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PEDIATRIC CCOP CONTROVERSY SPLITS GROUP LEADERS; NATIONAL CONSORTIUM FORMED; NCAB TO WATCH CLOSELY

One of the sharpest controversies generated by the advent of the Community Clinical Oncology Program was the decision by NCI to accept applications from pediatric CCOPs. The prospect of disturbing a process which most pediatric oncologists agree has been working well

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In Brief

NCI PONDERS HOW EXTRA $40 MILLION WILL BE SPENT, WILL SUBMIT PLANS TO NCAB AT UPCOMING MEETING

NCI EXECUTIVE Committee was scheduled to meet this week to draw up plans for spending the extra $40 million (above the 1982 level) approved by Congress for NCI in the lame duck session. Much of that was earmarked by the congressional appropriations subcommittees, including restoration of cuts in indirect costs. Plans for allocating the rest will be presented to the National Cancer Advisory Board at the Jan. 31-Feb. 2 meeting. . . . **VAINUTIS VAITKEVICIUS** has been named chairman of the Dept. of Internal Medicine at Wayne State Univ., and **LAURENCE BAKER** has replaced him as chief of the Div. of Oncology. Vaitkevicius also has assumed the positions of chief of medicine at Harper-Grace Hospitals and physician-in-chief of medicine in the Detroit Medical Center. Baker also is deputy director of the Comprehensive Cancer Center of Metropolitan Detroit. . . . **B.J. KENNEDY**, professor of medicine and oncology at the Univ. of Minnesota, was elected president of the American Assn. for Cancer Education at the organization's recent annual meeting in Birmingham. **FREDERICK PEAGLER**, Howard Univ. School of Dentistry, was named president elect. **STEPHEN STOWE** was reelected secretary and **BEVERLY RANEY** was elected treasurer. . . . **GEORGIA BURNETTE** has been appointed director of Roswell Park Memorial Institute's Nursing Dept. She has been director of rehabilitation at the Visiting Nursing Assn. of Buffalo. She succeeds Patricia Burns, who retired in 1981. . . . **MICHAEL SHIMKIN**, head of the Dept. of Community Medicine at the Univ. of California (San Diego), will receive the Distinguished Achievement Award from the American Society of Preventive Oncology at the society's annual meeting March 24 in Bethesda. . . . **JOSEPH ZABERTNIK**, head and neck surgeon and president of the Florida Div. of the American Cancer Society, recieved the National ACS Award at the society's recent annual meeting. . . . **GYNECOLOGIC ONCOLOGY** Group's business meeting will be held Feb. 3-5 in Phoenix. Contact John Kellner, Group Manager, 1234 Market St. Suite 430, Philadelphia 19107, phone 215-854-0770. . . . **ROBERT AVERY**, chief of the Public Inquiries Section of NCI's Office of Cancer Communications, has retired. His office handles 22,000 phone and mail inquiries a month.

CCSG AGREES TO CCOP AFFILIATIONS, BUT WITH PARTICIPATION BY MEMBERS

(Continued from page 1)

aroused opposition in some quarters and nearly resulted in action by the National Cancer Advisory Board to exclude pediatric CCOPs (***The Cancer Letter,*** Oct. 8).

The NCAB did agree to take a close look at the pediatric CCOP applications during the review process, to assure that the new mechanism does not encourage treatment of childhood cancer in less than optimal surroundings.

NCI received a half dozen pediatric CCOP applications, including a nine member Childrens Cancer Consortium, a national consortium encouraged by the Childrens Cancer Study Group. Approximately 16 other institutions are included in the other applications, some of which are using CCSG as a research base.

The controversy developed within CCSG, with leaders of the cooperative group split over the issue.

CCSG Chairman Denman Hammond persuaded NCI to include pediatrics in the program and was instrumental in putting together the national consortium. Associate Chairman William Krivit, head of the Dept. of Pediatrics at the Univ. of Minnesota, objected and raised the issue with members of the NCAB.

