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NCI CONSIDERING DRCCA REQUEST TO FUND MORE CCOPS FOR BETTER DISTRIBUTION; SOME WILL BE REREVIEWED

NCI's Executive Committee will consider either this week or next the request by the Div. of Resources, Centers & Community Activities to make a few more awards in the Community Clinical Oncology

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In Brief

KATTERHAGEN COMMITTEE TO MEET ON PDQ QUESTIONS; ACS GRANTS TOTAL HIGHEST IN HISTORY, $57 MILLION

PROTOCOL DATA QUERY (PDQ), NCI's new computer based information service for physicians, will be the subject of the meeting Sept. 2 in Chicago of the National Cancer Advisory Board's Committee on Cancer Control & the Community. The committee was asked by the Board at its May meeting to develop recommendations on how extensive and intensive NCI should promote PDQ. Committee Chairman Gale Katterhagen decided that issue could not be addressed without further consideration of the controversial questions involving the content of PDQ and its target audience. NCAB member Richard Bloch, whose initiative launched PDQ and whose contribution paid for a major portion of the building which will house it and other elements of the International Cancer Research Data Bank, feels the system should be open to all physicians and the public. The meeting will start at 9 a.m. in the Sheraton International Hotel at O'Hare Airport. . . . **AMERICAN CANCER SOCIETY** revealed that during the fiscal year which will end Aug. 31, it will have awarded more than $57 million for support of more than 650 research projects and postdoctoral fellowships. That is in addition to the Society's ongoing support of interferon clinical studies and epidemiological research. The highest in ACS history, those commitments include 363 new grants totaling $36 million and 305 renewal grants totaling $21 million, plus three special five year grants focused on cancer prevention. The newest of those is an $880,000 award to Fred Rapp, virologist at the Hershey Medical Center of Pennsylvania State Univ., for study of the cause and prevention of metastatic growth of cancer. Others went to Brian MacMahon of Harvard and Gerald Wogan of MIT for a joint project in biochemical epidemiology, and to Arthur Upton at NYU's Institute of Environmental Medicine for research on the control of environmental health hazards. The latter two are for $1 million each. . . . **WILLIAM LENNARZ** has been appointed chairman of the Dept. of Biochemistry at M.D. Anderson Hospital & Tumor Institute. Lennarz is professor of physiological chemistry at Johns Hopkins Univ. . . . **PATRICIA BURNS**, former director of nursing at Roswell Park Memorial Institute, has received the seventh annual William H. Wehr Award in recognition of her distinguished career in cancer nursing and education.

SOME CCOP BUDGET CUTS UNJUSTIFIED, DRCCA BELIEVES; ADJUSTMENTS MADE

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program to achieve better geographic distribution of CCOPs throughout the country. Those awards probably would go to CCOPs in the Southwest and Deep South.

The new awards probably would be funded for the first year out of the 1983 fiscal year budget, drawing on what remains of the $10 million NCI has committed to the program. The original 59 awards will require, with their research bases, somewhat in excess of $8 million (***The Cancer Letter,*** July 29).

In addition to the possible new geographically oriented awards, NCI has agreed to rereview a few of the unfunded applications which staff members felt were downgraded due to errors in the review process. If the new review moves any of them up into the funding range, they probably would have to receive their first year awards out of the 1984 fiscal year budget. NCI grants management staff still is working on getting out the 59 awards, and it does not seem likely that the rereview can be completed and additional awards made before the end of the 1983 fiscal year, Sept. 30.

DRCCA is in the process of adjusting some of the budgets which were slashed by reviewers, unreasonably in some cases, staff feels. Some of the cuts were so severe as to threaten the viability of those CCOPs and were not justified, staff argued.

Some CCOPs, concerned about their limited budgets and fearful of the effects of the impending Diagnosis Related Group reimbursement system, have considered dropping out of the program before it gets started. So far, none has, and DRCCA expects all to participate, at least through the first year.

NCI's Office of Cancer Communications recently sent out a news release announcing the 59 awards (which were published in ***The Cancer Letter*** June 3). The OCC release, including some additional information, follows in part:

Twelve of the successful applications were from community hospitals where NCI has been supporting Community Hospital Oncology Programs. CHOPs' objective was to improve the scope and quality of care for cancer patients through the development and implementation of patient management guidelines. CHOP institutions approved for community clinical oncology program awards are in Binghamton, Brooklyn, Hackensack, Cincinnati, Toledo, Marshfield, Wisc., Wichita, Roanoke, Kalamazoo, Mich., Evansville, St. Louis Park, Minn., and Los Angeles.

