1-17-84

THE CANCER LETTER

Vol. 10 No. 2
Jan. 13, 1984

Subscription $150 year North America
$175 year elsewhere

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

HCFA DISREGARDS PLEAS FROM CENTERS, ACCC, SEN. DOLE, NCAB, AACI; FINAL DRG REGULATIONS MADE EVEN TOUGHER

The Health Care Finance Administration completely disregarded the concerns of cancer center executives and hundreds of clinical investigators who asked that the final regulations on prospective payment be broadened to permit waivers for institutions engaged in clinical cancer research. The final regulations published Jan. 3 actually

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In Brief

ACOS MOVES UP SCHEDULE FOR TNM STAGING SYSTEM FROM 1986 TO "AS EXPEDITIOUSLY AS POSSIBLE"

AMERICAN COLLEGE of Surgeons Commission on Cancer has abandoned its schedule for implementing the TNM staging system developed by the American Joint Committee on Cancer which called for the system to be in use for all malignancies by 1986. Instead, the commission is requiring all hospitals involved in its Hospital Cancer Program to institute the AJCC staging system for all appropriate cancer sites "as expeditiously as possible." The commission had originally planned to implement the system in a stepwise fashion over four years beginning with all cases of breast cancer diagnosed after Jan. 1, 1982. "It was anticipated that the system would be implemented for gynecologic malignancies and lymphomas in 1983-84, with other sites added in 1985 and 1986," John Snyder, director of the ACOS Cancer Dept., said in a recent memo. "Discussion and design of the procedures to implement each of the various sites have gone slowly. Meanwhile, many hospitals have already established use of the AJCC system for all or most of the applicable sites." No reason, therefore, to stay with the four year schedule. . . . VINCENT DEVITA said he was "overwhelmed" by the response of cancer center directors to NCI's request that they review the PDQ state of the art statements which will provide treatment information on each cancer site to physicians. DeVita said the center directors "went over them with a fine toothed comb, and assigned individuals with appropriate expertise to help. They sent in many very constructive suggestions". . . ONCOLOGY NURSING Society has received a grant from NCI's Div. of Cancer Prevention & Control to sponsor a one day nursing student research course, scheduled for May 2 preceding the ONS annual congress in Toronto. Purpose of the course is to stimulate interest in cancer nursing research.

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ACCC TO PUSH FOR NEW BILL CREATING "DRG 471" FOR CLINICAL TRIALS WAIVER

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tightened waiver requirements and were more explicit in excluding community hospitals from any relaxation in diagnosis related group fee schedules than were the proposed guidelines published in September.

The final regulations did reduce the waiver requirement that 80 percent of a hospital's discharges must include cancer as the principal diagnosis. That was trimmed to 50 percent, reportedly to assure that M.D. Anderson Hospital would qualify. Anderson executives had been concerned that they would be hard pressed to meet 80 percent, since many patients admitted with cancer as the suspected problem are discharged with other ailments as the principal diagnosis.

HCFA appears to have listened only to Congressman J.J. Pickle (D.-Tex.) in drawing up its regulations. Pickle's amendment to the authorizing legislation provided for waivers for institutions engaged in treating cancer patients and in clinical cancer research. Pickle later said he intended that to apply only to the comprehensive cancer centers, which of course would include M.D. Anderson, Pickle's primary concern.

The waiver regulation also includes City of Hope Medical Center in California, and Fox Chase Cancer Center in Philadelphia. It also would include Roswell Park Memorial Institute and Memorial Sloan-Kettering Cancer Center in New York, except that that state is exempt for the present from the federal DRG regulations since a similar state system is in operation. Those institutions, including Fox Chase and City of Hope, would have qualified under the 80 percent requirement. Whether any others around the country will now come in under the 50 percent rule remains to be seen.

HCFA's final regulations were further tightened to the extent that other centers and university affiliated cancer hospitals may be excluded from the waiver possibility despite the reduction in principal diagnosis percentage. The final rule states that the institution cannot be a subunit of an acute general hospital or a university based medical center to be eligible for a waiver.

