THE CANCER LETTER

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WORKING GROUP TO LOOK AT GUIDELINES, MANDATES, CENTERS' ROLE IN PREVENTION, CANCER CONTROL

Cancer centers, already targeted for a two to three year study in a series of meetings around the country by the President's Cancer Panel, also will be the subject of a shorter but intensive set of "planning" meetings organized by NCI's Div. of Cancer Prevention & Control. A working group headed by Jerome Yates, DCPC associate director for

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In Brief

NCI TO PUSH "CANCER PREVENTION AWARENESS" THIS MONTH; THREE RFPs DELAYED FOR CHANGES

NCI'S OFFICE of Cancer Communications will initiate a national "Cancer Prevention Awareness Program" this month. It will involve the mass media in efforts to increase public knowledge of cancer and risk factors, attempt to improve attitudes toward cancer and especially toward prevention. Specific areas emphasized will include occupational exposure to smoking. "We need to pay attention to such efforts as getting the public to increase the amount of fiber in the diet," NCI Director Vincent DeVita told the National Cancer Advisory Board. "The combination of low fat and high fiber irrefutably is associated with lower incidence of cancer".... **THREE RFPs** announced last month (The Cancer Letter, Jan. 27) have been pulled back and will be delayed for about 30 days—epidemiologic surveys of leukemia for human T-cell leukemia/lymphoma virus; an epidemiologic cohort study of residents of chlordane treated housing; and support services for a mortality study of workers exposed to acrylonitrile. The delay is due to modifications in project plans.... **UNIQUE INTERNATIONAL** educational teleconference on the anticancer agent mitoxantrone (Lederle's trade name: Novantrone) is scheduled for Feb. 23, 1-4 p.m., broadcast by satellite from Toronto. D. Bergsagel, Princess Margaret Hospital, and James Holland, Mt. Sinai Medical Center, are cochairmen. Viewing locations will be established at 15 locations in the U.S. For information, contact Park Row Publishers in New York City, phone 212-349-0034.... **NCI STAFF** members recently recognized for outstanding performance include Maxine Singer (who won a Presidential Meritorious Executive Rank Award), Richard Adamson, Philip Amoruso, Harry Gelboin, Eli Glatstein, David Johns, and Robert Miller. NIH awardees also included Calvin Baldwin, former NCI administrative officer and now NIH executive officer.... **VIRGINIA LEGISLATURE** is close to approving a bill that outlaws performance of a biopsy and mastectomy during the same operation unless the patient has signed an informed consent statement giving specific advance permission for a mastectomy. California, Minnesota and Massachusetts have enacted similar legislation.

WORKING GROUP TO ZERO IN ON CENTER ISSUES, PANEL TO TAKE BROADER LOOK

(Continued from page 1)
centers and community oncology, will meet three times in the next 10 weeks to discuss such issues as:

—Ways to enhance existing cancer research resources through the integration of regional networking with community resources and research efforts.

—Intercenter collaboration.

--New directions for cancer centers in the context of cancer control research.

—The intent of Congress with respect to the establishment of cancer centers throughout the nation.

—Where do cancer control dollars fit into the centers?

The Panel's discussions will take on a broader perspective, with views to be sought from community representatives and public officials not affiliated with the centers.

"We will be addressing such issues as center guidelines, the mandates of the National Cancer Act, the role of centers in cancer prevention, the varying role of centers in different regions, and types of centers," Yates told The Cancer Letter.

The working group's first meeting is scheduled for March 12-13, with two other meetings planned for April. Yates intends to submit reports to the DCPC Board of Scientific Counselors and to the National Cancer Advisory Board at their meetings in May, and to the Assn. of American Cancer Institutes at its meeting in June.

