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DEVITA ASKS PANEL'S ASSISTANCE ON PERSONNEL CEILINGS, CONSTRUCTION, NEW NCAB APPOINTMENTS

National Cancer Institute Director Vincent DeVita last week asked the President's Cancer Panel to intercede with the White House and/or the Dept. of Health & Human Services to correct major problems confronting the Institute and

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In Brief

IT'S FINALLY OFFICIAL: DRCCA NAME CHANGED TO DCPC, OLD DCCP IS DIV. OF CANCER ETIOLOGY

IT'S OFFICIAL, finally, months after NCI had submitted requests to change the names of the Div. of Resources, Centers & Community Activities and the Div. of Cancer Cause & Prevention: The new name replacing DRCCA is the Div. of Cancer Prevention & Control; for DCCP, it is the Div. of Cancer Etiology. The programmatic organization of DCPC which the division has been using for more than a year was ratified by the department—Prevention Program, Cancer Control Science Program, and Centers & Community Oncology Program. The Field Studies & Statistics Program in DCE was changed to the Epidemiology & Biometry Program, reflecting the move of SEER from FSSP to DCPC. The Cancer Letter henceforth will refer to the divisions by their new names. . . . ROBERT GALLO, chief of NCI's Laboratory of Tumor Cell Biology which isolated the first human leukemia virus, will present the R.E. Dyer lecture Dec. 14 in the NIH Masur Auditorium, at 8:15 p.m. The title: "Human Tumor Viruses: The Search for Some is Over." Gallo and Lawrence Einhorn of Indiana Univ. School of Medicine last month received the American Cancer Society Medal of Honor. . . . 10TH ANNIVERSARY meeting of the Assn. of Community Cancer Centers will be held March 7-11 at the Hyatt Regency Capitol Hotel in Washington, with the theme, "A Decade of Progress, A Decade of Challenge." The meeting will focus on the topics of reimbursement, standards, and research. Speakers will include James Holland, Mt. Sinai School of Medicine; Michael Maher, Health Care Finance Administration; and Jeffrey Wasserman, of New Jersey Health Educational & Research Trust. . . . 14TH INTERNATIONAL Cancer Congress will be held Aug. 21-27, 1986, in Budapest. Correspondence should be directed to Congress Bureau, MOTESZ, Budapest, H-1361, P.O.B. 32, Hungary.

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NIH TIMID ON CONSTRUCTION SURVEY; HAMMER OFFERS TO PAY HALF OF COST

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the National Cancer Program. They are:

* The decision by the Office of Management & Budget to count the expert consultants NCI is permitted to hire outside of normal government personnel channels as part of NCI's personnel ceiling, in effect taking away the extremely valuable tool established in the National Cancer Act of 1971.

* The foot dragging and hostility at NIH headquarters, HHS, and OMB toward NCI's effort to obtain current information on cancer research facility needs, thus blocking development of an effort to increase the budget for construction and renovation grants.

* The imbalance on the National Cancer Advisory Board which would ensue if the vacancies which will occur next year are not filled for the most part with scientists.

DeVita told the Panel that NCI has always interpreted the authority in the National Cancer Act to hire expert consultants as meaning that they are not to be included in personnel ceilings imposed by OMB or HHS. The issue has come up in the past, and OMB has had to back down. "We have letters from (HHS) secretaries saying they will be exempt," DeVita said. "In spite of that, our experts now are included in the ceiling."

NCI's ceiling had been established at 2,134 full time equivalents, but NIH had to take a reduction of 250, and NCI's share of that was 49, making the current ceiling 2,085. With the expert consultants, NCI is over that ceiling by 151 positions.

"If at some point we have to absorb those positions, it will damage our fastest growing programs," DeVita said, mentioning chemoprevention and oncogene studies as two of them. "I do believe that the intent of Congress and expressions by the department have not resulted in a satisfactory resolution."

HHS has requested an easing of OMB's position for the Public Health Service, including NIH.

