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TEXAS (GALVESTON) SCORES NINE POINTS AHEAD OF RPMI IN ORGAN SYSTEMS COMPETITION; NCAB TO DECIDE AWARD

The ad hoc committee which reviewed the three applications competing for the Organ Systems Program Coordinating Center grant rated two of them virtually dead even, with the Univ. of Texas Medical Branch (Galveston) nosing out Roswell Park Memorial Institute by nine points, 263 to 272. That score is close enough to leave the issue in doubt; it will be considered by the

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In Brief

EPPLEY IS THE "NEW" CENTER GETTING AN NCI CORE GRANT; USC APPOINTS JONES BASIC SCIENCE CHIEF

EPPLEY INSTITUTE for Research in Cancer & Allied Diseases, at the Univ. of Nebraska in Omaha, will be the "new" cancer center to receive an NCI core grant this year. NCI Director Vincent DeVita had told a congressional subcommittee that a new center would be funded in Nebraska but did not identify it. Eppley has been in existence for years and at one time held one of NCI's largest contracts, for carcinogenesis research. This will be the first time the center has had a core grant. Edward Bresnick is the director... **PETER JONES,** associate professor of pediatrics and biochemistry at Los Angeles Childrens Hospital since 1977, has been appointed director for basic research and director of the Urological Cancer Research Laboratory at the Univ. of Southern California Comprehensive Cancer Center. He will be the first to hold the position there of director of basic research since the death of Charles Heidelberger more than a year ago. Jones, 37, received his PhD from the Univ. of London.... **JANET ROWLEY,** professor of medicine at the Univ. of Chicago and member of the National Cancer Advisory Board, is the first recipient of the $120,000 Hussain Makki Al Juma International Cancer Prize for her trailblazing work in the use of banding techniques in cytogenetics which led to the major discovery of the role of oncogenes in the induction of cancer. The award was established by a Kuwait businessman of the same name; the UICC assisted in the selection.... **DENMAN HAMMOND,** chairman of the Childrens Cancer Study Group, will receive the Lucy Wortham James prize for clinical research from the Society of Surgical Oncology May 14 in New York. His lecture is titled, "Multidisciplinary Clinical Investigation of Childhood Cancer: A Model for the Management of Adults with Cancer".... **V. CRAIG JORDAN,** associate professor of human oncology and pharmacology at the Univ. of Wisconsin Clinical Cancer Center, has received the 1984 Romnes Faculty Fellowship award of $30,000 for his contribution to an understanding of antiestrogenic drug therapy of breast cancer.

NCAB TO DECIDE BETWEEN GALVESTON, ROSWELL PARK ON COORDINATING CENTER

(Continued from page 1)

National Cancer Advisory Board at its meeting May 14-15. The NCAB's Committee on Organ Systems Programs will consider the review findings at a closed door meeting May 13.

The third application submitted, that of Rush-Presbyterian-St. Luke's Medical Center, was scored well back of the others and, presumbably, is out of the race.

There are those who are speculating that, since the scores are well past the anticipated RO1/PO1 payline of about 170-180, some pressures might be generated to throw them all out and try again. That will not happen. NCI intends to complete the phaseout of the existing four Organ Site Program headquarters grants (bladder, prostate, large bowel, pancreas) on June 30 and have the new coordinating center operating July 1.

The distance between the Galveston and RPMI scores and the RO1/PO1 payline is not considered relevant, since the task of coordinating the newly revamped Organ Systems Program is new and unique. The reviewers knew it would not be competing for money out of any other pool.

J. Palmer Saunders is the principal investigator for the Galveston application. Before he assumed his position at the UTMB Cancer Center, Saunders was director of the NCI Div. of Research Resources & Centers. That division then had responsibility for managing all of NCI's grants portfolio except the Organ Site Program. It was after Saunders left that those grants were split up among the program divisions, with the division limited to managing the assignment and review of grants.

Gerald Murphy is the principal investigator for the RPMI application. Murphy is director of RPMI and has headed the National Prostatic Cancer Project since its inception in the early 1970s.

Murphy was the only one of the four Organ Site Program project chairmen to compete for the coordinating center award.

The support mechanism for the coordinating center will be the cooperative agreement. The four project headquarters it will replace were funded by grants.