The working group consists of members of the DCPC Board, representatives of cancer centers, and NCI staff. The non-NCI members are Charles Cobau, Robert Cooper, Robert Day, Harry Eagle, Virgil Loeb and Charles Smart, all DCPC Board members; and Charles Moertel, Mayo; Albert Owens, Johns Hopkins; Henry Pitot, Univ. of Wisconsin; James Quirk, Memorial Sloan-Kettering; Alan Sartorelli, Yale; Richard Steckel, UCLA; and Charles Spurr, Bowman Gray.

SAMUELS CALLS FOR REEXAMINATION OF NCI'S MANDATES FROM CONGRESS

Sheldon Samuels, one of the six retiring (presumably) members of the National Cancer Advisory Board, wrapped up his term by calling for reexamination of NCI's congressional mandates for cancer control, particularly as they affect protection of workers exposed to potential carcinogens.

Samuels, who is director for health, safety and environmment of the AFL-CIO Industrial Union Dept., has served as chairman of the NCAB's Committee on Environmental Carcinogenesis. Under his chairmanship, the committee completed the monumental task assigned by the Board of defining quantitative risk assessment and developing a Board policy on that controversial issue. More recently, the Board assigned the committee the task of reviewing the progress and direction of programs related to occupational cancer. Samuels noted then that that job could not be completed before his term expired, but he did hold a committee meeting prior to the NCAB's meeting earlier this month. In his final report to the Board, Samuels said:

"When the Conquest of Cancer report was published, less than two decades ago, the consensus of the community that constitutes both the public and private sectors of the National Cancer Program was that with the condemnation of the abuse of radium, betanapthylamine and benzidine, the control of radiation associated with the roentgen tube, and similar educational measures associated with a few other physical and chemical carcinogens, the occupational and environmental cancer problem was solved. They believed that the residual problem of cancer control would yield to study and control of viral agents, smoking, genetics, diet and treatment.

"It was ironic that as the report was being written, indeed as it was being printed in shops probably contaminated with carcinogens, benzidine and betanapthylamine were being manufactured and used without control in large quantities in this country in contravention of the recommendations of the International Labor Organization. We were the only western industrial nation, in this regard, to have so little reverence for the lives of workers. As Dr. (Peter) Greenwald will testify, the labor movement with NCI assistance is still trying to help those mostly unorganized and helpless workers.

"At the same time, a handful of investigators in industry such as V.K. Rowe of DOW, in academia such as Philippe Shubik, Norton Nelson, Thomas Mancuso and Irving Selikoff, in government such as NCI's W.C. Hueper, William Lloyd and Paul Kotin, were destroying our complacency with unerring aim. This Board took important tentative steps in response on its own initiative. As the situation began to boil over in the '70s due to discoveries made possible by the passage of the Occupational Safety & Health Act of 1970—correctly interpreted and voiced by consumer oriented scientists such as Samuel Epstein, Sydney Wolfe, Marvin Schneiderman and Eula Bingham—the demand for a greater NCI role grew and culminated in the Maguire amendment to the National Cancer Act, a process aided by our chairman, Tim Lee Carter (at that time a member of Congress).

"All of the involved directors of NCI—Frank Rauscher, Arthur Upton, Vincent DeVita—have provided outstanding leadership in this area. The first

public health alert ever issued by any government on earth on an occupational hazard was issued by Secretary Califano (on asbestos hazards). The alert and associated support was skillfully and effectively directed by your own Paul Van Nevel (director of NCI's Office of Cancer Communications) and his group. It will remain a case study of a superb government public information campaign.

"From the earliest days of the national program, the pressures to increase the control portion of NCI's program grew. The correct emphasis on basic research lead to spinoffs: the creation of the National Institute of Environmental Health Sciences and the National Toxicology Program are well known byproducts of the ensuing debate.

