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COOPERATIVE GROUP OUTREACH EXTENDED THREE YEARS, GETS EXTRA $1 MILLION, UP TO FOUR MORE AWARDS

NCI's Cooperative Group Outreach Program will be extended for three more years and will be substantially expanded, with a total budget of $5 million a year (an increase of approximately $1 million), enough to increase the number of participating cooperative groups from the present level of six up to 10. The Board of Scientific Counselors of the Div. of Resources, Centers & Community

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In Brief

JACK MCSHULSKIS DIES FOLLOWING STROKE; CONGRESS GIVES FINAL APPROVAL TO APPROPRIATIONS BILL

JACK MCSHULSKIS, senior vice president of CDP Inc. and former NCI staff member, died Oct. 16 following a stroke at his home in Potomac, Md. He was 51. McShulskis worked in NCI's Office of Planning & Budget in the early 1970s and helped draw up the National Cancer Plan as called for in the National Cancer Act of 1971. He later moved to the Div. of Cancer Control & Rehabilitation, and joined CDP in 1977. He was working under CDP's contract with the Div. of Resources, Centers & Community Activities on planning division activities at the time of his death. . . . CONGRESS APPROVED the HHS appropriations bill agreed upon last week by House and Senate conferees, giving NCI a budget of $1.075 billion for FY 1984. Approval was by voice vote in the Senate, and 323-79 in the House. President Reagan was expected to sign the bill, but had not done so at press time. . . . CORRECTION: Gilbert Friedell, former director of the National Bladder Cancer Project and now professor at the Univ. of Kentucky and director of the McDowell Community Cancer Network, is not the principal investigator for Rush Presbyterian St. Luke's Medical Center in its application for the Organ Systems Coordinating Center. C. Frederick Kittle, director of Rush Cancer Center and of thoracic surgery there, is the PI. . . . MORE THAN 80 abstracts have been submitted for the 4th Conference on Human Tumor Cloning Jan. 8-10 in Tucson, sponsored by the Univ. of Arizona Cancer Center. Sydney Salmon and Jeffrey Trent are cochairmen. Deadline for receipt of abstracts for the 4th International Conference on Adjuvant Therapy of Cancer has been extended to Dec. 1. That conference, also in Tucson and sponsored by the UA Cancer Center, is scheduled for March 21-24. Salmon and Stephen Jones are cochairmen.

DRCCA BOARD OKAYS COOPERATIVE GROUP OUTREACH PROGRAM, 16 OTHER CONCEPTS

(Continued from page 1)
Activities gave concept approval to the program's extension at the Board's meeting last week.

The Board approved the concept of a total of 17 projects recommended by DRCCA staff (including one suggested by the Breast Cancer Task Force) for support grants, cooperative agreements, or contracts. One of the approvals assures that a survey of national cancer research facility needs will be undertaken, by NCI through a contract if the Dept. of Health & Human Services declines to do it.

The Board also approved a change in cancer center core grant guidelines which probably will not be controversial. The change will require approval by the National Cancer Advisory Board before it is implemented.

The Cooperative Group Outreach Program has supported through competitively awarded contracts the efforts of six groups to extend their clinical research activities into community hospitals. The six groups are the Childrens Cancer Study Group, Eastern Cooperative Oncology Group, Southwest Oncology Group, Radiation Therapy Oncology Group, National Surgical Adjuvant Breast & Bowel Project, and Northern California Oncology Group.

With an annual budget of approximately $4 million, the program has succeeded beyond the expectations of its original proponents. It has developed into an integral part of cooperative group activities and is accounting for a substantial part of group patient accrual. ECOG, for example, gets about 50 percent of its patients from outreach members. Educational programs specifically directed toward nurses and data managers have resulted in improved data collection and increased protocol implementation and compliance. Reviews of the program have found that community physicians can participate in clinical trials and provide data comparable to that received from university centers. More than 3,000 community physicians, nurses and other health professionals in more than 700 hospitals have participated.

The program was developed originally as a demonstration project which would be terminated after three years. After one extension, it was headed for extinction when NCI Director Vincent DeVita came up with the idea for the Community Clinical Oncology Program. He had expected the outreach program to be phased out as CCOP was implemented. However, the DRCCA Board decided in 1981 that outreach should be continued for two more years, at least, while CCOP was in its early stages. That extension will end in 1984.

As the shape of CCOP became more clear, it became obvious that the outreach program filled a need that would not be provided by the newer, glossier, and more expensive program.