With the new arrangement, the program will include five sites to start with--the four in the old program plus the Breast Cancer Task Force, which has been headquartered at NCI since it was started. The coordinating center will organize a working group for each of the sites. Those working groups, with the aid and assistance of the coordinating center, will survey ongoing research and unfunded research in their respective areas; conduct workshops and conferences; and develop research initiatives for recommendation to NCI.

Those initiatives will be submitted to the appropriate NCI division Board of Scientific Counselors for concept review. If approved, they will be developed into requests for applications (RFA), program announcements, or requests for proposals (contract RFP). If disapproved, they will be sent back to the coordinating center for refinement, redevelopment, or oblivion.

The coordinating center will recommend individuals for appointment to the working groups, with NCI concurrence. They may or may not include members of the respective existing working groups, but most likely will. In some instances, those groups include most of the country's expertise in their areas.

Some of the present members may not be interested. Under the former arrangement, they exercised considerable power—they not only developed their own ideas for research initiatives but they did not have to ask anyone else for concept approval, and they reviewed the subsequent applications. NCAB approval was required before the grants could be awarded.

Separation of program from review was the reason most cited for dismantling the old program. Another was the feeling among some NCI executives, and concurred in by some investigators not participating in the program, that the review was less stringent and thus some less meritorious work was being supported.

The program's grants have been reviewed by regular NIH study sections for more than a year now (with the clinical projects now part of the Cooperative Group Program and reviewed by NCI established committees), and they appear to be holding their own. They are scoring and are being funded at approximately the same rate as other ROIs. However, a number of those which could not score in the funding range have been dropped.

Responsibility for administering the program at NCI is with the Organ Systems Branch, with Andrew Chiarodo as chief, in the Div. of Cancer Prevention & Control. Chiarodo last week discussed the program with the Committee on Centers & Community Oncology of the division's Board of Scientific Counselors.

Chiarodo said that all initiatives from the working groups would be channeled through the DCPC board. DCPC Director Peter Greenwald added that the boards of the other three program divisions would have final concept consideration for those within their scope of work, but that the DCPC board and the Committee on Centers & Community Oncology would be kept informed.

Jerome Yates, director of DCPC's Centers &

Community Oncology Program, said, "One of the things we would like to see is the ability to respond rapidly in moving along with some type of applied research." Asked how a rapid response could be achieved when concepts first must clear the working group level and then hurdle not one but two NCI division boards, Yates said, "The system can be greased. We're not looking to add more layers of approval."

DCPC Director Peter Greenwald was a little more specific. "That is the function of the NCI Executive Committee," he said. The Executive Committee consists of the NCI director, deputy director, executive officer, and the division directors. "It can move things along that cross division lines. The system works well, The committee meets weekly."

Committee member Charles Cobau suggested that it should be the responsibility of the working groups to direct the concept to the appropriate division. Chiarodo agreed, but said that they still would be brought to the DCPC board.

Greenwald said the process also might be speeded up "by collapsing the time required for review." He insisted that concepts would not be subjected to double review, by his board and that of one of the other divisions.

"This is a very visible, sensitive arena," Committee Chairman Virgil Loeb commented. "It has been guarded very jealously, and it has been an excellent program."

The Organ Systems Coordinating Center award will be the major item of business for the NCAB meeting.

The Board's Committee on Organ Systems Programs, chaired by William Powers, will report its recommendation from its May 13 meeting at the Board's closed session May 15, when all other grants for this round will be considered.

The full Board, in an unusual two day (instead of three) meeting, will hear the report on centers being developed by DCPC; hear from Congressman William Natcher, chairman of the House Labor-HHS Appropriations Subcommittee; hear a status report on adjuvant chemotherapy from Sydney Salmon, director of the Univ. of Arizona Cancer Center who recently cochaired the Fourth International Conference on the Adjuvant Therapy of Cancer; consider and approve the 1986 fiscal year bypass budget (the one that goes directly to the President without being mutilated at NIH or HHS headquarters); and hear a report from Peter Fischinger, coordinator of the NCI AIDS Task Force, and Robert Gallo, whose brilliant work in identifying the virus which is the probable cause of AIDS could be a major step in controlling the problem. The May 14 session and first two hours May 15 are open.

SIX GRANTS AWARDED FOR RESEARCH ON CANCER, ELDERLY; FIVE MORE COMING UP

Six grants have been awarded by NCI in response to the RFA issued last year for research on cancer control for the elderly.