Krivit's objections centered on the fact that the existing Cancer Control Cooperative Group Program, in which groups were funded to bring community hospitals into their protocols, has been working well. "If something is working, don't fix it," Krivit told ***The Cancer Letter.*** "The Cancer Control Program should receive strong support and be the major funding mechanism for community projects. No one disagrees that if (that program) continues as the funding agency, that would be the preference."

Krivit and others have argued that CCOP could lead to competition for pediatric patients and result in some children being treated in community hospitals who should be referred to centers or other hospitals with more appropriate facilities and staff.

Krivit expressed his concerns at a CCSG meeting, but the members voted anyway to participate in CCOP, after agreeing to some safeguards to assure quality control. Chief among those is the requirement that CCSG will serve as a research base only for those CCOPs which are sponsored by CCSG members. Each CCOP institution, including those involved in consortia, must meet all the requirements of a CCSG affiliate before CCSG will agree to serve as its research base.

Hammond agreed that the Cancer Control Program has worked well, and in fact now is supplying about 25 percent of the patients enrolled in CCSG protocols. However, "we need a stable commitment," Hammond said. "Those cancer control contracts have a checkered history. It has been a very unstable program, with multiple leaders and reviewers. We need a sustained, reasonably long term commitment by NCI."

The Cancer Control Cooperative Group Program recently has been recompeted, with applications from nine groups. Six are presently funded, and if all nine of the new applications (including the existing ones) are funded, "that means that my contract will be negotiated down," Hammond said.

The Cancer Control Program was not intended originally to be permanent but was a demonstration effort, to encourage the groups to work with community hospitals. With the decision to proceed with CCOP, NCI first intended to let the contract supported group program lapse but was pressured into continuing it by group chairmen, hard pressed for funds with their level budgets from the Div. of Cancer Treatment.

"The contract program got us motivated to working with communities," Hammond said. "There is controversy over which will be best. I don't care which ultimately prevails, but we must have a stable commitment."

NCI Director Vincent DeVita initiated CCOP with the understanding that it would be a long term commitment. Some NCI executives now feel that there will be room for both, and that the contract program may be more suited to funding participation of hospitals which cannot meet the CCOP requirements.

Many of those that can elected to compete for CCOP awards primarily because (apparently, hopefully) they will receive more money for their efforts. They also are looking for enhanced prestige CCOPs are expected to bring, along with such ancillary benefits being held out as control of Group C drugs in their areas, participation in other cancer control efforts, chemoprevention clinical trials, etc.

Hammond said many community hospitals are hard pressed to continue working with groups under the contract mechanism, because that program does not provide sufficient money to pay for data managers and travel to group meetings.

About half of the institutions applying for CCOP represent new bodies of patients not presently participating in clinical trials, Hammond said. The other half are those who do supply 25 percent of CCSG patients, "but they may not be able to keep that up," without additional support. In addition, "the idea of CCOP is to have community oncologists as participants in clinical research, not just entering patients," Hammond said.

Hammond is not worried about the quality of treatment patients will receive through CCOP members. CCSG will monitor every patient to assure protocol compliance.

CORRECTION: A report in ***The Cancer Letter*** Nov. 19 left the impression that a 20-member consortium application in Oregon (the Oregon Comprehensive Cancer Program) was the only CCOP application from that state. In fact, the Providence Regional Community Clinical Oncology Program has submitted a separate application. It is a consortium including Providence Medical Center, Portland Adventist Medical Center, Dwyer Community Hospital, Woodland Park and Gresham Community Hospital. Providence Medical Center alone diagnoses more than 1,100 new cases and sees over 17,000 cancer patients each year.

