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SSO WORKSHOP CALLS FOR CERTIFICATION OF SURGICAL ONCOLOGISTS, INCREASED COMMITMENTS BY NCI, ACS

A Society of Surgical Oncology workshop, convened to develop an overall view of manpower and other needs for surgical oncology, came up with a series of recommendations aimed at strengthening surgical oncology research and education:

* The responsibilities of the surgical oncologist should

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In Brief

MURPHY NEW ACS PRESIDENT, ROBERT McKENNA NAMED PRESIDENT ELECT; GEHAN RECEIVES GOTTLIEB AWARD

GERALD MURPHY, director of Roswell Park Memorial Institute, was elected president of the American Cancer Society last week at the organization's 70th annual meeting. Robert McKenna, clinical professor of surgery at the Univ. of Southern California and director for regional activities of the USC Comprehensive Cancer Center, was elected vice president and president elect. New members of the Board of Directors are Denman Hammond, founding director of the USC center and associate dean of the School of Medicine; Samuel Hellman, physician in chief of Memorial Hospital, New York; Randolph Cameron, Avon Products executive; John Baity, New York attorney; Rosendo Gutierrez, Phoenix engineer; and Andrew Haas, president of the International Assn. of Heat & Asbestos Workers. . . . ANNUAL AWARDS presented at M.D. Anderson's Clinical Conference last week went to: Edmund Gehan, chief of biometrics at MDA and an expert in the design and interpretation of clinical cancer trials, the Jeffrey A. Gottlieb Memorial Award; John Ziegler, chief of education at the San Francisco VA Medical Center, the Heath Memorial Award; and Costan Berard, chairman of pathology and laboratory medicine at St. Jude Children's Research Hospital, the Joanne Vendenberge Hill Award and William O. Russell Lectureship. . . . BRIAN ISSELL, former director of clinical cancer research at Bristol Laboratories, has been appointed director of clinical investigations and vice president for research of Cetus Immune Corp., Palo Alto. . . . GRIFFUEL PRIZE won by Robert Gallo this year was worth 240,000 French francs, or about $30,000, not $41,000 as previously reported (The Cancer Letter, Oct. 14). The prize was worth $41,000 when Vincent DeVita won it in 1980; Gallo and 50 million Frenchmen are victims of the falling exchange rate.

NCI, ACS ASKED TO EXPAND SUPPORT OF POST RESIDENCY SURGERY TRAINING

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be delineated through a survey of current surgical oncologists and the formulation of guidelines outlining the expected role for surgical oncologists.

* Professional recognition of surgical oncology responsibilities should be secured through SSO certification or accreditation of surgical oncologists.

* The impact of surgical oncology on cancer patient management should be measured further through patterns of care studies utilizing existing data bases.

* Coverage of surgical oncology in medical school curricula should be augmented through establishment of divisions of surgical oncology, increased faculty representation, and summer student internships at surgical oncology units.

* Surgical training programs should rotate all residents through a surgical oncology experience.

* An estimate of the number of surgical oncologists needed in academic and community centers should be established based upon the number of institutional cancer programs and the distribution of other oncology disciplines.

* The post residency training of surgical oncologists should be expanded through commitment of funding from the National Cancer Institute, the American Cancer Society, and institutional resources to develop programs consistent with the SSO surgical oncology training guidelines.

* The Society of Surgical Oncology should remain committed to the continuing education of surgical oncologists, and advances in surgical oncology should be disseminated to the general surgical community through publications and the education programs of the American College of Surgeons.

* The Joint Commission on Accreditation of Hospitals should require every major hospital to maintain a cancer program based on a cancer committee with active surgical oncology participation, and surgical oncologists should be involved in the design of cooperative group protocol studies.

* Surgical oncology research should be promoted through increased funding commitments to existing grant mechanisms, training of surgical oncologists in grantsmanship, representation of surgical oncologists in grant review, survey of current funded research, and targeted workshops.