Another policy regarding the expert consultants invoked by HHS has severely restricted NCI's use of the authority to recruit highly qualified people. In the past, experts brought in for the one or two year appointments could be switched over to permanent appointments, provided they met the various personnel requirements. That enabled NCI to quickly fill vacancies with persons most likely to be qualified for those positions. In the event the appointment turned out not to be mutually satisfactory, it could be terminated before the permanent appointment was made, saving the government a considerable amount of money and giving NCI a lot of flexibility.

The department has not absolutely prohibted such conversions, but the rules now make it very difficult to carry them out. DeVita did not ask the Panel to take on that issue, but it could be on his list in the future.

DeVita more than a year ago brought to the Panel's attention the problem with OMB on construction funds. Although NCI requests at least $20 million every year, OMB has reduced that drastically, to $1.5 million last year and $1 million this year. Panel Chairman Armand Hammer said he would take the issue to OMB, and to the President if necessary, if he could have up to date information on cancer research facility needs.

NCI then asked HHS to support a survey with funds the department sets aside for such purposes. After a year of hemming and hawing, HHS managed to evade the issue by deferring to a government wide survey, to include NASA, the Dept. of Defense, the Dept. of Energy, and perhaps other agencies which support some kind of research.

NCI in the meantime had obtained concept approval from the Div. of Cancer Prevention & Control Board of Scientific Counselors to undertake the survey on its own, to be performed through a contract with an estimated cost of $150,000.

DeVita told the Panel that NIH now has turned down the project, refusing to allow NCI to proceed. (Whether NIH has the authority to block the project is something that could be challenged but probably will not. A negative position by NIH most likely would result in OMB's refusal to release funds for it.)

DeVita referred to a letter to Edward Sondik of DCPC from Helen Gee, chief of the NIH Program Evaluation Branch, presenting NIH's opinions.

Gee said she doubted that the survey could be completed in the time schedule outlined in the proposal and noted that "a minimum of three months has to be scheduled for OMB clearance." Besides, she said:

"NIH is collaborating with DoD, Dept. of Energy, and probably NASA in a science wide

investigation of facilities needs in the academic sector. It seems unlikely that OMB is going to clear two requests of this type, and if we attempt to just push through we (NIH) stand to invite pretty strong censure.

"If the central administrations of the institutions involved (how many of the 100 institutions are in universities and medical centers?) find that the cancer center directors have been given a 'head start' in expressing their needs, how do you suppose they are going to react to the rest of NIH being involved with all the rest of the agencies in a 'comprehensive' survey?

"The interagency group is trying hard to identify a means of getting the all science facilities study off to a quick start. As a first step we will probably ask all the principal research institutions to give us their five year building plans. This will be followed by a survey covering much the same ground you appear to be planning to cover.

"With all good will, Ed, I wish you would reconsider going it alone. We all stand a good chance of incurring OMB's wrath, but I'm even more concerned that we can create mischief with the research intensive institutions. At any rate, can't we get together to see if we can find an approach that will meet the needs of both NCI and the rest of NIH?"

DCPC had planned that the survey would be supervised by the Biometrics & Operations Research Branch, of which Sondik is chief.

The letter offended NCI executives on a number of counts. An issue that has the attention of the President's Cancer Panel, involving a project initiated by the Panel, should have merited a response from the NIH director rather than a branch chief. Gee obviously was not aware of the source. Her letter included the statement, "In telephone conversations, I've been told that the Cancer Board (or some such body) is demanding the information."

The prospect that following up on a request by Armand Hammer might incur OMB's wrath is not likely to cause DeVita or his staff to lose much sleep. Nor did it cause DeVita or Hammer to back off.

"I don't want to wait two more Panel meetings and find that nothing will be done," DeVita said. "With Defense, NASA, all the others involved in a big survey, I suspect that they might get a report by 1995."

The Cancer Program is supporting a scientific enterprise which has increased substantially during the last 12 years, and "they need places to work," DeVita said. "We are putting in less and less money, but they need NCI funds to draw in money from the private sector."