Rosemary Yancik, program director in the Div. of Cancer Prevention & Control, reported at the meeting of the Committee on Centers & Community Oncology of the division's Board of Scientific Counselors that in the first round, 41 applications were submitted, 15 were approved and six funded. They were:

Dana Farber Cancer Institute, Colin Begg principal investigator, for "Cancer Treatment in the Elderly: A Database Investigation;" Duke Univ., Harvey Cohen, "Characterization of Cancer Management in the Elderly;" Brown Univ., Vincent Mor, "A study of Treatment Choices Affecting Elderly Cancer Patients;" Univ. of New Mexico, Jonathan Samet, "Patterns of Cancer Care in Elderly New Mexicans;" Univ. of Michigan, Robert Kahn, "Cancer Symptoms in the Elderly: Support and Responses;" and UCLA, Sheldon Greenfield, "Patterns of Medical Care in Elderly Cancer Patients."

Yancik said that the second round had generated 25 applications, including 10 resubmissions from the first round. Seven were approved, five with priority scores which probably will place them in the funding range. They will go to the NCAB May 15.

Donald Fox, chief of the Research Facilities Branch, told the committee that the RFP for the National Research Facilities Survey had been sent to 10 organizations requesting it. The survey is being funded jointly by Armand Hammer and the American Cancer Society; NCI is involved only as "an interested bystander."

Hammer and ACS agreed to pick up the $150,000 estimated tab when it became obvious that neither the White House nor NIH was interested in developing information which could be used to circumvent their long standing opposition to NCI support of facilities construction and renovation. If the survey documents the need, estimated in an NCI survey for the National Cancer Advisory Board six years ago to be in the range of $250 million or more for NCI's share, Hammer has promised to take the case to the President and Congress, as chairman of the President's Cancer Panel.

NCI had requested permission to do the survey through a contract, but had been turned down by NIH and the Office of Management & Budget.

Fox said that contract proposals were due by May 1 and will be reviewed by ACS. The report will be due early in 1985. The survey will cover about 100 institutions, Fox said. "NCI supports research at about 250 institutions, so it was felt that a sample

of 100 would get a good representation." Requests for the RFP came from Rand Corp., CDP Associates, JWK International, and Maurice J. Perault & Associates, among others, Fox said. The contractor should be ready to start the survey immediately after Labor Day. "I think we know the questions to ask. We just have to design the question form."

"I think we know the answers," Committee Chairman Virgil Loeb said. "The problem is to ask the right questions."

Loeb asked if the survey will look at continuing needs as well as the immediate need to replace inadequate facilities, and Fox said that it would.

Committee member Robert Cooper said that "the critical point is not that this study has not been done. It has been done by Don and his associates. But this is an independent survey."

"Then we'll see if the machine responds any better to the independent survey than to the others," DCPC associate director Jerome Yates said.

HCFA CHIEF SAYS DATA WILL MAKE NO DIFFERENCE, WILL NOT CHANGE DRG REGS

The ad hoc committee convened by HHS Secretary Margaret Heckler at the suggestion of Sen. Robert Dole (R.-Kan.) to look at the question of the impact of Diagnosis Related Group reimbursement on clinical research had its meeting last week, and predictably, nothing was changed.

The meeting was closed, but **The Cancer Letter** has learned that Caroline Davis, administrator of the Health Care Finance Administration, refused to back down from the position that if clinical research causes any increases in the cost of patient care above the levels set for the appropriate DRG, the agency sponsoring the research—NCI in cancer clinical trials—should pay the additional costs. There will be no deviation from the strict and, in the opinion of many, inaccurate interpretation of congressional intent in the institutional exceptions which so far limit those exceptions to a handfull of institutions.

Davis did agree in a superfluous gesture which some present at the meeting interpreted as an implied threat, that HCFA would pay patient care costs for patients participating in clinical trials up to the DRG level. That was not and never has been the issue; there has been nothing in the regulations to indicate otherwise. But by making a point of that, some committee members felt that HCFA was implying that serious consideration had been given to not paying any of the patient care costs for patients in clinical trials. The issue has always been that the DRG limits do not cover the legitimate increased costs of patient care necessitated by clinical trial participation.

NCI Director Vincent DeVita has insisted that HCFA should continue paying patient care costs in clinical trials on the same basis that it has in the past. NCI does pay for such research associated costs as data collection and analysis, extra tests, experimental drugs, etc. DeVita had been named to the committee but did not attend the meeting; Deputy Director Jane Henney attended instead.

