THE CANCER LETTER

Vol. 11 No. 20
May 17, 1985

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Subscription $150 year North America
$175 year elsewhere

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WEICKER COMPROMISE ON 6,000 GRANTS FOR TWO YEARS HOLDS UP; NEW WAXMAN BILL WOULD RENEW CANCER ACT

Prospects for the National Cancer Program and biomedical research in general brightened considerably during the past week with these developments:

*The compromise on the number of NIH grants to be funded in 1985 and 1986 fiscal years worked out by Sen. Lowell Weicker (R.-Conn.) and

(Continued to page 2)

In Brief

DEWYS ASKED TO STEP DOWN AS PREVENTION HEAD BY GREENWALD; PAUL SHERLOCK OF MSK DIES AT 56

WILLIAM DEWYS, who has been associate director and head of the Prevention Program in NCI's Div. of Cancer Prevention & Control, has been asked to step down from those positions by DCCP Director Peter Greenwald. DeWys has a reputation as a hard worker and last week was commended by the DCCP Board of Scientific Counselors for his efforts in organizing and implementing the many-faceted Prevention Program. However, both DeWys and Greenwald acknowledged privately that they frequently disagreed on how things should be done, and Greenwald decided to find someone else for the job. He offered DeWys another position in the division; DeWys said he hasn't decided whether to accept it or to pursue other opportunities.... **CHARLES SMART,** chief of surgery at LDS Hospital in Salt Lake City and former longtime director of the American College of Surgeons Commission on Cancer, will join NCI in July as chief of the Community Oncology & Rehabilitation Branch in the Div. of Cancer Prevention & Control. Smart has been serving on the DCCP Board of Scientific Counselors but will have to resign with a year left on his term.... **JOHN COOPER** has been named chief of the Extramural Programs Branch in the Epidemiology & Biostatistics Program of the Div. of Cancer Etiology. He has been acting chief since the branch was established last July .... **JOSEPH CULLEN,** DCCP deputy director, has been appointed by the Surgeon General to chair an advisory committee that will carry out a comprehensive analysis of the scientific evidence related to smokeless tobacco and nicotine addiction, periodontal disease and carcinogenesis. Cullen has been talking with professional sports officials about encouraging athletes to refrain from using in public or endorsing smokeless tobacco.... **PAUL SHERLOCK,** chief of medicine at Memorial Sloan-Kettering Cancer Center, died of cancer May 5. He was 56. Sherlock was instrumental in establishing gastrointestinal oncology as a specialty and was the current chairman of the National Digestive Diseases Advisory Board and also of the FDA Gastrointestinal Drugs Advisory Committee. He went to Memorial as chief medical resident in 1959 and became chief of medicine in 1978.

TENTATIVE BYPASS BUDGET FOR FY 1987 ASKS $1.57 BILLION, BACKS 2000 PLAN

(Continued from page 1)

Sen. Peter Domenici (R.-N.M.) was included in the budget resolution passed by the Senate. The number agreed upon was 6,000 new and competing renewal grants each year. The compromise was a victory for Weicker and for scientists who have been battling the Office of Management & Budget over the latter's plan to reduce the number to 5,000 both years. Whether OMB will go along with the compromise and back away from its multiple year funding scheme remains to be seen. If it does not, then implicit in the Senate's action is the intention to provide NIH with enough money to bring the 1985 number up to 6,000 with a supplemental appropriation.

*The Senate budget resolution, which only establishes an overall spending limit for the 1986 fiscal year and leaves to the Appropriations Committee and its subcommittees the question of how that will be split up, reportedly and unofficially included an increase of $700 million for NIH over its 1985 appropriation. If that holds up, and if NCI, with about 25 per cent of the NIH budget, gets its proportionate share of the increase, that would amount to $175 million. NCI's total then would be $1.371 billion, about $90 million under the bypass budget request and about $300 million more than in the President's budget.