William Raub, NIH associate director for research and training who was present at the Panel meeting, said that NIH Director James Wyngaarden "feels as strongly as the Panel does about the need for research facilities improvement, and has said so at a number of forums and in discussions with the assistant secretary for health. . . . In reality, the Executive Branch is concerned, that the survey be as strong as it possibly can be."

In reality, as Raub must know, OMB does not want to know now and has not for at least the last 12 years any information which might support the case for federal support of health research construction. DeVita described OMB's "ideology, which I can say by heart, and that is if we build more buildings, we create more opportunities for scientists to work on more projects and more pressure on the budget to support them."

DeVita offered a suggestion on how to get around OMB's (and NIH's) lack of interest in supporting the NCI survey.

"I personally hoped we could get the study done, but it seems unlikely we can through the regular process. Perhaps some private organization, such as the American Cancer Society, could commission a study. It would take no more than one year, and cost no more than $150,000. I would suggest that the Panel approach ACS or some private foundation."

Hammer, who may be the largest individual contributor to cancer research of all time, did not hesitate. "I'll contribute one half of that," he said. "See if you can get the Cancer Society to contribute the other half. It's silly and absurd to quarrel over that amount. Let's go to work. Let's get this done. Then we can go to OMB and say, 'Here's what we want done about this problem."

DeVita said the Panel rather than NCI would have to approach ACS, and a letter was being drafted last week following the Panel meeting.

A spokesman for ACS this week told The Cancer Letter that the Society had not yet received a communication from the Panel. "I don't know what the reaction of our Board will be, but I know it will get every consideration. We have great respect for Dr. Hammer and his leadership." The request would require action by the ACS Board,

which next meets in February in New York.

Donald Fox, chief of the Research Facilities Branch in DCPC, presented a review of various national surveys of research facilities needs, going back to 1969. A survey that year by Westat under contract with NIH found that 41.5 million net square feet of health related research space was in use in 1968, and one fourth of it was in unsatisfactory condition, 6.5 million nsf needed remodeling, and 3.7 million nsf needed replacement. "In sum, more than 50 percent of all space was in poor condition," Fox said.

A survey of doctorate granting institutions in 1976 by the American Council on Education and funded by the National Science Foundation, Office of Education, and NIH found that 23 million nsf of space in 155 institutions was devoted to health research, of which 29 percent required renovation or replacement.

A 1977 survey sponsored by NSF reported that, although the federal government had become an important source of capital funds that built up the physical base for university research, that support peaked in 1965 when the government obligated more than $126 million for R&D plan in colleges and universities. By 1974, federal funds dropped to $29 million. In 1977, except for the NCI construction activity, there were practically no major federal R&D programs for construction at universities and colleges. Non federal sources of capital support also declined during that period.

Fox presented results of four other surveys documenting research facility needs, including the one by NCI staff in 1979 which found that cancer related needs would total $449 million from 1981 to 1985, of which $190 million would be sought from NCI. Those requests would, based on NCI's experience with construction grants, be trimmed to $149 million over the five year period. That led the National Cancer Advisory Board to recommend that $50 million be budgeted for construction in FY 1980, and $20 million a year for the following five years. NCI followed the NCAB's advice, but OMB did not.

DeVita told the Panel that he was "very concerned about the proper balance on the National Cancer Advisory Board" with six vacancies coming up next year. "Eight of the remaining members are practicing physicians one persuasion or another. I have nothing against physicians, or clinical research. I grew up in clinical research. But it seems to me that eight are enough to represent the various disciplines. We desperately need those vacancies filled by scientists. There's no reason to think that won't happen, but we are concerned that a balance won't be struck."

DeVita said NCI had prepared a list of candidates for the vacancies, as it always does, and submitted them to HHS. The department will develop its recommendations, to be sent to the White House. NCAB members are Presidential appointees.

NCAB member Rose Kushner, attending the Panel meeting, commented, "When I go through the pink sheets (grant review summaries, I cringe to think that Drs. Henderson, Rowley, and Boutwell won't be on the Board after the next meeting."