The final regulation still requires that, to qualify for a waiver, an institution must be recognized by NCI as a comprehensive cancer center or have a clinical cancer center grant (as either a center core grant or clinical program project grant).

In a seemingly incredible statement which some observers found hard to believe HCFA actually meant, the agency said its final rules on the cancer waiver were based on the assumption that Congress "was concerned about reducing the number of current programs in cancer treatment and research."

In fact, every expression that has come out of Congress in recent years dealing with cancer treatment and research is that clinical research programs should be more widely distributed around the country, permitting more patients to have access to them.

HCFA in the final regulations totally ignored:

* Sen. Robert Dole (R.-Kan.), chairman of the Finance Committee which, with the House Ways & Means Committee, is responsible for legislation dealing with Medicare and wrote the DRG authorizing bills. Dole wrote HHS Secretary Margaret Heckler, before the proposed DRG rules were published, stating that congressional intent clearly meant to include community hospitals in the cancer waiver.

A spokesman for Dole told The Cancer letter this week that he still is "very much interested in pursuing the issue and certainly will consider corrective legislation if that is the only option." Congress is still in recess and will reconvene Jan. 23.

* The National Cancer Advisory Board, which asked HCFA for a waiver rule which would apply to comprehensive or clinical cancer centers and community hospitals which place 25 or more patients a year on NCI approved protocols. HCFA's response: "We do not believe Congress intended that an exception or adjustment be granted to hospitals merely because they belong to a particular organization, because they participate in organized cancer treatment and research, or because they admit at least 25 patients annually under approved clinical protocols."

* The Assn. of Community Cancer Centers, Assn. of American Cancer Institutes, American Society of Clinical Oncology, and hundreds of physicians and others who sent comments to HCFA on the proposed rules.

ACCC members have been determined all along that they would seek new legislation if HCFA persisted in excluding community hospitals from the cancer waiver. Last week, the ACCC Board of Directors agreed that its annual "Congressional Day" (when members blitz Capitol Hill preceding the March meeting of

the association in Washington D.C.) would be devoted to pushing for a new bill creating "DRG 471". There are now 470 DRG categories, and No. 471 would be a new category for clinical trials. It would not attempt to average costs, as is done with the present DRGs, but would permit recovery of the extra costs involved with clinical research.

The ACCC Board also approved an ambitious three year "DRG Cancer Research Program" which would study a variety of problems associated with the new reimbursement system. The program will be financed by contributions from members and, the Board hopes, from private foundations.

The program will utilize Elm Services Inc.'s proprietary CHOP Data System, which is building a data base of clinical, survival, and financial information collected from 200 participating hospitals. CHOP DS was developed by Lee Mortenson, ACCC executive director and president of Elm.

The program will look at such issues as whether DRGs impact the quality of care, clinical trials, whether there are significant differences in costs for patients on clinical trials vs. average costs, whether the more costly procedures are used under DRG, whether DRGs affect mortality and morbidity, whether there is a significant difference in costs for hospitals which see more late stage patients.

Meanwhile, NCI is in the process of putting together some questions on the impact of DRGs on clinical research which it will submit to the National Center for Health Services Research, another HHS agency. NCI hopes that agency will work with NCI staff and with HCFA in an effort to develop approaches to the problem.

It does not seem likely that anyone in HHS will make much progress in that direction, because (1) HCFA does not even admit there is a problem and (2) everyone else in the department is reluctant to go up against HCFA as long as Heckler is staying on the sidelines. The secretary so far has not indicated that she has any appreciation of the issues. In all probability, the White House has put out the word that HCFA's regulations should not be challenged at this time.

Hospitals involved in clinical cancer research are finding out on their own how the new reimbursement system will impact their recovery of costs. At Presbyterian Hospital in Oklahoma City, Nehemiah Cherng, oncology epidemiologist; Robert Jaime, director of business offices; and Danny Vaughan, director of medical records, conducted a study of protocol cancer treatment costs. In a memo to William Hughes, director of oncology, and Dennis Millirons, hospital vice president, they wrote:

"We have conducted a survey to ascertain the difference in medical costs between the cancer patient on protocol treatment and those who receive conventional or standard treatment.