The 47 other local programs are being developed in a variety of communities:

- Small cities such as Sioux Falls (Sioux Falls Community Cancer Consortium); Cooperstown (Mary Imogene Bassett Hospital); Daytona Beach (Halifax Hospital Medical Center); Billings (Interhospital Oncology Project).
- Suburban areas such as Evanston, Ill. (Evanston Hospital); Summit, N.J. (Overlook Hospital); Manhasset, N.Y. (North Shore Univ. Hospital) and Mineola (Nassau Hospital), Long Island.
- Medium sized cities including Grand Rapids (Butterworth Hospital), Kalamazoo (Borgess Medical Center), Syracuse (St. Joseph's Hospital Health Center), Duluth (Duluth Clinic Ltd.), Pittsburgh (Allegheny Singer Research Corp.), Tacoma (Consolidated Hospitals), Des Moines (Des Moines General Hospital), Roanoke (Roanoke Hospital Assn.), and Augusta, Ga. (University Hospital).
- Certain areas of large cities—Newark (Beth Israel Medical Center), Chicago (Saint Mary of Nazareth Hospital Center), Denver (Presbyterian/St. Luke's Medical Center), New Orleans (Alton Ochsner Medical Foundation), Boston (New England Deaconess Hospital), Greater Los Angeles (Hospital of the Good Samaritan), and Central Los Angeles (St. Vincent Medical Center).

Examples of CCOPs approved for funding:

Eastern Maine Medical Center CCOP in Bangor will bring an organized community program to a state that does not have a medical school and to a six-county area large geographically but low in population density with a skewing of population to older age groups. It is organized as an individual institution plus satellite hospitals outside Bangor.

This CCOP is affiliated with the Dana-Farber Cancer Institute in Boston (recognized as a comprehensive cancer center by NCI in 1973) and closely associated with the Eastern Maine Medical Center since the early 1970s. Other research bases selected by the CCOP are three national clinical cooperative groups—Cancer & Leukemia Group B, Gastrointestinal Tumor Study Group and Radiology Therapy Oncology Group. The CCOP plans to enter patients each year on a variety of protocols, some requiring surgery and radiation therapy. Treatments will be for breast cancer, lung tumors, and gastrointestinal cancer.

On the other hand, the **Southern Maine CCOP** is a consortium with two hospitals (the Maine Medical Center and the Mid-Maine Medical Center) and a satellite private practice group, Oncology-Hematology Associates of Portland. Nine contiguous communities and Portland have a population of over one million from which to draw cancer patients who might be eligible for the protocols decided upon by Southern Maine CCOP.

In contrast, the **Greater Los Angeles CCOP** consists of the Hospital of the Good Samaritan plus a satellite—the Los Angeles Orthopedic Hospital. Thirty-six physicians will participate in placing patients on research protocols. Its research bases are the Univ. of Southern California Comprehensive

Cancer Center and the Southwest Oncology Group. In addition, three special category research bases have been chosen—the Children's Cancer Study Group, the Gynecologic Oncology Group, and the Gastrointestinal Tumor Study Group. A second CCOP, the **Central Los Angeles CCOP**, is an individual community hospital consortium which includes St. Vincent Medical Center and affiliated physicians' offices. St. Vincent Hospital has had a CHOP program since 1980.

The **Methodist Medical Center of Illinois** is a CCOP consortium composed of a hospital and two private practice groups (Oncology Hematology Associates and Midwest Radiation Therapy Consultants) serving a tri-county greater Peoria area. Six CCOP participants will provide the patients for protocol entry but a multidisciplinary team including physicians in other specialties, including surgery, will be involved in CCOP activities. This CCOP has chosen the Mayo Clinic Comprehensive Cancer Center as its primary research base, as well as the North Central Cancer Treatment Group and the Radiation Therapy Oncology Group. The CCOP expects to enter patients on treatment protocols for breast, lung, prostate and colon-rectum cancers.

Kansas City, Mo. CCOP is a consortium of six hospitals and affiliated physicians' offices. It has chosen to work with the Southwest Oncology Group and the Radiation Therapy Oncology Group.

Columbus, Ohio CCOP is a consortium of three hospitals and 18 physicians in the metropolitan area. Associations with Ohio State Univ. Comprehensive Cancer Center, the Southwest Oncology Group and the National Surgical Adjuvant Breast & Bowel Project are being continued.

Twin Tiers CCOP is composed of Our Lady of Lourdes Hospital in Binghamton, N.Y. and the Robert Packer Hospital and a clinic in Sayre, Pa., 40 miles away. Both hospitals have been involved in Eastern Cooperative Oncology Group protocols as satellites, with the Comprehensive Cancer Center at Roswell Park Memorial Institute, and with the Gastrointestinal Tumor Study Group. Twenty-two counties in the New York-Pennsylvania border region are served by these hospitals. There will be 18 physicians in this CCOP.

The **Tri-State CCOP** in greater Cincinnati consists of five hospitals serving Ohio, Kentucky and Indiana, all located within seven miles of each other. Currently they are participants in the Tri-State CHOP. This CCOP, with a core group of 29 physicians, has selected the Southeastern Cancer Study Group as its major cooperative group affiliation.

In Danville, Pa., the **Geisinger CCOP** is composed of physicians who are full time staff members at the Geisinger Clinic and Medical Center, half of whose patients come from five nearby counties, with 45 percent from 17 other counties. Research bases are the Mid-Atlantic Oncology Program, the Radiation Therapy Oncology Group and the Children's Cancer Study Group through Memorial Sloan-Kettering Cancer Center.