The terms of Maureen Henderson, Janet Rowley and Roswell Boutwell expire after the Board's February meeting. Boutwell was appointed earlier this year to fill out the unexpired term of Gerald Wogan, who had resigned. DeVita said he had recommended that Boutwell be reappointed to a full six year term.

The other members whose terms expire in 1984 are Irving Selikoff, Sheldon Samuels, and Morris Schrier. The latter two hold two of the six lay seats and, Kushner said, have been "very valuable members. I hope their replacements will be chosen from those with some interest or background in cancer."

"I criticize no one for wanting to be on the NCAB," DeVita said. "It is a very desirable thing to be a member of the Board. They are Presidential appointments. But I hope, Mr. Chairman, that we can count on you again to call the attention of the White House and the department to this problem."

The eight practicing physicians who will remain on the Board are Chairman Tim Lee Carter, Victor Braren, Ed Calhoon, Robert Hickey, Geza Jako, Gale Katterhagen, LaSalle Leffall, and William Powers. Although all but Carter and Calhoon have been or are engaged in science to one degree or another, none are researchers in basic science.

Other holdover members are Richard Bloch, Angel Bradley, Kushner, and Ann Landers, all lay members.

The Board's only statutory responsibility, other than advising the NCI director on the National Cancer Program, is to provide secondary review of grants. All grants over $35,000 in direct costs must be approved by the NCAB before they are funded (after

initial review of course by study sections). That's why Kushner cringes at the thought of not having any basic scientists around to help with the pink sheets.

DeVita presented the Panel with a revised draft of the proposed guidelines for the new Outstanding Investigator Grant. OIG is the brainchild of former Panel members Harold Amos and Bernard Fisher, and NCI has been struggling for nearly two years to write a set of guidelines acceptable to the Panel, the NCAB, NCI senior staff, NIH, and the scientific community. It has not been easy.

The current draft includes two options, the second of which is more detailed and, according to DeVita too restrictive. He prefers a more relaxed approach, but NIH, which he said is supportive of the concept, thinks otherwise.

Aims and objectives of OIG as described in the draft may be the only part of it that is not controversial. "This funding instrument is intended (1) to provide scientists with stable financial support and research flexibility over a relatively long but finite period of time, and (2) to encourage investigators to embark on long term projects of unusual potential in cancer research. This award recognizes an investigator because of his or her established and anticipated productivity. Emphasis will be placed on evidence of recent substantive contributions, i.e. seminal ideas and innovative approaches to resistant problems."

Under Eligibility, two options are offered for each of five major points:

A. Option 1—An investigator who has demonstrated outstanding research productivity over the preceding five year period is eligible to apply. Option 2--An investigator who has been awarded support through an appropriate competitive review process for a minimum of seven years of essentially consecutive (past plus committed) support immediately preceeding the grant application is eligible.

B. Option 1—There are no age restrictions on eligibility. Option 2—There are no age restrictions. Consideration will be given to eligible investigators who may not meet all of the eligibility criteria.

C. Option 1--Applications will be accepted only from U.S. institutions. Option 2--Applications will be considered only from domestic U.S. institutions.

D. Option 1--Letters of intent are suggested but optional. Option 2—Letters of intent are strongly recommended. They will allow the ad hoc NCI review committee to advise the potential applicant regarding eligibility and aid NCI in projecting review requirements. They should contain a CV including a complete bibliography and a listing of the applicant's major scientific contributions; a record of all federal and other competitively reviewed support for a current seven year period (past plus committed); and a brief statement of accomplishments in the preceding five years plus title and brief general statement of the projects expected to be undertaken with OIG support. This statement should not exceed three pages. Under Option 1, persons who wish to do so may directly submit an application for a PHS grant and follow the application procedure described in Form 398.

E. Option 1—If the applicant has chosen to submit a letter of intent it will be reviewed by an ad hoc committee convened by the director of the Div. of Extramural Activities. An applicant considered ineligible based on the stated criteria and the letter of intent will be so informed. A prospective applicant considered eligible will be so advised and invited to submit an application. Option 2—No difference other than being couched in language indicating that the letter of intent is expected, not optional.