"Since a high proportion of lymphoma patients were treated by protocol, 26 lymphoma cases were sampled for this study. In order to avoid the confounding factors, each protocol treated patient was matched with a lymphoma case treated conventionally and not on protocol. The following variables were set for the matching criteria: the same attending physician, sex, race, age (plus or minus five years), and diagnosis. The study period for all protocol and conventionally treated patients was Jan. 1, 1982, through Sept., 1983. Because of the variance in admission frequency and its potential impact upon charges generated, we went one step further and matched total admission frequency between the two groups to reduce any potential bias.

"The total charges for the protocol and non-protocol groups, respectively, were $428,527.40 and $327,587.80. The average charge per case for the protocol group was $16,481.82, while the average charge for each non protocol patient was $12,599.53. Thus, charges generated for patients on cancer treatment protocol was 31 percent higher than the non-protocol group. It is interesting to note that the total admissions for the two groups are very close; protocol group, 101, and non protocol group, 96. After classifying these patients by admission type, it was found that only 11 percent of the total admissions for the protocol group received outpatient chemotherapy. In contrast, 42 percent of the non protocol group was treated in the outpatient department. Therefore, the higher proportion of inpatient admissions among protocol treated patients is probably one of the reasons for a higher medical cost.

"The conclusion of this study is that the cost of cancer patients registered into protocols for treatment is apparently higher than those who received the conventional therapy."

An incident reported recently by Rodger

Winn, principal investigator for the Essex County (N.J.) Cancer Consortium Community Clinical Oncology Program, a limit imposed by the DRG schedule resulted in canceling a study.

It was a randomized study using infusion pumps which Winn's CCOP had planned in conjunction with its research base, Memorial Sloan-Kettering. But when the administrator at St. Barnabas Medical Center, one of the consortium members, saw that the infusion pumps would cost $30,000 and that this would not be covered by the DRG, he pulled the hospital out of the study.

New Jersey is another state with its own DRG system in operation and is not affected yet by the federal program, but the results are the same.

Cooperative group chairmen at their recent meeting agreed to join in the search for data on the impact of DRGs. Paul Carbone, chairman of the Eastern Cooperative Oncology Group and director of the Univ. of Wisconsin Clinical Cancer Center, was named to head a survey of all cooperative group members, affiliated hospitals and CCOP affiliates on costs of standard treatment, protocol treatment, comparison of reimbursement for each DRG category with actual costs, and other related information.

"The winds from the New Jersey experiment (with its DRG system) raise serious questions," Charles Coltman, chairman of the Southwest Oncology Group and head of the Group Chairmen's Committee, said. "We are also concerned when we hear from Dr. (Vincent) DeVita that NCI provides the funds for clinical research not covered by DRGs. We know that's not the case. We need to address this problem as cooperative group chairmen. It pits the clinical investigator against the hospital administrator in a very negative way."

Carbone reviewed data collected from his center, in which he found that there was very little difference between the DRG schedules and actual costs, over all, although there were differences for specific DRGs. But he admitted that the data were not conclusive and would not necessarily apply to other institutions.

"We need to know what the costs are," Carbone said. "Most hospitals are sophisticated enough to provide exact costs on specific DRGs. . . We need to get this information before we can argue about what should be done. The groups can do it, quickly, with a survey of our members."

"The real issue is that this (DRG reimbursement) won't be limited to Medicare," Coltman said. "It will soon go to all third party payers. . . One of my concerns is that we systematically address the impact up front. We don't want to take a wait and see attitude."

"The potential impact on NCI is enormous," Emil Frei, chairman of Cancer & Leukemia Group B, said. "Our ability to ask good questions in phase 3 studies depends on how well we do in phase 1 and 2 studies. Where DRGs will hit us is right on the front end, where we need originality. The best patient care often is research. DRGs will change that. We will have to treat patients with AML, which we can probably cure with research treatment, on the basis of the cost of standard treatment."

George Lewis, chairman of the Gynecologic Oncology Group, asked what would be done with the information Carbone's committee will collect. "Will it just pile up?"

