Aspects—Nov. 5-6, Brussels. Contact Dr. M. Staquet, EORTC Data Center, rue Heger-Bordet 1, 1000 Brussels, Belgium.

5th Annual Meeting and Symposium of the National Hospice Organization—Nov. 7-10, Washington D.C. Contact 1982 Fall Meeting, P.O. Box 207, Davidsonville, Md. 21035.

President's Cancer Panel—Nov. 8, NIH Bldg 31 Rm 4, 9 a.m., open.

30th Annual Scientific Meeting of the American Society of Cytology—Nov. 8-13, Chicago. Contact Dr. Warren Lang, Secretary-Treasurer, 130 S. 9th St., Suite 810, Philadelphia, Pa. 19107.

Innovative Cancer Chemotherapy Tomorrow—Nov. 10-12, New York. Chemotherapy Foundation Symposium. Contact Director, Page & Wm. Black Post Graduate School of Medicine, Mount Sinai School of Medicine, SUNY, Annenberg 5-206, 1 Gustave Levy Pl., New York 10029, phone 212-650-6772.

Inorganic and Nutritional Aspects of Cancer and Other Diseases—Nov. 10-13, La Jolla. Third conference of the International Assn. of Bioinorganic Scientists. Contact Dr. G.N. Schrauzer, Chemistry Dept., Univ. of California (San Diego), Revelle College, La Jolla 92093.

Cancer Special Programs Advisory Committee—Nov. 15-16, Linden Hill Hotel, Bethesda, Md. Open Nov. 15, 9-10 a.m.

Applications of Biological Markers to Carcinogen Testing—Nov. 15-19, Bethesda, Md. Symposium sponsored by the Environmental Protection Agency. Contact Claire Wilson, Associate Universities Inc., Suite 603, 1717 Massachusetts Ave. N.W., Washington D.C. 20036, phone 202-462-4475.

National Surgical Adjuvant Project for Breast & Bowel Cancers—Nov. 15-17, San Antonio. Contact Dr. Bernard Fisher, Univ. of Pittsburgh School of Medicine, 3550 Terrace St., Pittsburgh, Pa. 15261, phone 412-624-2671.

National Cancer Advisory Board Committee on Environmental Carcinogenesis—Nov. 15, NIH Bldg 31 Rm 11A10, 1 p.m., open.

Tutorial on Neoplastic Hematopathology—Nov. 15-19, Chicago. Contact Claude Weil, Univ. of Chicago, Center for Continuing Education, 1307 E. 60th St., Chicago 60637, phone 312-753-3186.

Controversies in the Management of Early Breast Cancer—Nov. 17, Biltmore Hotel, Los Angeles. Contact Bonnie Van-Waardenburg, Hospital of the Good Samaritan, 616 S. Witmer St., Los Angeles, Calif. 90017, phone 213-977-2345.

Contemporary Issues in Osteoporosis—Nov. 18, Roswell Park continuing education in oncology.

Cancer Centers Support Grant Review Committee—Nov. 18, NIH Bldg 31 Rm 10, open 8:30-10 a.m.

Annual Scientific Meeting on Clinical Oncology—Nov. 24-26, Sydney, Australia. Contact Clinical Oncological Society of Australia, Box 4708 GPO, Sydney NSW, Australia.

Radiological Society of North America—Nov. 28-Dec. 1, McCormack Place, Chicago. Contact American College of Radiology, 20 N. Wacker Dr., Chicago, Ill. 60606, phone 312-236-4963.

National Cancer Advisory Board—Nov. 29-Dec. 1, NIH Bldg 31 Rm 6, 8:30 a.m., open all three days for annual program review.

Clinical Cancer Program Project Review Committee—Dec. 2-3, NIH Bldg 31 Rm 6, open Dec. 2, 8:30-10 a.m.

Role of Nutrition in Cancer Prevention & Treatment—Dec. 9-10, Washington D.C., Shoreham Hotel. Second annual Bristol-Myers Symposium on Nutrition Research. Contact Ann Wyant or Kathryn Bloom, 212-546-4337.

New Concepts in the Management of Head and Neck Cancer—Dec. 9, Chicago. Contact Margaret Stewart, Administrative Coordinator, Illinois Comprehensive Cancer Center, 36 S. Wabash Ave., Chicago 60603, phone 312-346-9813.

Comprehensive Care of the Advanced Cancer Patient—Dec. 9, Roswell Park continuing education in oncology.

Congress of the European Society for Medical Oncology and Plenary Session of the European Organization for Research on Treatment of Cancer—Dec. 10-13, Nice. Contact M. Schneider, Centre A. Lacassagne, 36 Voie Romaine, 06054 Nice Cedex, France.