Under Application Procedure:

Option 1—A letter indicating clear and continuing institutional commitment to the applicant must be submitted. This commitment should include salary support at least to the current level, but may not be less than 25 percent. This minimum salary requirement may be waived under exceptional circumstances such as evidence of institutional provision of unusual levels of support of other types. Adequate physical facilities, staff and administrative resources appropriate to the role of the OIG awardee must be provided. Option 2—A letter indicating clear and continuing institutional commitment to the applicant must be submitted. This commitment should include salary support at least to the current level, but may not be less than 25 percent. Adequate physical facilities, staff and administrative resources appropriate to the role of the OIG awardee must be provided.

One option under review would require that the application be sent to 200 senior cancer investigators for review by mail. The reports and scores would be consolidated by NCI staff and submitted to the NCAB for approval. Under the other option, review would be by an unspecified initial review group, with

subsequent review by the NCAB.

Award size and conditions. Grants will be awarded for seven years, renewable, but not lifetime awards. Competitive renewal should be submitted at the end of the fifth year. Option 1--The actual dollar award will reflect specifically the investigator's current and projected research needs evaluated by the initial reviewers and reviewed by the NCI Executive Committee. Option 2--The same, plus, individual grants will not exceed $250,000 in direct costs per year in the first year. Normally OIG support will not be in excess of the investigator's current total grant support.

Option 1--The grant normally will provide that fraction of the investigator's salary that approximates the total proportion of salary awarded through current grants, but not to exceed 75 percent. This limit may be waived under exceptional conditions such as greater institutional support. Option 2--The same without the waiver.

Salary support will be included for technical staff, research staff and graduate students, but not for other academic faculty or institute equivalents. Salaries of other principal investigators may not be included.

Option 1--Other expenses, as would be included in RO1 grants, are legitimate costs. Option 2--The same, except that capital equipment costs are not included in the $250,000 ceiling.

Other noncontroversial provisions are in the draft, including review criteria and obligations of awardees.

DeVita objected to the requirement for seven years of prior support ("That would make most applicants at least 37. I've run through my mind all the outstanding 35 year old investigators who wouldn't be eligible"). He also did not like the prospect of rejections based on letters of intent.

"The real problem is in the review," DeVita said. "I know it's a problem because no one wants to approach it, other than to suggest the traditional NIH processes. This needs more debate among the Executive Committee, the NCAB, and I wouldn't be surprised to see the Panel go on the road again (to hear from the scientific community). DeVita objected to a cap on the award as being too artificial, and said another controversial point is that OIG awardees would not be eligible for other NCI grants. "I feel adamant this won't require more money. Investigators good enough to get this grant will be good enough to get others, and would be funded anyway. So I can't understand why we need a limit on the number of awards, but NIH feels differently. Our baby, born at the Panel, remains controversial."

SSO WORKSHOP URGES CERTIFICATION PROGRAM FOR SURGICAL ONCOLOGISTS

The Society of Surgical Oncology workshop on progress and plans in surgical oncology developed a wide range of far reaching recommendations addressing the problem of bringing the discipline into full partnership in multidisciplinary basic and clinical oncology efforts. Because those recommendations were directed to a wide variety of institutions and organizations, and because the problem has been generally recognized by oncologists of all disciplines as a serious deficit in the National Cancer Program, The Cancer Letter has reported summaries of each of the workshop's working group sessions. The final report, of the working group on liaison activities, follows:

The working group developed these recommendations directed to:

1. The Joint Committee on Accreditation of Hospitals—That all hospitals with 100 plus beds approved by JCAH have an active cancer committee including at least one surgical oncologist.

2. To all medical schools and comprehensive cancer centers—That medical students receive an expanded cancer core curriculum; that more careers in surgical oncology be stimulated; that all general and specialty surgery training programs provide a core curriculum in oncology; that more post graduate fellowships and other funded positions in surgical oncology be established; and that all medical schools establish a division or department of surgical oncology.