Most of the administration members of the committee repeated the refrain that "more data are needed" before any decisions can be made about increased payments for clinical trials. However, Davis was asked that, if data does document the need for and justify additional payments, would HCFA agree to it, she responded that it would not without new legislation.

Some observers have interpreted that answer to mean that Davis is under orders, probably those of the White House, to stonewall the issue. There is plenty of congressional authorization for HCFA to do just what the National Cancer Advisory Board, the Assn. of Community Cancer Centers, and other organizations and individuals have asked—that exceptions be made for the 200 or so centers and hospitals where NCI approved clinical trials are being conducted.

Davis' response also can be interpreted as an invitation to Congress to order, through new legislation, that those exceptions be made. Dole and other members of both houses have said they will do precisely that if an administrative solution cannot be reached.

ASCO, AACI ASK $1.3 BILLION FOR NCI, FULL FUNDING FOR CENTERS, GROUPS

The American Society of Clinical Oncology and the Assn. of American Cancer Institutes both requested an appropriation of $1.3 billion for NCI for the 1985 fiscal year in testimony before the Senate Labor-HHS Appropriations Subcommittee.

ASCO was represented by John Durant, president of the Fox Chase Cancer Center, and AACI was represented by Timothy Talbot, AACI board chairman and president-emeritus of Fox Chase.

Durant's testimony summarized four major points:

1. "We urge that the committee recommend the appropriation of $1.3 billion for NCI for fiscal year 1985, including the appropriations for research training and the Cancer Control Program.

2. "We urge that the committee express its intent that NCI supported clinical research, including that conducted by cooperative groups and cancer centers, be funded at recommended levels in the same manner as applied to RO1 and PO1 grants. This will require approximately $20 million of new funds.

3. "We urge the committee to call for a study by NIH of the patterns of funding of clinical research in all institutes since FY 1980. The study should focus on clinical research by physicians employing human subjects in clinical trials funded by each type of award employed since 1980 by each institute. The number of awards and the dollars allocated should be shown for each type of funding mechanism by year.

"We recommend that the committee request the report be delivered to the committee in January 1985, prior to the appropriations hearings upcoming next year. Such a study will enable the committee, OMB and NIH to accurately ascertain the impact of policy decisions on the funding of clinical research by all mechanisms.

4. "We also recommend that the stipend levels for NIH predoctoral and postdoctoral trainees be increased to levels equaling those in other federal agencies and in teaching hospitals. The estimated cost for such an increase, without decreasing the number of trainees, would be approximately $33 million."

Talbot said in his presentation that the total of $1.3 billion is "a realistic figure to keep the present machinery in operation. The NCI bypass budget requested $1.189 billion, which we do not believe is adequate to meet the existing needs. We have arrived at the figure of $1.3 billion in the following manner: We have added to the President's budget the standard deflator factor, which is generally accepted to be about 10 percent, plus about five percent for growth.

"We should like to draw special attention to the fact that the President's budget contains $1 million less than the 1984 budget for cancer centers. We strongly urge that this be increased from $78 million to $90 million for fiscal 1985. This figure is arrived at by applying the deflator factor plus growth, as above.

"In addition, however, there is now considerable public discussion by the NCI administration that there may be new cancer centers approved. We do not see the wisdom of doing that within the current budget restrictions and suggest that there be added $4 million more to provide for that possibility, which we assume would be based upon peer review."

Talbot also argued for full funding of core grants:

"Last year Congress directed that NIH should fund grants at the level of the budgets approved by peer review. NIH then decided that this directive would apply only to RO1 and PO1 grants, thus excluding core grants for centers, and grants for cooperative groups. We urge that this committee take appropriate action to ensure that cancer centers support grants are funded at levels that are recommended peer review, and suggest the following bill report language:

"Core grants are essential for the stability and continued excellence of cancer centers, and they directly enhance the effectiveness of RO1 and PO1 supported research programs that are conducted at these centers. Therefore, there should be no distinction between RO1 and PO1 grants and core grants with respect to their levels of funding. It is vital that core grants be funded at levels that have been recommended by peer review in precisely the same manner, and to the same degree, as the RO1 and PO1 grants."

DCPC SUGGESTS OPTIONS FOR MINORITY CENTERS, HOLDS DISCUSSION TO SEPTEMBER

One of the concerns being expressed by NCI staff in the current analysis of cancer centers, and by NCI Director Vincent DeVita in the series of meetings on centers being held around the country by the President's Cancer Panel, is the need they perceive for encouraging the development of cancer centers at minority institutions.