*Congressman Henry Waxman (D.-Calif.), chairman of the House Health Subcommittee, pushed through the subcommittee, quickly and without further hearings, his biomedical research authorization bill, which included renewal of the National Cancer Act. Waxman had intended to take the bill to the full Energy & Commerce Committee this week, but had not done so at **The Cancer Letter** press time.

A complete analysis of the new Waxman bill had not been made by press time, but members of his staff said it was almost identical to the bill President Reagan pocket vetoed last year. That bill had left intact most of NCI's authority as derived from the National Cancer Act of 1971, with one important exception: NCI's authority to review some of its own grants and contracts and the director's authority to appoint members of those review committees. The new bill reportedly restores those rights to NCI and also extends them to all other NIH institutes.

The new Waxman bill authorizes a total of $1.345 billion for NCI in FT 1986, which could pose a problem if the figure of $1.371 billion comes out of the appropriations process. More likely, both figures will be altered before either bill makes it to the floor.

The new Waxman bill also restores National Cancer Advisory Board appointments to terms of six years; last year's measure would have cut them to four.

The bill includes most of the provisions the Administration found obnoxious and provided the expressed reasons for the veto—it would establish a new institute for arthritis and another for nursing; require NCI, the National Institute for Child Health & Human Development and the NIH director each to have an associate director for prevention; and would require NIH to establish an animal research plan.

The bill last year was passed overwhelmingly by both houses; the President did not give them a chance to override the veto by disapproving it after Congress had adjourned. Waxman is confident Congress would override a veto this year and does not intend to give Reagan another chance for a pocket veto.

Sen. Orrin Hatch (R.-Utah), chairman of the Labor & Human Resources Committee, intends to push his version of the legislation through his committee as soon as possible.

*The National Cancer Advisory Board learned Monday that NCI has not lost any enthusiasm for its Year 2000 Plan when the 1987 fiscal year bypass budget was discussed. Deputy Director Jane Henney, speaking for Director Vincent DeVita who was in Italy (**The Cancer Letter**, May 10), told the NCAB that the unsettled situation with the 1985 and 1986 budgets made it difficult to develop details for the 1987 bypass. Nevertheless, she said it would essentially "ratchet everything forward one year." Assumptions in the 1986 bypass for the resources required to meet the Year 2000 goals would hold up in the 1987 bypass—Pay 40 per cent of approved grants; add five new centers a year until the number is doubled; fund cooperative groups at recommended levels, leading to doubling the number of patients on clinical trials; double the cancer control budget; and fund construction grants at $25-30 million a year.

Henney did not mention a total figure for the 1987 bypass. **The Cancer Letter** learned that the preliminary estimate is $1.57 billion, $110 million more than the 1986 bypass request.

A detailed bypass budget will be worked out by staff and the NCAB Budget Committee during the summer. It will be presented to the White House in September.

DCCP BOARD, NCAB APPROVE NEW CORE GRANT GUIDELINES, CONSORTIUM CENTERS

The Board of Scientific Counselors of the Div. of Cancer Prevention & Control and the National Cancer Advisory Board have both approved changes in the guidelines for cancer center core grants and for the new consortium cancer center support grants.

Changes in core grant guidelines had been

approved by cancer center directors at an April meeting in Bethesda (**The Cancer Letter**, April 19). The center directors also went along with the new consortium center concept and guidelines developed for it. Approval by the NCAB and the DCPC Board now makes official the core guideline changes and the new consortium grant mechanism.

Robert Cooper, DCPC Board member, said the consortium center grant, among other things, makes it possible for cancer centers to develop in areas without the resources for centers under the traditional guidelines. "That will help us meet the intent of Congress in 1971, and help immensely in meeting the Year 2000 goals," Cooper said.

Board member Laurence Kolonel asked if cancer centers with core grants would be eligible to participate as members of a consortium.

"Absolutely," answered Lucius Sinks, chief of the Cancer Centers Branch. "The Illinois Cancer Council is a model for that kind of organization."