* The Society of Surgical Oncology should facilitate interaction with other disciplines and specialties through liaison representation, joint meetings, and the dissemination of progress reports; new relationships should be augmented in particular with osteopaths, nurse oncologists, and the leadership of the National Cancer Institute.

The workshop, held in September at Roswell Park, was supported in part by grants from ACS and NCI. A 172 page report on the workshop presents background material on the problems facing surgical oncology and summaries of the participants' deliberations and recommendations. The report noted:

"More cancer patients are cured of their disease by surgery alone than by any single method, yet the involvement of surgery and surgeons in the multidisciplinary basic and clinical oncology effort is generally less than the other clinical oncologic disciplines. A combination of factors has caused this deficit. These conditions include increased emphasis at NCI and in the oncology community on chemotherapy and radiation therapy and a reluctance to identify surgical oncology as an activity requiring special attention. Rapid development of improved clinical chemotherapy for cancer and advances in technology in radiation therapy have resulted in an expansion of a cadre of experienced investigators in these two disciplines. Concurrently, because cancer surgery appeared to lack a scientific base for research, the spotlight came to focus on other fields in surgery such as transplantation immunology and cardiovascular physiology. Consequently, interest in basic and clinical cancer research among surgeons failed to develop, and the number of well trained oncologists decreased. "

The report acknowledged that since 1977, NCI and others have recognized the need to encourage development of surgical oncology. "Broad, renewed support for surgical oncology as a principal oncologic discipline included NCI's creation and support of the Surgical Oncology Research Development Subcommittee (SORDS) of the Div. of Cancer Treatment's Board of Scientific Counselors; the development of formal guidelines for certification of surgical oncology training programs; and the active promotion of and interest in continuing education programs on surgical oncology. The Society of Surgical Oncology

has initiated efforts to promote surgical oncology as an important aspect of the multidisciplinary basic and clinical oncology research effort. In 1981, the Society formally established a long range planning committee whose purpose was to set goals and priorities for the Society. The committee has concluded that fostering surgical oncology research and advanced surgical oncology training constitute the two most important tasks of the Society. Other aims that have been cited include promoting the subspecialty of surgical oncology in various areas of medicine and increasing the impact of surgical oncology within NCI.

". . . Considerable progress has been made toward developing a framework for surgical oncology planning and identifying directions that will benefit the surgical oncology community. This achievement has been evidenced by (1) increased representation of surgeons on NCI policy groups; (2) increased interaction of surgical oncologists with the public and private sectors; (3) increased targeted funding for surgical oncology research and training; (4) establishment of SORDS; and (5) development of guidelines for formal certification of surgical oncology training programs within cancer centers and academic institutions.

"However," the report continued, "much more needs to be done."

The workshop was conducted as a series of four concurrent working group sessions—research, chaired by Walter Lawrence and Bimal Ghosh; education, chaired by Harvey Baker; training and manpower, chaired by Robert Schweitzer; and liaison activities, chaired by Robert McKenna.

The working group on research considered the recently approved (by the NCI Executive Committee) guidelines for surgical oncology research. The guidelines are intended to help stimulate surgical oncology research grant applications while limiting overlap and duplication in other research categories.

"It was noted that without these guidelines" the report said, "grants which were essentially surgical oncology were assigned to inappropriate study sections and not given adequate review by surgeons and others with relevant expertise. This fact was borne out by NCI statistics which demonstrated that among 25 categories of research grant themes, applications which would be recognized as surgical oncology proposals by SSO and also by the new NCI guidelines showed a random assignment across nearly the entire spectrum of NIH study sections." In some cases, surgical oncology applications were assigned to NIH institutes other than NCI, the report said.