Jerome Yates, who heads the Centers & Community Oncology Program in the Div. of Cancer Prevention & Control, recently brought an option paper on minority institution centers to a meeting of the division's Board of Scientific Counselors Committee on Centers & Community Oncology. Yates asked that the matter not be discussed then and said it would be brought up before the board's meeting in September.

The option paper states:

"In order to increase research activity concerned with addressing the observations regarding cancer incidence, morbidity and mortality among minority groups, NCI is considering ways to encourage the development of cancer center activities at selected minority institutions.

"The current core grant guidelines are not designed to encourage such centers in that a substantial 'base' ($750,000 direct costs per year) of funded research is required. Most minority institutions cannot meet this requirement. Therefore, if minority institution centers are to be supported by core grants, the policy will have to be modified or exceptions made.

Option No. 1

"A modified P50 grant which would provide for the complete support of the center activity in one grant package including core (leadership salaries, shared resources, etc.) and research project and developmental or seed support.

Option No. 2

"The planning grant mechanism could be used to encourage these institutions. Such support could be used to plan methods of expanding research act-

ivities in order for those institutions to become eligible.

Option No. 3

"The $750,000 research base requirement could be lowered, perhaps on a selective case by case basis, in order to allow selected minority institutions to apply for core grants for clinical centers. Such exceptions would be made only after concurrence by the NCI Executive Committee and the National Cancer Advisory Board.

Option No. 4

"Start a new program (such as the 'Academic Clinical Oncology Program' suggested by Robert Frelick—see **The Cancer Letter**, April 27) to enable additional clinical research activities at selected institutions and thereby create a 'clinical' center at an institution doing mainly laboratory research."

NCI QUESTIONS, ANSWERS SUMMARIZE NEW DEVELOPMENTS ON AIDS VIRUS

NCI's Office of Cancer Communications has prepared a list of questions and answers in response to the deluge of requests for information on the discovery of the virus involved in the etiology of acquired immune deficiency syndrome. The list succinctly summarizes these new developments:

1. What are the new findings on AIDS from NCI that are being published in the May 4 "Science"?

A. Scientists at NCI have isolated variants of a human cancer virus, named human T-cell leukemia/lymphoma virus III. The virus was isolated from the T-cells of more than 50 patients with AIDS or pre-AIDS and grown in the laboratory.

2. How common is the virus in AIDS patients?

A. The scientists documented in "Science" isolation of the virus from 18 of 21 pre-AIDS patients, three of four clinically normal mothers of juveniles with AIDS, and 26 of 72 adult and juvenile AIDS patients. It was isolated from only one of 22 normal male, homosexual individuals, and from none of 115 normal heterosexuals. NCI scientists are continuing to isolate the virus from blood samples.

3. How many AIDS patients have antibody to HTLV-III?

A. At least 90 percent of patients with AIDS or pre-AIDS have antibodies to HTLV-III. It is not known at present what proportion of individuals at high risk of developing AIDS, such as intravenous drug abusers, hemophiliacs, blood transfusion recipients, and close heterosexual contacts of members of these high risk groups, may have antibodies to HTLV-III.

4. Do normal people in the general population have antibodies to HTLV-III?

A. Normal people in the general population tested thus far have either very low levels or no antibody to HTLV-III.

5. Why does NCI believe that HTLV-III causes AIDS?

A. The HTLV-III viruses specifically attack and kill the helper T-cells in the blood that are destroyed in AIDS. In addition, these viruses have been repeatedly isolated from the helper T-cells of patients with pre-AIDS and AIDS. Antibodies to the viruses are common in people who are at high risk of developing AIDS and are low or nonexistent in those who are not, making the laboratory findings very consistent with the epidemiology of AIDS. And, the biochemical and immunological characteristics of the virus are consistent with the predicted characteristics of an AIDS virus in the HTLV family. (For example, HTLV-III kills T-cells).

6. What exactly do the four papers in the May 4 issue of "Science" magazine report?

A. The four papers in "Science" by Dr. Robert Gallo and coworkers, Dr. Mikulas Popovic, Dr. M. Sarngadharan, Zaki Salahuddin, and Dr. Phillip Markham document:

*The scientists' ability to isolate the HTLV-III viruses from infected persons.