"Now once again we are at a stage in which basic congressional mandates to NCI must be reexamined. I refer you to the statement of the issue in the minutes of our (committee) meeting:

"'Dr. (Janet) Rowley agreed with the extraordinary importance of protection and education of workers exposed to potential carcinogens. However, she felt that this activity is not the appropriate function of NCI, which has the responsibility for supporting and conducting research into the causes of cancer, the associations between specific carcinogens and cancer, and the molecular mechanisms whereby certain carcinogens change a normal cell into a cancer cell. She stated that other governmental agencies, such as the National Institute of Occupational Safety & Health and the Environmental Protection Agency, have the responsibility for translating the results of this research into both public policy and prevention efforts. Dr. Rowley felt that if NCI is asked to turn its attention in a major way to intervening in the workplace, this will divert resources which should be devoted to understanding the fundamental etiology of cancer. She pointed out that this would be particularly unfortunate now, when there is presently underway a biological revolution in the understanding of mutagenesis and carcinogenesis.

"'Mr. Samuels agreed that NCI should be devoted entirely to research, but pointed out that the National Cancer Act assigned certain control functions to NCI which, although incompatible in his view with NCI's primary purpose, remain with the Institute.'

"I don't think it is appropriate to comment further on this point, except to say that while I agree with Dr. Rowley, and thus agree with her hope that the President will appoint basic scientists to replace Drs. Rowley, Henderson and Boutwell—oversight of the control function remains with you. I am not unhappy with the interests of those of you who will remain on the Board in this regard.

"You have access to some of the best civil servants and commissioned corps officers of the United States Public Health Service. You have the ear of the public and Congress. I pray that your deliberations and decisions will be wise. . . .

"Thank you for putting up with the emotions of a representative of our nation's working people."

NIH CONSIDERING INTRAMURAL NRSA PROGRAM; NCI ADVISORS UNENTHUSIASTIC

NIH is considering establishment of an intramural postdoctoral research training program for physicians which would be supported from the NIH National Research Service Award budget, but NCI advisors so far have been cool toward the proposal.

The NIH NRSA budget now totals $170 million which supports research training at institutions around the country. In 1981, Congress gave NIH authority to use NRSA funds to support NRSA fellows for research training at NIH. The proposal NIH has been circulating among its institutes would use up to $820,000 a year for 45 intramural fellows.

The Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control and the National Cancer Advisory Board both have expressed opposition to the proposal primarily because of the salary differential that would exist between the NRSA fellows and participants in the ongoing NIH Medical Staff Fellowship program. The stipend for NRSA fellows starts at $14,040 (for those with no experience) to $19,736 (seven years experience). Medical staff fellows start at $30,000 a year.

Moreover, a large percentage of NRSA fellows are likely to be members of minority groups.

"You would end up with low paid minorities working in labs with white, higher paid staff fellows," DCPC Board member Lewis Kuller said. "You're creating second class citizens," Board member Jerome DeCosse agreed.

Despite the low salary, some NIH executives feel they can sell the program to National Health Service Corps physicians. Those are physicians who received full tuition and living expenses from NHSC while attending professional schools and are obligated to pay back with service in federal penitentiaries, the Indian Health Service, or in medically underserved areas for a period of time equal to the time for which they received NHSC support. "Many of these students sign up before entering medical school, or early in medical school, and only later discover an aptitude for research," an NIH position paper said.

In 1981, NHSC legislation was modified to permit fulfillment of the payback obligation with research and academic activity after a period of training under NRSA training programs. "Without an NRSA training program at NIH, NHSC students are disenfranchised from receiving their research training at NIH unless they have an individual NRSA fellowship,"

the position paper said. "It should be noted that members of minority groups make up 35 percent of the NHSC.... It is difficult for a young clinician to get an individual NRSA award. In addition to finding a willing and acceptable sponsor, each applicant must prepare a research project which will succeed in national competition. This requirement automatically penalizes physicians with some research exposure but no formal research training. It should be emphasized that these people are no less intellectually capable than the PhDs who can compete for and obtain individual fellowships; they are simply trained in a different arena and are unprepared to develop a competitive research project. Moreover, they require a different postdoctoral training expertise."

The DCPC Board was sympathetic to the goals but not enthusiastic about the proposal. "I take it from the discussion that the Board would be inclined to support the program but strongly suggests it be structured with parity with other programs," Board Chairman Lester Breslow said.