The report reproduced the entire guidelines including examples of types of studies which may be considered surgical oncology (copies of the guidelines may be obtained from the Surgery Section, Clinical Investigations Branch, Cancer Therapy Evaluation Program, Div. of Cancer Treatment, NCI, Bethesda, Md. 20205). The opening paragraph states:

"This program includes a wide spectrum of studies in which surgery is the dominant feature in the prevention of cancer and in the diagnosis and treatment of patients with cancer. It encompasses the immediate care and physical restoration of patients in relation to surgical operations. Laboratory studies of pathobiologic changes occurring in cancer patients prior to, during or after surgery are of interest. Such laboratory studies may include animal models and may involve many scientific disciplines focused on the surgical cancer patient and surgical treatment. Epidemiologic studies that have a direct bearing on the practice of cancer surgery may be considered. All surgical specialties are included."

Under prevention, the guidelines state, "This aspect of the program includes studies of the efficacy of surgical procedures in preventing the development of invasive cancer in tissues or organs at high risk. These studies may be combined with or compared to other treatments. However, surgery must be the main feature of management and followup should be provided by the surgeon."

Under diagnosis, the guidelines say, "This aspect of the program includes operative and endoscopic procedures by which cells, tissues, secretions, exudates, or transudates are obtained for chemical, immunologic, cytologic, histopathologic or other laboratory examinations. These studies may be combined with specialized instruments for gaining access to the material of interest, and may involve comparison with radiographic, ultrasonic, or nuclear imaging procedures. Some studies may include the broad category of staging to determine the extent of disease and may involve an array of markers and other laboratory determinations in addition to the specific surgery."

Under treatment, the guidelines state, "These studies are concerned not only with

increasing cure rates but also with maximizing safety and palliation while reducing operative complications and deformity or malfunction. Indications and timing of procedures may be important features of the studies. In all of these studies, surgery is considered the central feature of the treatment. These studies may stress comparison of two or more treatments in a prospective randomized trial." (The guidelines list over three pages of examples of surgical oncology treatment, reconstructive and rehabilitative studies).

Under laboratory research, the guidelines state, "Basic and developmental laboratory research, involving animal models and encompassing any scientific discipline, will be considered for inclusion in the surgical oncology program provided the research has relevance for cancer patients whose problems may be amenable to surgical techniques and management. These studies may involve human models and under some circumstances may involve use of removed tissue such as organs or extremities. Such studies should clearly state in the title and/or summary the surgical significance of the project. Research not clearly associated with surgical oncology regardless of the disciplinary association or academic affiliation of the principle investigator may not be included in the surgical oncology program."

The workshop working group on research developed a "strategy for resolving unmet needs for surgical oncology research," broken down into four areas:

—Data Needs. Two surveys are needed to evaluate objectively the current status of surgical oncology research activity, as well as serving as baseline data for measuring future progress. These surveys are:

1. A comprehensive survey of clinical and research status of surgical oncology in all the university departments of surgery in the U.S. "This carefully planned and validated survey would allow determination of the efficacy of the planning process thus far by drawing comparisons with the more limited survey that was accomplished in 1980. More importantly, it would define clearly the current research base in surgical oncology and allow objective future planning for the needs in this area. Funding for professional support of this survey might be obtained appropriately from NCI, if a feasible mechanism can be identified, but the SSO should assume overall responsibility for this effort."

2. A survey of the funded grants and contracts in NIH relating to surgical oncology. This is urgently needed to establish more fully the extent and breadth of this activity within NIH. It is recommended strongly that NCI initiate this survey through already established mechanisms now that surgical oncology is a recognized "activity." This step should strengthen the capability of the Surgical Section in its role in this important process of expanding and correcting deficiencies in surgical oncology research. It thereby would strengthen the overall cancer research program of NCI.

The working group discussed but did not press for surveys to determine the number of persons who consider themselves surgical oncologists; a comparison of results of patients treated in community hospitals vs. academic hospitals; and comparison of patient data from departments of surgical oncology vs. patients treated in nonsurgical oncology departments.

—Expansion of the Cadre of Academic Surgical Oncologists. Initiation of NCI's Physician Investigator Development Awards was applauded as a positive step in achieving this goal, "but it was considered too limited in scope. Increase in future allocations to this program are recommended strongly to NCI."

