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MIHICH TO BE SIXTH NEW NCAB APPOINTEE; CENTERS WORRIED ABOUT CORE GRANTS, ROLE IN 2000 AD GOALS

Enrico Mihich, director of the Grace Cancer Drug Center and of the Div. of Experimental Therapeutics at Roswell Park Memorial Institute, will be the sixth new appointee to the National Cancer Advisory Board, **The Cancer Letter** has learned. His appointment will complete the 1984 selections by President Reagan, filling the vacancies created by the expiration of six terms this year.

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In Brief

SALMON, FIDLER HEAD ASCO, AACR; DURANT, PARDEE PRESIDENTS ELECT; NAMOVICZ, OTHER AOs PROMOTED

SYDNEY SALMON and **ISAIAH (JOSH) FIDLER** assumed the presidencies of the American Society of Clinical Oncology and the American Assn. for Cancer Research, respectively, at this month's meetings of the two organizations in Toronto. Salmon is director of the Univ. of Arizona Cancer Center and Fidler is chairman of the Dept. of Cell Biology at M.D. Anderson/Univ. of Texas System Cancer Center. Fidler was named vice president and president elect by the AACR board when the late Frederick Phillips resigned that position last December due to his failing health. Phillips died last March. **JOHN DURANT**, president of Fox Chase Cancer Center, was named ASCO president elect, and **ARTHUR PARDEE**, professor of pharmacology and chief of the Div. of Cell Growth & Regulation at Dana-Farber Cancer Institute, is the new AACR vice president and president elect. David Ahmann was reelected ASCO secretary treasurer, and new board members are Bruce Chabner and Martin Abeloff. Robert Handschumacher was reelected AACR secretary treasurer, and new directors are Robert Gallo, Albert Owens, Barry Pierce, and Alan Sartorelli.... ASCO ACCEPTED 494 new members during the year, putting the membership total at an all time high of more than 4,500. AACR took in 259 new members, and the membership total is 3,989.... **NCI ADMINISTRATIVE** officers move up: Robert Namovicz, who has been deputy to Philip Amoruso, NCI associate director for administrative management, has been appointed to the top administrative job in the National Heart, Lung & Blood Institute. Stephen Ficca, administrative officer in the Div. of Cancer Etiology, is Amoruso's new deputy. Michael Goldrich, administrative officer in the Div. of Cancer Treatment, has been named chief administrative officer of the National Institute of Allergy & Infectious Diseases. Donald Christoferson, who has been Goldrich's deputy, is the new DCT administrative officer.... **LORETTA ITRI** is not leaving the Div. of Cancer Prevention & Control Board of Scientific Counselors (**The Cancer Letter**, May 11); her term has been extended a year.

NEW NCAB LINEUP HEAVY ON SCIENCE; MIHICH CHAIRED BRMP DEVELOPMENT

(Continued from page 1)

The White House announced the other five appointments last week—Roswell Boutwell, reappointed to a full term; Helene Brown, Gertrude Elion, David Korn and Louise Strong (**The Cancer Letter**, May 18).

Those appointments were viewed as going a long way toward satisfying the critics who have contended that the membership of the NCAB has been weighted too heavily toward practicing physicians and away from scientific expertise. The addition of Mihich further strengthens the quality of science represented on the Board.

Mihich is an internationally recognized biochemical pharmacologist and immunopharmacologist. He was program chairman for the highly successful XIIIth International Cancer Congress held in Seattle in 1982. He has served as a member of the NCI Div. of Cancer Treatment Board of Scientific Counselors and chaired that Board's committee which developed recommendations that led to establishing the Biological Response Modifiers Program.

The appointment of Mihich has not yet been announced officially by the White House but will be made well ahead of the Board's next meeting, in September.

Members leaving the Board are Maureen Henderson, Janet Rowley, Sheldon Samuels, Morris Schrier, and Irving Selikoff.

The NCAB last week heard presentations from three center directors, billed on the agenda as an "interim report on cancer centers." Many center representatives have expressed understandable interest in and some concern over the series of meetings by the President's Cancer Panel and NCI planning groups on centers. Others are wondering about their role in NCI's ambitious effort to set goals for the year 2000.