Hospital of St. Raphael CCOP, which serves New Haven and 19 surrounding towns, will include the hospital and two group hematology-oncology practices. Yale Comprehensive Cancer Center, with which the hospital has long been affiliated, will be the primary research base. Studies will utilize Yale protocols for treatment of cancers of the lung and breast, and of Hodgkin's disease, lymphoma and leukemia. In the second and third years of this CCOP award, additional protocols of the RTOG and ECOG will be used.

In a densely populated and highly industrialized area adjacent to New York City, the **Bergen-Passaic CCOP** is a consortium of three hospitals: Hackensack Medical Center, Holy Name in Teaneck and Beth Israel in Passaic. Research bases are the Eastern Cooperative Oncology Group and Memorial Sloan-Kettering Cancer Center. Physicians in this CCOP have been associated in the past with both of these research groups. Each of the three hospitals has a large ongoing cancer control program and a CHOP award.

Billings Interhospital Oncology Project CCOP involves the cooperative efforts of three private practice physicians, a radiation therapy center and two hospitals. It is the major oncology referral center for the 450,000 persons in northern Wyoming, east central Montana and part of both Dakotas. Two medical oncologists and a surgical oncologist, and two radiotherapists with the Northern Rockies Cancer Treatment Center, are CCOP members. Participation is planned in SWOG protocols, studies of the National Surgical Adjuvant Breast & Bowel Project, and Univ. of Arizona Cancer Center studies.

Florida Pediatric CCOP is a consortium of four community hospitals located in St. Petersburg, Jacksonville, Orlando and Pensacola (70 to 337 miles from the CCOP headquarters in Gainesville which is located with the national Pediatric Oncology Group statistical office). These hospitals participate in a statewide network of eight multidisciplinary pediatric cancer treatment centers known as the Florida Assn. of Pediatric Tumor Programs Inc. Twenty-two physicians representing all disciplines will participate in Pediatric Oncology Group protocols.

MONITORING SYSTEM FINDS TWO MAJOR PROBLEMS; INVESTIGATORS SUSPENDED

NCI's site visit monitoring system of clinical trials which are supported by the Div. of Cancer Treatment, implemented earlier this year, found five apparent major problems in the first 194 audits involving 1,286 individual cases.

In two of these, the situation was clarified and no action was necessary, Robert Wittes, director of DCT's Cancer Therapy Evaluation Program, told the division's Board of Scientific Counselors. In another two, however, the existence of serious problems uncovered at the first site visit was verified and resulted in revocation of the investigators' form 1573 and suspension from the groups. In one of those cases, action is being taken to recover federal money. One remaining case is still under investigation.

Wittes said that the two serious problems involved data falsification. "Patient records were at variance with data submitted to the groups. It could not have been accidental." Wittes insisted that no patients were harmed.

DCT Director Bruce Chabner added that on the repeat site visits, representatives from FDA and NIH Office of Protection of Patients from Risk were involved in the review. "The patients were treated appropriately," Chabner said. "It's just that the information submitted was inaccurate. Action was taken, those investigators were suspended and no longer receive investigational drugs."

Wittes included in his report to the Board a statement describing the new monitoring program:

"The purposes of the NCI's site visit monitoring system are: 1) to assure the accuracy and quality of data generated by the clinical trials groups, 2) to assure the compliance of investigators with federal regulations regarding the use of investigational new drugs, 3) to function as an educational tool for investigators in order that their procedures for conducting clinical research are in accord with current standards.

"The monitoring is intended to focus on four major areas: 1) Data accuracy—to what extent is the research record in agreement with the basic patient record? 2) Informed consent—has the patient signed an informed consent document and is this document in compliance with accepted current guidelines? 3) Institutional Review Board—has the local IRB reviewed and approved the protocol on which the patient is being treated? 4) Drug accountability—do the drug logs maintained in the pharmacies of institutions carrying on clinical trials with experimental drugs reflect proper disposition of investigational agents? Also, have all adverse drug reactions been reported to NCI in a timely fashion?

"In addition, although most aspects of protocol compliance can be assessed more efficiently and are being assessed in other ways, major protocol deviations which may have an effect on the quality of care or the interpretability of the data will be looked for and assessed in the course of the audit.

"Several of the groups have had site visit monitoring procedures in place for their members for several years. Recently, however, it has seemed reasonable to include group affiliates or satellites in monitoring activities. The chief reason for this is that for most of the groups, a substantial (30-50%) fraction of patient accrual comes from the affiliates. In the course of looking into this issue, it has also become clear to NCI that the criteria of the various groups for affiliate membership vary significantly.