NCI and ACS were urged to develop funding instruments to help prepare "academic surgical oncologists for the future. . . . There is no single mechanism now available to accomplish this important task.

"Continuation of the NCI planning grant program for surgical oncology research development (P20s) should be encouraged. . . Only five out of the 28 P20 applications were funded. Although the working group felt that the P20 format at NIH was not flexible enough to permit a comprehensive program of training in clinical and research aspects of surgical oncology, it was recommended that it should be reissued on an annual basis. Some members thought that other funding mechanisms should be developed to address the other problems which are being encountered in the field of surgical oncology."

The group recommended that funding mechanisms for research training through NCI's Div. of Resources, Centers & Community Activities should be explored.

—Increase in Funding for Specific Research

Projects in Surgical Oncology. The working group called for an increase in assignment of academic surgical oncologists to policy making bodies of NCI, particularly the boards of scientific counselors of DCT and DRCCA. "Currently each board has only one general surgical oncologist, and it is recommended strongly that this underrepresentation be corrected."

The group asked for increased involvement of academic surgical oncologists in the grants review process of NIH by establishment of a separate surgical oncology study section, or increased representation on existing study sections.

The group suggested that new techniques are needed to acquaint "competent and productive surgical investigators with opportunities for funding as well as optimal methods for preparing grant applications." Among these might be seminars on grantsmanship at SSO meetings, and an exhibit on the grants mechanism prepared by NCI for demonstration at meetings of major national surgical associations.

--Planning Process for Developing Research Projects in Surgical Oncology with High Priority. The working group proposed a series of targeted and focused workshops be developed through SORDS. Among topics the group felt should be considered for workshop topics were adjuvant radiation and chemotherapy for soft tissue sarcomas; thyroid cancer surgery; local approaches to rectal cancer; colorectal hepatic metastasis management; preoperative adjuvant chemotherapy; intraoperative radiation therapy; operative management of carcinoma of the pancreas; nutritional repletion of the surgical cancer patient and its consequences; surgical management of lung metastasis; regional chemotherapeutic techniques; lymphadenectomy in thyroid, colorectal, and other cancers; melanomas; pre and post operative radiation therapy; hyperthermia; and comparison of surgery with radiation treatment in breast cancer.

"This list was not intended to be all inclusive," the report said, "and the working group agreed that it would need to be placed in an order of priority. The working group felt that these sessions would address several important needs in the surgical oncology community including the rapid dissemination of the most recent information on surgical techniques and considerations, the collaborative development of new protocols which could be investigated at the level of cooperative trials, or possibly through the grant mechanisms, and the raising of consciousness of the public and surgical community, and therefore of potential surgical oncologists to the role of modern surgical techniques in the treatment of cancer."

(The workshop recommendations on education, training and manpower, and liaison will be reported in future issues of The Cancer Letter).

CITY OF HOPE GETS DRG EXEMPTION, NO MORE LIKELY; ESTIMATES LISTED

The Health Care Finance Administration has added the City of Hope Medical Center to the exclusive list of institutions which qualify for exemption from the Diagnosis Related Group system of Medicare reimbursement. That brings to three the number of privileged few, the others being Fox Chase Cancer Center and M.D. Anderson Hospital.

There are others which would qualify which are located in states which, because they have their own prospective reimbursement programs in operation, will not participate for now in the federal DRG program.

While City of Hope is in, there appears to be little hope that others may qualify through any broadening of the regulations proposed in HCFA's Sept. 1 publication. The comment period for those proposals ended Oct. 17, and HCFA as well as members of Congress were swamped with requests for relaxation of the stringent limits, apparently to no avail.

In a letter to Donna Schmitt, director of patient and family services at Sharp Memorial Hospital in San Diego, Congressman Jim Bates (D.-Calif.) wrote:

"Sharon Ramsay of HCFA says that it is doubtful that this program will be expanded greatly even though 'every congressman and senator in the country' must have contacted (HCFA). Ms. Ramsay advises that the congressional intent is at question and that they have met with Congressman Pickle, the National Cancer Institute and the American Cancer Society to try and resolve the questions. Apparently this will not change the final outcome to a large degree, although it does appear that one more hospital, City of Hope in California, will receive an exception. Ms. Ramsay also advises that HCFA is always 'prohibited from paying research costs.'"