Harry Eagle, director of the Albert Einstein Cancer Research Center, said he was worried about the suggestion by NCI Director Vincent DeVita that basic research centers might fare better if they were to exchange their center core grant support for program projects.

Eagle defended use of core grants for laboratory centers and said, "Core grants work. . . I'm reminded of the ancient aphorism, 'If it isn't broke and is working well, don't fix it.' " Also, he said, if NCI is considering dropping core grants for basic centers, "why not all centers?"

DeVita's position is that program project grants (PO1s) and RO1s are always at the top of the NIH priority list in allocating funds while the centers core grant budget has lesser priority. The basic research centers would be better protected in future budget crunches, DeVita contends. The PO1 mechanism could be used to do the job of core grants for basic centers, he has said. Also, "If we have a finite number of centers we can support, we may have to choose (between clinical and laboratory centers)." The implication is that centers supported through large program projects rather than core grants would not count against a limit on the number of centers.

"The distinction between laboratory centers and mixed centers is to some extent artificial," Eagle said. "There are some laboratory centers doing clinical research."

Albert Owens, director of the Johns Hopkins Oncology Center, one of the 20 comprehensive cancer centers, said one of his major concerns at the moment is the prospective payment reimbursement system implemented last year by the government for Medicare.

Maryland is one of the states excluded from the national system because it had developed its own program. "We have grave concern about it," Owens said. Since the system was established, Hopkins has had 87 admissions of adults with acute leukemia. Reimbursement was $4,000 to $5,000 per discharge, Owens said. "Our cost averaged $55,000 per discharge."

Ernst Wynder, president of the American Health Foundation, said that speaking for the prevention community, "I accept this challenge" to reduce cancer mortality by 50 percent by the end of the century.

"It is a historical fact that for cancer as well as other major diseases, the mechanisms whereby a factor causes disease need not be fully understood in order to prevent it," Wynder said. "Modification, reduction or elimination of the factor will suffice. The two major risk factors for cancer as presently established are tobacco usage and dietary fat. If these two major risk factors for human cancer could be properly modified and controlled, we would already reach our desired goal."

Among the obstacles to prevention, Wynder said, "is the apathy toward prevention from all segments of society. . . There is disinterest in preventive medicine by the medical community, hospitals, the insurance industry and legislators." An example he said is a recent survey of 27 hospitals in New York using the pretext of a heavy smoker seeking assistance in breaking the habit. "Twenty four hospitals replied that they had no facilities for smoking prevention programs, three had some sort of smoking cessation program, two of which were run by the American Cancer Society, and one referred us to a hypnotist. Clearly, we would have received more favorable responses if we had inquired for a coron-

ary bypass or a pneumectomy. Even worse, in our public schools is the virtual neglect of health education. . . Physicians find that behavioral medicine and the giving of advice on smoking and nutrition uninteresting and unrewarding. When they study the insurance schedule, they find such efforts to be nonreimbursed... Having stated the obvious problems, I believe nevertheless that with the innovative leadership of the National Cancer Institute, positive changes in the practice of preventive oncology will occur."

Wynder said that efforts to develop appropriate recommendations for elimination of a product, its modification, or the introduction of chemopreventive measures, and evaluation of those efforts in a defined population, "are best carried out by a cancer control unit. This unit has the critical mass of expertise to launch a broad based preventive oncology program... The unit could be housed in a comprehensive cancer center, in a general hospital or health care center, or could be part of a cancer prevention center such as the American Health Foundation. A key to its success would be that the leadership of the center or institution would provide full support for the unit's work. . . An integral part of the plan is that the preventive efforts of such a unit must in the long run be supported by the same type of financial support that provides for therapeutic efforts... Insurance may soon pay for heart and liver transplants. We need to recognize that as part of a capitalistic system, as long as we reimburse for pneumectomies and coronary bypasses but not for helping in smoking cessation, to reduce one's weight, to treat asymptomatic blood pressure, or to modify a person's high fat diet, we cannot create a support industry for such services.

"Cancer control units, working within a supportive framework of a health establishment and being staffed by qualified and committed professionals and allied health professionals, will succeed if they have the support of the health care delivery system that will reimburse programs as it supports therapeutic care. In a capitalistic society, if we give preventive medicine the opportunity to prosper in the free market place, we will develop a cadre of young people who will make preventive medicine their career... We will meet the challenges given to us by the NCI leadership."