"Although it was originally hoped that up to 200 CCOPs would be funded, recommended levels of funding and the additional expenses of the research bases will allow only 62 to be supported," the staff justification for expansion and extension of the outreach program said. "Although geographic considerations were made in selecting some CCOPs, there are still large areas of the country without easy access to either a CCOP or a cancer center. It also became apparent in the development of CCOP that there were physicians in many communities who would not be able to meet the 50 patient per year protocol accrual required for a CCOP but who were interested in updating their knowledge of cancer management and able to participate in clinical research. Therefore, the outreach program intervention still has a place in our overall cancer control strategy. The continuation of the Cooperative Group Outreach Program would assure a wider geographic availability of the most up to date cancer care, assure more rapid answers to clinical research questions, and provide an additional segment of the health delivery system to test the diffusion hypothesis."

The basic premise of the outreach program, like that of CCOP, is that making clinical research protocols available to participating community physicians stimulates protocol quality care for all patients, not just those patients formally registered on protocols.

Outreach funds, for the most part, provide support for travel of community physicians to cooperative group meetings and for assistance in data management for protocol studies.

The program has been supported through contracts, but the recompetition will be funded through cooperative agreements. A request for applications will be issued spelling out the details. A total of $5 million will be earmarked, but whether that entire amount goes into the program depends on the number, quality, and recommended budgets of applications.

Five other national cooperative groups could compete for the awards--Cancer & Leukemia Group B, Southeastern Cancer Study Group, Gynecologic Oncology Group, Wilm's Tumor Study Group, and Pediatric Oncology Group. Also, three regional groups could compete--North Central Cancer Treatment Group, Piedmont Oncology Assn., and Mid-Atlantic Oncology Program.

The six groups presently in the program will get a small windfall, totaling about $250,000. That is the amount which had been budgeted for those outreach satellites which won CCOP awards. An institution cannot participate in both programs, and NCI originally intended that that money would be returned for reprogramming. The NCI Executive Committee has now decided that each group will retain whatever amount is refunded by its satellites-turned-CCOPs. The money will not necessarily have to be used to fund new satellites but may be used in the outreach program however the group may decide.

The prospect of tangling with Armand Hammer, chairman of the President's Cancer Panel, may have persuaded Dept. of Health & Human Services officials to reconsider their negative attitude toward undertaking a survey of the nation's cancer research facility needs. A report that HHS had cooled toward doing the survey with funds the department sets aside for evaluation (The Cancer Letter, Oct. 14) got Hammer's attention. NCI had decided to proceed with a contract to do the survey, and in fact obtained concept approval for the contract from the DRCCA Board last week.

However, Edward Sondik, chief of DRCCA's Biometric & Operations Research Branch, told the Board that "after several negative responses" in discussing the matter with HHS, "we have now received one positive response that this can be done."

Hammer has expressed interest in the construction program and the continued slashing of construction funds from NCI's budget every year by the White House. He has promised to take it up with the President once he has updated figures on cancer research facility needs.

The contract effort proposed by Donald Fox, chief of the Research Facilities Branch, would require one year to complete at an estimated cost of $150,000. It will not be competed unless HHS again declines to do the survey itself with one of the contractors it has available for evaluation studies through task orders.

Fox referred to previous surveys which documented facility needs:

--A 1978 national survey of laboratory animal facilities and resources prepared by the National Academy of Sciences under contract with the NIH Div. of Research Resources. This survey of 992 NIH grant eligible institutions found that 16 percent reported a need for replacement of some space then in use, 38 percent reported needs for remodeling to protect the integrity of space then in use, and 47 percent reported need for additional space.

--The 1979 survey on needs for upgrading cancer research facilities conducted by NCI staff at the request of the National Cancer Advisory Board. This found that 1980 construction needs totaled $221 million, of which $97 million would be sought from NCI. Projected needs for 1981-1985 were $449 million, of which $190 million would be sought from NCI. That survey led the NCAB to request NCI to budget a minimum of $25 million a year for construction. The White House has cut that request to $1 million a year.

--A 1981 survey by the Assn. of American Universities of 15 leading universities found that between 1978 and 1981, the 15 had spent $400 million for construction, major repair and renovation and special purpose research equipment. It was estimated that $765 million would be needed by those 15 universities over the next three years for research facilities and major equipment just to sustain the current level of activity of existing faculty.

--A 1983 report by the National Academy of Sciences which found that deterioration and obsolescence of research equipment and facilities threaten the quality and productivity of U.S research and education. The deficit was estimated to be at least $1 billion and has high as $4 billion.