Another disparity exists in that under the extramural NRSA program, institutions frequently supplement the individual stipends. That would not be possible for NIH NRSA fellows.

The NCAB took no formal action on the proposal, although comments were made about the low NRSA stipends. NCI later decided that a formal expression was desired from the Board, and members are being asked to vote on it by mail.

Phillip Chen, NIH assistant director for intramural affairs, told The Cancer Letter that the program would be voluntary, with each institute determining for itself if it would participate. He said several institutes had expressed interest. Chen insisted that "we get a lot of calls from young physicians interested in coming to NIH" and he feels many of them would accept the low stipends in order to get their research training there.

BLOCH PRESSES FOR PDQ PROMOTION TO PUBLIC; NCAB SAYS PHYSICIANS ONLY

Richard Bloch—the "R" of "H&R Block", now retired from that organization—developed an interest in the Cancer Program through a quite natural process: he had cancer and was cured. In the process, he discovered an appalling ignorance among some physicians about the diagnosis and treatment of the disease.

Bloch has dedicated his life and much of his fortune to doing something about that. One of the results is NCI's new PDQ system, designed to make it easy for practicing physicians to find quickly and easily state of the art information on diagnosis and treatment of cancer. PDQ not only was Bloch's brainchild but the NCI staff members who run it are housed along with their equipment, other NCI scientific publications staff, and the International Cancer Research Data Bank in a building purchased with the help of a large Bloch contribution.

Considering all this, no one blames Bloch for the paternalistic feeling he has for his "baby." But his fellow National Cancer Advisory Board members still will not go along with one aspect of the PDQ program ardently advocated by Bloch—an all out national publicity program designed to pressure physicians into using PDQ. Instead, the Board, with concurrence of most other NCI advisors who have been asked, has supported a low key approach directed only to physicians.

At the NCAB meeting earlier this month, Bloch read a statement in the closed portion of the meeting, later made public because it was not appropriate for a closed session. It follows:

"Yesterday afternoon, I was privileged to see a test preview of PDQ II. I have to, in this closed session, go on record to congratulate Vince and everyone else who worked on it for the tremendous job you have done. You have accomplished a super human task. PDQ II is excellent.

"It contains a wealth of knowledge written in understandable language, catalogued, referenced and cross referenced magnificently. The material is in the computer to help physicians world wide give their patients the best chance of beating or controlling cancer. And that's what it is all about.

"To say PDQ II is not what I dreamed it would be is only a matter of personal taste or opinion. It would be pointless to debate it. I have certain fears as to whether it is friendly enough to not frighten off some unsophisticated physicians. Being a perfectionist, I am concerned that some doctors may not take the time to read everything related to a type of cancer and may miss some phases of the recommended treatments. Being human, some doctor will not press the button to see the next frame and will miss the key testor. These I believe as a businessman will be corrected in time.

"The important thing is the job of getting the information in the computer. That enormous feat has been done. It is all there to enable any physician to obtain all the tests to offer the best therapy known today. The next task? Get enough publicity to be certain the very physician who needs it the most will use it. That is going to be an equally super human task.

"I would presently urge you not to waste any effort on publicity to physicians in mailings or medical publications other than any writeups they want to give you. If it costs money, it is not worth it. Remember, the job is not to get the 'good' doctors to use it. They are using every source of knowledge they can find today. They will welcome

this and use it without any urging. The few physicians, the ones who already know everything, the elderly thoracic surgeon who told me three years ago that I had not had lung cancer because everyone knows lung cancer can't be cured—if I had had it I would be dead—he is the one who must be made to use PDQ.

"This can only be accomplished through tremendous publicity to the public at large so that they will make their doctor use it. Our motive is not to make life easier for the qualified and dedicated physician, even though this will be accomplished. Our mission is to reduce the morbidity and mortality of cancer and this can only be done when that physician who knows the patient is untreatable learns there is a treatment.