"We have to start somewhere," Coltman said. "In political clout, we represent the largest collection of clinical investigators in the world."

Robert Wittes, director of NCI's Cancer Therapy Evaluation Program, said that in his contacts with Assistant Secretary for Health Brandt's office, "they are concerned. The data will be used."

CHAIRMEN COOL TO "DIRECTIVE" WORDS IN INTERGROUP STUDY GUIDELINES

NCI presented cooperative group chairmen with a new draft of "Guidelines for the Conduct of Intergroup Studies" at their recent meeting. Despite the fact that this draft was prepared by data coordinators from the groups, the chairmen were not enthusiastic about it.

"These should be guidelines, suggestions to help us organize intergroup studies," said Teresa Vietti, chairman of the Pediatric Oncology Group. "They should not be rules."

"They are intended as guidelines," Charles Coltman, chairman of the Chairmen's Committee, said. "If we don't encourage intergroup studies, we'll end up with a proliferation of disease specific groups and even protocol specific groups."

But Coltman, after more discussion, said, "I sense the need to couch this in more permissive rather than directive language. We can agree that one is not going to be drawn

and quartered for not adhering rigidly to these guidelines."

"I agree entirely with avoidance of rigidity," Edwin Jacobs, deputy chief of NCI's Clinical Investigations Branch, said. "We need to identify those things that are prerequisites to doing intergroup studies, so things will not fall through the cracks. Critical elements need to be identified."

The guidelines deal primarily with use of standardized procedures and forms and the identification of one individual and one group as the lead person and group for the study.

The draft opens with this preamble:

"These guidelines are presented to simplify the conduct of clinical trials involving one or more cooperative group. They have been developed on the basis of experience with current intergroup studies and the problems which they have presented to the participants. It is felt that by introducing standard procedures for the conduct of these trials, administration will be simplified."

The forceful language which turned off the group chairmen was primarily the frequency of "there will be" directives, not necessarily the substance of the directive. For instance:

"For each intergroup study there will be one primary intergroup study chairman, agreed on by all participants prior to study activation. The group with which the intergroup chairman is affiliated will be the group responsible for randomization, data management and analysis. If an intergroup chairman has affiliation with multiple groups, one of the groups must be clearly identified as the coordinating group. In addition each participating group will designate a study chairman to be the scientific representative for the study."

On protocol review:

"The coordinating group will be the group responsible for distributing protocol drafts to all groups. One contact person should be designated in each group to receive each draft and distribute it to appropriate group members. The contact person for each group will collect comments from appropriate group members at each stage of review and forward comments to that group's study chairman. The study chairmen from all participating groups will then produce a revised draft. The draft, along with a summary of protocol changes, will be typed and circulated only by the central coordinating office. Until the protocol is ready for submission to NCI, it is recommended that the groups do not prepare individual copies of the protocol in their own format."

A section on forms development demands that all groups use the same forms. A section on randomization spells out:

"There should be one central randomization desk for each intergroup study. The instructions for randomization/registration should be clearly defined in the protocol document. Upon completion of randomization, a copy of the registration form will be sent to the randomizing institution and to the central data collection office for the appropriate participating group. A copy will also be sent to any appropriate modality offices. If necessary, a telephone call can also be made to modality offices if turn around time is critical, but this call would be followed up by a copy of the registration form. Any special requirements like a telephone call should be defined prior to study activation."

On data management:

"Data management will be done according to the policies and procedures of the coordinating group. Evaluation of each case from all groups by the intergroup chairman will be according to the procedures of the coordinating group."

On data requests and queries:

"All data requests and queries should be sent directly from the data management coordinating office to a designee for the participating hospital. In addition, a copy of all requests will be sent to the appropriate group data collection office. It is recommended that there be only one identifiable contact for requests and queries for each main institution and its affiliates and that this person be the principal investigator for the main institution. The principal investigator will then be responsible for the distribution of the materials received. The PI will also be contacted if the required data is not submitted. He will be responsible for the performance of his affiliates. The coordinating center should not be required to contact individual affiliated hospitals.

