THE CANCER LETTER

Vol. 10 No. 13
March 30, 1984

Subscription $150 year North America
$175 year elsewhere

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

PHYSICIAN INDICTED FOR MAIL FRAUD AFTER ALLEGEDLY FALSIFYING DATA OF PATIENTS ON ECOG, CALGB TRIALS

A Niagara Falls physician has been indicted by the U.S. government under mail fraud charges arising from alleged falsification of data on patients he had entered onto clinical protocols of two

(Continued to page 2)

In Brief

THOMAS KING NAMED SPECIAL ASSISTANT TO LOMBARDI CENTER DIRECTOR; JOHN MACDONALD TAKES U. KY. JOB

THOMAS KING has been appointed special assistant to Director John Potter of the Vincent Lombardi Cancer Research Center of Georgetown Univ. King has headed the Kennedy Institute of Bioethics at Georgetown for the past three years, and before that was director of NCI's Div. of Cancer Research Resources & Centers (now the Div. of Extramural Activities)... AWARDS to be made by the American Assn. for Cancer Research at its annual meeting May 9-12 in Toronto are: Emmanuel Farber, Univ. of Toronto, the G.H.A. Clowes Memorial Award; John Minna, NCI, the Richard and Hinda Rosenthal Foundation Award; Charles Stiles, Dana-Farber Cancer Institute, the Rhoads Memorial Award; and George Hitchings and Gertrude Elion, Wellcome Research Laboratories, the Cain Memorial Award.... **AACR SCIENTIFIC** & Public Affairs Committee, chaired by John Laszlo, will sponsor a symposium on the evening of May 9, with these speakers: NCI Director Vincent DeVita, "NCI Budget Allocations—the Decision Making Process;" Alan Davis, American Cancer Society vice president for government relations, "Role of Private Agencies in Public Policy Development;" and Lawrence Loeb, "Smoking and Lung Cancer—Where Do We Stand?"... **JOHN MACDONALD,** former head of NCI's Cancer Therapy Evaluation Program who has been in private practice in Washington D.C., will become head of the Div. of Hematology/Oncology at the Univ. of Kentucky College of Medicine July 1. He will also hold the position of associate director for clinical activities of the McDowell Cancer Network.... **LANCE LIOTTA,** chief of NCI's Laboratory of Pathology, has received the 1984 Warner-Lambert/Parke Davis award for meritorious research in experimental pathology. Liotta and his group were cited for their pioneering research on specific biochemical mechanisms that play a role in tumor invasion and metastasis.... **OFFICERS, BOARD** members elected at this month's meeting of the Assn. of Community Cancer Centers include Paul Anderson, secretary, replacing Edward Moorhead, who was named president elect; Ann Welch, reelected as treasurer; new board members David King of Phoenix and Lloyd Everson of Fargo, N.D.; and Robert Enck, Binghamton, N.Y. and Jennifer Guy, Columbus, Ohio, reelected as board members. Irving Fleming, Memphis, was appointed to the board seat vacated by Anderson.

CALGB AUDIT ALERTED GROUP, FDA PROBE SAID TO FIND MD KEPT DOUBLE RECORDS

(Continued from page 1)

cooperative groups—Cancer & Leukemia Group B and the Eastern Cooperative Oncology Group.

William Wallens, 37, was charged with 10 counts of mail fraud which, federal investigators said, involved submission of false data and making false statements to the National Cancer Institute.

Wallens was indicted after evidence related to the charges was presented to a U.S. grand jury. The investigation had been carried out by the Food & Drug Administration.

The indictment returned by the grand jury contends that Wallen maintained two sets of data on 26 patients to which he had administered experimental drugs between August, 1977, and June, 1980. One set recorded actual dosage levels, adverse reactions, dates of laboratory tests and x-rays, and dates chemotherapy was given. The other set, which was reported to the cooperative groups and NCI, was falsified, the indictment says.

Wallens also was accused of directing his nurse and his secretary to make false entries and reports.

The 26 patients had been entered into 18 ECOG and six CALGB studies. The investigation was initiated by CALGB after its auditors, making a routine check of data from ongoing trials, became suspicious. They turned the matter over to FDA, which undertook a seventh month investigation.

Wallens had been dropped by ECOG before the allegations of fraud became known, ECOG Chairman Paul Carbone said, because of inadequate records he had submitted on his protocol patients.