RFA NIH-NCI-DRCCA-82-17

Title: *Patterns of Care for Eldery Cancer Patients: Implications for Cancer Control*

Application Receipt Dates: *April 19, Dec. 6, 1983*

NCI invites qualified researchers to submit grant applications for research projects to investigate problems and needs unique to the elderly in the diagnosis and management of cancer. NCI, in consultation with the National Institute on Aging (NIA), is directing a specific focus on the older adult who has cancer. Although the majority of cancers affect older persons disproportionately and the probability of developing cancer increases as one grows older, relatively little is known about how the problems of old age affect cancer patient workup, treatment and care. The dearth of data makes it impossible to provide definitive answers to the many questions which arise about the impact of old age on cancer patient management.

The purpose of this RFA is to solicit high quality research grant applications that address the mutual interests and concerns about cancer and old age as they interact and relate to clinical research and medical practice so as to contribute to our understanding of the management of cancer in the elderly. This initiative, by stimulating the fields of oncology, geriatrics, gerontology, and other relevant disciplines and professions to conduct multidisciplinary research, is intended to reduce the knowledge gap about cancer treatment and care in the older-aged population. Information is being sought on the natural history of cancer in the elderly, treatment patterns, the interaction of the normal and/or pathophysiological processes of aging and cancer, the overlap of intercurrent disease with cancer, and the extent to which interdisciplinary approaches may foster coordinated application of special skills for optimal cancer care for the elderly.

In the area of early detection, *when* the older person enters the medical care system could be significant for the course of potentially malignant lesions. Early detection efforts for older persons have been minimal. There is no information on what older persons do when they become aware of themselves as ill with signs and symptoms of cancer and the factors affecting promptness in their decisions to seek care.

When considering surgical, radiotherapeutic, chemotherapeutic or a combination of these therapies, age imposed compromises are particularly true for the very young and the elderly: Anatomic development and degeneration as well as physiologic factors must always be considerations in these situations.

The selection of surgical procedures which are conservative or aggressive in approach and palliative or curative in intent will be influenced by age, as will the incidence of complications during the postoperative recovery period. There are limited data relative to the choice of surgical treatment in the elderly.

Administering radiotherapy to the aged cancer patient is a common practice, yet again little information is available related to the incidence and type of complications associated with advancing age. Tolerance to irradiation varies with the radiation fields, dosage, and type of cancer under treatment.

Age dependent differences in drug absorption, distribution, metabolism, and excretion are all appreciated. Drug-drug interactions receive less attention but represent a significant hazard in the multiple medicated elderly. Adverse drug reactions (e.g., the stomatitis from adriamycin or 5-fluorouracil) in the elderly may represent life threatening situations. Changes in physiology (e.g., decreased renal function), anatomy (e.g., intracavitary fluid retention acting as a drug reservoir), and rapid weight changes altering drug-to-weight ratios all represent potentially hazardous changes for these patients.

To be responsive to this RFA, investigations which use descriptive and analytic (e.g., longitudinal, cohort, case-control, and cross-sectional) designs are acceptable. The study population in which research would be conducted should be well defined within a community or the general population. Use of objective, reliable, and valid measures is essential. Study settings may include nursing homes, hospitals, other health care institutions, the community, and the occupational context.

A single or combination of activities from the broad spectrum of early detection, early diagnosis, pretreatment evaluation, treatment, rehabilitation, and continuing care cancer control efforts may be addressed. Topics of major interest are listed below. However, grant applications are not limited to these areas. The list is neither all inclusive nor exclusive, nor is it an order of priority of interest. Related issues designated by the applicant will be considered as well.

- Patterns of care for the elderly cancer patient.

Not much is known about how physicians care for older aged cancer patients at the community level. Neither has there been a distinct focus on the behavior of neoplasms and tumor characteristics as they present in the elderly. It is known, however,

that multiple clinical problems of the aged frequently require physicians to look for subtle or masked features of adverse conditions in addition to the presenting complaint. These special features of aging and symptoms of illness in old age influence the treatment and care of the elderly cancer patient and tend to complicate carrying out prescribed regimens. Studies are needed on the assessment of the effectiveness of different treatments relative to cancer, the stage of the disease. and significant features and characteristics of old age (e.g., poor repair mechanisms, functional loss, greater susceptibility to toxicity of treatment). In these types of studies, a special effort should be made to minimize biases, for example, through the use of defined populations.