ACS TO BEGIN REVIEWING FACILITIES SURVEY PROPOSALS; DEADLINE JULY 1

The American Cancer Society will soon begin reviewing proposals from organizations seeking the contract to conduct the national survey of cancer research facilities needs jointly financed by ACS and Armand Hammer. Proposals will be accepted until July 1.

The survey is being conducted and paid for outside the government because NIH and the Office of Management & Budget blocked NCI's attempt to do it through a contract. Hammer, chairman of the President's Cancer Panel, has said he will ask the President and Congress for additional construction funds if the survey establishes the need.

ACS is organizing a working group to help administer the contract. Gerald Murphy, ACS president, will be chairman, and other members will include R. Lee Clark, William Hutchinson, William Shingleton, architect Gordon Orr of Wisconsin, and health facilities planner Paul Atkinson of New York.

CONCEPTS APPROVED BY DCPC BOARD INCLUDE NURSE RESEARCH TRAINING

Additional concepts acted upon the by Div. of Cancer Prevention & Control Board of Scientific Counselors at its meeting earlier this month follow here. Others were reported in the May 11 and 18 issues of **The Cancer Letter.**

Title: Formulation, dosage form preparation and packaging of chemopreventive agents. Estimated cost, $200,000 per year for task orders to be awarded under master agreement contracts of five years.

The DCPC Prevention Program has a need to establish under master agreement task order contracts a series of qualified contractors capable of providing needed formulation, dosage form preparation and packaging of investigational agents for new chemoprevention studies. In its initial series of studies, the chemoprevention effort has utilized available formulations directly or has been able to secure small lots of special formulations if these could be easily accomplished within the production schedules of the pharmaceutical manufacturers. In some instances, bulk product has been provided by the manufacturer with small lots of special formulations made through existing contracts of the Div. of Cancer Treatment. Although very economical and sufficient for our initial requirements, there have been some delays necessary because of the competing high priority activities at these cooperating facilities. Further, these previously utilized resources will not be sufficient to meet our future needs for larger scale, more complex and novel formulations.

NCI will request that potential contractors provide qualifications for preparing finished formulations of chemopreventive agents for human clinical trials. These may be tablets, soft or hard gelatin capsules (rarely liquids) and will require, in most instances, the formulation of comparable matched placebos. All contractors must meet FDA requirements for facilities preparing pharmaceuticals for investigational drug use. Packaging of chemopreventive agents will be by bottle or by individual subject dose a day or calendar packs. Contractors will be required to demonstrate a capability not only of meeting technical packaging

requirements but also ability to generate coded labels according to randomized allocation schemes for a specific trial. Three tasks will be outlined--formulation, dosage form preparation, and packaging. Potential contractors may submit capabilities to perform one, two, or all three tasks.

When needs for formulation, finished dosage form or packaging become known, specific task orders will be placed for bid to contractors qualified under the master agreement.

Donald Buell is the project officer.

Title: Purchase of 4-hydroxyphenyl retinamide (HPR) for breast cancer prevention studies. Estimated annual budget, $900,000, one five year award.

HPR is a new synthetic retinoid which has shown a high degree of efficacy in inhibiting chemically induced carcinogensis in the rat mammary tumor system. At the same time, preclinical toxicology studies reveal that HPR is much less toxic than other currently available retinoids. Thus this compound has good potential efficacy in breast cancer prevention, with a much improved therapeutic ration. An IND for HPR has been established with FDA and HPR is scheduled for phase 1 studies to be conducted by NCI at the NIH Clinical Center.

At the January, 1984, meeting of the Board of Scientific Counselors, a concept was approved to initiate chemoprevention trials using HPR for the prevention of bladder and breast cancer. At that time the program had a tentative commitment for supply of the agent from the company holding the patent. However, on subsequent review, the company decided to provide this agent only for phase 1 trials, for studies in skin disorders, and phase 3 trials in bladder cancer. It will be necessary for NCI to support agent acquisition costs for breast cancer prevention studies. This is because these studies will require large sample sizes (sample estimates--4,000 for prevention of second primaries, 12,000 for prevention of primaries in first degree relatives) and because the studies will take five to seven years for definitive results. The manufacturer was reluctant to support the breast study because it was estimated that the results would not be available and verified in time to submit to FDA as a claim of efficacy before the patent rights expire. The manufacturer will, however, assist NCI by preparing finished formulations from our purchased bulk product and by performing specialized analyses such as HPR blood levels.