Both Boards were insistent that funds for the consortium centers not come from the existing core grant budget or the RO1/PO1 grants pool. DCPC Director Peter Greenwald said the money would come from the cancer control budget and be requested from Congress.

NCAB member Louise Strong, noting that review of consortia applications would be by ad hoc committees, asked how continuity could be maintained. Sinks said that he hoped a core of members could be rotated through several reviews.

Helene Brown asked if consortium centers were intended for underserved areas. Sinks said it would be appropriate for them to be established for that purpose, but were not intended exclusively for that. Brown commented that the requirement for institutional commitment for the lead institution should be expanded to include all members of a consortium.

In response to Robert Hickey's question on what constitutes a geographic region (which consortium centers are supposed to serve), Sinks said, "That's flexible. It could cross state lines. A group is being organized in the Carolinas for both states."

The problem of how to arrive at an equitable ceiling for center core grants bothered the NCAB as it had center directors. The present cap limits centers to requesting no more than a 50 per cent increase over their current budget when they apply for renewal. The center directors had objected to staff's recommendation to continue the 50 per cent cap, which they felt was unfair to those with smaller grants. They could not agree on any new formula, and they asked NCI to continue studying the issue. Greenwald told the NCAB that the NCI Executive Committee decided that problem could be handled as exceptions.

CCOPs EXTENDED FOR ONE YEAR WHILE NCI AWAITS RESULTS OF EVALUATION

NCI has decided to extend administratively for one year the Community Clinical Oncology Program instead of planning now for recompetition and expansion of the program when the first three year awards expire in 1986.

Jerome Yates, Div. of Cancer Control & Prevention associate director and head of the Centers & Community Oncology Program, told the division's Board of Scientific Counselors last week that DCCP and the NCI Executive Committee had agreed that any decision on the future of CCOP should await more complete information now being developed in the comprehensive evaluation of the program.

The 60 CCOPs are now in the second year of the program and will start the third year in September. The extension will fund them for a fourth year starting in September, 1986.

The CCOPs and their research bases receive about $9 million a year from NCI. Extensions probably will be negotiated at present levels.

The DCCP Board readily agreed to the extension, but when Yates brought the matter to the National Cancer Advisory Board Monday, there was a distinct lack of enthusiasm for it.

"I understand that some CCOPs are good and some are not," Board member Helene Brown said. "I'm not particularly interested in giving a one year extension to a CCOP that may not be good."

Yates pointed out that each CCOP's performance is being closely monitored and that two were denied second year funding because of deficiencies (one later was reinstated on probationary status). "I think the taxpayers are being protected," he said.

William Longmire, member of the President's Cancer Panel, said he was inclined to object to extension of the program when only 26 per cent of approved grants are being funded.

Board member Rose Kushner noted that many of the successful CCOP applications were those which had been prepared "by a professional firm with a high level of expertise in grant writing (she was referring to Elm Services Inc. which assisted 17 applicants, 14 of whom were funded). I'm not sure the best prospects were funded. Some good ones might have been lost because they didn't know how to write a grant."

"Those with the best scores for the most part are doing well," Yates said. "That speaks well for the excellent review conducted by Barbara Bynum, Dennis Cain and Dorothy Macfarlane."

NCAB Chairman David Korn summed up the Board's position. "We're in a position where it would be imprudent to direct you to terminate this program now. But you would be well advised to come back with

a complete presentation and some evaluation data early next fall."

Yates said that better data would be available early next year, and Korn agreed, with the admonition, "Okay, but no more administrative extensions."

CCOP's two major goals are the evaluation targets: Bringing more patients from communities into clinical trials, and by expanding clinical trials into communities, making more readily available to all patients optimal cancer treatment—the "diffusion theory."

The first is comparatively easy to measure, and in fact most CCOPs are meeting their patient accrual goals, although the numbers are "less than I would like to see them but better than many people thought they would be," CCOP Program Director Robert Frelick told **The Cancer Letter.** Some of the cooperative groups are counting heavily on CCOP patients for their protocols.