During the past 11 years, NCI has spent over $212 million in construction grants (including renovation), as mandated by the National Cancer Act. During the earlier years of the program, grantees were required to match NCI funds on a 50-50 basis, then later 75 (for the grantee) to 25 for NCI.

The change in center core grant guidelines was one Jerome Yates, director of DRCCA's Centers & Community Oncology Program,

called "a housekeeping change," dealing with the payment of staff investigator salaries from core grant funds.

The present guidelines state that "program directors will not be funded unless they qualify as staff investigators (see Section 9.1.3) and direct bona fide programs." Section 9.1.3 states, "To qualify, an individual must either be the designated principal investigator on a research grant or contract or the director of a subproject of a program project grant (PO1) or subproject of a cooperative clinical research grant (R10)."

The change alters the first statement to read, "Program directors will not be funded unless they direct bona fide programs and are judged by peer reviewers of the core grant to be appropriate leaders of such programs." The reference to Section 9.1.3 was deleted, and the phrase leaving it to the peer reviewers to decide if individuals are appropriate leaders was added. Section 9.1.3, which defines staff investigators, remains unchanged.

Concept approvals clearing the Board last week included three projects to be supported through cooperative agreements with estiated first year awards totaling $700,000; a program announcement aimed at generating R01 grant applications, with no dollar amount estimated; competitive contract supported projects, including recompetition of an existing program, with an estimated $3.2 million in first year awards; and noncompetitive contracts estimated at $1.5 million the first year.

Cooperative agreement concepts approved:

Smoking prevention and cessation in the Black population. Estimated first year awards total $250,000, five years. Up to five awards may be made. Staff narrative:

Goals are to determine the long term effect of interventions designed to prevent the onset and/or reduce the prevalence of cigarette smoking in the Black population.

Most national data suggest that the prevalence of cigarette smoking among Blacks exceeds both that of other U.S. subpopulations and that of Whites. This is particularly true among Black males, although Black females also exceed White females in smoking prevalence. Further, recent data indicate that Black adolescents are particularly at risk both for starting to smoke earlier and to develop greater smoking prevalence rates than White adolescents. Although Blacks indicate a strong desire to quit smoking, there has been no research conducted concerning the development of either smoking cessation or prevention programs aimed at the special needs of the Black population.

The primary purpose of the proposed studies is to develop and evaluate durable interventions to prevent the onset and/or to reduce the prevalence of cigarette smoking among the U.S. Black population. Studies which propose to develop and evaluate the effectiveness of innovative programs aimed at the needs of high risk Black groups (e.g. adolescents, low income) will be encouraged.

At least one year of followup will be required after the end of the intervention period. Thomas Glynn is the project officer.

Smoking prevention and cessation in Hispanic populations. Up to five awards will be made, with an estimated total cost of $250,000 the first year. Staff narrative:

(Goals and objectives are similar to those described for Black population studies above). Until recently, cigarette smoking among Hispanic populations in the U.S. was not considered to be a major problem. The data upon which this opinion was formed, however, were based upon smoking patterns of nearly 25 years ago and without regard to systematic examination of either sex differences or Hispanic subpopulations. Recent data suggest that current smoking rates among U.S. Hispanics, particularly adult males and adolescents of both sexes, may be higher than among the Anglo population. There has been little or no research based attempt to prevent or intervene in the smoking habits of these populations, although some basis for broad intervention research with Hispanics does exist.

The primary purpose of the proposed studies is to develop and evaluate durable interventions to prevent the onset and/or reduce the prevalence of cigarette smoking among U.S. Hispanic populations. Studies which propose to develop and compare the effectiveness of innovative programs aimed at Hispanic subpopulations (e.g. Mexican-Americans, Puerto Ricans) will be encouraged.

One year, at least, of followup will be required from the end of the intervention period. Glynn is the project officer.

Automated flow cytometry research laboratories designed for detecting urinary bladder cancer. Three to five awards, with first year funding totaling $200,000, five years.

Objectives are to establish a small network of cooperating research laboratories for flow cytometry of exfoliated bladder cancer cells; determine the best state of the art methods and instrumentation for flow cytometry of bladder cancer cells; document flow cytometry scattergram patterns for different types of bladder tumors and for different modes of intravesical therapy; develop flow cytometry to replace cystoscopy for assessing and documenting tumor recurrence for intravesical therapy research protocols; and explore the use of urine in place of bladder washings as a source for cell samples for flow cytometry.