Therapy of Acute Leukemias—Dec. 11-14, Rome. Third international symposium. Contact Dr. Franco Mandelli, Organizing Secretariat, Cattedra di Ematologia, Universita di Roma, Via Chieti 7, 01161 Roma, Italy.

Monoclonal Antibodies in Oncology—Dec. 13, Paris. Quarterly scientific meeting and symposium of the French Federation of Anticancer Centers and French Assn. for Cancer Research. Contact Mrs. Berthomeau, Institut Curie, 26 rue d' Ulm, 75231 Paris Cedex 05, France.

FUTURE MEETINGS

Advances in Bladder Cancer Research—Jan. 5-8, Hyatt Sarasota, Florida. Second National Bladder Cancer Conference sponsored by the National Bladder Cancer Project and American Urological Assn. Latest and most important research findings which provide a basis for advances in the clinical management of bladder cancer, and to define unresolved problems in such a way that they can be approaches as research opportunities. Contact NBCP, St. Vincent Hospital, Worcester, Mass. 01610.

Current Results in the Treatment of Children with Cancer and Leukemia—Feb. 25-26, St. Jude Children's Research Hospital, Memphis. Seventh Annual Clinical Symposium, open to all physicians. Emphasis will be on diagnosis and treatment programs for primary disease as well as care of complications. Limited to first 200 who register, no registration fees. Contact Associate Director for Clinical Research, St. Jude Children's Research Hospital, Box 318, Memphis, Tenn. 38101.

Hyperthermia and Radiation Therapy in the Treatment of Cancer—March 5-6, Sheraton Palace Hotel, San Francisco. Eighteenth Annual San Francisco Cancer Symposium. Contact West Coast Cancer Foundation, 50 Francisco St., Suite 200, San Francisco, Calif. 94133, phone 415-981-4590.

J.D. Woodruff Symposium on Gynecologic Oncology—March 24, Cross Keys Inn, Baltimore. An update on the biology of cancer for the gynecologist, gynecologic oncologist, resident in obstetrics and gynecology, and radiation therapist. Sponsored by Johns Hopkins Medical Institutions. Contact Susan Bavaro, Office of Continuing Education, Turner 22, 720 Rutland Ave., Baltimore, Md. 21205, phone 301-955-6046.

1983 Oncology Update Symposium—April 9, Biltmore Hotel, Los Angeles. Sponsored by Northridge Hospital Medical Center. Latest developments in cancer prevention, early cancer detection, cancer immunology, cancer surgery and oncology nursing. Contact Sandra Rozzen, 213-885-5311.

Predictive Drug Testing on Human Tumor Cells—July 20-22, University Hospital, Zurich. Different techniques recently developed to individualize treatment of cancer patients. Competitive papers and a poster session, with an April 15 deadline for abstracts. Contact V. Hofmann, M.D., Div. of Oncology, University Hospital, 8091 Zurich, Switzerland.

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-FS-31005-67

Title: *Support services for radiation and related studies*

Deadline: *Dec. 13*

Studies of populations exposed to ionizing radiation are being conducted to investigate further the relationship between cancer risk and exposure to high doses, and to improve estimates of risk associated with lower doses. An immediate practical need is for risk estimates on which to base regulatory and other decisions about the use of nuclear and radiological technology in medicine and industry, and to assess the value of exposure avoidance as a means of cancer prevention. The study of radiation induced cancer is also a promising approach to understanding mechanisms of carcinogenesis in general. In addition, studies are being conducted of patients treated with cytotoxic drugs in addition to radiotherapy, utilizing various clinical trials in collaboration with the NCI Div. of Cancer Treatment.

The Radiation Studies Section of the Environmental Epidemiology Branch, Field Studies & Statistics Program, Div. of Cancer Cause & Prevention, NCI, plans and conducts epidemiologic studies to determine risk of cancer in populations receiving cytotoxic drugs. Studies are conducted to obtain information on patients diagnosed with cancer and on appropriate controls, as well as on populations or groups which may have been at unusual risk of developing cancer following exposure to radiation or drugs in medical, job related, or other environmental situations.

This will be a support or resource contract, with no independent research by the contractor although publications resulting from this study may recognize the contributions of key personnel of the contractor.

The RFP covers the data collection activities including collecting data on cancer and other medical conditions; on radiation exposures and other environmental factors; on occupation, residence, drugs, diet, and personal habits; and on social, cultural, or demographic background.