"Requests for data must be distributed by the coordinating data management office. Study chairmen must route any requests through that office and not deal with the institutions directly. Telephone requests are strongly discouraged. If a telephone call is absolutely necessary because of time critical reasons, it must be followed by a written

request, from the coordinating data management center. The institution must confirm the reply in writing or by submitting the requested materials (e.g. films, slides).

"In cases of persistent delinquency and lack of response to queries and requests, the coordinating group should notify the appropriate designated individual for that institution's cooperative group. The individual should be someone who has the authority to take appropriate action and will be identified to the coordinating group prior to the activation of the study."

On authorship:

"Authorship of the primary manuscript should generally be decided prior to activation of the study. It is recommended that the cooperative group chairmen prepare 'Guidelines for Authorship on Intergroup Studies.'"

There are other sections on statistical analyses, performance review, toxicity reporting, modality material collection and review, and treatment evaluation criteria.

Coltman asked that the draft be circulated and further comments submitted.

THIRD REPORT ON CARCINOGENS ADDS 29 SUBSTANCES TO 88 IN PREVIOUSLY

The "Third Annual Report on Carcinogens" prepared by the National Toxicology Program and dated December, 1982, is now available. This is the report which lists "known carcinogens" or those substances "which may be reasonably anticipated to be carcinogens" which Congress directed NCI to publish in legislation enacted in 1978.

NTP assumed that role when it was created out of NCI's Carcinogenesis Testing Program and elements of other HHS agencies.

The 1982 report (the 1983 report is now in draft form) adds 29 substances to the 88 listed in the previous report, and it updates material on 39 previously listed substances or processes.

The full report is available from the National Technical Information Service, 5285 Port Royal Rd., Springfield, Va. 22161, phone 703-487-4630. Refer to PB 83-135855. It costs $32.50.

A 230 page summary of the report is available free from Steve D'Arazien, NTP public affairs officer, Mail Drop B 204, NTP, Box 12233, Research Triangle Park, N.C. 27709. The summary includes everything in the full report except the appendices and some tables.

Of the 117 entries in the report, 19 substances or groups of substances and three technological processes are listed as known carcinogens. Ninety five substances or groups of substances are included because they "may reasonably be anticipated to be carcinogens." Nickel appears in both lists because occupational exposure associated with nickel refining is known to be carcinogenic although specific substances which may be responsible for the carcinogenesis in humans have not yet been identified; and elemental nickel and certain nickel compounds may reasonably be anticipated to be carcinogens.

For each substance or technological process, there is a summary description including a synoposis of the evidence that explains inclusion in this report. This is followed by a collation of regulatory information received from the participating agencies.

Among the 117 entries, two are natural substances which are not used or produced commercially: alfatoxins and cycasin. Two are food or cosmetic additives: saccharin and safrole. Safrole has been banned for most uses. The use of saccharin has been continued by Congressional mandate.

Twelve pesticides are listed, and there are 15 therapeutic substances, six of them used in treatment of cancer. The six are chlorambucil, cyclophosphamide, diethylstilbestrol, melphalan, procarbazine, and tris (1-aziridinyl) phosphine sulfide.

The remaining 83 substances may be classified as various industrial chemicals and byproducts.

The three occupational exposures known to be carcinogenic are those associated with the manufacture of auramine, the underground mining of hematite, and the manufacture of isopropyl alcohol by the strong acid process.

NCI CONTRACT AWARDS

TITLE: Transplacental carcinogenesis and tumor promotion in the Patas monkey
CONTRACTOR: Meloy Laboratories, $869,161.

TITLE: Laboratory rodent and rabbit facility, two contracts
CONTRACTOR: Microbiological Associates, $968,278 and $1,040,199.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who

will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-EBP-41018-67
Title: Followup study of patients treated for hyperthyroidism
Deadline: March 6
I. Introduction

In 1961, the National Center for Devices & Radiological Health, Food & Drug Administration, initiated the National Cooperative Thyrotoxicosis Therapy Followup Study to evaluate the risk of cancer following 131-I therapy for hyperthyroidism.