The matter of congressional intent is still at issue, even in Congress. The legislative language which provides for exemptions of institutions engaged in clinical cancer

research and treatment of cancer patients appears to be broad enough to include scores of institutions. However, HCFA elicited a comment from Congressman Jake Pickle (D.-Tex.) to the effect that that language (an amendment he authored) was meant only to include the comprehensive centers.

On the other hand, Sen. Robert Dole (R.-Kan.) has gone on record saying the intent of Congress was to include many more institutions, including community hospitals. Dole's opinion should not be lightly regarded by HCFA, since he is chairman of the Senate Finance Committee which has legislative authority over Medicare.

Meanwhile, hospital administrators have been struggling with the complicated reimbursement schedules released by HCFA to determine what they will be paid for each DRG. That is a formidable task.

Lee Mortenson, executive director of the Assn. of Community Cancer Centers, has put together a list of reimbursement figures for each DRG and each category. Those detailed lists have been sent to ACCC members, and are available to others who request them. Contact Elm Services Inc., 11600 Nebel St., Rockville, Md. 20852.

To give some concept of the range of reimbursible charges permitted for each DRG, Mortenson computed the schedules for a rural Illinois hospital and Chicago hospital. The rural figures, of course, are the lower ones. The figures are supposed to cover all costs charged to patients by the hospital for the specified DRG. They are what the government will pay for each of those categories—if the actual costs are less, the hospital makes a profit; if they are more, the hospital has to take the loss. Physician fees, including surgeons, anesthesiologists, and pathologists, are not included unless they are on the hospital's payroll.

Mortenson's figures for the two Illinois categories in cancer related DRGs follows:

DRG 3, brain or skull biopsy, under age 18, $7180-9800.

DRG 10, nervous system neoplasms, age 70 or older and substantial OR complications, $2640-4340.

DRG 11, as above, under age 70, $2535-4160.

DRG 46, various malignant and benign neoplasms of the eye, age 18 and over with complications, $1205-1980.

DRG 47, as above without complications, $1020-1680.

DRG 48, as above, under age 18, $820-1350.

DRG 64, nose and throat malignancy, $2185-3590.

DRG 73, benign ear, nose and throat neoplasms, age 18 and over, $1050-1730.

DRG 82, respiratory neoplasms, $2300-3780.

DRG 145, malignant and benign neoplasms of the heart, hemangioma, without complications, $2020-3330.

DRG 164, malignant neoplasms of the appendix, age 70 and older, $3700-6090; under age 70, $3260-5370.

DRG 172, digestive malignancy, age 70 and older, with complications, $2480-4075; under age 70, without complications, $2125-3495.

DRG 185, malignancies of the lip, gum, mouth, and cheek, age 18 and over, $1350-3320; under 18, $840-1380.

DRG 187, dental restorations from above malignancies, $800-1320.

DRG 188, benign neoplasms of mouth, esophagus, stomach, bowel, rectum, peritoneum, and GI tract, age 70 and older with complications, $1500-2470.

DRG 189, as above, age 18-69, $1330-2185.

DRG 190, as above, under 18, $680-1120.

DRG 199, hepatobiliary diagnostic procedure for malignancy, including OR procedures, $4965-8160.

DRG 203, malignancy of hepatobiliary system or pancreas, $2210-3630.

DRG 239, musculoskeletal and connective tissue malignancies, $2220-3650.

DRG 256, various benign neoplasms of the musculoskeletal system and connective tissue, $1760-2890.

DRG 257, total mastectomy age and older, with complications, $2240-3680; under age 70, $2170-3560.

DRG 259, subtotal mastectomy, 70 and older, with complications, $2050-3370; under 70, $1880-3100.