The technology of flow cytometry is undergoing rapid development and diversification in numerous autonomous laboratories. Labs that are currently active vary greatly in their instrumentation and methods of cell preparation, and thus the results they produce are not fully comparable. Also, rapid advancements are occurring in the area of applying new cell markers, such as monoclonal antibodies against tumor associated antigens.

This project will emphasize several areas of flow cytometry research. The first relates to the developmental work required to establish a network of laboratories that is specialized

for analyzing bladder cells. Studies would be supported to determine the spectrum and performance of available cell markers and dyes in the flow cytometry of normal, preneoplastic and neoplastic bladder cells. This work would provide for the coordinated development of new methods of cell collection, preparation, and preservation; of cell measurement and analysis; and of data analysis and processing. Methods would be developed among the cooperating laboratories for sharing technical capabilities and resources in electronics maintenance, computer programming and data analysis. The network would then cooperatively determine how automated flow cytometry would be best applied in replacing cystoscopy for documenting data on patients undergoing various intravesical chemo and immunotherapy schedules. Reference sets of flow cytometry scattergrams relating to the various forms of bladder cancer before and during specific intravesical treatments would be established. The last area would provide for research on the flow cytometry of exfoliated neoplastic cells in urine, rather than in bladder washings. This might move the technique of flow cytometry into the area of screening high risk populations.

It is anticipated that institutions with established flow cytometry laboratories which are involved in research in various forms of cancer will respond to this initiative. The funds required for such programs to extend themselves to fulltime study of bladder cancer will vary considerably among the potential laboratories. During the stage of negotiations, the existing capacity of each laboratory will be assessed with the aim of adjusting budgets to eliminate duplication in support. Such an evaluation will provide an opportunity for identifying ways to coordinate and share equipment and personnel.

It is recommended that the initial period of support last five years in order to provide the stability required for assembling the required highly skilled, multidisciplinary teams of clinicians, scientists and technicians.

The staff had proposed to support the project through contracts, with an annual budget estimated at $220,000. The Board decided that cooperative agreements would be more appropriate as the funding mechanism, and limited total cost over five years to $1 million.

The following program announcement received concept approval (these are intended to generate R01 grant applications, with no specific funds committed to the effort):

Vascular and lymphatic invasion in breast cancer. Number of awards to be determined by number and merit of applications. The narrative:

This is a modest project developed by the Breast Cancer Task Force to assist physicians in the control of established breast cancer. Its purpose is to develop additional methods to estimate prognosis and therapy, especially for stage 1 patients. These methods relate to the assessment of vascular and/or lymphatic tumor extension in the primary lesion, or assessment of factors leading to invasion. This project is part of an overall Task Force goal to develop new prognostic indicators for breast cancer.

The purpose of this project is to devise immunocytochemical, histochemical, or other methods to assess vascular and/or lymphatic invation in breast cancer, since these are recognized as useful prognostic and therapeutic indicators. These methods should be applicable in all hospital laboratories by pathologists using frozen or formalin fixed tissue sections. They would have the potential to replace current histochemical methods which are not reliable.

Survival following mastectomy for breast cancer is related to the total number of involved lymph nodes. Patients with four or more positive nodes can expect a less favorable outcome than those with less than four. Thus, the usual evaluation of a breast cancer patient includes not only tumor size and type, but also lymph node status and distant metastases.

However, as a result of recent advances in the diagnosis and treatment of breast cancer, our reliance on lymph node status is no longer possible in every case. Surgeons are now performing less aggressive dissections, especially for clinical stage 1 cancers. In cases treated only by wedge resection, or those destined for radiotherapy, lymph node sampling may not be complete. Furthermore, since 1960, there has been a decline in the number of patients with axillary metastases (as a percentage of all breast cancer patients), related no doubt to mammography and earlier diagnosis. In the Breast Cancer Detection Demonstration Project, for example, 80 percent of patients with lesions less than 1 cm had no axillary nodal metastases and 13 percent had no nodes examined. In another study, 95 percent of patients whose lesions were detected by mammography alone had no axillary metastases.

As the number of patients without axillary metastases has increased, there has been a greater appreciation for the fact that at least 20 percent of such women still die of breast cancer. Thus, for women who are node negative or in whom sampling is not complete, it is necessary to develop other criteria which can provide an estimate of prognosis and guide for therapy. Furthermore, the need for these criteria will increase as our ability to find more patients with smaller cancers also increases. One such criterion which seems reasonably well established is the extent of vascular and/or lymphatic invasion.