• Variations in response factors to signs and symptoms of cancer by older aged persons.

To a large extent, improved cancer cures depend on early recognition and appreciation of signs and symptoms of the disease and prompt referral to treatment. Actions taken by older persons in response to the signs and symptoms of cancer will affect the cure, number of complications, and sequelae. Elderly persons are often excluded from most early cancer detection efforts. Though they represent one of the groups at highest risk, older aged persons have not been singled out as a target group. Research strategies to ascertain what factors influence decisions made by older persons in response to signs and symptoms of cancer and the individual variations which may result in delay are needed.

• Analysis of existing data bases which are relevant to addressing cancer patient management for older persons.

Secondary analyses of surveys or studies which have been designed to address other issues in treatment of cancer or other chronic illnesses, the processes of normal aging, long term care, and related health issues may be appropriate. This choice would require a detailed explanation of the data elements in the data base identified as a candidate for this research to determine the utility of addressing the problems at the interface of cancer and aging raised in this RFA. Special attention must be given to ascertaining biases in the data base.

• Evaluation of tolerance of and response to standard or experimental chemotherapy regimens.

Studies should involve entry of patients across the entire age spectrum (with efforts to minimize selection bias) into predetermined chemotherapy protocols with doses based either on surface area or adjusted for physiologic parameters such as creatinine clearance. Data should be collected on other factors known to affect toxicity or response to therapy so that the independent effect of age can be evaluated in a multivariate model. Tumors selected for study should be those of intermediate sensitivity to chemotherapy such as breast cancer, small cell lung cancer, head and neck cancer and ovarian cancer so that one has a reasonable statistical probability of observing either increases or decreases in response rate as an effect of age. A similar approach might be considered for surgery, radiation therapy, or multimodality treatment interventions.

• Socio-emotional and economic consequences of cancer for the older person and family members.

Cancer is an isolating illness, and old age is an isolating phenomenon. As a person grows older, various forms of social support diminish. There is a decline in social network involvement. Geographic distance may preclude kinship network involvement. The older individual may experience loss of friends, family, and spouse. Sickness may also be demoralizing and alienating. Often the cancer patient must be cared for in the home by a family member, friend, or spouse who is also in relatively poor health. Then, too, since cancer affects both the patient and family as a unit, family stress, health, and the organization of health behavior are high priorities which may be addressed.

• Epidemiologic studies.

Specific questions which address the problems concomitant with old age (e.g., effects of previous illnesses and concurrent illnesses; stages of disease at detection; second primaries; recurrence) in combination with the general epidemiologic concerns about the patterns of disease occurrence and the influential factors are of interest. Much useful information can be derived from epidemiologic studies on incidence and mortality in old age. Experimental epidemiologic approaches (i.e., clinical trials or community trials) to examine treatment, intervention, or preventive efficacy are appropriate.

Frequently, old age or elderly is defined using the chronological age of 65 as a point of demarcation. However, this arbitrary age cutoff, while perhaps useful for dealing with age limitations for entitlements or eligibilities for various programs, may not be useful for the research encouraged by this RFA. Applicants should address critically the issue that physiological and chronological ages do not necessarily coincide. With advancing chronological age, there are greater variations in physiological age.

Methods should be proposed by the applicant which express physiological age of the study subjects. For the most part, persons in their middle to late seventies present the most profound medical problems. Parameters to be considered in describing the elderly patient could include level of physical activity, response to graded levels of physical activity, response to graded levels of exercise, or, in the case of clinical research, measurement of organ function such as creatinine clearance or hepatic clearance of a marker substance.