DRG 261, breast procedures for nonmalignancies, except biopsy and local excision, $1480-2430.

DRG 262, breast biopsy and local excision, $930-1530.

DRG 272, malignant melanoma, 70 and older with complications, $1740-2860; under 70, without complications, $1670-2750.

DRG 274, malignant breast disorders, 70 and older with complications, $2040-3360; under 70, without complications, $1820-2995.

DRG 276, various benign breast disorders, $1225-2015.

DRG 284, various malignant and benign skin neoplasms, under age 70 without complications, $1210-1980.

DRG 300, malignant and benign endocrine neoplasms, 70 and older with complications, $1965-3230; under 70 without complications, $1645-2705.

DRG 303, kidney, ureter, and major bladder procedures for neoplasms, $5130-8440.

DRG 318, kidney and urinary tract neoplasms, age 70 and older with complications, $1850-3040; under 70 without complications, $1605-2640.

DRG 338, testes procedures for malignancy, $1830-3010.

DRG 344, other male reproductive system OR procedures for malignancy, $2260-3720.

DRG 346, male reproductive system malignancy, age 70 and older with complications, $1895-3120; under 70 without complications, $1680-2760.

DRG 352, other male reproductive system benign neoplams, $1290-2120.

DRG 357, uterus and adenexa procedures for malignancy, $3875-6375.

DRG 363, D&C, conization and radio implant for malignancy, $1310-2165.

DRG 366, female reproductive system malignancy, age 70 and older with complications, $1705-2805; under 70 without complications, $1170-1920.

DRG 369, various female reproductive system benign neoplasms, $1405-2310.

DRG 395, aplastic anemias age 18 and older, $1580-2600.

DRG 398, benign neoplasm of the thymus and lymph nodes, age 70 and older with complications, $1795-2960; under 70,without complications, $1710-2810.

DRG 400, lymphoma or leukemia with major OR procedure, $5710-9390.

DRG 401, lymphoma or leukemia with minor OR procedure, age 70 and older with complications, $2520-4150; under 70 without complicaions, $2290-3760.

DRG 403, lymphoma or leukemia, age 70 and older with complications, $2370-3890; age 18-69 without complications, $2380-3815; under 18, $3740-6150.

DRG 406, myeloproliferative disorders or poorly differentiated neoplasms with major OR procedures and complications, $4580-7530; without complications, $4315-7100.

DRG 408, myeloproliferative disorders or poorly differentiated neoplasms with minor OR procedures, $2300-3780.

DRG 409, radiotherapy, $1640-2700.

DRG 410, chemotherapy, $710-1170.

DRG 411, history of malignancy without endoscopy, $1460-2400; with endoscopy, $690-1130.

DRG 413, other myeloproliferative disorders or poorly differentiated neoplasms, age 70 and older with complications, $2220-3650; under 70 without complications, $2095-3440.

DRG 465, aftercare with history of malignancy as secondary diagnosis, $410-685.

DRG 467, various diagnoses defined as complications or comorbidities, $1980-3255.

ACS INITIATES THREE YEAR CAMPAIGN TO STEP UP COLORECTAL SCREENING

The American Cancer Society has announced that it will undertake a major three year accelerated campaign to reduce the U.S. death toll from colorectal cancer which in 1983 will be diagnosed in 126,000 adults and result in approximately 58,100 deaths.

The campaign will be based on the premise that early detection can save the lives of 75 percent of colorectal cancer patients. The focus will be on individuals past age 50, since 93 percent of colorectal cancers are found in that age group.

The campaign will attempt to expand the use of three standard diagnostic techniques for the early detection of colorectal cancer in asymptomatic persons:

1. Proctosigmoidoscopy. More than 60 percent of all colorectal cancers can be detected this way.
2. Digital rectal examination, by which 12 to 15 percent of colorectal cancers can be found.
3. Testing for hidden blood in the stool, which can be helpful in identifying cancer or precancerous conditions in the colon and rectum.