NCI immediately withdrew investigational drug privileges from Wallens pending results of the FDA probe. That suspension is still in effect, and he has not received investigational drugs since February, 1983.

NIH has placed Wallens' name in its "alert" system, which requires that study sections and other review bodies be notified of the charges against Wallen should he be involved in a grant application or contract proposal. That policy was initiated after NCI and Director Vincent DeVita came under fire from some members of Congress for not notifying the National Cancer Advisory Board of charges against clinical investigator Marc Straus when a large grant application by Straus was approved by the NCAB. Implication of the policy is that, guilty or innocent, no one is going to be awarded NIH support while charges of fraud against him are being investigated.

Wallens has never been funded directly by NIH, so the question of debarment has not come up.

Data on all patients entered by Wallens have been purged from CALGB and ECOG records.

In working with the cooperative groups, Wallens was associated with Roswell Park Memorial Institute, which is a member of both groups. RPMI officials declined to comment on the situation.

Emil Frei, director of Dana-Farber Cancer Institute and chairman of CALGB, commented to **The Cancer Letter** that "the cooperative groups, through the National Cancer Institute, have developed sound quality control mechanisms. It was the group that identified the problem, and the quality control mechanism worked."

While it is unfortunate that the charge of data falsification has been made, Frei said, "the good news is that, if fraud has been perpetrated, it was discovered."

Roswell Park and NCI officials declined to comment on the case. Wallens also refused to discuss the case with Buffalo and Niagara Falls newspaper reporters and did not return a call from **The Cancer Letter.**

ACCC PRESSES CAMPAIGN FOR "DRG 471;" COBAU SAYS IT IS "COUNTERPRODUCTIVE"

The Assn. of Community Cancer Centers is well into its campaign for "DRG 471", the prospective reimbursement category for patients in clinical trials which the association hopes will be added to the first 470 diagnosis related groups. ACCC fears that with the Health Care Finance Administration refusing to reimburse research costs, many institutions will be unable to participate in clinical trials.

ACCC President John Yarbro has made adoption of DRG 471 the only goal of his year in office, and the association is underwriting a national survey to provide the government with information on the cost of cancer care and cancer clinical research, and how far the DRGs will go in covering those costs.

Those fears are not unanimous among community oncologists, however. One, a former member and past president of ACCC, does not agree that DRGs threaten clinical trials and, in fact, feels that ACCC's campaign could boomerang.

Charles Cobau, director of medical oncology at Flower Hospital in Sylvania, Ohio, sent the following letter to Yarbro:

"Perhaps as a former member of ACCC you will permit me to convey to you and other members of the Board of Trustees some observations about the present stand of ACCC in the matter of diagnostic related groups (DRGs) and their potential impact on research cost. We all recognize that clinical research involves performance of studies and collection of data not directly contributing to patient management. The data are required for the meritorious purpose of understanding more fully the

natural history of disease and the response of the patient to the application of a specific intervention. In the past added cost has been absorbed by a third party reimbursement either unwittingly or by knowing benign acquiescence in the interest of furtherance of medical science. In fact, however, there is no specific provision in either federally funded or private funded programs for the reimbursement of such costs. (In fact, it is my understanding that the Health Care Finance Administration has directed that Medicare reimbursement specifically exclude research costs).

"My concern is that the efforts of ACCC to call attention to this problem may prove to be strongly counter productive. By calling attention to the fact that much research activity is currently funded by third party reimbursement, you may actually invite a much closer scrutiny of current billing practices by nonfederal as well as federal funding sources. If these sources are called upon by their subscribers to eliminate all research costs from their reimbursement formulas we would suddenly find ourselves much worse off than we currently are under DRGs.

"Obviously the imposition of DRG requires each of us to practice oncology much more efficiently than previously. My belief is that we can rise to this challenge by a variety of adjustments in the way we practice. These will enable us to 'average out' the 10-15 percent of patients on clinical research protocols against the vast majority of patients who are not. What we must avoid is a case by case review by third party carriers to eliminate cost due to research. This is what could happen if ACCC is successful in its current thrust to increase awareness of the cost of clinical research."

