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NCI PLANS TO RECOMPETE CCOP; FUTURE DIRECTION TO BE DISCUSSED AT DCPC BOARD, NCAB MEETINGS

NCI has decided to continue the Community Clinical Oncology Program and is making plans for recompetition of awards under the program. A preliminary agenda for planning the successor RFA for CCOP will be presented at the Jan. 23-24 meeting of the Board of Scientific Counselors of the Div. of Cancer Prevention

(Continued to page 2)

In Brief

DCT REORGANIZING SOME LABS, BRANCHES, PLANS TO ESTABLISH OTHERS; WEICKER, NATCHER HONORED

REORGANIZATION of laboratories in the Div. of Cancer Treatment's Developmental Therapeutics Program is awaiting a final answer on whether NCI will get some relaxation of the ceiling on positions imposed by the Office of Management & Budget. DCT wants to abolish two labs, Medicinal Chemistry & Biology and Chemical Pharmacology, and replace them with three new ones—Laboratory of Biological Chemistry, Laboratory of Pharmacology & Experimental Therapeutics and Laboratory of Experimental Therapeutics & Metabolism. David Johns, presently chief of Medicinal Chemistry & Biology, would head Pharmacology & Experimental Therapeutics; Richard Cysyk, presently head of the Drug Metabolism Section in Chemical Pharmacology, would be chief of Biological Chemistry; and Cysyk would be acting chief of Experimental Therapeutics & Metabolism. DCT has reorganized the Biological Response Modifiers Program: the Biological Therapeutics Branch was abolished, replacing it with the Laboratory of Experimental Immunology with John Ortaldo as acting chief, and with the Clinical Research Branch with BRMP Director Dan Longo as acting chief; and a section was removed from the Laboratory of Molecular Immunoregulation and reestablished as the Laboratory of Biochemistry. Longo also is acting chief of that lab but is close to completing recruitment of someone for the job on a permanent basis. In other DCT staff appointments, John Antoine, who came to NCI from the Univ. of New Mexico to head the Radiation Research Program, has been on the job for several months. His permanent appointment as associate director is imminent. The Regulatory Affairs Section of the Investigational Drug Branch in the Cancer Therapy Evaluation Program has been lifted to branch status, with Dale Shoemaker remaining as chief.... **FEDERATION OF AMERICAN** Societies for Experimental Biology has established an annual public service award and announced that the first one will be shared by Congressman William Natcher (D.-Ky.) and Sen. Lowell Weicker (R.-Con.) "for their outstanding contributions to biomedical research." Natcher and Weicker are chairmen of the House and Senate health appropriations subcommittees.

EVALUATION ASSESSING DIFFUSION HYPOTHESIS, CCOP PATIENT ACCRUAL

(Continued from page 1)

& Control, Jerome Yates, who heads the division's Centers & Community Oncology Program, told **The Cancer Letter.**

DCPC is in the process of establishing a committee that will be charged with making recommendations for policy regarding recompetition of the program, and whether a successor RFA or a different mechanism should be employed for recompetition.

While committee members have not yet been named, Yates expects the policy committee to include some individuals from DCPC's board as well as members of the CCOP evaluation and oversight committee. The new committee is slated to meet in late February and again in late April.

DCPC's evaluation committee will also meet in February to review preliminary data from the CCOP evaluation underway. The committee will meet again in mid to late April to review the rest of the data from the evaluation.

Yates expects the matter of the CCOP recompetition to go before the DCPC board's Committee on Centers & Community oncology in early May, after which it will go to the full Board of Scientific Counselors for concept approval.

The matter would be presented to the National Cancer Advisory Board in May as an informational item, he said. The CCOP recompetition would return to the DCPC committee in July, at which time Yates hopes an RFA would be issued.

If the activities sought in the recompetition of the program "are similar to existing CCOPs, we would like to protect the continuity of the program" by having the RFA out as soon as possible, he said.

NCI plans to hold regional meetings with community oncologists and cancer program leaders in order to obtain input from the cancer community about the program. The meetings will probably be held in March.

CCOP is probably one of the few programs that will be modified on the basis of its evaluation, Yates said.

The program provides funding to community hospitals and consortia that are interested in participating in clinical research. A total of 60 CCOPs are currently funded by NCI. The CCOPs and their research bases receive about $9 million a year. The programs received their first year of funding in 1983. The three year program was scheduled to expire in 1986, but NCI decided to administratively extend the program for another year. The extension will fund the CCOPs for a fourth year beginning in September (**The Cancer Letter,** May 17).