"PDQ II is knowledge, nothing more. It is a better textbook. But if it is not used for the benefit of the patient who needs it, it is worth no more than an unopened book.

"Vince, I take my hat off to you and your entire staff. What you have accomplished approaches the impossible. I have full confidence you will be able to move mountains and get all the media, television, radio news services, newspapers, and periodicals to give you tremendous initial and continued free publicity."

The Board, however, did not change its policy, and for the present, at least, Bloch's theory will go untested. NCI will push PDQ through mailings to physicians and news releases to professional publications. No organized effort will be directed to the mass media, although NCI certainly will respond to queries from all segments of the press.

NCI is negotiating with a number of computer communication "vendors"—firms which package various data bases and offer access to them through computer hookups for modest fees—to handle PDQ II. The issue of promotion probably will not be left up to NCI once the vendors are on line and start their own efforts to drum up business.

The state of the art information now sequestered in PDQ's electronic core was laboriously compiled with the help of more than 200 consultants and many cancer centers who responded to Director Vincent DeVita's request for assistance. The data base will be regularly updated by a "PDQ Editorial Board." That board, for 1984, includes Daniel Ihde as editor in chief, and Joseph Aisner, Samuel Broder, David Danforth, Anatoly Dritschilo, John Durant, Eli Glatstein, Jerome Goldstein, William Hoskins, Walter Lawrence, Sanford Leiken, James Miser, Stanley Order, Robert Ozols, David Pistenmaa, Jack Roth, Omar Salazar, Charles Schiffer, Patrick Walsh, and Robert Young. Susan Hubbard and Robert Esterhay provide NCI staff resources, and Linda Blankenbaker is executive secretary.

TACOMA, WHICH MAY NOT BE TYPICAL, FINDS CANCER DRGs ARE PROFITABLE

The federal government's diagnosis related group (DRG) system of reimbursement for Medicare patients has been in operation for nearly half a year, and the questions about the impact it will have on the quality of cancer care and on clinical research have not even begun to be answered.

Gale Katterhagen, Tacoma medical oncologist and a member of the National Cancer Advisory Board, has been the NCAB's chief advocate for some kind of effort to find the answers. "I strongly feel this is an issue for the NCAB," Katterhagen said at a meeting of the Board's Committee on Cancer Control and the Community which he chairs. "What is the impact on cancer care in general, and on those entered into clinical trials?"

Katterhagen's hospital, Tacoma General, recently analyzed its own brief experience with DRGs. "We found that only half of the 470 DRGs apply to our institution," he said. The computer projected that those DRGs which would provide reimbursement less than costs would result in a $4.5 million loss; those projected with a favorable return would net $1.5 million. Cancer, however, would not be the big loser, according to this analysis.

Only one of the unfavorable DRGs in Tacoma is related to cancer, Katterhagen said. And 70 percent of the profitable DRGs are related to cancer.

The Tacoma situation may not be typical, however. Washington has the lowest average length of hospital stay of any state; and none of those in the analysis were involved in clinical trials.

"From our experience, it looks as if cancer can do business as usual," Katterhagen said. "The question I have is, can we do this one to two years from now? With more patients on clinical trials (Tacoma is participating in the Community Clinical Oncology Program), will it be the same?"

NCAB member William Powers said he was concerned that DRGs would lead to "a two tier medical care system, as we had when I was an intern. There were private patients and ward patients. Actually, there was a third tier—those who did not get any care at all."

Jerome Yates, associate director for centers and community oncology in NCI's Div. of Cancer Prevention & Control, noted that the cooperative groups are starting to collect data on the impact of DRGs and that "we are working with the Health Services Research Office to look at these questions." That office is located in the office of the HHS assistant secretary for health. The Health Care Finance Administration which administers Medicare also reports to the assistant secretary and presumably also is interested in assessing the impact of the program.

