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WAXMAN COMPROMISE BILL CLEARS HOUSE; CENTERS LINE ITEM TRADED FOR GUARANTEE OF MINIMUM NUMBER OF 55

A compromise measure which eliminated or softened features of the Waxman bill that had aroused stiff opposition in the House and Administration was all that was needed to move the legislation through the House before

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In Brief

NCAB TO HEAR PROGRAM REVIEW, REPORTS ON AIDS, MONOCLONAL ANTIBODIES, CANCER RESEARCH AT DREW

ANNUAL PROGRAM review presented by NCI staff and chairmen of the various Boards of Scientific Counselors for the benefit of the National Cancer Advisory Board is on the agenda for the Board's Nov. 28-30 meeting. These will include reports on information dissemination, by Paul Van Nevel, Susan Hubbard, Barbara Blumberg, and Judith Stein; Div. of Extramural Activities, by Barbara Bynum; Div. of Cancer Cause & Prevention, by Richard Adamson and DCCP Board Chairman Barry Pierce; Div. of Cancer Treatment, by Bruce Chabner and DCT Board Chairman Samuel Hellman; diagnostic and therapeutic research on monoclonal antibodies, by Ronald Herberman, Steven Larson, Kenneth Foon, and Thomas Waldmann; Div. of Cancer Biology & Diagnosis, by Alan Rabson and DCBD Board Chairman Peter Nowell; and Div. of Resources, Centers & Community Activities, by Peter Greenwald and DRCCA Board Chairman Lester Breslow. In addition, special reports are scheduled on current cancer research at Drew Medical School, by Lawrence Alfred; carcinogenesis studies using human tissues and cells, by Curtis Harris; human chromosomes and cancer, by Peter Nowell; pathology of AIDS, by Cheryl Reichert; immunological approach to the AIDS problem, by Gene Shearer; and randomized trial of carotene and cancer in U.S. physicians, by Charles Hennekens. . . . RUTH KIRSCHSTEIN, director of the National Institute of General Medical Sciences, turned down the prospect of appointment as commissioner of the Food & Drug Administration. . . . THOMAS WALDMANN, chief of the Metabolism Branch in the Div. of Cancer Biology & Diagnosis, has been awarded the Wellcome Visiting Professorship for the 1983-84 academic year. Waldmann was recognized for his contributions to the understanding of human immunology.

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CENTERS LINE ITEM IN WAXMAN BILL SWAPPED FOR GUARANTEED MINIMUM 55

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last week's adjournment of Congress. The House passed the bill by voice vote, breaking a deadlock that had threatened to hold up biomedical research reauthorization, including renewal of the National Cancer Act.

The compromise reportedly was also acceptable to Sen. Orrin Hatch (R.-Utah) and his colleagues on the Labor & Human Resources Committee. Only a few technical imperfections were all that prevented Hatch from taking the bill to the Senate floor before adjournment. Hatch had completed committee action on his own reauthorization bill, which was relatively noncontroversial.

Most of the controversial aspects of the bill authored by Henry Waxman (D.-Calif.), chairman of the House Health Subcommittee, had little to do with NCI or the National Cancer Act, with one exception. Waxman and the parent Energy & Commerce Committee had agreed on inserting a line item dollar authorization for cancer centers, strongly supported by the Assn. of American Cancer Institutes. The bill's opponents in the House, led by Congressmen Edward Madigan (R.-Ill.) and James Broyhill (R.-N.C.), objected to provisions in the bill which they said limited the flexibility of NIH managers in running their programs. NCI had strenuously objected to the centers line item for the same reason.

In a compromise engineered by Richard Shelby (D.-Alabama), Waxman agreed to drop the line item dollar authorization for centers in return for language which places a floor under the number of centers NCI will support. The number was placed at 55, which is the number NCI presently supports—20 comprehensive centers, 19 clinical centers, and 16 laboratory centers.

NCI actually now funds 59 active center core grants. There are three separate core grants for the Univ. of Chicago, Northwestern Univ., and the Illinois Cancer Council which NCI reports as one center under the ICC Comprehensive Cancer Center; there are two separate core grants for the Univ. of Pennsylvania and Fox Chase Cancer Center which NCI reports as one comprehensive center; and there are separate core grants for Georgetown Univ. and Howard Univ. which NCI reports as one comprehensive center.