Yates, Frelick, DCCP Director Peter Greenwald and NCI Director Vincent DeVita had hoped CCOP could be expanded after the first three years, assuming the program were successful. They had hoped, and still do, that new CCOPs could help fill in geographic gaps around the country where patients do not have reasonable access to cancer centers or cooperative group affiliates. It had been their intention to issue a new RFA before the existing CCOPs would be required to recompete, so that the new applicants would not have to go head to head against the established programs. It appears now new and existing programs will be competing together. That does not necessarily mean that the experienced CCOPs will freeze out the others; if enough money is added to increase the total numbers, new programs could be added even if they could not beat out any of the existing ones.

As for the present 60 CCOPs, they appear to be relatively stable at the moment. Two are still on probation, with accrual and audit problems, and a couple of others may be on thin ice. DCPC has two or three months to determine if any will be dropped from third year funding. There are none at present which have indicated to NCI they are considering dropping out voluntarily, as Memphis did last year.

DCCP BOARD SEEKS STANDING STUDY SECTION FOR CANCER CONTROL GRANTS

Not satisfied that cancer control grant applications are getting a fair review, the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control launched an effort last week to establish a standing study section for those grants.

The Board approved unanimously a motion asking its Budget & Evaluation Committee to examine ways in which a new study section could be set up, including initiating discussions with NCI's Div. of Extramural Activities and the NIH Div. of Research Grants.

Board member Robert Cooper initiated the discussion when he mentioned that one of his investigators (at the Univ. of Rochester Cancer Center) had his grant proposal rejected "because the reviewers said it was hypothetical and experimental," Cooper said. He noted that most investigator initiated grants go to DRG, with NCI having no control over how they are reviewed, or by whom. "Can't we have a standing study section to review cancer control grants?" he asked.

Board member Saxon Graham suggested that a standing study section might be established "to review proposals resulting from concepts approved by this Board. Ad hoc study sections don't have the people with the background to understand the aims and goals of our program. It would be good to have at least one study section that does understand. It is direly needed. I don't think those applications get fair review. They don't get real peer review."

Board member Kaye Kilburn pointed out that the National Heart, Lung & Blood Institute "has the same need and frustration. There might be a way to make this broader." But Board member Philip Archer warned, "If it's too broad, nothing will get done."

DCCP BOARD APPROVES CONCEPTS FOR PRIMARY CARE, WORKER, BLACK STUDIES

Two new grant supported programs, to encourage primary care physicians to practice cancer prevention and control and to establish worker health promotion interventions, and a large contract supported effort for cancer control interventions in black populations were given concept approval last week by the Board of Scientific Counselors of the Div. of Cancer Prevention & Control.

The Board also gave concept approval to recompetition of a biomedical computing software services contract, and to a noncompetitive contract for a lung cancer prevention study in China.

The concept proposals and Board discussion follow:

Practice of cancer prevention and control activities in primary care medicine. Three three-year grants anticipated, at an estimated total cost of $3.8 million.

The goal of this project is to have primary care physicians do cancer prevention and control activities in their usual office practice. The objectives are:

—Characterize primary care physicians' practice of cancer prevention and control activities, and identify barriers to their increased practice of these activities.

—Design interventions to increase the number of primary care physicians who routinely do cancer prevention and control activities.

—Conduct controlled intervention studies (phase 3) to increase the number of primary care physicians who do cancer prevention and control activities in their usual office practice.

The importance of involving primary care physicians in a national cancer control effort is potentially very great. For example, data from the National Ambulatory Care Survey indicate that in 1980 Americans visited a physician an average of 2.7 times a year. Three specialties accounted for 54.8 per cent of all office visits: general practice and family practice (33.3%), internal medicine (12.1%) and obstetrics/gynecology (9.4%). Over half of the patient visits to each of these physician groups involved persons between the ages of 20 and 64.