DCPC and the NCI Executive Committee agreed to extend the program instead of planning for its recompetition last year. The extension was made so that any decision on the future of CCOP could be based on the more complete information that will be available this spring from the comprehensive evaluation of the program.

When Yates presented the matter to the NCAB in May, board Chairman David Korn advised him that the board would be unwilling to okay another administrative extension and that he should return with evaluation data and a complete presentation on the program.

The evaluation will address CCOP's two major goals--bringing more patients from communities into clinical trials, and the diffusion hypothesis. The diffusion theory holds that optimal cancer treatment will be made more readily available by the expansion of clinical trials into communities.

Although the results of the evaluation won't be complete for a few months, the program has clearly met its goal of increasing patient accrual into clinical trials. CCOPs "have successfully demonstrated that they can accrue patients to clinical trials and protocols," Yates said. NCI anticipates no changes in the evaluation of patient accrual. "It appears that accrual is increasing over the past year," he added. Some of the cooperative groups have been reported to rely heavily on CCOP patients for their protocols.

Early evaluation of CCOP has also shown that "the quality of records and evaluation materials are as good as or even better than some group members," he said.

The evaluation's report on the diffusion hypothesis won't be available until mid April, he said. The evaluation is looking at both diffusion and CCOP's role in local cancer control activities.

Much of the evaluation will be completed in mid February, with the remainder expected to be completed in mid April.

Slow patient accrual was cited as the reason for NCI's dropping two CCOPs from the program's second year of funding. The Tri-State CCOP in Cincinnati and the Nassau Hospital in Mineola, N.Y. were dropped by NCI in 1984 because of failure to enter a sufficient number of patients into research protocols. The Nassau CCOP was later reinstated. Similar problems were experienced by many of the

other CCOPs in the early days of the program. One of the major problems that has limited patient entry is the lack of a sufficient number of good protocols to accommodate the type and number of eligible patients available in the community. For example, CCOPs have large numbers of lung and colon cancer patients available, but have very few good protocols in which to place them.

In addition, many centers have traditionally focused on pilot studies with "exotic" protocols, which do not require the numbers of patients available from the communities, and are not always appropriate for CCOP patients. NCI staff has asserted that more and better protocols are needed from the cooperative groups and centers in order to realize the full potential of CCOP.

Other delays were due to the need for the centers to gain NCI approval for protocols used in the trials. Because centers were not required to obtain NCI approval of their protocols in the past, the centers had to submit proposals to NCI, then wait for approval.

Two CCOPs voluntarily withdrew from the effort. Southwind CCOP of Evansville, Indiana declined to accept first year funding when the review committee cut its budget request by more than half. The Memphis CCOP decided not to accept second year funding after completing its first year in the program. That group cited "lack of significant clinical advantage" to patients participating in the studies as the major reason for its withdrawal from the program.

The Memphis CCOP entered only 25 patients on protocols during the year instead of its goal of 60 patients for the first year. In a letter to NCI explaining the group's decision to leave the program, Ronald Lawson, the Memphis CCOP's principal investigator, suggested patient accrual might have been increased if "studies and/or effective drugs not avalable in the community had been more readily available." He also said that "additional work not related to clinical protocols placed an undue burden on already underfunded CCOP personnel."

NCI officials originally intended to open another round of competition for the program before the current CCOP awards expired. Shortly after the program was underway, NCI Director Vincent DeVita told a congressional appropriations subcommittee that he hoped to have a total of 200 CCOPs funded by the year 1990.

DeVita is scheduled to discuss NCI's current plans for the program at the annual meeting of the Assn. of Community Cancer Centers April 2-6. Three representatives of cooperative groups and principal investigators from funded CCOPs will join in the discussion (See related story).

DEVITA TO DISCUSS NCI CCOP PLANS AT ACCC ANNUAL MEETING IN APRIL

NCI Director Vincent DeVita will discuss NCI's plans for the Community Clinical Oncology Program at the annual meeting April 2-6 of the Assn. of Community Cancer Centers. He will be joined in the discussion by three representatives of cooperative groups and principal investigators from funded CCOPs.

"This is the year when NCI is likely to re-release the CCOP request for proposals, and we want to assure that those who wish to apply hear about how the program has been doing, and where it is likely to go in the future," said David King, this year's program chairman and a member of the association's Board of Trustees.

CCOP has been among the most popular of NCI's initiatives in cancer control. More than 190 hospitals and communities vied for the award during the first competition in 1982.