"In early 1983, therefore, DCT asked each of the groups to do the following: 1) Develop a comprehensive policy for affiliates, including criteria for affiliation. 2) Expand the site visit plans of each group to include affiliates so that they would be monitored in parallel with monitoring of the members. 3) On a one time basis, accomplish the audit of all affiliates within each group within a 12-18 month period. 4) Develop and submit a budget to NCI for carrying out these tasks.

"We have discussed these issues further with the group chairmen at their meeting in March, 1983, with a view toward establishing certain minimum criteria for affiliation, as well as guidelines for a uniform system of results reporting to the NCI.

"At present the site visit monitoring is actively going forward in the groups for both members and affiliates. NCI staff is interacting with the individual groups concerning such matters as criteria for affiliation, site visit plans, and budget.

"Although the full scale effort has been in place for only a few months, we have some preliminary results. Of the 13 groups now active, 10 have site visit monitoring procedures in place. The three which do not are new groups and are actively developing their plans. Within the 10, 125 members have been audited thus far. Of these, the results of 88 audits have been reported to NCI. In addition, the results of 69 affiliate audits have also been reported to us. Together these amount to the examination of 1,286 individual cases.

"Thus far, we are aware of 38 with IRB deficiencies and 48 with informed consent deficiencies of one sort or another. (The report here discussed the five problems mentioned above.)

"Because of problems with informed consent documentation, and with some of the documents themselves, DCT has implemented a policy of informed consent review, in parallel with the review of the clinical trials protocol. When a protocol document comes to DCT for approval, the informed consent for that protocol is reviewed in detail for the presence of the essential elements. Comments on the informed consent go back to the principal investigator along with comments on the protocol. Responsibility then rests with the principal investigator to modify the informed consent as necessary so that it is in compliance with current federal standards.

"The problem of accountability for investigational drugs has been approached by the distribution of drug logs to every center carrying on investigational drug studies. An audit of a sample of these drug logs

is an integral part of every site visit. Taken together with the records of drug shipments from the Investigational Drug Branch, they can provide an accurate accounting of the disposition of experimental drugs.

"In early 1981, DCT formed an Adverse Drug Reaction Committee to deal as effectively as possible with the reporting of adverse drug reactions from the clinical trials community. This committee meets monthly, discusses the reports of ADRs, and their likely relation to the experimental drug in question.

"Obviously the costs of (monitoring) are substantial. They should be seen, however, not only in relation to the budget of the cooperative groups, but also to that of the CCOPs and the cancer centers, which are also to be included in this activity.

"In summary then, at this point the clinical trials system within the cooperative groups appears to be fundamentally healthy. Most of the problems that have arisen appear likely to respond to education within the clinical trials community. As more data accumulate over the next 12-18 months, we shall have a better idea of where the problems are and can take more specific steps to remedy them."

Charles Coltman, chairman of the Southwest Oncology Group, added, "The level of response of the cooperative group chairmen to this program is very high. They sense the level of concern nationally (about cancer clinical trials). I've been astonished at the responsiveness."

Daniel Hoth, chief of the Investigational Drug Branch, responding to a question on how FDA feels about the monitoring system, said that staffs of the two agencies meet regularly. "In their usual fashion, while they will not approve it, being reluctant to put their stamp of approval on it, they haven't rejected it. Our day to day relationship has been excellent."

"We feel very confident we're taking all reasonable measures to protect patients," Chabner said. "The rapid reporting of adverse reactions, the informed consent system, and monitoring of clinical trials are all up and working."

The monitoring system cost $1.5 million in the 1983 fiscal year, and DCT expects it to cost $2 million next year.

"I hope, if all goes smoothly, rather than build up the system, we can phase it down, with fewer site visits," Board member Brigid Leventhal said.

Wittes agreed. "Two million dollars would fund a lot of R01s," he said.

WYNDER GROUP FINDS NO ASSOCIATION BETWEEN COFFEE, PANCREATIC CANCER

Investigators from the American Health Foundation have found no association between coffee consumption and pancreatic cancer, an article in the August issue of *Cancer Research* reports.

An epidemiological study by Ernst Wynder, Nancy Hall and Marcia Polansky of the Mahoney Institute of AHF compared the coffee consumption of 275 male and female cases of patients with pancreatic cancer and 7.949 control patients without this disease, who were personally interviewed in six American cities. No differences were found between cases or controls by either amount or duration of coffee consumption.

The data also failed to show an association between alcohol consumption and pancreatic cancer. Similar to findings of previous studies, the existence of a weak association with cigarette smoking was confirmed. The lack of excess risk related to coffee consumption for either sex remained prior to and following adjustment for cigarette smoking.

Although this study does not specifically differentiate between regular and decaffeinated coffee, the issue is currently being addressed by the Mahoney Institute investigators. Preliminary analysis of the data shows no association of decaffeinated coffee consumption with increased risk of pancreatic cancer.

The authors suggest that prior studies that linked pancreatic cancer and coffee might have reached different conclusions had there been more appropriate selection of controls and adjustment carried out for confounders, particularly cigarette smoking. Furthermore, the Mahoney Institute study observed no consistent correlation between per capita coffee consumption in various countries and the incidence of pancreatic cancer in each country, supporting the conclusion that no causal relationship exists between the consumption of coffee and the risk for cancer of the pancreas.