ACS BOARD ACCEPTS HAMMER'S OFFER, WILL SUPPORT CONSTRUCTION SURVEY

The American Cancer Society Board of Directors last week approved participation with Armand Hammer, chairman of the President's Cancer Panel, in a project to support a survey of cancer research facility needs in the United States. Hammer had offered to put up half the estimated $150,000 the survey will cost if ACS would provide the other half.

Hammer made the offer when it became clear that neither NIH nor the Dept. of Health & Human Services would permit NCI to go it alone on the survey, and that even if they did, the Office of Management & Budget probably would sidetrack it. HHS claims to be in the process of doing a similar survey of all the nation's research facility needs and that one limited to cancer would be duplicative. NCI executives feel that if the broader survey ever does get off the ground, it will be years before it is completed. Hammer agreed.

NCI will have no official role in awarding the contract for the survey, since it is now entirely in ACS' hands. At least one organization has expressed interest in the task and estimates that the survey could be completed within six months from the time the contract is awarded.

Hammer has said that if the survey demonstrates the need for stepped up government support of research facility construction and/or renovation, the Panel will carry the fight for an increased construction budget to the White House and Congress.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

SOURCES SOUGHT

Project No. NCI-44018-38
Title: Computer Support Center
Deadline for statements of capability: March 12

NCI is seeking small business sources capable of responding to a potential request for proposals for developing and optimizing software and using it on computers operated by the respondee in support of automated data processing tasks of the Office of International Affairs. Units within the OIA to be supported and interfaced with include the Computer Communications Branch, the Scientific Information Branch, and the International Cancer Research Data Bank Section of SIB. Tasks to be supported include the creation, updating and production of technical information products and services (primarily on line cancer databases and preparation of publications) and the development and optimization of computing and communications activities of the Computing and Communications Center at the R.A. Bloch International Cancer Information Center.

The small business size standard for procurement is a firm, including its affiliates, that is independently owned and operated, is not dominant in the field of operations in which it is bidding on government contracts, and whose average receipts for its preceding three fiscal years do not exceed $4 million.

MINIMUM REQUIREMENTS

A. Computer hardware which is currently installed, fully operational, and available to the full extent necessary for carrying out the demonstration (item D below). Response must define and describe in detail the available hardware configuration including, but not limited to the following: CPU memory size, number of bits (e.g. 16 bit, 32 bit system), amount of rotating memory in gigabytes, as well as data rate for the transfer (the BUS) to peripheral equipment expressed in kilobits/second, number of tape drives, (number of tracks, BPI), and number of accessible ports for online use.

B. At least two full time programmers (or equivalent) with extensive PL/I or other high level language experience (programming activities averaging at least 30 hours per week over at least a two year period) who are (or will be) available for work on this project. Letters of commitment (if they do not already work for the contractor) and a detailed description of the extent of programming experience must be provided by these individuals.

C. Software which is currently installed, fully operational and available and staff support for the type of data base management system to the full extent necessary for carrying out the demonstration listed in D. below and the project. Desired features and capabilities of the DBMS are as follows:

1. The DBMS allows a data base designer to establish several different logical relationships between two or more groups of data, with little duplication of data. Further, these relationships may be changed and new relationships defined between existing and new data without restructuring the existing data base.

2. The data structure editor module (or equivalent) of the DBMS lets a designer define any number of key fields in a record for direct access. (A key field comprises one or more data elements, which may or may not be contiguous in a record). At the same time, it supports sequential retrieval based on a primary sequence key in a record.

3. The retrieval module (or equivalent) of the DBMS provides keyed access to individual words in a text field, including access based on the proximity (or relative position) of these words in a field. If text searching is not an inherent feature of the

DBMS, it then allows a programmer to manipulate data (e.g. key words) and the index records to achieve the same effect.

4. The data structure editor module (or equivalent) of the DBMS supports access to, and update of, the same data base by several applications programs running concurrently. The DBMS maintains update locks at the record level thus allowing parallel processing without compromising data integrity. For update processing, it may be necessary to lock an entire file, but an applications program can release the file as soon as it completes its updates against the file. A file is not automatically locked for the duration of the job.