Meanwhile, ACCC has presented a summary of its position and of some preliminary studies it has made in a paper presented to NIH Director James Wyngaarden:

ACCC has conducted four preliminary studies on the cost differential of patients on clinical trials. These studies, while preliminary, suggest that patients on formal clinical trials cost more than comparable patients managed with conventional therapies. This makes intuitive sense, since patients on trials usually have additional procedures, tests and measurements required by the protocol to check the progress of the therapy and provide the necessary data for analysis. Moreover, these patients are frequently involved in toxic, high intensity therapy, which prolongs length of stay, and requires above average levels of support.

The four studies outlined below suggest that clinical research will be discouraged by hospital administrators who are concerned about costs under the new federal reimbursement system, diagnosis related groups (DRGs). Prior to the enactment of DRGs, hospital administrators had incentives to provide higher levels of care; under DRGs there are incentives to provide lower levels of care.

Because the cost reimbursement system always paid for a percentage of all patient care costs, the NIH research system could rely on third parties and Medicare/Medicaid to cover the costs of inpatient care, procedures, measurements, and most of the supportive care. This will no longer be true under the fixed price, prospective reimbursement system.

Thus, it is not surprising that one hospital administrator recently returned his NCI CCOP award, stating that the costs of participating in clinical research under the new system far outweigh the benefits. In another case, a hospital administrator analyzed a protocol prior to its implementation and, while it was a high priority, approved protocol, denied the use of the protocol, citing the loss the protocol would generate above the "average DRG compensation."

At a time when hospital administrators are predicting that 1,200 to 2,000 of the 7,000 U.S. hospitals will close, and when many hospitals are reporting major staff layoffs, research that costs more than conventional care will be considered an unnecessary frill. This effect is likely to be felt first in community hospitals, but will be readily apparent in university hospitals as the medical education adjustment is restricted.

From a research policy perspective, this unintended consequence of the new DRG system has major implications. Only protocols that cost less than conventional care are likely to receive significant accruals. Investigators will find that their choice of studies is artificially limited to only those regimens that cost less, a dangerous barrier to scientific inquiry. New and experimental therapies, regardless of efficacy, will be judged in relation to their total costs.

There are several publications on the impact of DRGs on innovation by a diverse group of sources: the Office of Technology Assessment, the Grace Commission, the Health and Educational Research Trust of New Jersey, and by the authors cited in this briefing paper. Despite this diversity, they concur that DRGs suppress innovations that cost more than conventional care.

The four preliminary studies cited below looked at actual data from three tertiary care, sophisticated community hospitals. All of the data relates to cancer patient clinical trials of varying intensities.

Mortenson and Winn reviewed 715 inpatient admissions from a New Jersey hospital in the last half of 1982, where the DRG system has been in effect for three years. Of the 715 admissions, 25 were for 21 patients on formal, NIH approved clinical trials.

The trials varied in intensity, they said.

The authors documented a $47,000 loss on the 715 admissions, $22,214 of which was attributable to the 21 patients on clinical trial. Thus, three percent of the patients contributed to 47 percent of the loss. Loss per patient on trial was $1,057, while the loss of all other cancer patients was $35 per admission. This loss did not include the matching funds contributed by the medical center to an NCI CCOP ($105,800), nor the award itself ($60,000) which partially covered the costs of research data collection.

Losses varied by the intensity of the protocol; three patients of the 21 even made a small amount (an average of $774). But as intensity increased, so did loss, up to a maximum of $3,178 average loss for each patient on a phase 2 melanoma trial.

A retrospective study developed by investigators in Oklahoma matched 26 lymphoma patients treated on protocol with 26 not treated on protocol. Matches were made using physician, sex, race, diagnosis and age (+/- five years) as criteria. To ensure comparability, matches were also established on the basis of total admission frequency.

The study demonstrated a $100,940 cost differential between the two groups of patients, an average per case cost difference of $3,882 for each protocol patient above comparable nonprotocol patients.

Subsequent to the release of federal regulations setting the criteria for reimbursement under DRGs, Mortenson recalculated the data from the initial study. Rates were recalculated on the basis of the regional variations in cost, local labor variations and hospital case mix. Hospital costs were inflated using state approved (market basket) adjustments.

The result was a $34,000 loss on 21 patients over 25 admissions, $12,236 more than under the New Jersey rates or an additional $582 for each patient on protocol.

A yet to be published study, based on data from Long Beach (California) Memorial Hospital, illustrates a similar set of information. Patients entered on clinical trials were reviewed in contrast to those within the same DRG for the same period of time (three months of 1983).