OHIO PICKS UP WHERE NCI LEFT OFF, GIVES $1 MILLION TO CANCER CONTROL

The Ohio legislature has allocated nearly $1 million to the Cancer Control Consortium of Ohio for the 1983-84 fiscal year to fund the consortium's effort to stimulate, develop and implement a coordinated, community based, statewide cancer control program using available resources and to encourage new programs to meet specific, documented needs.

The consortium was developed initially by the Ohio State Univ. Comprehensive Cancer Center's Cancer Control Program and supported by a cancer control developmental grant from NCI.

Ohio thus becomes one of the few states which has moved to pick up support of cancer control programs left unfunded when NCI shifted emphasis from funding cancer center based outreach activities to cancer control research.

Objectives of the Ohio consortium included:

• Establish regional councils to develop plans, assess needs, strengthen ongoing programs, stimulate program development, and coordinate resources at the local level.

• Serve as a state resource for cancer control program review, development, and coordiation.

• Develop a long range, statewide cancer control plan to serve as a stimulus to state government and participating organizations, to identify areas of need and define programs to meet those needs.

• Develop a mechanism for implementation and evaluation of new and ongoing programs.

• Develop and implement a statewide cancer incidence data collection and management system.

• Promote community hospital cancer programs.

• Provide support for the Ohio Cancer Information Service.

• Work with existing organizations to assist in the development and implementation of prevention, screening, rehabilitation and educational programs.

Seven Regional Cancer Resource Centers based at Ohio medical schools will be the focus of regional cancer control activities.

"We feel this is a unique and major step towards optimizing the cancer resources of the state," C.J. Cavalaris, director of the OSU Cancer Control Program, said.

NEXT ISSUE WILL BE SEPT. 9

This week's issue of *The Cancer Letter* is the final issue for two weeks. The next issue will be Vol. 9 No. 34, dated Sept. 9. Although staff will be away for some of that time, the office will not be entirely closed. Those who wish to contact us may try by phone, and if a human doesn't answer, the tape machine will.

Components of the consortium are:

Cancer Data Management System—The requested budget provides for staffing and necessary computer procedures to follow over 40,000 new cancer cases per year.

Regional Cancer Resource Centers—These centers, located at medical schools, will staff regional councils which are the key to the organizational structure of the consortium. A regional council is a means by which all interest groups, associations and individuals can study, plan and implement cancer control activities.

Central Cancer Coordinating Office—This will work work with regional councils to conduct needs assessments, prioritize needed programs and implement and evaluate those programs. This office will serve as a clearinghouse for cancer information.

Ohio Cancer Information Service—OCIS uses toll free telephone lines to communicate the most accurate, up to date information on cancer to patients, the public, and health professionals.

Developmental Fund—Community hospital minigrants to assist rural hospitals in developing cancer programs.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR SEPT., OCT., FUTURE

NCAB Committee on Cancer Control & the Community—Sept. 2, Chicago, Sheraton International Hotel, 9 a.m.

8th International Meeting on N-Nitroso Compounds—Sept. 4-9, Banff, Canada. Contact International Agency for Research on Cancer, 152 cours Albert-Thomas, 69372 Lyon Cedex 08, France.

European Congresses of Radiology, Radiotherapy, and Oncology—Sept. 5-10, Bordeaux. Contact P.M.V., Congres de Radiologie, 100 avenue Charles de Gaulle, B.P. 246, 92205, Neuilly Sur Seine, France.

2nd International Workshop on Design & Application of Tumor Prostheses for Bone & Joint Reconstruction—Sept. 5-8, Vienna. Contact Secretariat, Workshop, Wiener Med. Akademie, Alserstr. 4, 1090 Vienna, Austria.

Progress and Controversies in Oncological Urology—Sept. 8-10, Noordwijkerhout, The Netherlands. Contact Prof. Dr. F.H. Schroder, Dept. of Urology, Erasmus Univ., PO Box 1739, Rotterdam.

11th Annual Meeting of the International Society for Oncodevelopmental Biology & Medicine—Sept. 11-15, Stockholm. Contact ISOBM Congress, c/o RESO Congress Service, S-10524, Stockholm.

Breast Cancer Task Force—Sept. 12-14, NIH Lister Hill Center, 8:30 a.m. each day. Presentations Sept. 12 on new methods for early detection and diagnosis of breast cancer. The Task Force will consider new initiatives in breast cancer on Sept. 13 and 14.

International Conference on Cutaneous Oncology—Sept. 12-16, The Hague, The Netherlands. Contact Dr. Richard Dobson, Dept. of Dermatology, Medical Univ. of South Carolina, Charleston, S.C. 29425.

Professional Oncology Education Review Committee—Sept. 12-13, NIH Bldg 31 Rm 9, open Sept. 12 8:30-10 a.m.