5. The DBMS normally updates all data and index records immediately, during interactive processing. However, a designer may choose to defer the update of selected indices to a later process, in which case the DBMS saves the necessary update data for later use by a utility program.

6. A number of utility programs are viewed as an integral part of the DBMS. There are utilities for the initial loading, or subsequent addition, of large volumes of data to a data base; these also create the necessary index records. Another utility supports the reorganization or restructuring of a data base, including associated indices. Still another creates index records for a newly defined key field in an existing record.

D. Demonstration of computer hardware (item A above) and software (item C above) capabilities as follows:

Sources who document that they comply with all minimum requirements listed above will be supplied with copies of files containing data of the type used to build the PDQ database. These include a cancer information file (2,000 records); a person file (15,000 records); an organization file (5,000 records); and a protocol file (5,000 records averaging 6,000 characters per record).

In order to satisfy this requirement, sources must demonstrate to an NCI site visit team within two weeks from the receipt of files on magnetic tape (9 track, 800-1600 BPI, ASCII) that they can use their proposed hardware and software to perform the following functions: 1) Mount the four PDQ files listed above in the computer configuration proposed for this project; 2) Create a new record in each of the four files; 3) Call up the newly created records and/or subrecords (data elements) within the entered records, using a unique record and/or data element identifier; 4) Use an online editing capability to change specified words and/or numbers in the newly created records and in randomly selected records from the four files; 5) Produce a tape of the four files with the changes made; and 6) Perform a retrieval of the protocol file using specified text words and index terms combined in a Boolean logic expression to identify those records which satisfy the retrieval criteria. Produce a retrieval of the records on the display terminal with the ability to retrieve all elements of the record and print the information.

The magnetic tapes of the files must be returned to NCI at the conclusion of the demonstration or at the end of the two week period, if the source chooses not to conduct a demonstration.

OUTLINE OF WORK TO BE PERFORMED

A. PROCESS INPUT DATA—Develop and optimize computer programs and related procedures needed for the preparation and processing of input data required for building and updating records and files. These files shall contain bibliographic records describing the published literature, descriptions of research projects, data related to the treatment of cancer, mailing lists and other information. NOTE: At present, the databases for which input records are processed by the current CSC include CANCERLIT, CANCER EXPRESS, CANCERPROJ, CLINPROT, PDQ1 and PDQ2. All these databases are part of the MEDLARS system of the National Library of Medicine and can be searched by any user who has access to the MEDLARS system. The databases are fully described in manuals published by NLM and available from the National Technical Information Service.

B. Perform database creation, maintenance, update and regeneration activities—Use the processed input as prepared above to create magnetic tapes needed for periodic updating or regenerating OIA databases and files.

C. Perform searches of OIA databases and files—Use file searching strategies and techniques based on search profiles to create new files consisting of records which are needed by OIA. Send printouts and/or tapes containing retrieved information, copies of files, and portions of files retrieved through the use of search profiles.

D. Provide data processing required for OIA publications—Create new and optimize existing programs and use them to generate magnetic tapes containing data required for production of publications needed by OIA.

E. Carry out activities related to publication and tape distribution.

F. Provide support of, and interface with, the Computing and Communications Center--This shall include preparing input for use by the CCC, receiving and processing output from the CCC, providing programming and data entry services, a system for online interaction with the CCC which will permit contractor's staff to interact through an online system directly with data in the CCC and will permit NCI to interact directly through an online system with data stored in the contractor's computer.

G. Prepare and deliver statistics and reports describing activities of this contract.

H. Carry out other data processing and computer support services required for operation of the project.

All responses will be evaluated on the basis of the information provided in response to the minimum requirements and performance of the demonstration.

Submit 10 copies of capability statements and supporting documentation.