The Prevention Program considers studies of breast cancer prevention to be of very high priority. Approval of this request, coupled with the previously approved support for the clinical trial costs will make possible the conduct of a clinical trial using HPR in the prevention of breast cancer.

In the rat mammary system, HPR at 2mM/kg diet is nontoxic and considerably more effective than retinyl acetate or 13-cis retinoic acid at nontoxic doses of 1mM/kg diet.

NCI will purchase, through competitive procurement, sufficient bulk HPR to support a five year study involving 5,000 subjects half of whom will be randomized to receive the active agent. A dose of 500 mg/day translates to 1.25 kg/day or approximately 450 kg/year.

Although human phase 1 data are limited, it is estimated that the dose for a long term phase 3 trial is not likely to exceed 500 mg/day and could be lower.

The intention, therefore, is to purchase up to 450 kg of HPR on a yearly basis for five years. The total cost estimate of $900,000 is based on a price of $2,000/kg. This might be less as a result of competitive bids.

Buell is the project officer.

CONTRACT RECOMPETITIONS APPROVED

Title: Cancer Communications System. Estimated first year total cost, $3.8 million, up to 30 awards in recompeting the existing network of CCS offices.

Goals of the Cancer Communications System are:

A. To use communication as a cancer control modality to reduce cancer incidence, morbidity and mortality. This will contribute to the overall NCI goal of a 50 percent reduction in cancer mortality by the year 2000 by making available the latest state of the art information on cancer prevention, screening, treatment and continuing care to cancer patients, their families and friends, the general public at risk to cancer and health professionals.

B. To establish a high quality communications mechanism which can serve as a resource and/or data base for stimulating the development and implementation of new research projects in cancer communications, in cooperation with the grantees funded through the program entitled "Cancer Communications System Research" (the concept for which was also approved by the Board--see **The Cancer Letter**, May 11).

C. To provide regional cancer centers and other major community cancer organizations with a resource to interface and communicate with other information resources and their various publics.

The overall goal will be met by the following objectives:

A. To develop and extend a cadre of cancer communications professionals who can plan, administer, promote and develop support materials for cancer information and education programs which comprise the CCS.

B. To provide the general public and health professionals with access to accurate, current information on cancer. This will be accomplished by establishment, operation and evaluation of a national toll free telephone information system, known as the Cancer Information Service (CIS). Additional education and information activities will be developed to complement and enhance the CIS system, based on community interests and needs.

C. To develop and maintain directories of cancer resources including agencies, organizations and services available to the general public, cancer patients and their families within a designated service area.

A Cancer Communications Network program is

operational under sponsorship and funding of NCI. This program, in existence since 1976, was recompeted in 1981 and current program funding expires in November, 1984. Program staff have responded to well over one million inquiries from cancer patients and their families, the general public and health professionals through the CIS. The number of inquiries has risen over the years; steadily at first, now sharply. From 61,000 inquiries in 1976, the number rose to 278,534 in 1983. Thus, every day approximately 1,160 Americans call the CIS. The increase in calls is related to increased efforts on the national level to publicize and promote the CIS in response to local and national needs. Greater national visibility for the CIS has been made possible through use of a new toll free telephone number, 1-800-4-CANCER, which automatically connects callers with the office serving their area. In addition, cancer related stories in the mass media have increased over the years, whetting the public appetite for more detailed information about cancer.

New initiatives in evaluation of the CIS on a national level have served to ensure that a program of high quality is available to the public. Through the use of a new, centralized reporting form, data are now available on a national basis regarding the cancer concerns of CIS callers. A test call system, in use both on a national and local basis, monitors the quality of responses to typical inquiries. A survey of users of the CIS has been recently implemented, which will enable NCI staff to monitor user satisfaction with the program.

Through data collected from the user survey, it will also be possible to monitor the influence of the CIS on the health behavior of its users. This information is important when considering the overall goals of DCPC and NCI. CIS can contribute to these goals by helping individuals access the medical care system earlier, leading to earlier detection and more effective treatment of cancer. In addition, referrals to resources such as stop smoking clinics can influence behaviors which are linked to cancer incidence.