Over the three month period, 15 patients were placed on formal, NIH clinical trials. These patients can be grouped under five different DRGs which had a total of 27 discharges over the period. The net loss for the 27 admissions was $45,112, of which $41,399 is attributable to the 15 clinical trials patient discharges. Thus 56 percent of the patients generated 92 percent of the loss. While the hospital uniformly expects that Medicare will reimburse at 70 percent of the charges, in these cases the average was only 55 percent.

ACCC is in the process of developing a three year research study on this question with several related questions on the ability of DRGs to adequately compensate late stage cancer patients, or to suppress the dissemination of innovations in therapy. This quasi-experimental design is an interrupted time series with over 70 community and university institutions participating. The study will include information on the patterns of care, mortality and cost.

At the urging of third party carriers, 10 states have now extended the federal DRG system to all payors. Other states are considering similar legislation as is Congress. Thus, it is likely that fixed price reimbursement will be extended to all patients on clinical trial.

Moreover, preferred provider organizations (PPOs) are developing in a large number of communities. These organizations give significant discounts to clusters of patients (from five to 25 percent). While the discounting may achieve other HHS and congressional objectives, it is also a force which militates toward lower prices for care.

In combination, these forces, and others active in the medical marketplace, drive hospital administrators to cut "frills" like research.

There are several basic alternatives: do nothing; wait and/or do research; seek modifications to the DRGs now; seek additional funding to cover the disparity. ACCC has chosen the third alternative, suggesting that artificial barriers to research formulation and design are detrimental and not the intent of Congress. The association is also conducting a long term research effort, as noted above, but considers the likely impact of waiting to be a major detriment to research in the meantime.

Specifically, ACCC has suggested that Congress establish a new DRG (DRG 471) strictly for patients on formal, NIH clinical trials. These patients would be monitored through the usual research process and would have their patient care costs covered by straight cost reimbursement. This is essentially no change from pre-DRG days.

In addition, the association has suggested that NIH be asked to establish a task force in conjunction with other extramural research groups to develop a mechanism which would allow NIH to monitor the tests required by protocols to assure they are necessary to the study in question. This might be something as simple as a two or three page justification submitted to NIH with each protocol during the approvals process, reviewing the necessity of each required test, measurement or other procedure in the protocol.

In this way, Congress would be assured that NIH was working for cost effective research, while investigator freedom to pursue effective therapies

was not hampered by cost constraints.

The other two alternatives, doing nothing or seeking additional funding, both seem unacceptable. Taking no action is tantamount to agreeing that the only beneficial research is cheap research. The latter alternative would establish a bureaucracy at NIH which would need to be as complex as that already established by the Social Security Administration and HCFA. Moreover, this pot of dollars would again artificially limit the research activities to the size of the total appropriation.

CCOPS AT SIX MONTHS: SOME EXCEEDING PATIENT GOALS, MOST ARE ON SCHEDULE

The Community Clinical Oncology Program is now six months old, most of the 61 awards having been made by last September following a two year gestation which locked NCI, community oncologists, the National Cancer Advisory Board, some members of Congress, cancer centers, cooperative groups, and NCI boards of scientific counselors into one round of debates after another. Many of the participants in that process felt it would never get off the ground, but it did and apparently is working.

Robert Frelick, Delaware medical oncologist and former president of the Assn. of Community Cancer Centers who was hired by NCI to oversee development of the program and nurse it through its infancy, told **The Cancer Letter** last week that approximately two thirds of the CCOPs were placing patients into protocols in the numbers they had anticipated. At least one has already exceeded its goal for the entire year, and others are ahead of schedule.

One of the major goals of the program, if not the most important bottom line, was to provide a big, new pool of eligible patients for the cooperative groups and cancer centers. With communities treating 85 percent of all cancer patients, the groups and centers—"research bases"—were finding it increasingly difficult to secure enough patients for their clinical trials.

Six of the cooperative groups had solved that problem, at least in part, by taking advantage of the Cooperative Group Outreach Program supported by NCI which funded efforts to involve community hospitals in group protocols. Since that program was initiated in the late 1970s, an increasing percentage of the patients going into the protocols of the groups with the outreach contracts was coming from the participating community hospitals. Community patients also were being entered through other more informal avenues. Some of those hospitals are now CCOPs, so the question arises, does that flow of patients from CCOPs actually represent a net increase going into clinical trials?

Frelick said he believes it is a net increase, "although not across the board," and remains confident that the program will produce a significant increase in protocol patients.