Evidence shows that tumor cell invasion of vascular and/or lymphatic channels can be a prognostic sign in breast cancer. Inflammatory carcinomas which have the worse prognosis are characterized by diffuse lymphatic permeation, both in the subcutis and deeper layers of the breast. A number of clinicopathological studies have also associated vascular invasion with prognosis. A significantly reduced five year survival rate was observed in women with vascular invasion as opposed to patients without demonstrable invasion. In a study of patients with stage A breast cancer, vascular invasion was associated with a reduced 10 year survival, but only in the presence of lymph node metastases.

In a group of premenopausal patients, the two year recurrence free rates were significantly greater in women without vascular invasion than in those with invasion. A similar trend was observed in postmenopausal patients, although the data did not reach statistical significance. In a series of patients surviv-

ing 25 years after radical mastectomy, the frequency of vascular invasion was significantly less than in those patients who did not survive 25 years.

Of 242 patients, the five year survival was 98 percent with no detectable blood vessel invasion or axillary metastases, 59 percent with blood vessel invasion but no nodal metastases, and 12 percent with both. Overall, vascular invasion has been found in five percent to 50 percent of patients studied.

Conclusions reached from studies on vascular invasion also seem to hold for lymphatic invasion. In the absence of lymph node metastasis, the presence of tumor cells in lymphatic spaces within the breast is associated with a greater risk of distant metastasis.

Among the predictors of recurrence in stage 1 patients, the presence of tumor emboli in breast lymphatics is the one most strongly associated with recurrence. In fact, stage 1 patients with lymphatic emboli are at sufficient risk for recurrence to warrant consideration for adjuvant therapy. Also, the high frequency of treatment failure in stage 1 patients with lymphatic emboli is not a result of occult lymph node metastases. (Rosen, Nealon, and others) have concluded that the most reliable predictor of recurrence in stage 1 patients is lymphatic invasion. Furthermore, intralymphatic tumor emboli are more common in American than in Japanese patients, a finding which may account for the better prognosis of women in Japan. In stage 1 patients, the frequency of lymphatic invasion has varied from less than 10 percent to more than 35 percent.

Thus, while the overall prognosis for women with stage 1 breast cancer is favorable, there are two histologic findings--vascular and lymphatic invasion--which are associated with a less favorable outcome. Even on clinical grounds alone this correlation is not surprising since invasion of vascular and lymphatic channels is a prerequisite for distant metastases.

The Task Force believes that a better assessment of intravascular tumor growth, or knowledge of other factors that correlate with invasion would provide for:

--Identification of a possible high risk group for recurrent disease, especially in stage 1 (T1N0M0) patients.

--A determinant for followup procedures.

--A potential discriminant to select patients for adjuvant therapy or additional radiotherapy.

--A more accurate overall estimate of prognosis for the individual patient.

The concept approvals for contract supported projects will be reported next week in ***The Cancer Letter.***

NCI CONTRACT AWARDS

TITLE: Data management support for Radiation Research Program
CONTRACTOR: The Orkand Corp., Silver Spring, Md., $310,796.

TITLE: Smoker compensation and cigarette smoke yield
CONTRACTOR: Franklin Institute, $190,033.

TITLE: Preparation and supply of fresh and cultured mammalian cells
CONTRACTOR: Biotech Research Laboratories, Rockville, Md., $394,488.

TITLE: Community cancer care evaluation
CONTRACTOR: Fred Hutchinson Cancer Research Center, $2,939,761.

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

European Conference on Clinical Oncology--Nov. 2-5, Amsterdam. Contact 2nd ECCO, Organisatie Bureau, Amsterdam, BV Europaplein 14, 1078 GZ Amsterdam, The Netherlands.

Current Concepts in Cancer Therapy--Nov. 3-5, St. Louis. Contact Loretta Giacoletto, Office of CME, Washington Univ. School of Medicine, Box 8063, St. Louis, Mo. 63110, phone 314-454-3873.

Sixth Annual San Antonio Breasat Cancer Symposium--Nov. 4-5, San Antonio. Contact Terri McDaniel RN, Cancer Therapy & Research Center, 4450 Medical Dr., San Antonio, Texas 78229, phone 512-690-0655.

Multimodality Therapy for Head & Neck Cancer--Nov. 4-5, Dearborn, Mich. Contact Don Ragan, PhD, Radiation Oncology Dept., Wayne State Univ., 4201 St. Antoine, Detroit 48201.