Thus, the definition of "old age" or "elderly" is flexible for the RFA and is dependent on investigator defined parameters. Applicants are expected to identify what is meant by "old" in the context of the research and be able to evaluate the correlation of outcome variables and chronolocial and physiological age.

Applicants funded under this RFA will be supported through the customary NIH grant assistance award in accordance with PHS policies applicable to research project grants including cost sharing. NCI plans to support up to six awards within the limits of the funds for both review cycles under this RFA if sufficient high quality applications are received. Awards will be for three year projects. NCI intends to commit as much as $1.2 million a year for the program, depending on budgetary factors and the number of high quality applications received.

Peer review will consider the following criteria:

—Relevance and significance of the issues to the overall objectives of the RFA.

—Scientific merit of the research project design and feasibility of the procedures that are to be used.

—Potential for evaluating success of the project.

—Experience, commitment, and leadership ability of the staffing for the research project which must include medical professionals in oncology and/or geriatrics at the leadership level; the qualifications and experience of other members of the study team to do the proposed research.

—Availability of multidisciplinary expertise from related fields of gerontology, epidemiology, behavioral and social sciences, and health care as required.

—Adequacy of existing and proposed facilities and resources.

—Reasonableness of the budget in relation to the research and/or demonstration effort.

—Adequacy of the proposed means for protecting against hazardous or unethical research procedures.

Applications should be submitted on the standard research grant application form PHS 398. Application kits are available at most institutional business offices or from the Div. of Research Grants, NIH.

Each prospective applicant should submit a letter of intent covering the following points for the proposed project to Dr. Rosemary Yancik, NCI, DRCCA (see address below). This letter should be sufficient in detail for NCI staff to screen for project responsiveness to this RFA.

Topics to be addressed by letter of intent:

A. A brief description of the intended project.

B. A description of available research facilities.

C. Positions and research interests of the principal investigator(s) and staff who will be involved in the study.

D. Plans for oncology and geriatric collaboration, delineation of staff roles, manner of anticipated participation of principal investigator(s) and multidisciplinary approach.

E. Projections for patient involvement in the study.

Letters of intent are due Feb. 15 for the April 19 application deadline, and Sept. 15 for the Dec. 9 deadline.

The conventional presentation for grant applications should be utilized. The points identified under the Review Criteria must be considered. The words "RFA: Patterns of Care for Elderly Cancer Patients: Implications for Cancer Control" must be typed in bold letters in line 2 of the face page

Enclose a cover letter indicating that the application is in response to this RFA. A copy of the cover letter should also be sent to Dr. Yancik.

The original and six copies of the application should be sent or delivered to: Div. of Research Grants, NIH, Room 240, Westwood Bldg., 5333 Westbard Ave., Bethesda, Md. 20205.

Two additional copies should be sent to: Referral Officer, Grants Review Branch, Div. of Extramural Affairs, NCI, Room 826, Westwood Bldg., 5333 Westbard Ave., Bethesda, Md. 20205.

All correspondence related directly to application development, letters of intent, and the copies of the cover letter which accompany the applications should be directed to: Rosemary Yancik, PhD, NCI, Div. of Resources, Centers & Community Activities, Blair Bldg. Room 729, 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-CN-35009-10

Title: *Community cancer care evaluation*
Deadline: *March 23*

The purpose of this project is to carry out an integrated evaluation of the Cooperative Group Outreach Program CGOP), and the Community Hospital Oncology Program (CHOP), and the Community Clinical Oncology Program (CCOP). Specifically the evaluation will determine the extent to which the programs independently and/or through their interaction (a) lead to changes in the patterns of cancer care in communities where such programs are implemented and (b) lead to the introduction of new technology into patient care management. Each program is nationwide in scope.

The contractor will be responsible for design and

implementation of all phases of the evaluation. The project will include primary collection by the contractor of detailed descriptive information about each program, as well as the supervision of multi-institutional data collection, quality control, and reporting and statistical analysis of technical biomedical data.