The compromise thus does not provide the security of earmarked funds sought by AACI, but may provide some stability through legislating the minimum number of centers NCI is required to support.

Dollar amounts in authorization bills are no guarantee that the beneficiary will receive that amount, with the totals being determined by the appropriations committees, with concurrence of the House and Senate when the appropriations bills reach the floor. But a line item authorization requires the appropriations committees to earmark money for the activity named and prevents the agency from "reprogramming" that money into other areas.

Cancer center executives have felt that during the years of tight budgets, NCI has not allocated enough money to the centers support program.

The new language in the bill now directs NCI, "with the concurrence of the National Cancer Advisory Board, to pay all or part of the costs of planning, establishing, strengthening, and providing basic operating support for at least 55 centers for basic and clinical research."

The committee report on the bill, which was not available by press time this week, will include language making it clear that the number of 55 depends on the number of core grants each cycle needed to maintain that figure clearing peer review with fundable scores.

Is there a danger that 55 as the "minimum" number will become the maximum? Not likely, since the congressional intent is clear. Also, NCI Director Vincent DeVita has gone on record that more centers are needed. The battleground for AACI and individual center representataives will continue to be the appropriations committees, where they still have the opportunity to persuade members to demand that definite sums be allocated by NCI for centers.

The most important feature of the compromise bill, one which was needed to get Madigan and Broyhill to drop their substitute bills, was reinstatement of Section 301 of the Public Health Service Act. That section provides the Dept. of Health & Human Services with broad, flexible authorities under which a vast array of health programs have operated, including NIH. Waxman had sought to codify much of Section 301 and provide Congress with much more extensive and detailed oversight of NIH, the individual institutes and programs.

The Administration has not dropped its

opposition to the House bill, even with the changes in the compromise. An Office of Management & Budget message to the House during debate on the bill stated that while the White House prefers the Shelby substitute, OMB will seek amendments in the Senate or in the House-Senate conference. The Administration has opposed all along creation of a new National Arthritis Institute, although that probably is not going to be a debatable issue between the House and Senate. The Hatch bill, like the Waxman/Shelby measure, would establish the Arthritis Institute.

The Shelby substitute included something neither Hatch nor Waxman had sought for NIH—a National Institute of Nursing, reportedly put in by Madigan. OMB said it also would oppose that feature of the compromise when it reaches the Senate.

One other change in the compromise which made the Waxman bill more acceptable to Madigan and Broyhill, at least, if not the Administration, was that the National Institute of Occupational Safety & Health was left with the Centers for Disease Control rather than transferred to NIH, as Waxman had proposed.

Still in the bill is the requirement that each institute at NIH have an associate director for prevention, except for the National Institute for General Medical Sciences, and the National Institute of Environmental Health Science. Eliminated was the Waxman requirement for an NIH AD for prevention.

The House bill still does not include one change NCI has sought for years—raising the maximum size of grants which may be awarded by NCI without approval of the National Cancer Advisory Board from $35,000 to $50,000. The Senate bill does that.

NCI's bypass budget authority remains intact in the Shelby substitute, but the compromise took out the Waxman provision which would have extended that authority to all other NIH institutes and would have required that those budgets be submitted directly to Congress without going through the White House.

All other features of the National Cancer Act remain intact, as they do in the Senate bill, including presidential appointment of the NCI director and NCAB members, and the President's Cancer Panel.

The Shelby substitute did not change the dollar authorization figures for NCI: $1.163 billion for research in FY 1984 and $64 million for control; $1.221 billion and $74 million in FY 1985; and $1.3 billion and $84 million in FY 1986.

The bills will carry over to the next session of Congress, starting in January, when it is likely that the Senate will act right away.

DRG REGULATION OPPONENTS MAY HAVE GAINED POWERFUL ALLY – ANDY JACOBS

Those who are still fighting for more exceptions to the Diagnosis Related Group reimbursement regulations may have recruited a powerful new ally.

Congressman Andrew Jacobs (D.-Indiana), chairman of the House Ways & Means Committee's Health Subcommittee, has written to Caroline Davis, administrator of the Health Care Finance Administration, asking for more liberal interpretation of the regulations.