Div. of Cancer Cause & Prevention Board of Scientific Counselors—Sept. 14-15, NIH Bldg 1 Wilson Hall. Closed 9 a.m.-noon Sept. 14.

International Congress of Urological Cancer—Sept. 14-16, Sydney, Australia. Contact Dr. Derek Raghavan, Conference Secretary, Ludwig Institute, Univ. of Sydney, Sydney 2006.

International Symposium on Human Choriogonadotropin—Sept. 15-16, Cassis, France. Contact Secretariat, Laboratoire de Hormones Proteiques, Faculte de Medicine, F-13385 Marseille Cedex 5, France (91) 78 68 55.

National Toxicology Program Subgroup on Design of Chronic Studies (of Ad Hoc Panel on Chemical Carcinogenesis Testing & Evaluation)—Sept. 15, Dept. of Labor Conference Rm N3437, 200 Constitution Ave., Washington D.C., 9 a.m.

Cancer Research Manpower Review Committee—Sept. 15-16, NIH Bldg 31 Rm 4, open Sept. 15 8:30-9 a.m.

Third National Seminar on Community Cancer Care—Sept. 16-18, Hyatt Regency, Indianapolis. Contact Office of Continuing Medical Education, Methodist Hospital of Indiana, 1604 N. Capitol Ave., Indianapolis 46202.

2nd International Conference on Hormones & Cancer—Sept. 18-23, Monte Carlo. Contact Dr. S. Iacobelli, Laboratorio de Indocrinologia Molecolare, Universita Cattolica del S. Cuore, Largo Gemelli 8, 00168 Rome, Italy.

UICC Latin American Conference on Clinical Oncology—Sept. 18-22, Lima, Peru. Contact E. Caceres, Inst. Nacional de Enfermedades Neoplasicas, Av. Alfonso Ugarte 825, Lima.

Soft Tissue Tumor Symposium—Sept. 19-21, New York. Contact Dr. Steven Hajdu, Dept. of Pathology, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York 10021.

European Assn. for Cancer Research—Sept. 19-21, Copenhagen. Contact Dr. J. Kieler, Danish Cancer Society, Lab. of Environmental Carcinogenesis, Ndr Frihavnsgard 70, DK-2100, Copenhagen 0, Denmark.

9th European Congress of Pathology—Sept. 19-24, Hamburg, Germany. Contact Hamburg Messe und Congress GmbH, Cong. Orgn., Postfach 30 23 60, 2000 Hamburg 36, Fed. Rep. Germany.

NIP Panel Subgroup on Techniques to Supplement or Foreshorten Cancer Tests—Sept. 21, Humphrey Bldg, First Floor Auditorium, 200 Independence Ave., Washington D.C., 9 a.m.

American College of Epidemiology-Centers for Disease Control—Sept. 22-23, Atlanta. Annual meeting. Contact Dr. Philip Brachman, CDC, 1600 Clifton Rd. NE, Atlanta 30333.

6th Annual Diagnostic Cytopathology Course—Sept. 22-24, New York. Contact Marilyn Black, Course Secretary, Cytology Services, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York 10021.

4th National Conference on Cancer Nursing—Sept. 22-23, Anaheim, Calif. Contact Marian Frerichs, Programs Committee, American Cancer Society, 777 Third Ave., New York 10017.

Modifiers of Carcinogenesis—Sept. 22-23, Copenhagen. For information, see above under European Assn. for Cancer Research.

4th Asian & Australian Conference of the International Society of Radiographers & Radiological Technicians—Sept. 22-26, Yokohama. Contact L. Morimoto, Japan Assn. of Rad. Techn., 1-26-27 Shinkawa Chuo-Ku, Tokyo 104, Japan.

2nd Annual Antibody Techniques Workshop—Sept. 23-25, East Lansing, Mich. Contact Joan Allam, Michigan State Univ., College of Human Medicine, phone 515-353-7822.

Joint Autumn Meeting of the Royal College of Radiologists—Sept. 23-24, Liverpool. Contact British Institute of Radiology, 36 Portland Pl., London W1N 3DG, UK.

American Assn. of Oral and Maxillofacial Surgeons—Sept. 23-27, Las Vegas. Contact B. Degen, AAOMS, 211 E. Chicago Ave., Suite 930, Chicago 60611.

Sexuality & the Cancer Patient: Nurse, Where Are You?—Sept. 24, Widener Univ., Chester, Pa. Contact Vivan Middleman, Widener Univ. School of Nursing, Pennsylvania Campus, Chester 19013.

American College of Radiology—Sept. 26-29, Denver. Annual meeting. Contact S. Aubin, ACR, 20 N. Wacker Dr., Rm 1660, Chicago 60606.

6th Asia-Pacific Cancer Conference—Sept. 27-30, Sendai, Japan. Contact Conference Secretariat, Japan Convention Services, Nippon Press Center Bldg, 2-2-1, Uchisaiwaicho, Chiyoda-ku, Tokyo 100, Japan.