Offerors should have at least five years experience in largescale (at least 10 man years) program evaluation studies in health related fields; at least five years experience in managing largescale cancer data bases, and statistical analysis using the data bases and data quality control; and experience in conducting research in the study of diffusion and knowledge transfer in the area of health services/biomedical research especially related to cancer.

The personnel requirements include (1) a physician with a minimum of three years of clinical experience in cancer research with a demonstrated competence through publications in referenced journals, and (2) a doctoral level person in biostatistics/epidemiology (or equivalent) with five years of experience in the development and analysis of largescale clinical data bases and the technical design and implementation of health services research in operational settings.

It is anticipated that a three-year incrementally funded cost reimbursement type contract will be awarded to the successful offeror. A preproposal briefing is planned for Feb. 3 in Bethesda, Md.

Contract Specialist: Joan O'Brien
RCB, Blair Bldg. Rm. 2A01
301-427-8745

RFP NIH ES-83-50015

Title: *Toxicology and carcinogenesis bioassays in rodents*

Deadline: *Approximately March 18*

Bioassays will be performed via 1) dosed feed, gavage, dermal (by skin paint) and dosed water routes of administration. The contractor must have the capability in-house or by subcontract to perform hematology, urinalysis, clinical chemistry and reproductive toxicology studies; and/or 2) inhalation route of administration and have the cabability to perform the above studies.

All laboratories must be capable of performing all prechronic studies Task I and/or chronic studies Task II. A master agreement (basic ordering agreement) as defined in the federal procurement regulations shall be issued as a result of this RFP. The initial award is nonmonetary and is exclusively for the purpose of establishing justifiable, limited field of competition among contractors who, once qualified, will then be allowed to compete with each other.

Contract Specialist: Susan Hoffman
NIEHS-NTP
Blair Bldg. Rm. 1A01
301-427-8774

RFP N01-CM-37590-68

Title: *Preparation and supply of fresh and cultured mammalian cells*

Deadline: *Feb. 18*

Provide large quantities of well characterized normal, virus infected, and transformed cells grown in culture. It is anticipated that 100 grams of fibroblastic cells grown as monolayer and 100 grams of suspension cultured cells will be required each year. The contractor should also be able to process up to 125 samples of human leukemic blood and supply the leukocytes to the government. The contractor should be able to freeze fresh cells in a viable state and should have short term storage facilities for the serum samples and leukocytes for eventual transfer to a central storage facility within a week.

All aspects require strict quality control and maintenance of complete records. These services will include daily courier services for pickup and delivery of specimens. The organization must be located within a 35-mile radius of the NIH, Bethesda, Md. location so as to be able to provide fresh specimens within one hour of processing to enable the government to carry out biochemical, biological and immunological studies. It is expected that one award will be for a three and one half year period, September 1983 through March 1987.

RFP NO1-CM-37575-68

Title: *Tissues and cells and conduct of routine tests in support of tumor cell biology studies*

Deadline: *Feb. 25*

Supply tissues, cells and small quantities of fresh type C RNA tumor viruses and conduct routine tests for viral antigens. It is anticipated that the contractor will examine: (a) human tissues and cultured cells for type C RNA tumor virus antigens, (b) serum samples for antibodies to human and subhuman primate type C viruses, (c) human peripheral blood or serum samples for the presence of biologically active virus by infectivity assays, (d) fresh human tissue explants and established cell lines for the presence of growth factors, (e) human normal and neoplastic tissues for growth in culture in the presence and absence of growth factors and (f) supply small quantities of 1000x concentrated type C RNA tumor viruses.

All aspects require strict quality control and maintenance of complete records. These services will include daily courier services for pickup and delivery of specimens. The contractor's facilities must be within a 35 mile radius of the main campus of NIH at Bethesda, Md. in order to provide fresh specimens within one hour of processing to enable the government to carry out biochemical, biological and immunological studies. The contractor must have adequate

biohazard containment facilities to process biological materials (P_2) and preparation of radio-iodinated proteins for RIA. It is expected that one award will be made for a four year period.