There currently exists no other national system with extensive quality control and evaluation mechanisms whereby individual members of the public can obtain state of the art information related to cancer.

This concept is a reformulation of the program, based upon the needs of NCI and the advice of an expert advisory group. Each CCS office shal work to achieve the common listed objectives within its defined area of service, but must also participate as a contributing member of the network in meeting national needs identified by NCI.

Each office shall cooperate and coordinate activities with voluntary organizations, federal, state and local government agencies, and professional organizations concerned with cancer. These activities shall be governed by regional needs and interests.

The CCS offices should function as a network, sharing information with one another and with the CCS project officer. Frequent opportunities for network interaction will be established by the project officer in collaboration with regional offices.

NCI reserves the right to select successful offerors on the basis of geographic location as well as the usual technical and fiscal criteria associated with such awards. This stipulation is designed to assure an adequate geographic distribution among network offices to cover the U.S.

Judith Stein is the project officer.

Board member Erwin Bettinghaus noted that some critics have contended that CIS is duplicative of efforts by the American Cancer Society. "That is not true. ACS may be starting some similar efforts, but these can be coordinated with the NCI system and can help fill gaps."

Other objections have been made because the system in the past has not had a research component. The new CCSR initiative should meet those objections, Bettinghaus said. CCS "has a rich data base it is accumulating." Critics have pointed to the high turnover among staff and volunteers working in the CIS officers. "I've always regarded that as a plus. This has created a cadre of knowledgeable people across the country who can provide nodes of information."

Board member Virgil Loeb, although endorsing the concept, said he had some reservations about overlaps with other agencies. "The Leukemia Society and ACS have for years attempted to educate the public about cancer... One of the most sensitive areas is patient referrals. Just telling callers to 'see your doctor,' or 'see your cancer center' is not helpful. There is a complementary system being developed by ACS. The use of volunteers, locally, is very attractive. Regional offices run by NCI will not supplant that. I hope you can assure us that you will have ongoing dialogue with other complementary systems."

Stein said that physician referrals are not dictated by NCI but are determined by the parent institutions (of the contracting organizations), which are comprehensive or community cancer centers.

"I would love to see ACS get into this," DCPC Deputy Director Joseph Cullen said. "This is the purview of ACS. The problem is, they have no standardized system, no training program for volunteers. We hope they can get it up and running, but it isn't yet. We are talking with them."

"Referrals are a major, major issue," Board member Robert Day said. "The way we do it (at the Hutchinson Cancer Center) is we have a panel. I make sure it is rotated. We are working around the region to help develop local groups which can do it."

"There is a great difference on how we view this now and how we did three years ago," Board member Charles Cobau said. "We came very close to scuttling this program then. I think this emphasizes how we need to let programs mature. Three years ago, it cost $50 a call. Now, it is $10."

The program was approved for recompetition three years ago over strong opposition of some Board members and with dire predictions that it would not

be renewed again. However, there was no opposition this time, and approval was unanimous.

Title: Smoking, Tobacco and Cancer Program support services contract. Estimated first year cost, $350,000, one award for five years. The present contractor is Prospect Associates.

The task of this contract will be to provide the NCI STCP with the necessary support services to plan, develop and implement a broadly based and rapid growing intervention research program in smoking preventing and cessation.

DCPC coordinates the STCP for all of NCI. This means that a number of organizational units within NCI are repeatedly reviewed and brought together to plan, develop and implement activities in toxicology, pharmacology, carcinogenesis, epidemiology, biobehavior, education, communications and training, all leading to control and intervention research and technology transfer in smoking prevention and cessation. Specifically, this refers to the coordinating of staff and resources of the Div. of Cancer Etiology, Office of Cancer Communications, and DCPC.

In order to accomplish this and to do so in a timely manner and response time in keeping with the needs of one of NCI's fastest growing control programs, it is necessary for DCPC to have the support of a nonfederal contractor. This contractor assists the program in all of its administrative and technical activities. In the past year, the contract has provided support for planning and conducting seven workshops, several intramural and extramural working groups, technical reports, staff presentations, developing a historical information base, and reviewing all major smoking prevalence surveys conducted since the first Surgeon General's report.

Betty Hawks is the project officer.