*The development of a method for growing the viruses in T-cells in the laboratory in bulk amounts.

*The biochemical and immunological characterization of proteins and genes of the viruses.

*The presence of viral antibodies in blood samples of infected people.

7. Besides isolating these viruses, what else is important about the NCI findings?

A. A finding of key importance is that the NCI scientists have found a special cell strain of T-cells that can produce this virus in large amounts yet are not killed by it. This enables NCI to produce virus and viral proteins in amounts large enough for blood testing and future attempts at vaccine development. NCI scientists have also developed a special test for the presence of antibody to the virus in blood.

8. Who were Dr. Gallo's other collaborators in these studies and what was their role?

A. Dr. Gallo's group collaborated with clinicians and scientists from the NCI Immunology Branch, Memorial Sloan-Kettering Cancer Center, Duke Univ., the Univ. of North Carolina, North Shore Univ. Hospital on Long Island, Walter Reed Army Institutue of Research in Washington D.C., the Univ. of Medicine & Dentistry of New Jersey in Newark, and New England Deaconess Hospital in Boston, that provided blood and tissue samples for this research. The NCI effort was set up as a coordinated AIDS task force headed by Dr. Peter Fischinger, NCI associate director, with Drs. Gallo and Samuel Broder as the scientific and clinical directors respectively. Scientists from other HHS agencies and

the extramural community provided regular advice and consultation.

9. What does having antibody to HTLV-III mean?

A. The antibody being detected in the AIDS and pre-AIDS patients recognizes the envelope, or outside, of the virus. Therefore, a person with high levels of antibody to HTLV-III is almost certainly infected by the virus and the virus is or has reproduced in that person's T-cells and probably is still present. It is not known for sure whether the presence of antibody always means the viral infection is active; it is possible it could also signal a past infection.

10. Does that mean that a person with antibody to HTLV-III is going to develop AIDS?

A. The answer to that question is not known at present. It does mean that the individual should be closely monitored for the development of AIDS or pre-AIDS symptoms.

11. Do the new NCI findings indicate that a blood test for AIDS is near?

A. Yes, in fact, a simple, rapid test of blood samples for antibodies to HTLV-III is already available in the laboratory. Scientists at NCI are now collaborating with scientists at NCI's Frederick Cancer Research Facility to develop procedures for large scale production of the viral proteins needed to test large numbers of blood samples for antibody to HTLV-III.

12. How long will it be before a blood test will be available to the medical community?

A. NCI scientists predict that within six months they will be able to produce the amounts of viral proteins needed for large scale testing of blood samples by blood banks and diagnostic laboratories. Testing of limited numbers of blood samples, between 5,000 and 10,000 per week, can be done now.

13. Do these findings mean that new treatments and a vaccine for AIDS are now possible?

A. NCI scientists do believe it will be possible to develop new approaches to the treatment of AIDS and that a vaccine is a real possibility.

14. How long will it be before a vaccine is developed?

A. NCI and HHS scientists predict that within two years they will be able to develop a prototype vaccine for clinical testing. Clinical trials on new AIDS vaccines may require several years.

15. What is the relationship between HTLV-III and the virus isolated by French scientists at the Pasteur Institute in Paris?

A. It is not yet clear whether the 50 isolates of HTLV-III are related to the virus or viruses reported by the French scientists. Collaborative research is currently under way between NCI and the Pasteur Institute to examine this issue. Until more detailed studies of the biochemistry, immunology and epidemiology of the French virus or viruses are completed, it is not possible to draw the conclusion that they are the same or that they are different. In the meantime, it is clear that the 50 isolates of HTLV-III are probably causing AIDS in the United States.

Even if the viruses are the same, it is also clear that the NCI studies are the first to report the ability to isolate the HTLV-III viruses repeatedly from a large number of AIDS patients, and the first impressive correlation of virus isolation with related antibody from patients and those at risk of developing the disease. It is also the first time these viruses have been produced in quantities in permanently growing cell lines so that: (1) they can be properly characterized; (2) they can be used for mass production of viral proteins for blood tests and possibly for vaccine development; and (3) they have been shown to be related to the HTLV-I and HTLV-II cancer viruses.

16. What does this research indicate about transmission of AIDS from one person to another?

A. The research is still consistent with other evidence that AIDS is usually a sexually transmitted disease, or transmitted via blood products from AIDS or pre-AIDS patients.