Hematological Histochemistry Meeting—Sept. 27-29, Cambridge, UK. Contact Royal Microscopical Soc., 37/38 St. Clements, Oxford OX4 1AJ, UK.

NCI Div. of Cancer Treatment Board of Scientific Counselors—Sept. 29-30, NIH Bldg 31 Rm 10, 8:30 a.m. both days, closed Sept. 29, 5 pm-adjournment.

Nutrient Data Base Applications—Sept. 29-30, Marriott Hotel Astrodome, Houston. Contact Jeff Rasco, Conference Services, HMB Box 131, UT M.D. Anderson Hospital, 6723 Bertner Ave, Houston 77030, phone 713-792-2222.

International Symposium on Cellular & Molecular Biology of Neoplasia—Oct. 2-6, Honey Harbor, Ontario, Canada. Contact Susan Oliphant, Ontario Cancer Institute, 500 Sherbourne St., Toronto, Ontario M4X 1K9, phone 416-924-0671, ext. 4998.

National Cancer Advisory Board—Oct. 3-5, NIH Bldg. 31 Rm 6, 8:30 a.m. each day. Closed Oct. 4.

American Society of Therapeutic Radiology—Oct. 3-7, Bonaventure Hotel, Los Angeles. 25th annual meeting.

6th Congress of the Yugoslav Cancer Society—Oct. 4-7, Skopje, Yugoslavia. Contact I. Dimcev, Yugoslavia Cancer Society, 91000 Skopje, ul. Dame Gruev 3, Yugoslavia.

Biometry & Epidemiology Contract Review Committee—Oct. 5, NIH Bldg 31 Rm 7, open 9:30-10 a.m.

Clinical Aspects of Metastasis—Oct. 6-7, Roswell Park continuing education in oncology.

Society of Nuclear Medicine—Oct. 6-9, Seattle. Contact Jean Parker, PO Box 40279, San Francisco 94140.

7th Annual International Imaging Conference—Oct. 9-17, Kona, Hawaii. Contact Conference Secretary, Dept. of Radiobiology, West Park Hospital, 22141 Roscoe Blvd., Canoga Park, Calif. 91304, phone 213-340-0580, ext. 280.

President's Cancer Panel—Oct. 12, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York, 9 a.m.

International Symposium on Detection & Treatment of Minimal Residual Disease in Acute Leukemia—Oct. 12-14, Rotterdam. Contact Dr. J.W. van der Velden, PO Box 5201, 3008 AE Rotterday, The Netherlands.

International Symposium on Peptide Hormones as Mediators in Immunology & Oncology—Oct. 13-15, Celle, West Germany. Contact Reiseburo Bangemann, Herr Michael Schnelle, Lister-Meile 78, 3000 Hannover 1, West Germany.

UICC Workshop on Doctor Involvement in Public Education About Cancer—Oct. 16-18, Kibbutz Shefayim, Israel. Contact David Reed, UICC, 3, rue du Conseil-General, CH-1205 Geneva, Switzerland.

Medical Oncology Review Course—Oct. 17-22, Honolulu. Contact Maxine Topping, Postgraduate Div., American College of Physicians, 4200 Pine St., Philadelplhia 19104, phone 215-243-1200 or 800-523-1546.

Cancer Control Grant Review Committee—Oct. 17-18, NIH Bldg 31 Rm 8, open Oct. 17 8:30-9 a.m.

Clinical Trials in Cancer Medicine: Past Achievements and Future Prospects—Oct. 19-21, Fondazione G. Cini, Venice. 6th annual Bristol-Myers Symposium on Cancer Research.Contact Kathryn Bloom, Bristol-Myers Co., 345 Park Ave., New York 10154.

NCI Div. of Resources, Centers & Community Activities Board of Scientific Counselors—Oct. 20-21, NIH Bldg 31 Rm 10, 8:30 a.m. each day.

NCI Div. of Cancer Biology & Diagnosis Board of Scientific Counselors—Oct. 20, NIH Lister Hill Center, Rm B1N 30B, 9 a.m.

Forum for Death Education & Counseling—Oct. 20-23, Holiday Inn Mart Plaza, Chicago. 6th annual conference. Contact Vickie O'Sullivan, Continuing Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago 60612, phone 312-942-7095.

NIH Consensus Development Conference on Precursors to Malignant Melanoma—Oct. 24-26, Lister Hill Center Auditorium, 9 a.m. Contact Michele Dillon, Prospect Associates, Suite 401, 2115 E. Jefferson St., Rockville, Md. 20852, phone 301-468-6555.

Interscience Conference on Antimicrobial Agents & Chemotherapy—Oct. 24-26, Las Vegas, Nev. Contact R. Bray, American Society for Microbiology, 1913 Eye St.NW, Washington DC 20006.

Developmental Therapeutics Contract Review Committee—Oct. 27-28, NIH Bldg 31 Rm 10, open Oct. 27 9-10 a.m.