GI Malignancies--Nov. 4-5, Cincinnati. Contact Thomas O'Connor, Medical Staff Education, Bethesda Hospital, 619 Oak St., Cincinnati 45206, phone 513-559-6131.

Cancer Clinical Investigation Review Committee--Nov. 7-9, NIH Bldg 31 Rm 6, open Nov. 7, 8:30-9 a.m.

National Hospice Organization--Nov. 8-12, Minneapolis. Annual meeting and symposium. Contact Helen Noller, Conference Chairperson, 2344 Nicollet Ave., Suite 150, Minneapolis, Minn., 55404, phone 612-871-7222.

Newer Perspectives in Human Lymphoma--Nov. 9-12, Shamrock Hilton Hotel, Houston. Contact Office of Conference Services, Box 18, M.D. Anderson, 6723 Bertner Dr., Houston 77030, phone 713-792-2222.

Cancer Preclinical Program Project Review Committee--Nov. 9-10, NIH Bldg 31 Rm 9, open Nov. 9 9-10 a.m.

Molecular Events in Differentiation and Neoplasia--Nov. 10, Roswell Park continuing education in oncology.

Head & Neck Cancer Congress--Nov. 11-12, Marseille. Contact P. Gehanno, Societe Francaise de Carcinologie Cervico-Faciale, 53 bis rue Jouffroy, 75017 Paris, France.

4th Asian-Oceanian Congress of Radiology--Nov. 13-18, Bangkok. Contact X-Ray Computer Center, 137/3 Asoke Rd., Bankok 10110, Thailand.

Cancer Regional Studies Review Committee--Nov. 15, NIH Bldg 31 Rm 7, open 8:30-9:30 a.m.

Childhood Cancer: Current Controversies--Nov. 17-19, Caribbean Gulf Resort Hotel, Clearwater Beach, Fla. Contact Cindi Butson or Randy Kraft, Seminar Coordinators, Florida Assn. of Pediatric Tumor Programs Inc., PO Box 13372, Univ. Station, Gainesville, Fla. 32604, phone 904-375-6848.

Field Trials on Oral Carcinoma & Bone Tumors of Facial Skull--Nov. 17-18, Basel, Switzerland. Contact J. Prein, Kiefer-und Gesichtschirurgie, Kantonsspital, 4031 Basel.

High Frequency Ventilation--Nov. 18-20, Memorial Sloan-Kettering Cancer Center. International symposium. Contact Charlene Landis, CME Conference Planner, MSKCC, 1275 York Ave., New York 10021, phone 212-794-6754.

European Society of Urological Oncology & Endocrinology--Nov. 24-26, Rome. Third Congress. Contact F. DiSilverio, Dept. Urology, Policlinico Umberto 1, Viale del Policlinico, 00161, Rome.

Radiological Society of North America--Nov. 27-Dec. 3, Chicago. 68th scientific annual meeting. Contact RSNA, 1415 W. 22nd St., Ste. 1150, Oak Brook, Ill. 60521.
Chemical Modifiers of Cancer Treatment--Nov. 27-Dec. 1, Banff, Canada. Contact Frances Glica, American College of Radiology, 925 Chestnut St., 7th Floor, Philadelphia 19107, phone 215-574-3154.
National Cancer Advisory Board--Nov. 28-30, NIH Bldg 31 Rm 6, 8:30 a.m. Annual program review. Open all three days.
Annual Scientific Meeting on Clinical Oncology--Nov. 30-Dec. 2, Brisbane. Clinical Oncology Society of Australia. Contact the society, POB 4708 GPO, Sydney NSW, 2001 Australia.
Cancer Centers Support Grant Review Committee--Dec. 1-2, Linden Hill Hotel, Bethesda, open Dec. 1 8:30-9:30 a.m.
Role of Gastrointestinal Tract in Nutrient Delivery--Dec. 1-2, Shoreham Hotel, Washington D.C. Bristol-Myers Symposium on Nutrition Research. Contact Div. of Continuing Medical Education, Indiana Univ., 1120 S. Drive, FH224, Indianapolis 46223.
Reducing the Risk of Infection in Biomedical Laboratories--Dec. 1-2, Twin Bridges Marriott Hotel, Arlington, Va. Sponsored by the NIH Div. of Safety. Contact 1983 NIH Research Safety Symposium, 8630 Fenton St. Suite 508, Silver Spring, Md. 20910, phone 301-585-7400.
Clinical Cancer Program Project Review Committee--Dec. 1-2, NIH Bldg 31 Rm 10, open Dec. 1 8:30-10 a.m.
President's Cancer Panel--Dec. 1, NIH Bldg 31 Rm 3, 9 a.m.
Symposium on Gynecologic Oncology--Dec. 3, Memorial Sloan-Kettering Cancer Center. Contact Charlene Landis, MSKCC, 1275 York Ave., New York 10021.
Comparison of Mechanisms of Carcinogenesis by Radiation and Chemical Agents--Dec. 6-7, National Bureau of Standards, Gaithersburg, Md. Contact Mary Clark or Lynne Plummer, Verve Research Corp., 6110 Executive Blvd. Suite 250, Rockville, Md. 20852, phone 301-984-7188.
Advances in Cancer Therapy--Dec. 8-10, Waldorf-Astoria Hotel, New York. Sponsored by Ohe American Cancer Society. Contact Dr. Nicholas Bottiglieri, ACS, 777 Third Ave., New York 10017.
Update on Neurological Oncology--Dec. 8, Roswell Park continuing education in oncology.
Clinical Cancer Chemotherapy--Dec. 12-16, Delhi, India. Postgraduate courses sponsored by UICC. Contact David Reed, UICC, 3 rue du Conseil General, 1205 Geneva, Switzerland.
New Drugs in Cancer Therapy--Dec. 15-17, Brussels. Fourth NCI-EORTC symposium. Contact Dr. M. Rozencweig or Dr. M. Staquet, EORTC Data Center, 1 rue Heger-Bordet, 1000 Brussels, Belgium.