17. What is HTLV?

A. The first member of the HTLV family of retroviruses, HTLV-I, was isolated in 1978 and first published in 1980, also by Dr. Gallo and his coworkers. It has been reisolated many times since then in this country and abroad from a form of leukemia and lymphoma that affects mature T-cells. Extensive epidemiologic studies have linked HTLV-I to clusters of these cancers in certain parts of the world, particularly southern Japan, the Caribbean, and parts of South America and Africa. A related virus, called HTLV-II, has been isolated rarely, originally from patients with a hairy cell leukemia, by Dr. Gallo and his group in collaboration with UCLA scientists.

18. When was a relationship between HTLV and AIDS first reported?

A. Dr. Gallo and his collaborators first reported an association between HTLV and AIDS in the May 12, 1983 issue of "Science." However, this was HTLV-I, which the scientists emphasized might not itself be the cause of AIDS, but might be related to a variant virus that could cause the disease. In that respect, Dr. Max Essex and his collaborators at the Harvard School of Public Health and the Centers for Disease Control at the same time reported indirect evidence linking an HTLV related virus with AIDS.

19. What is a retrovirus?

A. Retroviruses are so named because their genetic information is the chemical ribonucleic acid (RNA). These viruses contain an enzyme, reverse

transcriptase, that enables them to convert their RNA to deoxyribonucleic acid (DNA), the hereditary chemical comprising the genes of human and animal cells. In so doing, retroviruses use the genetic machinery of the cells they infect to make the proteins they need for survival. In the process, many retroviruses can cause a variety of ailments in the animals, including depressed immune functions and cancer.

20. How big is a retrovirus?

A. It is 110 to 140 nanometers in diameter. A nanometer is 1 billionth of a meter, or 1 billionth of 39.37 inches. It can be seen in the cytoplasm of a cell only with an electron microscope, which magnifies it at least 100,000 times.

In a press release accompanying the list of questions and answers, NCI Director Vincent DeVita said, "Although this evidence does not prove absolutely that these viruses cause AIDS, it is very strong evidence that we have isolated the causative agent. Short of preventing the disease with a vaccine, we may find no better proof."

AIDS is often a fatal disease characterized by a severe loss of natural immunity that predisposes the patient to severe opportunistic infections and other disorders. These include pneumocystic carinii pneumonia and Kaposi's sarcoma, a rare cancer that starts in cells of blood vessel walls. It occurs predominantly among homosexual men with multiple sex partners, intravenous drug abusers, hemophiliacs, blood transfusion recipients, and close heterosexual contacts of members of these high risk groups. The severe immune deficiency in patients with AIDS is caused by destruction of immune system cells in the blood, helper T-cells.

FRIEND, MOLONEY, RAUSCHER TO BE HONORED FOR EARLY VIRUS RESEARCH

Three scientists will receive distinguished achievement awards from the AMC Cancer Research Center "in recognition of their germinal contributions to the field of cancer virology" at an international conference on RNA tumor viruses in human cancer scheduled for June 10-14 in Denver.

The three scientists are Charlotte Friend, Mount Sinai, New York; John Moloney, former director of NCI's cancer virus program; and Frank Rauscher, American Cancer Society vice president and former director of NCI.

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-CO-54051-36
Title: Technical support services to the International Cancer Research Data Bank and Office of International Affairs
Deadline: Approximately June 21

The services required will be definitized by work orders issued during the period of performance. The work orders will be issued under the following areas:

1. Obtaining background information and preparing documents needed for planning or implementing specific ICRDB/OIA functions.
2. Monitoring the quality of products and services produced by ICRDB.
3. Developing and implementing methods to evaluate usefulness of ICRDB products, services.
4. Updating of special publications or compilations of new publications.
5. Taking steps to make potential users aware of ICRDB products and services.
6. Preparation or acquisition and/or dissemination of documents, reports, letters, and other representations.
7. Developing and implementing methods and documents for responding to requests for information.
8. Task administration and documentation of contract activities.

These services will be provided under a level of effort, cost plus fixed fee contract for 61,840 labor hours. Offerors will not be considered eligible for award unless they can demonstrate their ability to meet with the project officer in Bethesda and then provide certain deliverables, such as slides or charts, computer data, logistical support, or other products to Bethesda within 24 hours.

The proposed contract is a 100 percent small business set aside.

Contracting Officer: Patricia Rainey
RCB Blair Bldg Rm 332
301-427-8877

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