The following two concept approvals represent recompetition of one support contract for the Diet, Nutrition & Cancer Program presently held by Capital Systems Inc. NCI decided to separate clinical trials support from general support services.

Title: General support services for the Diet, Nutrition & Cancer Program. Estimated total first year budget, $126,000. One three year contract.

The goals of this procurement are to provide assistance for planning and formation of technical documents and to provide workshop, conference, and meeting support for the DNCP. Major objectives include statistical assistance in all nutrition and diet related areas of the DNCP; and development and preparation of technical documents such as the annual status report, the annual budget report, requests for scientific information, preparation of graphs, tables, reports and other original documents, materials for the DNCP Working Group, editing for accuracy, grammar, style, etc.

William DeWys and Elise Mackie are the project officers.

Title: Clinical trial support services for the DNCP. Estimated total first year budget, $200,000. One three year contract.

The contractor will provide statistical, analytical, data management, and coordinating support for intervention trials in the Diet, Nutrition & Cancer Program. This will include statistical support in the design, development and format of diet and nutrition preclinical and clinical intervention studies; support for analyses of results of diet and nutrition research studies; data management for diet and nutrition research studies; and operations support in the performance of multi-institution research trials.

DeWys and Mackie are project officers.

The Board approved the concept of a new program of predoctoral research training for cancer nurses. The program was developed at the urging of the Oncology Nursing Society.

Title: Individual predoctoral research fellowship for cancer nurses. Estimated total annual budget, $35,000 first year, $70,000 second year, $117,000 third year. Up to three awards are anticipated for each of the first two years and four for the third year. All funds will come from the annual NRSA budget.

Goals and major objectives are to provide a total of 10 active nurse fellowships in support of cancer nurse research training. The program will be evaluated in 10 years to determine its ability to produce PhD cancer nurses having high potential for research. The program's effectiveness will be judged according to the nature of the fellows' careers and their research publication records.

This award will be made to successful cancer nurse applicants who hold, at a minimum, the baccalaureate degree. The award will be up to five years since it is intended to support the awardee until he/she earns a PhD in a cancer science. This wil be subject to NRSA rules. The award will pay a predoctoral stipend of $5,292, an institutional allowance of $1,500, and tuition and fees.

Oncology nursing has emerged as a nursing specialty. The Oncology Nursing Society has more than 7,000 members. Nationally, specialization in oncology nursing is available in 15 master's programs and three doctoral programs. This specialty has a strong interest in promoting research and research training. At the same time, less than two percent of the membership have doctorate degrees. The national need for cancer nurses trained to that level is acute. Many academic and research positions remain unfilled for months or years. The Public Health Service's Div. of Nursing which for many years has taken the lead in fuding nurse research training has suffered a drastic reduction in its training budget, even though the annual, and later, biennial needs reports by the National Academy of Sciences have stressed consistently the grave shortage of research trained nurses and the inadequate pool of academic nurses holding a PhD degree. Compounding this dismal picture insofar as cancer is concerned is the fact that the Div. of Nursing's responsibility is to nursing in general. Consequently, oncology nursing cannot receive the specific attention it needs to become an even more effective contingent in the prevention and management of cancer.

Oncology nursing research promises to play an important role in developing significant interventive technology essential to NCI's goal of reducing cancer mortality by 50 percent by 2000 AD. Oncology nursing research can make important contributions to cancer control. This research will impact on cancer prevention through studies on patients' education, behavior and health practices, and through studies on health risks in the work place. It can also have a positive impact on early cancer detection and screening through studies on self examination behavior and cancer system awareness and on patient behavior that facilitates detection. Cancer treatment can be furthered by studies dealing with promotion of compliance with treatment and the prevention or management of treatment side effects.

Olga Jolly is the project officer.

(Additional concepts approved by the Board will be published next week in **The Cancer Letter**).