"To put it mildly, I'm concerned about the Sept. 1, 1983, Federal Register announcement of DRG regulations which allow Cancer Program waivers for just two institutions," Jacobs wrote. "I understand Sen. Dole shares my concerns. What would be wrong with a regulation which would give waivers to organizations with 25 or more patients on the NCI approved clinical trials list? I am told that about 225 institutions would qualify and that each of them is making a significant contribution to the effort of eradicating one of the most dread human fates."

Jacobs' subcommittee has purview over all Medicare legislation. Sen. Robert Dole (R.-Kan.) is chairman of the Senate Finance Committee, which has the same responsibility in that body. Dole, House Ways & Means Chairman Daniel Rostenkowski, Senate Finance Health Subcommittee Chairman David Durenberger (R.-Minn.), and Jacobs are the key individuals in Congress if any effort is attempted to correct DRG regulations through legislative action.

Dole has gone on record as insisting that the intent of Congress was to permit waivers for institutions involved in clinical cancer research, including community hospitals. If HCFA continues to ignore that position, the only recourse would be a new bill mandating those waivers.

Although the mood in the Administration, and perhaps also in Congress, has been to give the new reimbursement program a chance to get started before making any major changes in the regulations, Congress has been

swamped with mail demanding revisions in the regulations, and in all probability, most of it has been from persons concerned about how they will affect reimbursement for treatment of cancer patients. Congress might well be receptive to legislation clarifying its intent in the act authorizing DRG reimbursement and demanding that that intent be carried out by HCFA.

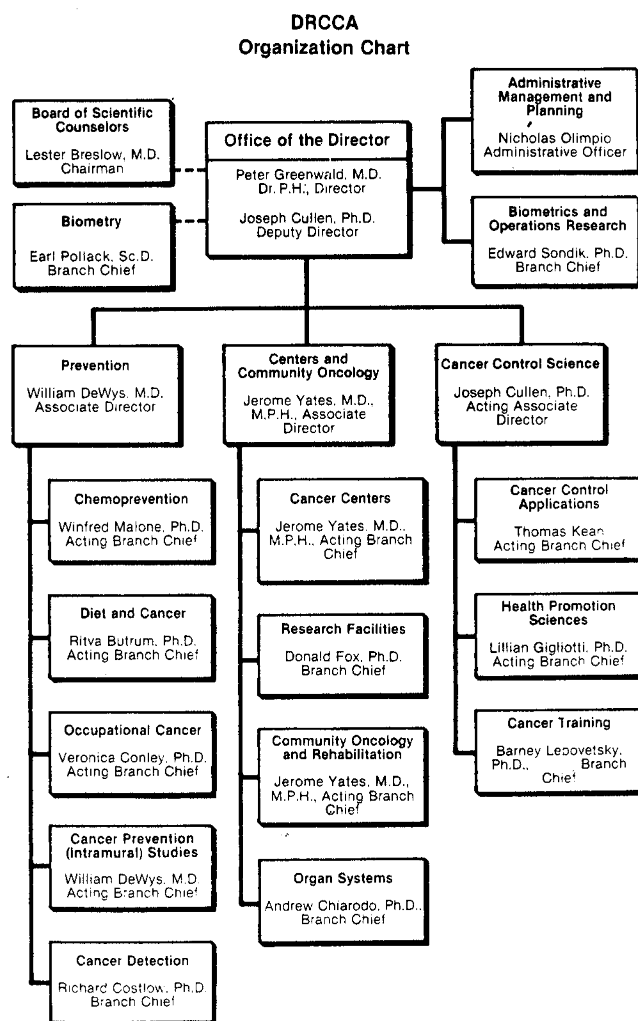
DRCCA STAFF BOOMS TO 145, STILL GROWING; RECRUITMENT CONTINUES

For the past two years, the NCI division which has grabbed the most attention is the Div. of Resources, Centers & Community Activities, which name will be changed any day now to the Div. of Cancer Prevention & Control. The attention has come about because it grew from a handful of employees to a staff of about 145, and is still growing; because some fundamental concepts of cancer control, one of its major responsibilities, have been drastically changed; because some important and visible components of other divisions were transferred into it; because it has initiated some vital and controversial new programs; and because Director Peter Greenwald has recruited some dynamic and sometimes controversial people to help him run those programs.