Meeting attendees will hear from Southwest Oncology Group Chairman Charles Coltman, North Central Cancer Treatment Group Chairman Charles Moertel, and Peter Decker, chairman of cancer control for the National Surgical Adjuvant Breast & Bowel Project. Lloyd Everson, David King, and Philip Stott, three principal investigators, will discuss "The Good News and Bad News" of CCOP participation.

Two other portions of the program will focus on CCOP: an informal paper presentation session by CCOP investigators on the "CCOP experience" and a workshop with NCI staff on "Applying for the second round of CCOP." Both sessions will be open to all meeting attendees.

Freestanding cancer centers will be the subject of two special sessions to be held at the meeting. The centers "are clearly one of the most interesting and dynamic areas in community cancer care," King said.

The first session will be the formation of a Freestanding Cancer Center Special Interest Group, chaired by Thomas Sawyer of Orlando. The second session is a Workshop on Freestanding Cancer Centers to be chaired by Ruth Brokmeier of Tampa. "Both sessions are intended to spark discussion on freestanding centers, their development, financing and reimbursement," he said.

Current hospice issues will be the focus of an afternoon session, jointly sponsored by the Hospice Assn. of America, the National Assn. for Home Care and ACCC. The session will be chaired by Robert Enck and Deborah Horan. Enck currently serves as secretary of ACCC and is vice chairman of HAA. Horan is executive secretary of HAA.

Topics to be covered include surgical involvement

with terminally ill cancer patients and legal/malpractice issues of hospice care. ACCC members will also be briefed on pending legislative issues that affect the reimbursement of hospice care during ACCC's annual legislative briefing.

The meeting will also include an hour and a half session on the management of patients with acquired immune deficiency syndrome. Parkash Gill, assistant professor of medicine at the LAC-USC Medical Center, will chair the session. Topics include the ethical aspects, the practical aspects of managing AIDS patient care, and dealing with staff and public reactions.

Joint Assn. of American Cancer Institutes-ACCC paper presentations will be made on population based cancer control, cancer diet, nutrition and chemoprevention. ACCC sessions will include administrative trends, clinical practice issues and research in the community. "Working with Dr. Paul Engstrom at Fox Chase, Lee Mortenson (ACCC executive director) and Dr. Paul Anderson have been able to bring the Fourth Advances in Cancer Control Meeting and paper presentation sessions to this annual meeting," he said.

ACCC Delegate Representatives will consider several proposals to expand the qualifications of delegate member institutions during the annual meeting. Board members will make recommendations to the House on ways to expand membership categories. Proposals under consideration include the addition of freestanding cancer centers, health maintenance organizations, preferred provider organizations, and some physician practices to Delegate membership.

PROPAC STUDY TO PROVIDE IN DEPTH ANALYSIS OF SIX CANCER DRGs

Preliminary results of a study by the Prospective Payment Assessment Commission on six cancer Diagnosis Related Groups could be available in time for the group's meeting at the end of the month.

PROPAC is studying the appropriateness of current DRGs for lymphomas and leukemias as well as chemotherapy. The Assn. of Community Cancer Centers identified the lymphoma/leukemia and chemotherapy DRGs as having insufficient reimbursement weights in a paper presented to the commission this summer. At that time, ACCC asked PROPAC to review the DRGs (**The Cancer Letter**, Sept. 6). The paper raised concerns over the impact of Medicare's prospective payment system on the quality of cancer care and research in the U.S.

PROPAC is doing an in depth analysis of DRGs 400 through 404 (leukemias and lymphomas) and 410, chemotherapy. The six DRGs were chosen because they were identified by staff and outsiders alike as being particularly heterogeneous, a PROPAC spokesman told **The Cancer Letter.** In addition, "a number of individuals and groups have called us and brought them to our attention," he said. The commission received cards, letters and phone calls from hospital administrators, physicians, professional groups and Congress about the cancer DRGs.

The PROPAC study will examine Medicare data from all discharges for those DRGs in fiscal 1984, looking at charges and length of stay. Most hospitals participating in the federal prospective payment system were included in the system by the end of FY 1984, so the study will include data from approximately 5,000 to 6,000 hospitals.

Although PROPAC began looking at cancer DRGs last year, it did not start its in depth analysis of the cancer DRGs until after September. An outside contractor began work on the project the first of the year.

If results are available, the findings of the study will be summarized at PROPAC's meeting Jan. 21 in Washington. Any significant findings from a preliminary analysis of the DRGs would also be noted, but results from the analysis probably won't be ready until the commission meets again in early March.