Funding levels associated with contract concepts are preliminary staff estimates for purposes of discussing and planning. Actual funding of any contract is determined based upon proposals submitted in response to RFPs and detailed negotiations. Endorsement of a project concept may not necessarily result in issuance of a contract. Organizations interested in submitting proposals to implement approved contract concepts are cautioned to carefully read any resulting RFP and not to assign undue weight to staff budget estimates. Notice of availability of the RFPs will appear in **The Cancer Letter.** Dollar estimates listed with RFA concepts (grants and cooperative agreements) are the amounts NCI plans to set aside to support those projects. Those amounts also are subject to budget changes, and final awards will depend on amounts approved by peer review and availability of funds.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR JUNE, JULY, FUTURE

NCI Div. of Cancer Treatment Board of Scientific Counselors—June 4-5, NIH Bldg 1 Wilson Hall, open June 4 8:30 a.m.-adjournment and June 5 11 a.m.-adjournment.

Cancer Resources & Repositories Contract Review Committee--June 6-7, NIH Bldg 31 Rm 9, open June 6 9-9:30 a.m.

NCI Div. of Cancer Etiology Board of Scientific Counselors--June 7-8, NIH Bldg 31 Rm 10. Open 1 p.m.-adjournment June 7, 8:30 a.m.-adjournment June 8.

Prevention of Cancer--June 7, Roswell Park continuing education in oncology.

AIDS: Diagnosis & Management—June 8-10, Warwick Post Oak Hotel, Houston. Sponsored by Univ. of Texas System Cancer Center/M.D. Anderson Hospital. Contact Office of Conference Services, Box 131, MDA, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

RNA Tumor Viruses in Human Cancer--June 10-14, Denver. International conference. Contact Dr. Jean Hager, Conference Coordinator, AMC Cancer Research Center, 6401 W. Colfax Ave., Denver 80214, phone 303-233-6501.

NCI Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--June 11, NIH Bldg 31 Rm 8, 8:30 a.m., open.

Second International Conference on Malignant Lymphoma—June 13-16, Lugano, Switzerland. Contact Dr. F. Cavalli, Div. of Oncology, Ospedale San Giovanni, 6500 Bellinzona, Switzerland.

National Conference on Radiation Oncology—1984--June 14-16, Hilton Hotel, San Francisco. Contact American Cancer Society, National Conference on Radiation Oncology, 777 Third Ave., New York 10017.

Cancer Precursors of the Cervix, Vagina and Vulva--June 15, Sacramento. Contact Office of Continuing Medical Education, School of Medicine, TB 150, Univ. of California, Davis 95616.

Assn. of American Cancer Institutes--June 17-19, Memorial Sloan-Kettering Cancer Center, New York. Annual meeting.

Tumor Promotion & Enhancement in the Etiology of Human & Experimental Respiratory Tract Cancer--June 17-20, Williamsburg, Va. Contact Dan Tisch, Symposium Coordinator, Northrop Services Inc., PO Box 12313, Research Triangle Park, N.C. 27709, phone 919-549-0652.

Peptide Hormones in Lung Cancer--June 18-20, Marburg, West Germany. Contact Prof. G.D. Soerenson, Dept. of Pathology, Dartmouth Medical School, Hanover, N.H. 03755.

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

Cancer Education Review Committee—June 21, NIH Bldg 31 Rm 8, open 8:30-10 a.m.

International Conference on Head & Neck Cancer--June 22-27, Baltimore. Contact Program of Continuing Education, Univ. of Maryland School of Medicine, 10 S. Pine St., Baltimore 21201.

CHOP Symposium—June 22, NIH Bldg 1 Wilson Hall, 7:45 a.m.

Clinical Cancer Investigation Review Committee--June 25-26, NIH Bldg 31 Rm 6, open June 25 8:30-9 a.m. and June 26 1:30-3 p.m.

Ninth International Convocation on Immunology--June 25-28, Amherst, N.Y. Contact Dr. James Mohn, Director, Ernest Witebsky Center for Immunology, 210 Sherman Hall, SUNY, Buffalo, N.Y. 14214, phone 716-831-2848.

7th International Congress of Endocrinology--June 26-29, Univ. of Wisconsin Clinical Cancer Center, Madison. Workshop on "Estrogen and Antiestrogen: Basic & Clinical Aspects." Contact Craig Jordan, PhD, Dept. of Human Oncology, WCCC, Univ. of Wisconsin, 600 Highland Ave., Madison 53792, phone 608-263-9076.

Fourth International Conference on Prolactin--June 27-29, Charlottesville, Va. Contact Robert MacLeod, Chairman, Prolactin Congress, Univ. of Virginia School of Medicine, Charlottesville 22908.