Contract Specialist for above 2 RFPs: Karlene Wakefield
RCB, Blair Bldg. Rm. 212
301-427-8737

RFP NCI-CM-37578-08

Title: *Screening of radiosensitizers and radioprotectors*

Deadline: *Approximately March 17*

NCI requires organizations having capabilities and facilities to conduct a program of screening potential radiosensitizer and radioprotector compounds.

The objectives of the radiosensitizer portions of the project are: a) to collect physical-chemical data, such as electron affinities, lipid to water partition coefficients, and solubilities in aqueous solution on about 50 compounds per year; b) to evaluate about 20 compounds per year for radiosensitizing properties in a mammalian cell culture system; and c) to examine about 10 compounds per year as radiosensitizers in tumor bearing mice using at least two separate tumor systems and a different endpoint for each system (regrowth delay of tumors, tumor cell survival and modification of the radiation dose required for curing 50 percent of the tumors).

Objective of the radioprotector portion of the project is: to increase the therapeutic ratio of radiation therapy by testing for compounds which protect normal tissues, but offer little or no protection of tumor tissue against ionizing radiation. Compounds which are superior to or which protect tissues not protected by the current reference compound, WR-2721 (aminopropyl-aminoethyl phosphorothioic acid), are being sought.

Three general screens will be conducted (1) protection against hematopoietic death (about 50 compounds per year); (2) protection of other normal tissues (skin, gut, central nervous system, etc.) and determination of selectivity using mice bearing EMT6 tumors (about five compounds during the contract period); and (3) further determination of selectivity using three additional murine transplanted solid tumor systems from the following panel: C3H mammary carcinoma, Lewis lung carcinoma, B16 melanoma, and the KHT sarcoma (about five compounds during the contract period).

A three year period of performance is projected. The contractor shall provide facilities necessary for the conventional maintenance of approximately 1,000 NCI furnished mice per week. Level of effort required: year 1, 4.5 staff years; year 2, 4.5 staff years; year 3, 4.5 staff years.

Contract Specialist: James Ryan
RCB, Blair Bldg. Rm. 228
301-427-8737

RFP NCI-CM-37591-20

Title: *Task order managed computer programming support*

Deadline: *Approximately March 22*

NCI's Div. of Cancer Treatment, Developmental Therapeutics Program, Information Technology Branch, is seeking organizations to provide system design, development, and programming services. These services will be used under a task order managed level of effort contract. This is a readvertisement of a requirement that was unsuccessfully competed as a 100 percent small business set aside.

It is anticipated that one contract will be awarded on a level of effort basis. As a specific need arises the work to be accomplished and the cost thereof will be determined by a task order on a noncompetitive basis. It is also anticipated that the award will be for a three year incrementally funded period of performance. The contract will be written on a level of effort basis as follows: Period I, 1700 staff hours, Period II, 3300 staff hours, Period III, 3300 staff hours.

At this time no specific details can be provided for any particular task. In general, programs will be required for maintenance support, operations support, or development support. Objectives may be the conversion of a file from one graphic format to another, the substitution of parallel telecommunication by a multiplexer, and the interfacing of a software package or new equipment with an existing system. The resolution of specific operating problems may also be involved.

Experience is required in planning and designing scientific information systems, with information management and principles, in implementing large and complex scientific data bases; in the use of graphics, with graphic terminals such as the Hewlett-Packard 2647A and 2648A, with Versatec printer/plotters and their software packages; in data communication, in particular with selection of multipoint networks, data concentrators, and various types of multiplexers; in the selection, use and interfacing with mainframe, micro- and minicomputers; in planning, implementing and monitoring security procedures for online multiterminal systems; in system performance and productivity optimization. Personnel proposed should include a chemist/biologist and a mathematician.