DRCCA's organizational chart has been changed so often that one version is out of date before the previous one has been printed. However, the influx of new branches, programs and people may be stabilized, for the moment, and the chart on this page is current.

Newest addition is the Biometry Branch, headed by Earl Pollack, which was moved from the Div. of Cancer Cause & Prevention. That branch includes the SEER Program, which tracks cancer incidence and mortality rates. Four sections and 40 people moved with Pollack to DRCCA, including section chiefs John Young, Max Myers, and David Byars. John Gart was the only section chief in the branch to remain with DCCP.

All of those positions in the chart shown as being held by "acting" branch chiefs (or in the case of the Cancer Control Science Program, acting associate director), eventually will be turned into permanent appointments. In some cases, the acting chiefs will get the permanent appointments; in others, new people will be recruited. New people definitely will be recruited (not necessarily from outside NCI) for those positions which



are being filled by individuals higher up the ladder, namely Cancer Prevention Studies Branch, now headed by William DeWys, who is associate director and head of the Prevention Program; Cancer Centers Branch and Community Oncology & Rehabilitation Branch, headed by Jerome Yates, who is AD for the Centers & Community Oncology Program; and associate director and head of the Cancer Control Science Program, held by Joseph Cullen, who is also deputy director of the division.

Greenwald discussed DRCCA's new mission and mandates in his report to the division Board of Scientific Counselors last month.

"DRCCA serves as the effector arm of the National Cancer Institute, integrating basic laboratory and clinical research findings to reduce cancer incidence, morbidity, and mortality through applied research. The division's goals and specific objectives support this mission. They are based on three fundamental assumptions:

"—That the scientific method of inquiry is

applicable to cancer control research.

"—That the pursuit of excellence in science is the prime consideration in setting priorities for action.

"—That the planning and conduct of activities are built on existing strengths of the National Cancer Program.

"To carry out the DRCCA mission, the division has developed several strategies," Greenwald's report continued. "First. to ensure that the nation achieves a scientifically based cancer prevention and control program, the division subjects cancer interventions to the following orderly sequence of research phases: I, hypothesis development, II, methods development; III, controlled intervention trials; IV, defined population studies; V, demonstration and implementation studies. . .

"A second DRCCA strategy is to establish priorities for allocating research resources to the cancer prevention and control phases that will provide the greatest return on investment. Research studies supported by the division need not all be at the same point of development; the strength of available scientific evidence determines which phase in the research process will be funded for a given intervention. . . .

"A third major objective is resource development. This activity includes the improvement of oncology training for physicians and other health professionals; research on development of tools and techniques applicable to a broad range of studies; and support of construction and renovation of facilities to promote cancer control research. . . .

"A fifth strategy is to integrate cancer control as a research effort into other cancer programs and to build on existing strengths of the National Cancer Program."

SSO EDUCATION WORKING GROUP LISTS "MAJOR UNMET NEEDS AND PROBLEMS"

A workshop organized by the Society of Surgical Oncology on progress and plans in surgical oncology produced a number of far ranging recommendations aimed at strengthening the discipline in research and education. In last week's issue, The Cancer Letter reported the workshop's broad recommendations and specific suggestions offered by a working group on research.

The working group on education considered a number of "major unmet needs and problems" and offered recommendations on how to meet those needs and address those problems. Those needs identified were, as reported in the workshop proceedings:

1. There is still a lack of understanding of the importance of multidisciplinary cancer care and the role of adjuvant modalities in cancer management, particularly for less common tumors (sarcoma, testicular cancer).
2. Need to characterize the attitudes of general physicians, general surgeons, and surgical oncologists towards surgical oncology, and an analysis of how these different attitudes affect the role expected of surgical oncologists.
3. There may be a lack of acceptance of the surgical oncologist and his role in total cancer care. This disregard is in no small part due to lack of recognition by the surgical specialty boards but extends to neglect for representation at NCI, American College of Surgeons, American Cancer Society, and medical schools. The working group considered this concern a most important unmet need.
4. Perception of a lack of acceptance by general surgeon colleagues, based particularly on fear that the surgical oncologist will draw patients away from the general surgeon.
5. The possible failure of surgical oncologists to interact effectively with other oncology specialists in the care of cancer patients, and the possible failure of surgeons to take a stronger role in coordinating patient care.
6. Lack of a good data base concerning the number of surgical oncologists needed in various settings, and the types of services needed and the role of surgical oncologists in different settings.
7. Absence of a clear definition of the surgical oncologist in the educational program of academic centers.
8. Need for better coverage of cancer in medical school curriculum.
9. Lack of qualified surgical oncologist faculty members in medical schools. This concern was considered an important problem.
10. Lack of funding for surgical oncology education programs and fellows. In the surgical community, there is a lack of knowledge concerning existing sources of funds other than NCI and ACS.
11. Lack of surgical oncology publications in journals widely read by general surgeons and primary care physicians.
12. The general surgeon's lack of knowledge of the importance of staging and subsequent

failure to stage patients in practice.

13. There is a lack of understanding on the part of the surgical community of the importance of protocols and clinical trials. Surgeons may not be involved extensively in designing clinical trials. Surgical patients may not be entered in sufficient numbers into clinical trials. General surgeons are not perceived as being aware of current clinical protocol studies.

14. Problems in keeping abreast of advances in research in such fields as immunotherapy, epidemiology, surgical pathology, and biological response modifiers.

15. Need to provide surgical oncologists and surgeons with more knowledge of relevant aspects of radiation therapy and chemotherapy.

16. Lack of education concerning rehabilitation and followup care of cancer patients and the surgeon's role in these activities.

17. Need for education concerning cost effectiveness of proper cancer management.

18. Need to educate physicians concerning the value and use of computers in data processing and research (e.g. PDQ-2).

19. Awareness in surgeons and surgical oncologists concerning the need for evaluation of educational programs.

Those needs and problems the working group felt to be most important were the lack of board certification by surgical oncologists, the potential failure of surgeons and surgical oncologists to take a leading role in cancer management, and the apparent lack of qualified surgical oncologists on medical school faculty. It was felt that without acceptance by the general surgical community and more widespread visibility, the surgical oncologist could not be effective as an educator or role model.

The working group offered these recommendations:

1. Adequate recognition of surgical oncologists by appropriate examination and certification by SSO.

2. Define the role of and need for the surgical oncologist in cancer care and how this role differs in various settings.

3. Establish tumor boards or multidisciplinary cancer conferences at every hospital which treats cancer patients.

4. Establish in every medical school a division of surgical oncology headed by a qualified surgical oncologist. ACS and NCI should make available the initial funds to start up these divisions. Every surgical resident should be rotated through these divisions.

5. Include a course in basic and clinical oncology in every medical school curriculum, including laboratory sessions which utilize the skill station concept. Liaison between SSO and the American Assn. of Medical Colleges could seek to influence medical school curriculum with regard to inclusion of more cancer training (although some committee members felt this might not be very practical).

6. Summer scholarships for medical students at approved surgical training programs. Funds should be sought from SSO or the James Ewing Foundation. Medical students should be invited to SSO meetings.

7. Ask NCI to reestablish funds for residency and fellowship training in surgical oncology.

8. Define training or experience considered prerequisites for performance of cancer surgery.

9. Publish SSO articles in major surgical journals which are reviewed by general surgeons, not only "Cancer" (the journal of SSO). Present, in journals like "Ca" or "Your Patient and Cancer," a series of educational articles for the general surgeon and other physicians on special topics in surgical oncology (e.g. staging, surgical oncology techniques).

10. Continuation of the development and widespread adoption of the Cancer Management Course of ACOS, with particular emphasis on use of the skill stations.

11. Put together a SESAP self instructional package in the field of cancer, with emphasis on surgical oncology.

12. Develop a way of recognizing general surgeons for participation in continuing medical education concerning surgical oncology.

13. Provide education in multidisciplinary cancer care.

14. Training clinicians in the use of electronic data equipment and its importance for surgical oncology research, perhaps as a skill station in the Cancer Management Course.

The working group stressed the importance of exposing medical students to surgical oncology and to surgical oncology role models, as well as the role of SSO and other organizations in all aspects of surgical oncology education.