Although some CCOPs were off "to a running start," there were a few "glitches" which bothered some of the others, although most of the problems have been minor ones, Frelick said. In one instance, attorneys for an institution nitpicked over the informed consent forms and held things up unnecessarily, making some impractical demands.

Relations between the CCOPs and their research bases "seem to be going quite well" despite a few differences. A situation existed in some groups in which member institutions had been getting credit for patients entered onto group protocols by community physicians through those institutions. Now, those physicians are going through their local CCOP, and the group members feel their funding may be threatened unless they can make up the difference in patients from other sources. NCI will not give credit to two different organizations for the same patients.

There have been no comments about lack of quality on the part of CCOPs, Frelick said. "Remember, they were picked from 191 applicants primarily because of their experience. Several are outstanding groups."

Some CCOPs have encountered certain peculiarities in the program relating to funding. One hopsital told Frelick that it could get more money by remaining as a member of the Cooperative Group Outreach Program than affiliate with a CCOP, contrary to NCI's philosophy. In other cases, CCOP institutions are eligible to become full members of cooperative groups but think they can get more money through CCOPs than the groups, something NCI does not want to encourage.

CCOPs and their research bases are being required to submit their first annual reports by the end of June, although they will have been in operation only three quarters of a year. NCI must have the reports in order to develop recommendations for second year funding before the end of the fiscal year, Sept. 30.

NCI Director Vincent DeVita recently told a congressional appropriations subcommittee that he hoped to open a new round of competition for additional CCOP awards, with the goal of funding a total of 200 by the year 1990. Frelick indicated that this new competition would not await recompetition of the 61 existing CCOP cooperative agreements, which are for a three year period.

It is somewhat ironic that one of the impediments holding back to some extent the flow of new patients from CCOPs into clinical studies is the lack of suitable protocols from the research bases. CCOP physicians, for instance, have lung and colon cancer patients available in large numbers, with very few good protocols in which to place them.

HAMMER, ACS AGREE ON PROCEDURES FOR FACILITIES SURVEY CONTRACT

Armand Hammer, chairman of the President's Cancer Panel, and the American Cancer Society have agreed on procedures which will be undertaken in the selection of an organization to conduct the cancer research facilities survey being jointly financed by Hammer and ACS.

Since the survey is being supported entirely by private funds and since NCI was prohibited by the Administration from participating in it, NCI will not be involved in the contract award or management process.

The Panel is sending out over Hammer's signature letters to seven or eight organizations which have expressed interest in doing the survey. The letters will include copies of that portion of the minutes of the Panel meeting last December in which research facility needs and the proposed survey were discussed. The letters will invite the organizations to submit unsolicited proposals to Alan Davis, ACS vice president for governmental relations, 777 E. Third Ave., New York 10017.

Organizations which have not yet expressed an interest in competing for the contract may obtain copies of the Panel minutes and Hammer's letter by contact the Panel exectuve secretary, Dr. Elliott Stonehill, NCI, Bldg 31 Rm 11A23, Bethesda, Md. 20205.

The deadline for receipt of proposals by ACS is May 1.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR APRIL, MAY, FUTURE

National Council on Radiation Protection & Measurements—April 4-5, Washington D.C. 12th annual meeting. Contact NCRPM, 7910 Woodmont Ave., Suite 1016, Bethesda, Md. 20014, phone 301-657-2652.

Diagnosis & Treatment of Neoplastic Disorders: Medical, Surgical & Radiotherapeutic Aspects—April 5-6, Johns Hopkins Medical Institutions. Tenth annual symposium. Contact Office of Continuing Education, Johns Hopkins Univ. School of Medicine, 720 Rutland Ave., Baltimore 21205, phone 301-955-6046.

Management & Theory of Pain in Cancer Patients—April 5-7, Four Seasons Hotel, Houston. Contact Office of Conference Services, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Cervical Neoplasia--April 6-7, Stouffers Hotel, Houston. Contact Office of Conference Services, Box 131, M.D. Anderson, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Developmental Therapeutics Contract Review Committee—April 6-7, NIH Bldg 31 Rm 3, open April 6 9-9:30 a.m.

1984—Update on Cancer Therapy—April 6, Rush-Presbyterian-St. Luke's Medical Center, Chicago. Contact Monica Boyce-Richards, Rush Cancer Center, 1725 W. Harrison St., Chicago 60612, phone 312-942-6029.