NCI wishes to contract with an organization which is highly experienced in conducting and managing all support phases of nationwide epidemiologic studies on cancer in relation to ionizing radiation and cytotoxic drugs. These include: (1) designing data collection forms; (2) preparing manuals for abstracting, coding, interviewing, and tracing; (3) abstracting, keying, editing, updating, and coding data; (4) tracing individuals; (5) obtaining death certificates; (6) interviewing; (7) assessing exposure information; (8) validating medical information; (9) creating and manipulating data files; (10) implementing quality control procedures; and (11) arranging for shipment of biological specimens. Particular emphasis will be placed on data collection, data preparation, and data processing. All potential contractors must be able to dem-

onstrate that they are capable of providing support to multiple studies being conducted simultaneously throughout the United States.

Relevant support activities are now ongoing, carried out by another contractor whose contract will expire in the near future. This will be a five year procurement. It is anticipated that the contract will begin in June 1983, but the actual initiation date will depend on the progress of the competitive process.

Personnel needed include: eight full time key personnel: one program manager, four data collection managers; two programmer/analysts, and one coding/abstracting supervisor. Four of these persons must also function as study managers. Additional part time or full time personnel to account for approximately 23 person-years may be drawn from computer programmers; data entry personnel; clerk/-typists; tracers; coders; abstractors; interviewers; field supervisors; form designer; trainer of interviewers/-coders/abstractors; survey design specialist; and nosologist, plus additional administrative personnel.

Contract Specialist: Camille Battle
RCB, Blair Bldg. Rm 114
301-427-8888

RFP NCI-CM-37568

Title: *Development of human tumor models for correlating in vitro sensitivity with in vivo response rate*

Deadline: *Approximately Dec. 3*

NCI's Div. of Cancer Treatment, Development Therapeutics Program, Drug Evaluation Branch, is seeking organizations with the expertise to develop improved preclinical antitumor drug screening models based on sequential in vitro and in vivo testing against batteries of human tumors. Specific objectives are to determine whether in vitro assays, using transplantable human tumors propagated in athymic (nude) mice as the source of cells, can be developed into screens capable of distinguishing drugs with selective activity in vivo against the same tumors; and to develop screening protocols based on sequential testing in vitro and in vivo against batteries of human tumors of specific type with expression of therapeutic efficacy as percentage responders.

Two or more batteries, each battery consisting of 10 tumors of similar histology and tissue of origin, shall bae established in serial transplantation in athymic mice. Each tumor shall be from an individual patient who has not received prior specific anticancer drug treatment; shall be established as xenografts in mice directly from surgical or biopsy material and not from primary cell culture; shall be capable of propagation by serial transplantation in vivo at a "take rate" of nearly 100 percent without interspersion of cell cultures "in-line" between successive in vivo generations; shall be capable of culturing in vitro from any in vivo transplant generation in a manner conducive to quantitative and reproducible measurement of cytotoxicity; shall be capable of transplantation into a sufficient number of athymic mice for in vivo drug testing; and exhibit stable growth and reproducible drug responsiveness over successive in vivo transplant generations.

Study of at least two tumor types (20 tumors) will be required; additional types may be offered. Drugs will be generally restricted to known clinical drugs, those in early clinical trial or in later stages of development. Thus, for this "model development" project, drugs will be generally used as tools to validate the model. Conduct of major tasks might be expected to follow the following sequence for each battery:

1. Establishment of human tumor xenografts in vivo. 2. Selection of 10 tumors to constitute the "battery." 3. Testing of selected drugs in vitro, and in vivo regardless of in vitro responses, to establish correlations and reproducibility. 4. Determination of extent to which in vivo testing can be limited to in vitro "actives." 5. Validation of in vitro/in vivo mode model system with additional selected drugs. 6. Determination of added value of this approach for specific disease oriented screening over commonly used screening approaches; estimation of costs and time to screen 50-100 compounds per year; and development of precise protocols for use in larger scale screening laboratories.

Offerors will be expected to stipulate, in detail, appropriate in vitro and in vivo experimental methodologies for technical tasks 1-5 above. Offerors must propose a principal investigator experienced in both in vitro and in vivo drug screening; must document their ability to obtain eligible human tumors as specified from biopsies or surgical specimens; must document availability of an essentially pathogen-free environment for breeding, maintenance and use of athymic mice.

One award will be made for a three and one-half year incrementally funded period of performance. The contract will be written on a level of effort basis as follows: Period I 4.6 staff years, period II 9.2 staff years, period III 9.6, and period IV 10 staff years.

Contract Specialist: Charles Lerner
RCB, Blair Bldg. Rm 228
301-427-8737

The Cancer Letter _Editor Jerry D. Boyd

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