The study to be supported by this contract is a second followup of patients identified in the original TT study and who were alive at the end of the first followup. Location information will be abstracted from hospital charts or special logs created in the initial followup. Death certificates will be collected for all deceased patients and questionnaires will be sent to those patients still alive. Other necessary data (e.g., pathology reports, private physician reports) may be obtained from clinics, federal, state local institutions as well as other individuals.

The Radiation Studies Section of the Environmental Epidemiology Branch, Epidemiology & Biostatistics Program, Div. of Cancer Etiology, NCI, plans and conducts epidemiologic studies which examine the risk of cancer in populations exposed to ionizing 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 project will involve the contractor in both research and support activities with no independent research by the contractor although publications resulting from this study may recognize the contributions of key personnel of the contractor.

The RFP covers all phases of epidemiologic followup studies including assisting in the (1) implementation of the study of late effects in patients treated for hyperthyroidism; (2) preparation of study materials; (3) data collection; (4) data analysis; and (5) documentation of all individual steps.
II. Type of contractor(s) sought

NCI wishes to contract with an organization(s) highly experienced in designing, conducting and managing all phases of epidemiologic followup studies. This includes: (1) obtaining hospital clearances, state vital records departments, and other necessary sources; (2) preparing data collection forms; (3) preparing manuals for abstracting, coding, tracing and interviewing; (4) tracing individuals to determine their vital status; (5) locating living individuals and a current address for these patients; (6) interviewing persons or sending mail questionnaires; (7) abstracting, keying, editing, updating, and coding of data; (8) obtaining death certificates for those who died; (9) validating various medicl information; (10) abstracting radiation exposure information; (11) creating, editing, and updating data files; (12) analyzing study data; and (13) collaborating in preparation of study reports and publications. Most of the tracing activities to determine vital status and to locate a current address for living subjects wil be performed by other NCI contractors. Multiple awards will be considered for this study.
III. Time period of study

Each contract is to be awarded for three years. It is estimated that each contract will begin approximately Sept. 1, 1984, but the initiation date will depend upon the progress of the competitive procedure. Each year will be funded separately, but funds for succeeding years can be anticipated, unless affected by budgetary restrictions.
IV. Personnel

Personnel needed include one project director; one fulltime field supervisor; one programmer analyst; and one coding/abstracting supervisor. The same person may be nominated as the project director (principal investigator) and field supervisor, only if this person fulfills all of the requirements for both positions. Other parttime or fulltime personnel to account for approximately three person-years per year for three years may include any of the following:

Computer programmers, data entry personnel, clerk/typists, tracers, coders, abstrctors, form developer, coders, and nosologist.

The RFP will be available Feb. 6.
Contract Specialist: Camille Battle
RCB, Blair Bldg Rm 114
301-427-8888

RFP NCI-CM-47564-20
Title: Operation and maintenance of the Developmental Therapeutics Program data processing system
Deadline: Approximately April 6

NCI's Div. of Cancer Treatment, Developmental Therapeutics Program, Information Technology Branch, will make available to interested contractors a request for proposal for data processing support services. The government will supply all necessary mainframe computer time. The successful bidder shall furnish all necessary personnel, labor, materials, supplies, equipment and facilities (except as furnished by the government) to operate and maintain the Biological Data Processing System and several other subsystems of the Drug Information System and shall provide data processing support and services for related programs of the DTP.

NCI screens approximately 10,000 chemical substances annually for antitumor activity. This testing results in about 13,000 input transactions per fortnightly update cycle. Nearly 500,000 substances have been tested in the 20 years of testing in the program. This has resulted in a data base of some 9.1 million records (1.9 billion bytes). Operation and maintenance of the subsystems of the DIS shall be performed so as to provide data processing functions on a regular schedule requiring timely completion of data input and output, using prescribed media, including prescribed forms for input of data from five screening laboratories within the U.S. and Europe, and formats for reporting.

The contractor will also be responsible for establishment and maintenance of procedures for data preparation, reporting and control, and documentation for either newly written or modified programs.