New Drug Therapy—April 6, New York. Contact Communications Media for Education, PO Box 712, Princeton Jct., N.J. 08550, phone 609-799-2300.

International Clinical Hyperthermia Society--April 8-13, Milan. 5th annual meeting. Contact Dr. John McLaren, Emory Univ. Clinic, 1365 Clifton Rd., Atlanta 30322.

Breast Cancer: An International Seminar—April 8-14, Edinburgh. Contact Courses Dept., The British Council, 65 Davies St., London W1Y 2AA. he British

President's Cancer Panel—April 9, Univ. of Southern California, Mayer Auditorium. 9 a.m., open.

Cancer Therapeutic Program Project Review Committee—April 9-10, NIH Bldg 31 Rm 9, open April 9, 9-9:30 a.m.

Breast Cancer Task Force—April 9-11, NIH Bldg 31 Rm 10, 8 a.m. each day, all open.

In Vivo Effects of Interleukin-2--April 10, NIH Clinical Center, Jack Masur Auditorium. Contact Martha Harshman, Biological Response Modifiers Program, Bldg 567 Rm 135, NCI-FCRF, Frederick 21701.

Vertebrate Animals in Health Research—April 11-12, National Academy of Sciences, Washington D.C. Contact Office for Protection from Research Risks, Bldg 31 Rm 4B09, NIH, Bethesda, Md. 20205, phone 301-496-7005.

Tumors Involving the Skin--April 12, Roswell Park continuing education in oncology.

Acute Leukemia Symposium—April 12-13, Detroit. Contact Dr. L. Baker, Div. of Oncology, Wayne State Univ., PO Box 02188, Detroit, Mich., phone 313-494-4700.

14th Annual Radiation Therapy Clinical Research Seminar—April 12-14, Gainesville, Fla. Contact Dr. William Mendenhall, Radiation Therapy Div., Box J-385, J. Hillis Miller Health Center, Gainesville, Fla., 32610, phone 904-392-3161.

Radiation Oncology—April 13-15, Ann Arbor. Contact Office of Continuing Medical Education, Towsley Center, Box 057, Univ. of Michigan Medical School, Ann Arbor 48109.

Oncology Update 1984--April 14, Sheraton Grande Hotel, Los Angeles. Contact Ann Richards, Administrative Director, Northridge Hospital Medical Center, 18300 Roscoe Blvd., Northridge, Calif. 91328, phone 213-885-8500.

Cancer Resources & Repositories Contract Review Committee—April 24-25, NIH Bldg 31 Rm 8, open April 24, 9-9:30 a.m.

5th Annual Symposium on Environmental Epidemiology--April 24-26, Pittsburgh. Contact Univ. of Pittsburgh, phone 412-624-1559.

Gynecological Malignancies—April 25, Wright State Univ., Dayton. Annual Nicholos J. Thompson Cancer Update. Contact Mary Fisher, Postgraduate Medicine & Continuing Education, Wright State Univ. School of Medicine, P.O. Box 927, Dayton, Ohio 45401, phone 513-429-3200 Ext. 377.

Ethics for a Categorical Institution--April 26-27, Shamrock Hilton Hotel, Houston. Contact Office of Conference Services, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Planning of Radiological Departments--April 29, Dorado, Puerto Rico. Contact Dr. Harry Fischer,

Univ. of Rochester Medical Center, PO Box 648, Rochester, N.Y. 14642.

Oncology Nursing Society—May 2-5, Toronto. Ninth Annual Congress. Contact ONS, 3111 Banksville Rd., Suite 200, Pittsburgh, Pa. 15216, phone 412-344-3899.

Div. of Cancer Prevention & Control Board of Scientific Counselors—May 3-4, NIH Bldg 31 Rm 10, 8:30 a.m. both days, open.

American Society of Clinical Oncology--May 6-8, Toronto. 20th annual meeting. Contact ASCO, 435 N. Michigan Ave., Suite 1717, Chicago 60611.

Surgical Pathology of Neoplastic Diseases--May 7-11, New York. Contact Dr. Philip Lieberman, Chief, Surgical Pathology Service, Memorial Hospital, 1275 York Ave., New York 10021.

Biometry & Epidemiology Contract Review Committee—May 8-11, NIH Bldg 31 Rm 8, open May 8 9-9:30 a.m.