3. To all approved hospital cancer programs—That more active general surgical and oncologic surgical participation be encouraged in all cancer program activities.

4. To the Society for Surgical Oncology, and "probably the most important recommendation"—That a certificate in surgical oncology, after a qualifying written examination, be issued to successful applicants with recertification every five years; and that a grant application advisory committee be established.

5. To the American Cancer Society—That start up support be provided to encourage medical and dental student cancer clerkships and to assist cancer centers and

medical schools in establishing 10 approved training programs in surgical oncology.

6. To the National Cancer Institute—That renewed efforts be made to expand surgical research, training and educational activities and to involve more surgeons in cooperative multidisciplinary site oriented studies; that patterns of care of the patient receiving surgical care for cancer be established (SSO will submit a proposal in 1983-84); that it give support to core cancer studies in medical schools, to use of the PDQ program and determination of its effectiveness, and to research funding from other institutes of NIH.

7. To the American College of Surgeons—that it continue the commitments to cancer core curriculum, patterns of care studies, and to the Commission on Cancer's involvement of surgeons in cancer treatment in hospitals across the country.

8. To use all existing oncologic data bases in order to study a large population which can identify any deficiencies in surgical care.

The working group listed four unresolved topics:

1. How to meet the needs of surgical oncologists in the community.

2. Definition of the role of the surgical oncologist in multidisciplinary cancer care.

3. Need for liaison of SSO with many organizations such as JCAH, AMA, AAME, surgical specialty boards, gynecologic oncology, nursing oncology, etc.

4. How to involve osteopathic surgeons in this group.

In what working group members felt might be the most important issue, they overwhelmingly supported the conclusion that certification or its equivalent is essential. "Due to the problems associated with applying for certification through other channels, the best sponsoring body might be the Society of Surgical Oncology," the group's report said.

"Surgery is a keystone in the diagnosis and management of neoplasia," the report continued. "Formal recognition could complete the process of identifying surgeons who devote special efforts to education and to achieving special skills over and above basic surgical residency training. Certification could convey to the medical profession the extra qualifications acquired by surgical oncologists.

"Special qualifications include, but are not limited to, concepts in tumor biology, pathology, and histology; experience with the latest developments in radiation therapy, chemotherapy, and immunotherapy; skill in organizing multidisciplinary teams of consultants; and basic knowledge and experien in advanced oncologic surgical techniques. Potential surgical oncologists could receive added impetus, via special certification, toward selecting surgical oncology for their specialty.

"SSO is considered an appropriate conferring organization due to the fact that surgical oncology involves so many diverse disciplines and specialties that no other organization or group of organizations could accomplish expeditiously this objective. It also was noted that at the present time the climate may not be conducive for the creation of a new certifying board.

"The working group discussed in some detail criteria for potential eligibility and the contents of the examination. Suggested qualifications could be membership in SSO; special post residency training, including but not limited to SSO approved training programs; successful completion of residency training programs in one of the following: surgery, otolaryngology, plastic surgery, orthopedics, neurosurgery, thoracic surgery, colorectal surgery, pediatric surgery, gynecological oncologic surgery, or urologic surgery; and letters of sponsorship from two SSO members.

"While no written examination could be tailored readily to meet the needs of each distinct surgical specialty, the working group agreed that certification or its equivalent could be designed to establish the applicant's fundamental knowledge of the neoplastic process at a higher level than that achieved in basic residency programs. Technical knowledge could be included only to the extent of broad principles of cell biology, immunology, pharmacokinetics, radiation therapy, and the diagnosis and treatment of cancer by the several major modalities which are used in all specialties."

Members of the working group were Chairman Robert McKenna, Harold Douglass, John Lore, Condict Moore, Gerald Murphy, William Shingleton, and Charles Smart.