Recent studies suggest that primary care physicians do not routinely practice cancer prevention and control activities. National data indicate that less than 20 per cent of women over the age of 50 have ever had a mammogram. While progress has been made in encouraging women to have a regular Pap test, a 1984 national survey revealed that 11 per cent of eligible women have never had a Pap test. Studies indicate a number of reasons for primary care physicians not including recommended cancer prevention and control activities in their routine office practice. Among the most frequently cited reasons are: concern about efficacy, cost, patient acceptance, lack of awareness of the scientific literature, and confusion over which recommendation to follow. An NCI sponsored study of four primary care physician groups found significant differences between and within these groups in terms of their perception and practice of cancer prevention and control activities.

Therefore, the proposed RFA requires that interventions be designed to increase the number of primary care physicians who routinely do cancer prevention and control activities in their office practice. Possible interventions include cancer prevention and control continuing education programs, computer reminder systems, inclusion of a cancer prevention and control section in the medical encounter form, primary care practice audits, and similar interventions directed at the primary care physician and components of his/her ambulatory practice system.

At the minimum the cancer prevention and control practices that primary care physicians should routinely do are diet and smoking cessation counseling, and the screening activities recommended by NCI. However, it is acceptable to encourage primary care physicians to do additional cancer prevention and control activities, e.g., a digital rectal examination for prostate and colon cancer detection. It is recognized that primary care physicians do not address prevention in a disease specific manner; rather, there is a tendency to identify risk factors that relate to the major causes of premature morbidity and mortality for persons of specific age and sex groups. Therefore, it is acceptably, probably desirable, for the cancer prevention and control activities to be integrated into a broader office based prevention package. The interventions will then be evaluated for efficacy in phase 3 studies. The end point to be assessed is the primary care physician's behavior, i.e., the physician does cancer prevention and control activities in his/her routine office practice. It is necessary that the actual practice of cancer prevention and control activities be verified via such methods as chart audits, physician or patient interviews, audiotaping of encounters, billing records, or other such procedures.

It is expected that more than one method will be necessary to verify the actual practice of the cancer prevention and control activities. The ability to generalize results to usual patterns of primary care practice is important. Therefore, factors such as patient demographics, type of practice, (e.g., solo, group, etc.), and provider specialty will be considered in the review process.

"I was surprised to find out how little cancer prevention goes on in primary physician offices," Board member Erwin Bettinghaus said. "I look forward to innovative proposals from this concept."

"It seems to me that the reason primary care physicians don't (practice cancer prevention) is that talking to patients about prevention is just not part of medical education," Board member Laurence Kolonel said. "Most physicians are interested only in treating the present illness adequately enough so that the patient will come back. I'm pessimistic about the success of this."

"I agree with Larry on the one hand, but I'm somewhat excited about it on the other," Board member Virgil Loeb said. "Primary care physicians have abdicated to specialists their responsibility for cancer. With the increasing tendency of primary care physicians to assume more responsibility for cancer care, it should be natural for them to talk with patients about prevention."

"I'm enthusiastic about involving physicians in prevention," Board member Jerome DeCosse said. "What really needs to be done is to reduce the cost of mammograms and flexible endoscopy."

"I'm both cynical and practical," Board member Kaye Kilburn said. "I have been engaged in postgraduate education most of my career, and the process has been a big, fat zero. Continuing medical education programs are more enjoyable in Hawaii than when they are held in Los Angeles, but with equal lack of effect. I am impressed by prevention work that many dentists are doing. Physicians don't have to be too much involved. They can use materials, posters, pamphlets and such that can be picked up in their offices and waiting rooms. That wouldn't change the physician a bit but it would give the physician's aura to the material."

"There is no reason why a residency program couldn't apply for this," said Donald Iverson, DCPC associate director and head of the Cancer Control Science Program. There is material in the literature on why physicians don't do such things as screening. Cost is a factor, but it was found that they don't give any advice where cost is not a factor, such as on diet and exercise. They say that don't feel they have the expertise. Physician behavior is difficult to change but it can be changed."