American Assn. for Cancer Research--May 9-12, Toronto. 75th annual meeting. Contact AACR, West Bldg Rm 301, Temple Univ. School of Medicine, Philadelphia 19140, phone 215-221-4565.

Molecular Biology & Its Relevance to the Treatment of Colon Cancer--May 12, Roswell Park continuing education in oncology. Contact Gayle Bersani, Cancer Control Coordinator, RPMI, 666 Elm St., Buffalo 14263.

Joint Annual Meeting of the Society of Surgical Oncology and Society of Head & Neck Surgeons—May 13-17, New York. Contact SSO/SHNS, 13 Elm St., Manchester, Mass. 01944.

Society for Clinical Trials--May 13-16, Omni International Hotel, Miami. Contact SCT, 600 Wyndhurst Ave., Baltimore 21210, phone 301-435-4200.

National Cancer Advisory Board--May 14-16, NIH Bldg 31 Rm 6, 8:30 a.m. each day, closed May 15.

National Tumor Registrars Assn.—May 15-18, Hotel Continental, Chicago. Tenth annual meeting. Contact Suzanna Hoyler, American College of Surgeons, 55 E. Erie St., Chicago 60611, phone 312-664-4050.

Reach to Recovery—May 15-18, Jerusalem, Israel. 3rd European Conference. Contact Secretariat, Reach To Recovery, PO Box 50006, Tel Aviv 61500, Israel.

Current Concepts in Leukemias & Lymphomas—May 19, Amarillo. Contact Dr. Phillip Periman, Medical Director, Harrington Cancer Center, 1500 Wallace Blvd., Amarillo, Texas 79106.

Regional Breast Cancer Symposium--May 21-22, Kansas City, Kan. Contact Jan Johnston, Office of Continuing Education, Univ. of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kan. 66103, phone 913-588-4480.

International Symposium on Liver Metastases--May 24-25, Leiden, The Netherlands. Contact Dr. Paul Sugarbaker, NCI, Bldg 10 Rm 2B07, Bethesda, Md. 20205, phone 301-496-1437.

Recent Trends in Clinical Radiation Oncology--May 24-26, Williamsburg, Va. Contact Sheri Rosner, Program Coordinator, Box 48, MCV Station, Richmond, Va. 23298.

FUTURE MEETINGS

RNA Tumor Viruses in Human Cancer--June 10-14, Denver. International conference, with reports on oncogenes, virus related sequences in human cancer, experimental model systems, human diseases associated with RNA tumor viruses. Contact Dr. Jean Hager, Conference Coordinator, AMC Cancer Ressearch Center, 6401 W. Colfax Ave., Denver 80214, phone 303-233-6501.

Cancer Precursors of the Cervix, Vagina and Vulva--June 15, Sacramento. For gynecologists, obstetricians, and other practitioners involved in the health care of women. Contact Office of Continuing Medical Education, School of Medicine, TB 150, Univ. of California, Davis 95616.

Assn. of American Cancer Institutes—June 17-19, New York. Annual meeting. Contact James Quirk, Vice President, Memorial Sloan-Kettering Cancer Center.

Research & Clinical Applications of Nuclear Magnetic Resonance in Cancer--June 20-22, Hyatt Regency Hotel, New Orleans. Sponsored by the NCI Organ Systems Program. Contact National Pancreatic Cancer Project, NMR Symposium, Dept. of Surgery, LSU Medical Center, 1542 Tulane Ave., New Orleans 70112.

Conference on Immunity to Cancer--Sept. 10-12, Williamsburg, Va. Invited papers on identification and characterization of tumor antigens, immune responses to tumor antigens, regulation of immune responses to tumor cells, immunotherapy and biomodulators, and immunotherapy and future prospects. One page abstracts are invited. Early registration is suggested, since the conference will be limited to 300 participants. Submit abstracts to and obtain information from Carole Kirby, Biological Response Modifiers Program, NCI, Frederick Cancer Research Facility, Bldg 567 Rm 129, Frederick, Md. 21701, phone 301-695-1418.

Role of Cyclic Nucleic Acid Adducts in Carcinogenesis & Mutagenesis—Sept. 17-19, Lyon. Contact Dr. B. Singer, 135 Melvin Calvin Hall, Univ. of California, Berkeley 94720, or Dr. H. Bartsch, IARC, 150 Cours Albert-Thomas, F-69372 Lyon Cedex 08, France.