In its letter, ACCC detailed its concerns about the use of DRGs for cancer treatment to PROPAC Executive Director Donald Young. The association warned that the prospective payment system's failure "to recognize the longer stays and greater costs involved in clinical cancer research will not only discourage and eventually eliminate most such research, but will also exert a profound chilling effect on the most successful cancer treatment paterns as currently practiced."

It also contended that "at least several [DRGs] pertaining to cancer are weighted far too low, with a resulting negative and unintended impact on practice patterns, not only in those particular DRGs, but in cancer treatment generally."

ACCC's first survey collected actual cost, charge and reimbursement data from 16 community hospitals, all of which were association members.

At that time, leukemia, DRG 401, and acute leukemia, DRG 403, were identified as the most seriously underpaid cancer DRGs. That survey found an average loss per discharge of $1,418.05 for acute leukemia patients and an average loss per discharge of $1,355.43 for leukemia.

Of 620 discharges for chemotherapy DRG 410, hospitals experienced an average loss of $641.49 per discharge, the survey said.

A just released ACCC survey of more than

13,000 discharges at more than 20 community hospitals confirms the earlier study's findings.

The problems pinpointed in the earlier survey remain the same—clinical trials, chemotherapy, and adult myleocytic leukemia , ACCC Executive Director Lee Mortenson told **The Cancer Letter.**

The report, "Cancer DRGs" is first of a series and compares 72 key cancer DRGs. In the introduction, ACCC notes that "Our basic concerns about DRGs remain the same: First, there seems to be a significant problem in the funding of clinical research patient care costs. Second, chemotherapy is clearly underweighted. Third, adult myelocytic leukemia patients are clearly underweighted."

Chemotherapy "now appears to have a major problem in its current weighting," it adds. The report speculates that the underweighting may be due to the way patients were previously coded, and to changes in the coding. For example, a lung cancer patient previously coded as a lung cancer patient for each admission, is coded under DRG 410 (chemotherapy), the lowest cost DRG, when readmitted for chemotherapy.

"As a result, we are seeing a large number of institutions that are reporting that DRG 410 is a significant loser. Since this is also one of the highest volume cancer DRGs, this is emerging as a major problem for cancer programs in many areas," the report says.

The report notes that difficulties with the coding of AML patients is also easy to understand. Because there was only a small number of AML patients available to the Health Care Financing Administration during the initial runs of the program, the small sample size could have led to miscalculations of the appropriate weighting of these patients, it says. "Surely it is obvious that most institutions, even university cancer centers, cannot sustain adequate treatment of the induction phase of these patients on $3,000 for the entire admission."

According to preliminary data collected by ACCC, the three cancer DRGs producing the greatest loss are DRG 410 (chemotherapy), DRG 345 (Other male reproductive system O.R. proc exc for malig) and DRG 403 (lymphoma or leukemia age 70 or above &/or CC.) DRG 410 was reimbursed at $825,384 below cost on 1,372 discharges; DRG 345 at $812,042 below cost on 42 discharges, and DRG 403 at $450,942 below cost on 796 discharges.

Other DRGs that fell "well below cost" are DRG 303 (malignancy, ureter & major bladder procedure for neoplasm), which was reimbursed at $248,198 below cost on 220 discharges; DRG 401 (lymphoma or leukemia with minor O.R. proc age 70 or above &/or CC), $192,532 below cost on 109 discharges; DRG 188 (Other digestive system diagnoses age 70 or above &/or CC), $190,895 below cost on 408 discharges; DRG 366 (malignancy, female reproductive system age 70 or above &/or CC), $132,500 below cost on 184 discharges; DRG 413 (Other myeloproliferative disorder or poorly differentiated neoplasm diagnosis age 70 or above &/or CC), $109,119 below cost on 306 discharges; DRG 406 (Myeloproliferative disorder or poorly differentiated neoplasm with major w/ O.R. proc & CC), $101,780 below cost on 64 discharges; and DRG 400 Lymphoma or leukemia with major O.R. procedure ($94,910 below cost on 119 discharegs).

The 10 DRGs are responsible for 91% of the loss generated by DRGs, accounting for $3,158,302 of the $3,462,418 reported loss. Another 16 DRGs below cost generated the remaining loss.

Although the survey identified more than 70 cancer DRGs, 15 DRGs accounted for more than 65% of all cancer discharges. DRG 82 (Respiratory neoplasms) accounted for the largest percentage, 11.79% of all cancer discharges, followed by DRG 410 (Chemotherapy), which accounted for 10.12% of all cancer discharges. Of the 15, ACCC data suggested that nine are "winners" and six are "losers."