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 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-41009-76

TITLE: Preparation of monoclonal/monospecific antibodies to oncogene products of avian and mammalian retroviruses
DEADLINE: Approximately March 6, 1984

NCI has a requirement for a contractor or contractors to prepare hybridomas producing monoclonal/monospecific antibodies against the well defined domains of the gene products of the following oncogenes:

Task A--src, myb, erb B, erb A, fps, yes, ros, myc, rel

Task B--sis, mos, rash, rask, abl, fes, fos

The contractor shall produce a minimum of three monoclonal antibodies and one monospecific antibody per gene. The contractor shall annually produce a minimum of 300 ml of each antibody, as well as 25 frozen viable cell cultures of each hybridoma producing a monoclonal antibody. All materials shall be shipped to a government repository and shall be accompanied by characterization information.

Contractors may propose on tasks A and B, task A only, or task B only.

Estimated date of issuance of RFP is Jan. 6.

CONTRACT SPECIALIST: Steve Metcalf
RCB, Blair Bldg Rm 114
301-427-8888

SOLICITATION 222-84-2002(P)

TITLE: Acute and chronic carcinogenesis, mutagenesis, teratogenesis, and general toxicological research
DEADLINE: See below

Thousands of laboratory animals, primarily rodents, are bred/purchased, maintained on experiment, fed chemically dosed or undosed feed or drinking water, and subsequently removed for pathological evaluation. Two extremely critical activities, animal care services and diet preparation operations, are necessary to maintain experimental animal colonies. A sizable staff is required to provide services necessary for operations of this magnitude.

Monthly animal care operations typically involved activities associated with animal populations of 20,000 mice; 12,000 rats; 100 rabbits; 65 nonhuman primates; 10 dogs; and occasional numbers of guinea pigs and goats. Experimental chemicals are administered directly to the animals by biologic techniques such as gavaging. Concentrations, the number of dose groups, volumes and methods of administration are dictated by experimental protocol and design.

The above services are required on-site at the National Center for Toxicological Research (NCTR), Jefferson, Ark. All equipment and supplies will be provided by the government. Both services will involve some facets of work activity and products maintained under specific pathogen free barrier conditions. In order to ensure this microbiological control, restrictive standard operating procedures have been developed and must be rigidly enforced. Furthermore, many of the experimental chemicals employed are known or suspected to be toxic to man; therefore, chemical containment and surveillance regimens are employed as measures of occupational safety.

Animal Husbandry Services for approximately 90,000 square feet of aniimal room space and support area:

Services include delivery to and pickup from animal rooms all cages, feed, racks, etc. Provide ancillary services including operation of washers and sterilizers; maintenance of corridors, storerooms, etc.; delivery of animals and equipment; operation of vehicles; and biological support activities such as collection of biological samples, and animal restraints. On site diet prepartion services. Clean room facility operation; dosed feed and water operations; and ancillary duties related to the primary task of preparing, mixing, and delivering test diets.

Evaluation of qualification data: Data submitted by small businesses will be evaluated on the following factors in descending order of importance:

Personnel available who are experienced in animal husbandry and diet preparation services; corporate experience in this or similar work; and familiarity with AALAS and good laboratory practices as it relates to these services.

In the event no Small Business Set Aside is made, large business concerns should request the solicitation based on this notice, since this may be the only official notice of this solicitation. Large businesses need not submit qualifying data.

Small business concerns having the capability to furnish the services described below are requested to submit qualification data to the address below by Dec. 30. Such data should include experience and qualifications in areas of toxicology, diet preparation, laboratory animal sciences (animal husbandry), or related disciplines. Specify extent of involvement in AALAS. Include summaries of similar or related services performed, with references and telephone numbers. For key on-site personnel, include resumes of experience. The solicitation will be available approximately Jan. 25.

FOOD & DRUG ADMINISTRATION
National Center for Toxicological Research
Contracts & Procurement, Attn. Willard Hill
Jefferson, Ark. 72079
Telephone 501-541-4483

RFP CANCELLATION

RFP NCI-CM-47629-26, "Development and marketing of SR-2508 as a radiosensitizer" has been cancelled. Reissuance of the subject RFP is not anticipated.

The Cancer Letter _Editor Jerry D. Boyd

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