Urologic Cancer—Oct. 1-3, Boston. Contact Harvard Medical School, Dept. of Continuing Education, Boston 02115, phone 617-732-1525.

Monoclonal Antibodies & Breast Cancer—Nov. 8-9, San Francisco. Advances in preparation and use of monoclonal antibodies in the diagnosis and future treatment of breast cancer. Contact Dr. Roberto Ceriani, Bryce Lyon memorial Research Laboratory, Children's Hospital Medical Center, Grove and 52nd St., Oakland, Calif. 94609.

First International Conference on Skin Melanoma--May 6-9, 1985, Venice. Contact Secretariat, Melanoma Conference, Istituto Nazionale Tumori, Via Venezian 1, 20133 Milan, Italy.

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 tor 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-EB-41025-60
Title: Environmental cancer utilizing pre-paid health plans
Deadline: May 25

The Div. of Cancer Etiology of NCI, Environmental Epidemiology Branch, has a need to evaluate rapidly hypotheses concerning the environmental causes of cancer. A rapid and relatively inexpensive way to accomplish this for various environmental exposures is by utilizing already recorded information from a pre-paid health plan (PPHP) or large groups of patients with a particular cancer, and on a comparable series of persons without the disease.

Because of the nature of PPHP records, the primary hypotheses that can be tested involve those associated with the use of therapeutic drugs, medical irradiation, clinical conditions, surgical procedures, occupation, location of residence, and exposures that are highly correlated with one of these variables. Utilizing longitudinally recorded information concerning demographic and specific exposure characteristics of cases and controls, representative of the group from which the cases are drawn, is a valuable way to test hypotheses rapidly and to determine whether more etensive study is required.

Duration of this contract is expected to be four years, targeted for award in September 1984. There are no specific geographic requirements for the location of the contractor. It is assumed that the contractor will be the organization under which the PPHP is administered.

Respondent must (1) have at least 20 years of experience in providing outpatient and inpatient medical services for a defined population; (2) have a pre-paid health plan base in excess of over 150,000 individuals annually, averaged over the last 15 years; (3) have the capability of identifying all cases, or a representative sample of all cases that have occurred in this population over the last 10 years; (4) have a computerized system for the health plan population which would allow an unbiased selection of comparison individuals, matched to the cancer cases on the basis of age, sex, date of health plan entry, and presence within the plan at a specified date; (5) have provided the inpatient and outpatient medical services for the base population and have readily identifiable the complete inpatient and outpatient records, and the capability of asembling these records in an efficient manner; and (6) have extensive experience in designing abstract forms and have used them to collect data from their own records; (7) have experience in computerization and computer editing of large data files; and (8) have research capabilities in the form of an M.D., a computer specialist, and others (optionally) who have research experience in utilizing a particular PPHP's records in the conduct of cancer research, and interest and experience in etiologic research. If necessary, more than one award may be made.
Contract Specialist: Thomas Porter
RCB, Blair Bldg. Rm 114
301-427-8888

RFP NCI-CN-45187-03
Title: Centers for Radiological Physics Programde.
Deadline: May 15

NCI's Div. of Cancer Prevention & Control is soliciting proposals to continue to provide for a number of regional centers for radiological physics and their coordination. Primary objective of these contracts is to ensure uniformly high quality of radiological physics services in diagnostic and therapeutic radiology.

Approximately six centers and a coordination program will be funded to provide regional resources for review, consultations and education. Centers will be required to coordinate their activities with the other centers in order to ensure inter-regional uniformity and to evaluate the impact of the centers on the national cancer control eforts. This proposed procurement is subject to the availability of funds.
Contracting Officer: Shirley Kyle
RCB, Blair Bldg. Rm. 2A01
301-427-8877

RFP AMENDMENT NCI-CP-EB-41026-60
Title: Investigations of cervical cancer in Latin America

The synopsis is amended to notify respondents that the RFP will be available on or about April 16, not March 28, as originally announced. Due date for receipt of proposals is extended to May 30.

In addition, for informational purposes only, Latin America includes Mexico and all Spanish and Portuguese speaking nations in Central and South America.

NCI CONTRACT AWARDS

TITLE: Detailed drug evaluation and development of treatment strategies for chemother-
apeuticagents strategies for chemother-
CONTRACTOR: Southern Research Institute, $1,837,645.

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.