Scripps Cancer Symposium—Oct. 31-Nov. 2, Sheraton Harbor Island Hotel, San Diego. 7th annual symposium for physicians and 3rd annual symposium for nurses. Contact Nomi Feldman, Conference Coordinator, 3770 Tansy, San Diego 92121, phone 619-453-6222.

Tutorial on Neoplastic Hematopathology—Oct. 31-Nov. 4, Pasadena, Calif. Contact Claude Weil, Tutorial Coordinator, International House, Univ. of Chicago, 1414 E. 59th St., Chicago 60637, phone 312-753-2277.

FUTURE MEETINGS

Clinical Cytopathology for Pathologists—March 26-April 6, 1984, Johns Hopkins Univ. Designed for pathologists who are certified (or qualified) by the American Board of Pathology or its international equivalent. An intensive refresher in all aspects of clinical cytopathology, with time devoted to newer techniques, special problems, and recent applications. Slides and text will be sent to participants within the U.S. and Canada for home study during February and March. Contact John Frost, M.D., 604 Pathology Bldg., Johns Hopkins Hospital, Baltimore 21205.

Gynecological Malignancies—April 25, 1984, Wright State Univ., Dayton. Annual Nicholas J. Thompson Cancer Update. Contact Mary Fisher, Arrangements Coordinator, Postgraduate Medicine & Continuing Education, Wright State Univ., PO Box 927, Dayton 45401, phone 513-429-3200 ext. 377.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-41004-72

TITLE: In vitro evaluation of chemical candidates for in vivo testing
DEADLINE: Oct. 13

NCI is a major source of chemical candidates for testing by the National Toxicology Program. In many cases in reviewing certain compounds or classes of compounds, in vitro data could facilitate the process of chemical selection. In addition, investigators of the Div. of Cancer Cause & Prevention require the support of mutagenicity assays on an infrequent basis.

The offerors are required to test up to 45 compounds per year in one or both of two assays, the Ames bacterial mutagenicity system and the mouse lymphoma system. Five salmonella strains will be used in all tests. The Ames assay and the mouse lymphoma assay will be run with and without activation—rat and hamster for the Ames and rat only for the lymphoma. Each test will be accompanied by positive controls as well as by solvent or negative controls and bacterial checks as required.

Awards will be made for one or two systems to one responder; multiple awards may be made on this basis.

This effort is currently under contracts with Research Triangle Institute, Research Triangle Park, N.C., and Microbiological Associates, Bethesda, Md.

CONTRACT SPECIALIST: Jackie Ballard
RCB, Blair Bldg. Rm. 115
301-427-8888

RFP NCI-CM-47629-26

TITLE: Development and marketing of SR-2508 as a radiosensitizer
DEADLINE: Approximately Oct. 20

NCI desires to engage in a no-cost contract with an appropriate organization for the joint development of the drug SR-2508 N-(2-hydroxyethyl)-2-nitro-1H-imadazolyl-1-acetamide, as an agent for sensitizing tumors to the effects of radiation therapy.

In vitro and in vivo studies (Int. J. Radiation Oncology Biol. Phys., Vol. 7, No. 6, pp 695-703, June 1981) have shown that the radiosensitization efficacy of SR-2508 is equal to that of misonidazole but that 3.1 times greater doses are needed to produce equivalent neurotoxicity in the mouse. Drug levels in the dog are approximately 2.4 times greater than those achieved with misonidazole.

Extrapolating from the mouse and dog data it would be expected that levels of SR-2508 of at least 7.5 times those of misonidazole can be achieved in human tumors for the equivalent level of neurotoxicity. The increased tumor levels of SR-2508 and the reduced neurotoxicity should permit maximum radiosensitization of hypoxic human tumor cells to be achieved in conventional daily fractionation therapy schedules.

An investigational new drug application for this drug has been filed with FDA and phase I clinical studies are currently being planned. It is planned that a written agreement will be consummated with a competitively selected organization to share in the further development of SR-2508.

The U.S. government owns the patent rights to the use of SR-2508 as a radiation sensitizing agent and anticipates granting a license to the successful organization in consideration for the significant sharing in further development of th drug in the preclinical and clinical stages. Respondents to this RFP should include any request for license (exclusive or nonexclusive) that the respondent may require of the government under Patent #4371540 in accordance with 41 C.F.R. 101-4.104-2 or 41 C.F.R. 101-4.104.3.

It is anticipated that the selected firm will use the data developed jointly with the NCI to process a new drug application with FDA should such action be deemed worthwhile based on the clinical results obtained. This should lead to the eventual sale of the formulated drug by the selected firm to fill the nation's requirements.

The government does not intend any reimbursement for services rendered. Cost recovery and profit earned, if any, will be by means of sale of SR-2508 by the successful offeror.

This is a reissuance of RFP-NCI-CM-37577-25, which was issued Feb. 16, 1983, and which was later canceled.

CONTRACT SPECIALIST: Carolyn Swift
RCB, Blair Bldg. Rm. 228
301-427-8737

The Cancer Letter _Editor Jerry D. Boyd

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