"At $500 a throw for a colonoscopy, I assure you tht if you get everyone over age 60 or 65 to have one every two years, preventive medicine would boom," Board member Lewis Kuller said.

"There are too many inconsistencies on what recommendations a physician should make," De Cosse said. "Physicians need one voice to tell them, 'This is the best.' When they get that, they will recommend it to their patients."

"Smoking ought to be something they all can focus on," Board member Saxon Graham said.

"We've heard a lot of comments on this concept," Board Chairman Barbara Hulka said. "Some might be included in the RFA, and others are good ideas for applicants to consider."

Lillian Gigliotti is branch project officer.

Worker health promotion interventions. Five 5-year grants, estimated total cost $7.5 million.

The goal is to determine the effect of phase 3 cancer prevention/control worker health promotion interventions on the cancer related health behavior of participants. Major objectives are:

*To evaluate the effects of the health promotion interventions on the cancer related behavior of participants.

*To determine how effective primary and secondary prevention activities are incorporated into pre-employment and/or periodic medical examinations offered to workers, retirees and/or their dependents.

*To determine how effective primary and secondary prevention activities are incorporated into the health benefits packages offered to workers, retirees and/or their dependents.

The project will develop, implement and evaluate health promotion and education interventions (which deal with cancer risk factor reduction, cancer prevention and control) designed to be delivered to workers, retirees and/or their dependents. Studies applicable to this project can include health promotion programs already developed and in use which require the addition of a cancer prevention and control module, and the development, implementation and evaluation of new cancer prevention and control programs. The proposed study design should reflect the type of cancer control research classified as phase 3. Impact evaluation of the interventions may be determined at the individual, group (e.g., worker-family unit, worker teams in the same establishment), or organizational level (e.g., comparisons between establishments in the same corporation), using a variety of experimental and quasi-experimental designs. The research should attempt to effect substantial changes in the cancer related health behavior of participants, not simply statistically significant changes. It is anticipated that programs and program materials developed and evaluated under this project will have broad applicability to a variety of worker groups.

There are two major programmatic aspects to be studied in the proposed research. First, the development, implementation and evaluation of interventions designed to reduce the risk for and/or improve early detection of prominent cancers among participants (e.g., smoking cessation, dietary modification, utilization of effective early detection modalities for breast and cervix cancer). Interventions designed to address unique cancer risks experienced by participants, e.g., sun exposure, occupational exposure, are appropriate components of a comprehensive health promotion program. Efforts to reach worker groups at high risk and/or difficult to reach are strongly encouraged. The applicant will be expected to provide a rationale and supporting evidence for the effectiveness of proposed interventions. End points of interest are to be specified in terms of the cancer related health behavior of participants.

Second, this research will take advantage of opportunities to reach workers through the mechanisms of pre-employment and/or periodic medical examinations, and through services included in health benefits packages. End points of interest are to be specified in terms of the inclusion of potentially effective primary and secondary prevention activities and their utilization by participants.

Study participants may include workers, retirees and/or their dependents. Innovative strategies to involve all eligible participants in a particular work setting are encouraged. Followup of study participants for at least three years following the intervention is required. It is anticipated that state and local health departments, unions, large corporations, consortia of small businesses, intermediaries such as conference boards, nonprofit organizations, etc., health insurance plans, and academic institutions will be in the position to respond to this initiative. Interdisciplinary teams of researchers, managers and representatives of employee groups are encouraged. It is expected that all objectives be addressed by applicants for this initiative. Diverse settings (e.g, rural and urban locale, type and size of industry) will be sought to increase the potential for wider application of effective programs.

Lillian Gigliotti is program director.

Kullen suggested that the National Heart, Lung & Blood Institute's experience in nutrition might be utilized in this study. Gigliotti said she has talked with NHLBI about it; that institute has issued an RFA dealing with cardiovascular risks among workers. "We would like investigators to develop ideas to produce dietary modification. We want in the RFA strong emphasis on good research, and controls. We hope to show a measurable outcome."