Broad goals of the campaign will be to obtain a 150 percent increase from the present 12 percent, to at least 30 percent, in the number of adults past 50 who are reached annually with educational programs about colorectal cancer, and to provide continuing medical education programs on the doctor's role in the early detection of colorectal cancer for the nation's more than 200,000 family and other primary care physicians.

If the campaign is successful, ACS believes that by 1987:

1. The number of family and primary care physicians who regularly perform colorectal cancer tests for patients past age 50 will rise by 25 percent.
2. The number of patients past age 50 who

have ever had a proctoscopic examination will rise from the present 36 percent to 50 percent.

3. The number of persons past age 50 who have ever had a digital examination will rise from the present 52 to 66 percent.

4. The number of persons past age 50 who have ever had a stool blood test will rise from the present 19 to 40 percent.

ACS will collaborate with the American Society for Gastrointestinal Endoscopy, the American Academy of Physicians, and other medical groups in developing programs to encourage wider use by physicians of the 35cm flexible sigmoidoscope.

If only 10 percent of those in the over 50 target group who are not now being regularly examined for colorectal cancer would obtain examinations during each of the next three years, ACS estimates that 10,500 lives could be saved and about 170,000 person years could be added to the lives of those who actually get the disease. This could result in savings of more than $160 million in treatment costs and more than $190 million in earnings that would otherwise be lost.

The ACS checkup guidelines for persons without symptoms recommend an annual digital rectal examination from age 40 on, annual stool blood test from age 50 on, and sigmoidoscopy every three to five years from age 50 on after two initial negative sigmoidoscopies a year apart.

ACS pointed out that persons who are at higher risk of developing colorectal cancer may need more frequent exams at earlier ages. This should be determined by their physicians. High risk factors include a familial polyposis, Gardner's syndrome, ulcerative colitis, a history of polyps or prior colon cancer, and family history of cancer of the colon or rectum.

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.

SOURCES SOUGHT

RFP NCI CP-FS-41012-77

TITLE: Late effects of therapeutic ionizing radiation for benign disorders
DEADLINE FOR CAPABILITY STATEMENTS: Dec. 21

The Radiation Studies Section of the Environmental Epidemiology Branch, Field Studies & Statistics Program, Div. of Cancer Cause & Prevention, NCI, plans and conducts epidemiologic studies which examine the risk of cancer in populations exposed to ionzing radiation. These studies are conducted to strengthen the quantitative basis for risk estimation, to improve understanding of the role of host and environmental factors that influence the dependence of cancer risk upon radiation dose, and to provide insights into mechanisms by which cancer is produced.

This sources sought announcement seeks only to identify sources of patient populations irradiated for prior to 1965 benign diseases or conditions. These would include: 1) enlarged thymus gland, 2) enlarged tonsils, 3) lymphoid hperplasia, 4) pertussis, 5) hearing problems, 6) tinea capitis, 7) postpartum mastitis, 8) benign gynecological disorders, 9) ankylosing spondylits, 10) cellulitis, 11) epilation, 12) gynecomastia, 13) peptic ulcer, 14) polycythemia vera, and 15) other benign conditions. NCI would like to determine whether such populations can be identified, and whether epidemiologic studies could be conducted on the late effects of therapeutic ionizing radiation for benign disorders.

These populations should not have been previously studied for late effects and must not be under current study. Medical records, sufficient to provide information for locating the patients, and radiotherapy records must be available for these populations.

A brief response to this announcement must include: 1) a paragraph describing the exposed population (i.e., the reason for radiation therapy, calendar years during which the exposure occurred, estimated number of subjects receiving radiotherapy); 2) confirmation that medical records are available that include radiotherapy dates and information that might be useful for locating the patient today (e.g., last known address, Social Security number, parents' name, etc.); 3) a brief description of the technique and exposures used for irradiating the particular benign disorder; and 4) a statement on the availability for study of a comparable group of patients who did not receive radiation, and if so, the estimated numbers.

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

The Cancer Letter _Editor Jerry D. Boyd

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