The current BDPS is a stand alone system for acquisition and management of biological data collected in connection with NCI's program for the screening of potential antitumor agents. It is one of approximately 12 subsystems of the DIS, which is an on-line biological, chemical and management information system. Data are transferred automatically between subsystems of the DIS to support queries and generate reports upon request. The chemical names file, which contains 227,000 entries, is one such subsystem and the supplier name and address file with 8,500 entries is another.

Computer facilities of the NIH Div. of Computer Research & Technology are to be used for the majority of data processing activities performed under this contract with file preparation on the IBM 370, and searching and report generation on the DEC 10. Due to the dynamic nature of the systems, inputs and outputs, as well as the programs, are subject to change.

A document viewing room will be available by appointment for interested parties and will contain the present documentation of the system. This will include program documentation, input/output formats, record layouts, and program run instructions. A preproposal conference will be held. Locations and dates of the documentation viewing room and the preproposal conference will be announced in the RFP.

One award is anticipated to be made as the result of this RFP, for a five year incrementally funded period of performance. The government estimates the level of effort to be 23.75 staff years for each of the five years. The RFP will be available after Feb. 8.

Contracting Officer: Charles Lerner
RCB, Blair Bldg Rm 228
301-427-8737

RFP NIH-ES-84-4
Title: National Toxicology Program: Chemical repository and safety support

Deadline: Approximately April 3

A large scale screening program is underway by the National Toxicology Program for the testing of potential environmental pollutants in the forms in which they are initially utilized by man. Two repositories of chemicals which support this screening program are presently being maintained by the Radian Corp., Austin, Texas. This solicitation provides for consolidation of the two repositories and immediate followup repository support subsequent to the current contracts which are scheduled for completion by Sept. 29, 1984.

The contractor selected for award cannot be a current contractor performing under existing NTP contracts for the blind testing of chemicals in the NTP Cellular and Genetic Toxicology Program, or affiliated with such a contractor.

The repository will provide for safe procurement, storage, computerized tracking and dispensing of chemicals in a fashion which guarantees chemical integrity and maintains confidentiality of identity. The contractor wil also provide requisite procurement information gathering and dissemination and computer support service. Generation of chemical safety data sheets, emergency procedures and safe handling documents is also necessary.

It is to be assumed that all chemicals are potentially hazardous (i.e., carcinogenic, mutagenic, teratogenic, high acute toxicity). The chemical repository will have an initial capacity of approximately 2,000 unique chemicals and a growth capacity of approximately 350 new chemicals per year for each of five years.

Estimated release date of the RFP is Feb. 3.
National Institute of Environmental Health Sciences
Procurement Office, OA Att: Hollis Hawkins
PO Box 12874
Reearch Triangle Park, N.C. 27709

RFP NO1-CN-45181-10
Title: Methodology and analysis of fiber and fiber components in food

Deadline: March 16

NCI is soliciting RFPs from organizations interested in developing analytical procedures to measure total dietary fiber and fiber fractions in food. The data will be incorporated into a matrix data base for use in the calculation of dietary intakes of these components in clinical trials of dietary interventions, dietary assessment studies, and nutrition guidance efforts conducted by NCI.

This proposed procurement is subject to the availability of funds. Date of issue is approximately Jan. 31.

Contract Specialist: Joan O'Brien
RCB, Blair Bldg Rm 2A01
301-427-8745

SOURCES SOUGHT

Title: Computerized cancer research data service

Deadline: Jan. 31

A. Continuing tumor registrar education, including telephone consultaton, continuing education workshops; B. Quality control data; C. Providing services assuring the collection of standard data, consistent with national guidelines; D. Provide detailed computerization of data.

Concerns having the ability to furnish the above services are requested to give written notification (including a telephone for a POC) to the procuring office listed below. This is not a formal solicitation. Concerns that respond should furnish detailed data concerning their programs and capabilities and may request to receive a copy of the solicitation when it becomes available.

S.K. Kilgore, Chief, Supply Service (90)
VA Medical Center/Vancouver Division
PO Box 1035
Portland, Ore. 97207
206-696-4061, ext. 629

The Cancer Letter _Editor Jerry D. Boyd

Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.