Participants felt that SSO should play a major role in bringing about the recommen-

dations made by this working group. "SSO can play a pivotal role by accepting recommendations of these working groups, and those who are representatives on larger committees and/or institutions (i.e. ACS, ACOS, AACE, AJCC, NCI, cancer centers) should urge them as well to accept these recommendations. ACS should be asked to support the cost of bringing surgical oncologists initially into medical school faculties and possibly to support summer fellowship programs for medical students. Other organizational support also should be solicited actively," the working group report concluded.

The working group on education was chaired by Harvey Baker. Other members were Douglas Holyoke, William Hutchinson, Edwin Mirand, Peter Mozden, John Raaf, Charles Sherman, and Kent Westbrook.

(Working group reports on training and manpower and on liaison activities will be presented in future issues of The Cancer Letter).

CORRECT PHONE NUMBER OF D.C. CIS

The phone number for the Washington D.C. metropolitan area Cancer Information Service listed in The Cancer Letter Nov. 11 issue was incorrect. The correct number is 202-636-5700. Washington is one of four areas which are not using the new national number, 1-800-4-CANCER.

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

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. 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.
Developmental Therapeutics Contract Review Committee—Dec. 1, NIH Bldg 31 Rm 2, open 9-9:30 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.
Scientific & Social Response from Exposure to Dioxin & Related Materials—Dec. 6-7, Key Bridge Marriott, Arlington, Va. Sponsored by the Society for Occupational & Environmental Health. Contact SOEH. 2021 K St. NW, Washington D.C. 20006, phone 202-737-5045.
National Cancer Advisory Board Committee on Environmental Carcinogenesis—Dec. 6, O'Hare Hilton, Chicago, 9 a.m.
Advances in Cancer Therapy—Dec. 8-10, Waldorf-Astoria Hotel, New York. Sponsored by The 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.
National Bladder Cancer Project—Jan. 4-7, Hyatt Hotel, Sarasota, Fla. 10th Investigators' Workshop.
Fourth Conference on Human Tumor Cloning—Jan. 8-10, Univ. of Arizona Cancer Center, Tucson. Contact Mary Humphrey, Conference Coordinator, UACC, Tucson 85724, phone 602-626-6044.
NCI Div. of Resources, Centers & Community Activities Board of Scientific Counselors—Jan. 12-13, NIH Bldg 31 Rm 10, 8:30 a.m.
Vail Midwinter Seminar—Jan. 18-20, Marriott/Mark Resort, Vail, Colo. American Cancer Society Colorado Div. Contact Chris Heminway, ACS, 2255 Oneida, Denver 80224.
Latin American Cancer Congress—Jan. 23-28, Panama City. Also, Latin American Cancer Nursing Seminar, Central American and Panamerican Cancer Congress, Latin American Meeting of Cancer Control Volunteers, and Latin American Cancer Chemotherapy Congress. For all of above, contact E. Aviles, Inst. Onc. Nacional, Apto. Postal 6-108, El Dorado, Panama, Rep. of Panama.
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.
National Surgical Adjuvant Breast & Bowel Project—Jan. 26-28, Hilton Riviera Hotel, Palm Springs, Calif. Contact Dr. Bernard Fisher, Dept. of Surgery, Univ. of Pittsburgh, 3550 Terrace St., Pittsburg 15261, phone 412-624-2671.
National Cancer Advisory Board—Jan. 30-Feb. 1, NIH Bldg 31 Rm 6, 8:30 a.m., closed Jan. 31.

FUTURE MEETINGS

Cancer in the 80s: Breakthroughs in Diagnosis & Treatment—Feb. 1, Biltmore Hotel, Los Angeles. (Previously announced as Feb. 8). Contact Dolores Gay, Hospital of the Good Samaritan, 616 S. Witmer St., Los Angeles 90017, phone 213-977-2352.
Vitamin A and Cancer Prevention—Feb. 28-29, NIH Bldg 31 Rm 10, 8:30 a.m. Epidemiologic studies and clinical trials. Contact Dorothy Benton, Nutrition Program, NIADDK, 3A Westwood Bldg, Bethesda, Md. 20205, phone 301-496-7823.
Gastrointestinal Oncology—March 1-2, Hoffmann Auditorium, Memorial Sloan-Kettering Cancer Center. Contact Charlene Landis, CME Conference Planner, MSKCC, 1275 York Ave., New York 10021, phone 212-794-6754.
Appraisal of Interstitial Brachytherapy—March 30,