Cooper questioned the "potential for generalizability" and suggested that corporations might be more interested if they can be convinced the interventions would result in decreased health care costs, or increase in productivity of workers. "Will you require evaluation of productivity and health care costs? If you don't, the prospect for generalizability would be limited."

Gigliotti agreed, "That is an excellent suggestion."

Kuller disagreed. "I don't believe it is ever

possible in these programs to show cost effectiveness. If we go in and say we can save money for industry, or improve productivity, I guarantee it will fail. We should face it straight and say we can improve health and reduce the number of people getting cancer, and we don't give a hoot if we reduce costs."

"It really doesn't make sense to have a diet program for cancer alone," Board member Mark Hegsted said. "Heart disease, diabetes, obesity are affected. If we're going to have a diet program, we've got to break this bureaucratic restriction and involve others agencies."

"We all agree," DCPC Director Peter Greenwald said. "A common theme and message for chronic disease is to cut down on fat in the diet. On the other hand, discrete categorical programs can have an impact, as the Heart Institute did with lowering cholesterol. We have talked about joint programs, but they are difficult to combine. It complicates the picture when you have too many cooks."

"The answer is that heart disease and diabetes are a lot easier to deal with than cancer," Hegsted said.

"In the years I've worked with industry, I found companies don't worry about cost or productivity from their health programs," Cancer Control Science Program Director Donald Iverson said. "They are interested in improving the health of their employees. They don't have the ability to look at the impact on costs."

Cancer control interventions in black populations. Five smoking cessation contracts; five avoidable mortality contracts; one support and quality control contract, all for five years at a total estimated cost of more than $13 million.

Goals and major objectives are:

a. To develop and test cancer control interventions that address the significant differences between blacks and whites in cancer incidence, mortality and survival.

b. To stimulate greater involvement in cancer control by researchers with significant understanding of and direct experience in working with the black community.

c. To enhance the cancer control research capabilities of involved investigators by providing an opportunity for the exchange of information on and mutual addressing of common research issues.

This concept calls for three separate procurements:

1. Reissue the smoking prevention and cessation in the black population RFP originally approved in October, 1983.

2. Reissue the reduction of avoidable mortality from cancer RFP originally approved in January, 1984, and focus specifically on cancer in the black population.

3. Procure an analytical support and quality control unit.

A working group convened earlier this year concluded that NCI's goals for the Year 2000 should include the eradication of differences in cancer incidence, mortality and survival rates based on race, in addition to the general 50 percent reduction. Many recommendations to achieve this were provided by the working group. Central to these recommendations is the need to stimulate the conduct of cancer control studies by investigators/institutions that have significant research experience with and/or responsibility to populations that are predominantly black. Development of each of the procurements proposed in this concept will seek to involve such investigators and institutions.

Smoking cessation and prevention in the black population: These studies will determine the long term effect of interventions designed to prevent the onset and/or reduce the prevalence of cigarette smoking in blacks. Specifically they will (1) develop and evaluate innovative intervention strategies to prevent or reduce cigarette smoking in blacks and (2) develop and evaluate assessment procedures for determining the long term effectiveness of smoking interventions among U.S. black populations. The original issuance of this RFA resulted in a single award out of 28 applications.

Reduction of avoidable mortality from cancer in black populations: This will be a re-issuance of the original concept with two changes; (1) The focus will be on black populations, and (2) the intervention focus will include access to both primary and secondary prevention services. The aim of this program is to identify and remedy key factors that contribute to avoidable mortality from specific cancer sites in blacks. Specifically they will (1) identify key factors that contribute to avoidable mortality; (2) implement interventions to address these factors; (3) evaluate the effectiveness of the interventions; and (4) identify prototype approaches to the reduction of avoidable mortality for widespread dissemination. The original issuance of this RFA resulted in two awards out of 16 applications.

Analytical support and quality control unit: This unit will provide a common coordinating and analytic resource for all studies funded through the above procurements. Specifically it will (1) provide statistical consultation to all participating study investigators; (2) perform quality control checks on data collection, processing and analyses performed by the participating investigators; and (3) foster an ongoing exchange of information between investigators and mutual problem solving of major research issues that arise.