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

RFP NCI-CN-35012-46

Title: *Epidemiologic study of black/white differences in cancer patient survival*

Deadline: *Feb. 22*

The Behavioral Medicine Branch of the Div. of Resources, Centers & Community Activities, and the

Field Studies & Statistics Program of the Div. of Cancer Cause & Prevention, both of NCI, intend to conduct a prospective study of black/white differences for patients with invasive or in situ cancer of the female breast, colon (exluding rectum), urinary bladder and corpus. Data will be collected from the medical record, from pathologic review of the tumors and from patient interview and will include, but not be limited to, information on what brought the patient to a physician, delay in seeking treatment, family history of cancer, prior and concurrent illnesses, prior estrogen usage, socio-economic indicators, treatment including compliance, extent of disease, estrogen receptor determinations (breast), morphologic characteristics of the primary tumor, dietary information, alcohol consumption, and smoking history. Identifiers will be collected on all patients to permit followup for survival.

This RFP has two parts: Patient data collection centers, and a Coordinating center. Offerors may submit proposals for one or both parts assuming they meet the respondent requirements.

Contract Specialist: Deborah Castle
RCB, Blair Bldg. Rm. 2A07
301-427-8745

SOURCES SOUGHT

Project No. NCI-CO-33852-30

Title: *National survey of public knowledge, attitudes and practices related to cancer*

Deadline: *Jan. 28*

NCI is seeking small business sources capable of responding to a potential request for proposals to conduct a national survey of public knowledge, attitudes, and practices related to cancer.

The survey to be accomplished will utilize telephone interviews of approximately 30 minutes in duration. The primary sample for this survey will be 2,000 American citizens, ages 18 and over, approximately equally divided by sex. These interviews must be obtained from a national sample drawn on a random probability basis. An additional 1,500 interviews using purposive or random samples of blacks, hispanics, and blue collar workers will also be accomplished.

The contractor for this survey will be required to develop and pretest a survey instrument, prepare and execute appropriate sampling and analysis plans, conduct all required interviews, process and edit the resulting data, accomplish all analyses, prepare full technical reports (including graphics) of the study findings, and formally present the study findings at a meeting of appropriate NCI staff. Emphasis throughout this study shall be placed on obtaining valid and reliable data, and appropriate attention must be given to effective quality control procedures.

Potential small business offerors who respond to this sources sought announcement must demonstrate the capability to perform all aspects of the work required for this study. Specifically, potential offerors must: (1) demonstrate an appropriate understanding of the technical issues faced in a study such as this; (2) have access to suitable facilities and technical equipment necessary to accomplish this study; (3) provide evidence of direct experience in conducting a study of this magnitude on a national basis; (4) show that experienced and accomplished staff, capable of performing the tasks required in this study are available; (5) demonstrate that key personnel will be available throughout the study despite anticipated dealys of 30-90 days at two points in the contract while OMB clearances are obtained; (6) demonstrate the capability to draw a random sample from the national population, as well as the required purposive samples; (7) have a Spanish language capability for constructing a survey instrument and conducting interviews with that purposive sample; (8) show the capability to prepare high quality technical reports of the type likely to come out of this study; and (9) have an appropriate management and administrative structure conducive to the successful accomplishment of a study of this size.

Small businesses (average annual receipts for the preceding three fiscal years does not exceed $2 million) who believe they possess the capability to perform this study are invited to submit a statement of corporate qualifications. This statement must address the preceding technical evaluation criteria, and may not exceed 40 pages (8½ x 11 inches) of double spaced, typewritten, original text. This statement must also identify any anticipated subcontracts to be entered into and the approximate percentage of the total study effort they will encompass. A statement that no subcontractor will be necessary must be made if that is the case. Preprinted statements of corporate capability may be attached as additional information. Resumes of key personnel are required and may also be attached to the original text. Letters of recommendation from clients for whom similar work has been accomplished must also be attached.

Submit six copies of the required statement and attachments.

Contract Specialist: Elsa Carlton
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