Hyperthermic Oncology—July 2-6, Aarhus, Denmark. Fourth international symposium. Contact Dr. Jens Overgaard, Symposium Chairman, Institute of Cancer Research, Radiumstationen, DK-8000 Aarhus C., Denmark.

Cancer Control Grant Review Committee—July 9, NIH Bldg 31 Rm 8, open 8:30-9 a.m.

Medical Screening & Biological Monitoring for the Effects of Exposure in the Workplace--July 10-13, Clarion Hotel, Cincinnati. Sponsored by NIOSH, NCI, EPA. Contact Jenny Watson, Conference Coordinator, Technical Resources Inc., Suite 408, 10215 Fernwood Rd., Bethesda, Md. 20817.

Clinical Cancer Program Project Review Committee—July 16-17, Bethesda Marriott Hotel, open July 16 8:30-10 a.m.

Cancer Preclinical Program Project Review Committee—July 17-18, NIH Bldg 31 Rm 10, open July 17 9-9:30 a.m.

International Cancer Conference—July 17-19, Bogota, Colombia. Contact J. Ospina, Instituto Nacional de Cancerologia, Calle la 9-85, Bogota.

International Conference on Head & Neck Cancer—July 22-27, Baltimore. Contact Program of Continuing Education, Univ. of Maryland School of Medicine, 10 South Pine St., Baltimore 21201.

FUTURE MEETINGS

Advanced Seminars in Dermatology—Aug. 1-5, Incline Village (Lake Tahoe), Nev. Includes sessions on malignant melanoma, premelanoma lesions, and AIDS. Contact Office of Continuing Medical Education, School of Medicine TB 150, Univ. of California, Davis 95616.

Rocky Mountain Cancer Conference--Aug. 9-11, Fairmont Hotel, Denver. 38th annual conference for medical professionals. Contact Chris Heminway, RN, 303-758-2030, or American Cancer Society, 2255 S. Oneida, Denver 80224.

Oncology Nursing Conference VI—Sept. 12-14, Hyatt Regency Hotel, Houston. Impact of DRGs on cancer nursing, substance abuse and the nurse, occupational exposure of nurses to antineoplastic agents, and pain control for cancer patients. Contact Office of Continuing Services, Box 131, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Nutrition and Disease: Cancer--Sept. 14-15, Hyatt Islandia Hotel, San Diego. Contact Nomi Feldman, Conference Coordinator, 3770 Tansy, San Diego 92121, phone 619-453-6222.

Leukemia Society Annual Symposium--Sept. 18, Alameda Plaza Hotel, Kansas City, Mo. Contact Jan Johnston, Office of Continuing Education, Univ. of Kansas Medical Center, Kansas City, Kan. 66103, phone 913-588-4480.

Adriamycin: A Decade of Experience--Sept. 22, McCormick Center Hotel, Chicago. Review of structure activity relationships, pharmacology, analogues, methods to reduce toxicity, and mechanisms of drug resistance. Contact Jacqueline Samuel, Univ. of Chicago Cancer Research Center, Box 444, Chicago 60637.

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-44018-38
Title: Computer support for cancer information dissemination
Deadline: Approximately June 30

This is a 100 percent small business set aside.

The purpose of this proposed contract is to continue to operate and optimize a Computer Support Center (CSC) providing staff skilled in computer operations to develop and optimize state of the art software and use it on state of the art computer hardware to carry out automated data processing services needed by NCI's Office of International Affairs for updating and production of technical information products and services, primarily cancer databases and publications.

The second purpose of the contract is support of the NCI Computer & Communications Center (CCC) located at the R.A. Bloch International Cancer Information Center in Bethesda, Md. These services will be provided under a completion type, cost plus fixed fee contract. Offerors will not be considered eligible for award unless they provide documentation demonstrating they will provide the following at the time of contract award:

1. Computer hardware as specified in the RFP which is installed, fully operational, and available to the full extent necessary to carry out the workscope.

2. At least two fulltime programmers with extensive PL/I or other high level language experience.

3. Software currently installed, fully operational, and available, and staff support for the type of data base management system described in the RFP.

4. Arrangements for use of the Atlas software written in Promis programming language.

A preproposal conference and demonstration of the government's system will be held. The RFP will state the date, time, and location.

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

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