The smoking and avoidable mortality projects originally intended for funding as grants resulted in a minimal number of awards following issuance of RFAs. To provide an opportunity for further program development, these studies will be reissued as contracts modeled on the community smoking cessation interventions for heavy smokers concept approved in January, 1985. This concept provides for a one year feasibility trial before funding for full scale implementation of the intervention study is committed. With this provision, special emphasis on notifying the scientific community that works extensively in black populations, and careful delineation of the technical evaluation criteria, it is believed that more high quality projects can be elicited through the contract mechanism. Budgets for

the two substantive procurements are identical to those approved in the original concepts except for the initial feasibility year, which is reduced.

Claudia Baquet and Thomas Glynn are project officers.

DCCP Deputy Director Joseph Cullen attributed in part the failure of the two RFAs to generate more fundable applications to inadequate distribution of the announcement of their availability. "We believe it did not get to enough people to get the response we wanted," Cullen said. Those who did respond but who did not fare well in review benefitted from that experience and should do better this time, he said.

Iverson emphasized that the RFPs will not be directed to black investigators but to investigators with access to black populations.

Biomedical computing software services in support of the Biometry Branch. Recompetition of a contract now held by Information Management Services, five years, estimated cost, $335,000 a year.

The contractor will provide statistical programming support for the research projects being conducted by the Biometry Branch. This includes the analysis of large sets of medical data often involving complex statistical analysis, sophisticated data handling and analytic techniques, and

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CONCEPT REVIEW FIGURES ARE ESTIMATES ONLY: RFPs, RFAs NOT YET AVAILABLE

The dollar estimates with each concept review brought before the various boards of scientific counselors are not intended to represent maximum or exact amounts which will be spent on those projects. They are intended only as guides for board members to help in determining the value of the projects in relation to resources available to the entire program or division. Responses should be based on the workscope and description of goals and methods included in the RFPs (contracts) and RFAs (grants and cooperative agreements). Availability of RFPs and RFAs will be announced when the Institute is ready to release them.

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extensive plotting by digital computer. The facilities of the NIH Div. of Computer Research & Technology will be used for all computer processing. Computer programs will generally be written using the fortran and cobol languages, but other languages and computer systems such as SAS may be used if more appropriate. The contractor's primary responsibility will be the building and editing of large and small data bases and providing adequate documentation and backup for these systems of records. This sometimes involves the transfer of medical data from paper records to machine readable form. The work scope requires that the contractor display knowledge of graphics display software and use the WYLBUR text editor as well as other DCRT facilities, particularly the DEC-10 system. Although the statistical analysis of these data will be conducted under the close supervision of members of the Branch, the contractor's project leader and/or key personnel should be experienced in the statistical analysis of medical data and some formal training in statistics is desirable.

Donald Corle is the project officer and David Byar is the program director.

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 NO1-CM-27510

Title: Cancer Therapy Evaluation Program information system

Deadline: Approximately June 25

The Cancer Therapy Evaluation Program of NCI's Div. of Cancer Treatment intends to enter negotiations with Information Management Services Inc. for the purpose of acquiring additional hours and level of effort under the existing statement of work. A subcontracted portion of this contract maintains and operates the Drug Distribution and Protocol Monitoring System data base. DDPMS is an automated procedure used to verify the accuracy of investigational drug requests as required by FDA. The system also provides management information to the program, cooperative groups and private organizations.

The CTEP-IS and the DDPMS are now running as separate systems, with some linkage, on the IBM 370 mainframe computer at DCRT, NIH. A design that unifies the CTEP-IS and DDPMS in a single microcomputer or minicomputer based system is presently being developed and is to be completed by Sept. 17, 1985. Additional time and hours are necessary to further refine the system. The government intends to negotiate with only one source. Interested persons may identify their interest and capability to respond to the requirements or submit proposals.

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