Hoffmann Auditorium, MSKCC. Contact Charlene Landis, address and phone above.
Diagnosis & Treatment of Neoplastic Disorders: Medical, Surgical & Radiotherapeutic Aspects--April 5-6, Johns Hopkins Medical Institutions. 10th annual symposium. Contact Office of Continuing Education, JHU School of Medicine, Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-6046.
Ethics for a Categorical Institution--April 25-26, Shamrock Hilton, Houston. Sponsored by M.D. Anderson Hospital. Contact Office of Conference Services, Box 131, M.D.A., 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

RFA 84-CA-01

LETTER OF INTENT RECEIPT DATE: Jan. 1, 1984
APPLICATION RECEIPT DATE: Feb. 1, 1984

The Div. of Resources, Center & Community Activities and the Div. of Cancer Treatment, NCI, invite applications for cooperative agreements to support participation in a multi-institutional randomized clinical trial of a low fat diet aimed at reducing the incidence of beast cancer in women at increased risk for breast cancer. The investigators will identify, enroll and follow participants in this trial using a protocol developed jointly by the investigators and NCI staff.

Applications are solicited to fund participants in three categories: 1) clinical units, 2) nutritional coordinating unit(s), and 3) a statistical coordinating unit. Applicants may apply for more than one category (clinical, nutrition, statistical), but the applilcations should be cast as separate documents for review. Requirements for each of these units are outlined in the complete RFA.

The trial, a single protocol, will be initiated in three stages, The first stage will involve a meeting between the investigators and NCI staff for the purpose of writing the protocol for this study. The second stage will be a feasibility study, during which the protocol will be implemented at three institutions (selected on the basis of priority score and accrual potential) with particular emphasis on documenting protocol adherence in the study and control groups. In stage three the protocol will be implemented in all remaining clinical units.

Copies of the complete RFA and additional information may be obtained from Ritva Butrum, PhD, Diet & Cancer Branch, Blair Bldg. Rm. 619, NCI, Bethesda, Md. 20205, phone 301-427-8753.

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.

AMENDMENTS

Sources Sought RFP NCI-CP-FS-41011-77 entitled "Cancer following irradiation for peptic ulcer," (The Cancer Letter, Oct. 28):
The date of receipt of capabilities of statements has been extended to the close of business, 4 p.m. local time Dec. 15.

Sources Sought RFP NCI-CP-FS-41012-77 entitled "Late effects of therapeutic ionizing radiation for benign disorders," (The Cancer Letter, Nov. 18):
The date of receipt of capabilities statements has been extended to the close of business, 4 p.m. local time Jan. 6, 1984.

RFP NCI-CP-FS-41000-53

TITLE: Biomedical computing support services
DEADLINE: Feb. 3, 1984

NCI has a requirement for computer related research and services in support of the scientific activities of the Biostatistical Branch. The contractor will function in a supportive role carrying out specific tasks and will not engage in independent research.

The contractor will be responsible for developing technical approaches to problems proposed by the project officer and investigaators, and will independently design and develop software requested by NCI staff. This support will include the analysis of large data sets often involving complex statistical analysis, sophisticated data handling techniques and state of the art graphics production.

The contractor must have established, or be willing to establish at the time of award, offices within one hour's commuting distance of the Landow Building, 7910 Woodmont Ave., Bethesda, Md., to facilitate consultation with NCI staff. Frequent use of the Div. of Research and Computer Technology facility at NIH in Bethesda, Md., and frequent personal interaction with members of the NCI, require the close proximity of the contractor's facility.

In accordance with Section 15 of the Small Business Act, 100 percent of this procurement will be set aside for small businesses. In order to qualify as a small business for this procurement, a prospective contractor's annual receipts for its preceding three fiscal years must not exceed $4 million.

The RFP will be available on or about Dec. 19.

CONTRACT SPECIALIST: Eileen Webster
RCB, Blair Bldg. Rm 114
301-427-8888

The Cancer Letter _Editor Jerry D. Boyd
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