FUTURE MEETINGS

Fourth Conference on Human Tumor Cloning--Jan. 8-10, Univ. of Arizona Cancer Center, Tucson. A combination of competitively selected and invited papers, demonstrations and posters will be presented. Contact Mary Humphrey, Conference Coordinator, UACC, Tucson 85724, phone 602-626-6044.
The Patient with Bowel Cancer: A Nursing Update--Jan. 24, Hilton Inn, Northeast Philadelphia. Contact Jacqueline Sander, Episcopal Hospital, Front St. and Lehigh Ave., Philadelphia 19125, phone 215-427-9916.
Cancer in the 80s: Breakthroughs in Diagnosis and Treatment--Feb. 8, Biltmore Hotel, Los Angeles. Acceptable for up to six hours category 1 credit towards CMA, AMA certificates in continuing medical education. Contact Dolores Gay, Hospital of the Good Samaritan, 616 S. Witmer St., Los Angeles 90017, phone 213-977-2352.
18th Annual St. Jude Clinical Symposium--Feb. 24-25, St. Jude Children's Research Hospital. Current results in treatment of children with cancer and leukemia. Emphasis on diagnosis and treatment for primary disease and complications. Registration required, no fees; 200 physicians to be accepted on a first come basis. Contact Director, St. Jude Children's Research Hospital, Box 318 Memphis, Tenn. 38101.
Advanced Course on Clinical Cancer Chemotherapy--Feb. 27-March 2, St. Gallen, Switzerland. Contact David Reed, UICC, 3 rue du Conseil General, 1205 Geneva, Switzerland.
Infusion Cancer Chemotherapy: Techniques and Clinical Trials in Systemic and Regional Chemotherapy--March 1-3, New England Deaconess Hospital, Boston. Contact Dept. of Continuing Education, Harvard Medical School, 25 Shattuck St., Boston 02115, phone 617-732-1525.
UCLA Winter Oncology Conference--March 1-3, Miramar Sheraton Hotel, Santa Monica, Calif. Current results and methods of therapy for the more common malignancies and those requiring the most intensive interdisciplinary collaboration. Phone 213-825-7257.
J.D. Woodruff Symposium on Gynecologic Oncology--March 15-17, Hyatt Regency Hotel, Baltimore. Sponsored by Johns Hopkins Medical Institutions. Contact Susan Bavaro, OCE, Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-6046.
Oncology Nursing Society--May 2-5, Sheraton Centre, Toronto. Ninth annual congress. Contact Nancy Berkowitz, ONS, 3111 Banksville Rd. Suite 200, Pittsburgh, Pa. 15216, phone 412-344-3899.