Contract Specialist: Barbara Mercer
RCB Blair Bldg Rm 314
301-427-8877

RFP NCI-CM-47653-20
Title: Maintenance of rodent production centers
Deadline: Approx. April 30

NCI is seeking organizations with the capabilities and facilities for producing pathogen free rodents. To be considered for award of a contract, respondents should meet the following criteria: (1) have existing facilities which have the capability and performance records which document the successful exclusion of pathogenic organisms, (2) principal investigator and other key personnel should have experience and expertise with rodent inbreeding procedures and with the production of highest quality rodents, (3) organizational experience with the production of highest quality laboratory animals.

It is anticipated that a total of four to eight contracts will be awarded for this effort depending upon program needs and availability of funds. Only one award will be made to any organization. Each award will be for 4,000 cages (mouse equivalent). It is anticipated that awards will be for a three year incrementally funded period of performance.

This is a partial small business set aside. Two awards are set aside for small business.

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

RFP TMD 8410
Title: Use of explant culture techniques in human-animal comparative biochemical studies for risk assessment of chemical carcinogens
Deadline: Feb. 29 for submission of requests for expanded description of the project, April 15 for applications

The Environmental Protection Agency seeks assistance by cooperative agreement of organizations qualified to comparatively evaluate the metabolism, DNA adduct formation, sister chromatid exchange induction, and initiation of unscheduled DNA repair synthesis of 4,4-methylenebis (2-chloroanaline) and benzotrichloride in cultured explants of bladder and tracheobronchial tissue from humans and laboratory animals. The studies will be used to evaluate the relevance to human health of animal tumorogenicity data obtained on these chemicals. Each potential applicant must request, in writing, an expanded description of the proposed cooperative agreement before the close of business Feb. 29. The expanded description, which will include an application kit, will describe EPA's research needs as well as those minimum capabilities required in order to be considered a competitor for this cooperative agreement. An award of $100-200,000 per year could be expected in July, 1984. This cooperative agreement can be awarded only to public or nonprofit private agencies, organizations and/or individuals. Profit making institutions should not apply. Request for the expanded description and submission of the final proposal should be made to:

F.B. Daniel
Health Effects Research Laboratory
U.S. Environmental Protection Agency
26 W. St. Clair
Cincinnati, Ohio 45268
Phone 513-684-7482

RFP 84-31
Title: Data from cancer registries located in Los Angeles and San Francisco
Deadline: April 8 for submission of statement of capability

Concerns having the ability to furnish the following data are requested to give written notification (including a phone number for a point of contact) to the procuring office listed below. Data will be used to evaluate possible association between nonHodgkin's lymphoma (NHL) and acquired immune deficiency syndrome (AIDS). Information will be provided from data routinely collected by cancer registries and be provided on computer tapes compatible with IBM 3083. Data shall cover time period 1976-1983 for all males, ages 20-49, diagnosed with NHL (including mycosis fungoides, malignant neoplasms of brain or leukemia). Privacy act provisions shall apply to this procurement. Information shall include case number, date of diagnosis, age at diagnosis, race, marital status, census tract of residence, county code of residence, primary site, histologic type, other cancer diagnosis including date and treatment, occupation and survival. Data on all cases diagnosed from 1976-1982 will be provided within 30 days after award. Data for 1983 must be provided on the following schedule: 90 percent of cases within six months of diagnosis, 100 percent within 12 months of diagnosis. It is the government's belief that only one source in each location can provide this data. However, concerns that respond should furnish detailed information regarding their capabilities and may request a copy of the solicitation when it becomes available.

PGO, Centers for Disease Control
255 E. Paces Ferry Rd. NE
Atlanta, Ga. 30305
Attn: Ada Turner, Contract Specialist
Phone 404-262-6571

CONTRACT AWARDS

TITLE: Preparation and updating of clinical protocol summaries
CONTRACTOR: Informatics General Corp., $44,806.

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

The Cancer Letter _Editor Jerry D. Boyd
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