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-FS-41011-77

TITLE: Cancer following irradiation for peptic ulcer
DEADLINE: Dec. 1
The Radiation Studies Section of NCI's Div. of Cancer Cause & Prevention, plans and conducts epidemiologic studies of the occurrence of cancer in populations exposed to ionizing radiation. The results of these studies are used to strengthen the quantitative basis for risk estimation and to provide knowledge that may lead to a further understanding of the

role of host and environmental factors that influence the dependence of cancer risk upon radiation dose.

Purpose of this Sources Sought announcement is to identify patient populations treated by x-ray therapy for peptic ulcer prior to 1965. Respondents to this announcement must be able to document the following:

1) The existence of at least 2,000 patients treated for peptic ulcer prior to 1965 with x-ray therapy prior to 1965;

2) the existence of at least 2,000 patients with peptic ulcer not treated with x-ray therapy prior to 1965;

3) confirmation that medical records exist for these patients and that they include sufficient information to facilitate tracing patients; and

4) confirmation that radiotherapy records exist for patients treated by x-ray therapy for peptic ulcer. These records should be complete (dates of treatments, machine parameters, field size, number of treatments, etc.) so that organ specific radiation doses can be estimated. A photocopy of a typical radiotherapy record must be enclosed.

A brief response to this announcement should include: 1) a description of the exposed population (number of patients, calendar years of x-ray treatment); and 2) a description of the non-exposed comparison group (number of patients, type of treatment, calendar years of treatment); 3) a description of information contained in the medical records, including a description of information available to be used for tracing patients (the last known address, Social Security number, etc.); and 4) confirmation and a description of the radiotherapy records, including a photocopy of a typical radiotherapy record that indicates exposure, field size, and other pertinent information.

CONTRACT SPECIALIST: Patrick Williams
RCB, Blair Bldg. Rm 114
301-427-8888

RFP NCI-CP-FS-41010-65

TITLE: Operation of a computerized death certificate procurement and management system and tracing using other vital records systems

DEADLINE: Jan. 5, 1984

NCI would like to set up master agreements with organizations having an established corporate unit specifically operating for death certificate procurement and tracing using other vital records such as birth certificates, marriage licenses, etc. Since hundreds of death certificates must be ordered simultaneously from states on a monthly basis, proposers must have a computerized death certificate procurement and management system (DCPMS) for monitoring, recording and reporting on the widespread eath certificate procurements. This DCPMS must be in place and in operation. Organizations which obtain death certificates occasionally or routinely while tracing individuals, but which do not have an operating unit specifically functioning as a DCPMS as required for this procurement, will not be eligible for consideration. The contractor may also occasionally be asked to trace via other types of vital statistics records, but this would constitute a very minor aspect of the work scope.

No other types of tracing activities will be needed under ths procurement, not via credit bureaus, motor vehicle bureaus or directories, or any other means, as NCI has already contracted with other organizations for such purposes. Experience in these other tracing activities will not count as experience toward the present procurement.

The RFP will require provision of many details of relevant years of experience and utilization of the corporate DCPMS, including detailed descriptions of projects wherein this system was used, and results of the efforts.

Personnel assigned to this activity at this time must also be listed with proportion of time, and their duties described. These mandatory details must be provided in the technical proposal. However, following awards of master agreements to qualified, successful respondents, several master agreement order RFPs may be issued describing the subjects to be traced via death certificate procurement and other vital records, and fixed price per subject bids will be solicited from the awardees.

Although MAO RFPs for tracing subjects using vital records other than death certificates will be used on a study-by-study basis, the government intends in MAO RFPs to procure death certificates to cover several studies and to last for six to 12 months. MAO awards will be made to the lowest bidder, providing the bid is acceptable to NCI. No funds accompany the MA itself, only the MAOs.

A prerequisite requirement for eligibility is that the respondent must trace individuals as a major corporate activity, or must have a component devoted specifically to tracing individuals.

A curriculum vitae should be provided only for the death certificate procurement manager, who must be experienced in obtaining death certificates from many states simultaneously, and must have managed this specific activity under a corporate DCPMS system. No separate salary will be paid for this or any other individual working on the contract, as the fixed price per subject bid submitted by the MA recipient should incorporate costs for all personnel.

Awardees will be monitored by an NCI project officer and an assistant project officer, who will require written reports at specified intervals. A specific NCI log form for each subject must also be filled in and submitted. Contractors must not add to their own corporate files any information and results on subjects whose names and other data are provided by NCI.

The RFP will be available on Nov. 28.

CONTRACTING OFFICER: Sydney Jones
RCB, Blair Bldg Rm 114
301-427-8888

The Cancer Letter _Editor Jerry D. Boyd

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