ACCC approximated cost for a broader analysis of the cancer "winners" and "losers" by examining data on 5,633 discharges with cost information from a variety of perspectives. While the association determined that the data was too weak for major analyses, it did a set of computations on cost data, using 78% of charges as the method of approximating cost. The analysis used the high end percentage based upon total reported costs versus total reported reimbursements.

The preliminary data found that DRG 395 (Red blood cell disorders for patients age 18 or above) had the highest margin above costs, with $403,649 above cost calculated on 779 discharges. DRG 172 (Digestive malignancy age 70 or above and/or CC had the second highest margin above costs with $382,103 above cost on 553 discharges. The report identifies 10 high margin DRGs that account for $2,441,452 of the total $3,859,764 for all cancer DRGs, or 63.3% pf the profit generated above cost. An additional 34 other DRGs above cost contribute the remainder.

ACCC cites the "slim margin between reported reimbursement and cost" as a cause for concern for cancer programs. "Clearly several DRGs are significant losers, and we have already begun to see the effect of this loss in the changing configurations of cancer care over the past 12 to 18 months. As cost data from reporting institutions continues to improve and as institutions begin to target and eliminate or adjust their costs for 'losers,' we are bound to see some shifts in these figures."

CANCER RESEARCH INSTITUTE USING WALL STREET TACTICS TO RAISE $10 MILLION

The Cancer Research Institute Inc. of New York, the organization founded by the daughter of the first physician to treat cancer patients with an immunological substance, has initiated a unique and ambitious effort to more than triple its support of immunology research.

Cancer Research Institute has organized a "Wall Street Sponsoring Committee" and launched a campaign to raise $10 million utilizing the traditional Wall Street financing mechanism of selling "securities."

The Wall Street Sponsoring Committee is composed of senior officials of prominent Wall Street firms. Each firm or its principals have made a commitment of $50,000 to Cancer Research Institute. The committee is cochaired by Peter Cohen, chairman of the board of Shearson Lehman Brothers; Jerome Kenney, president of Merrill Lynch Capital Markets; William Mayer, managing director of First Boston Corp.; Thomas Strauss, executive managing director of Salomon Brothers; and Frederick Whittemore, managing director of Morgan Stanley.

Invitations to join this syndicate will be issued by the committee to 1,300 firms, including member organizations of the New York and American stock exchanges and the Securities Industries Assn. Membership in the syndicate is attained by making a tax deductible contribution to the Cancer Research Institute. Brackets have been established, but each firm is free to choose its own level of giving. Contributions will be acknowledged through the issuance of a receipt modeled on a stock certificate. The closing date for syndicate participation is June 1, 1986.

The invitations are accompanied by a "prospectus" similar to those announcing new stock issues. It describes the organization and its current activities and summarizes how it expects to use the $10 million it plans to raise:

*$2 million to increase the size of CRI's fellowship program over the next three years.

*$3 million toward investigatorships of four years' duration at $50,000 annually. CRI would like to make a minimum of 10 such awards in each of the next four years; the balance of the $5 million required during the first four years of the program would be provided from CRI's general funds.

*$5 million for a seed capital fund providing two year grants in support of innovative projects, including research into AIDS.

As funds permit, CRI would also like to establish a distinguished investigators program for leading cancer immunologists, the prospectus says.

The law requires prospecti for all new stock issues to explain risks investors are taking and detail why they may never see a return on their money. The CRI prospectus says that while immunology "is indisputably in the mainstream of research and some of the most promising therapies on the horizon are immunological in nature. . . it is difficult to draw conclusions about the future course of developments. No one can provide a timetable with respect to the control of cancer."

CRI was founded in 1953 by Helen Coley Nauts, daughter of William Coley, a surgeon who in 1893 observed that a patient with neck cancer experienced spontaneous regression after developing an acute streptococcal infection. He formulated a mixed bacterial vaccine that produce complete disappearance of cancer in a significant number of patients. His work was not widely acknowledged at that time, and the field languished.

In 1940, Nauts started compiling details from hospital records and published reports of 896 cases of cancer patients who had been treated with various preparations of her father's mixed bacterial vaccines. She founded CRI on the premise that resistance to cancer not only existed but also could be strengthened or stimulated as a form of treatment or prevention. Nauts served as executive director of CRI until 1982 and presently is director of science and medical communications.

CRI entertains applications for grants and training fellowships from researchers in the U.S. and around the world. Funding decisions are made by members of the institute's Scientific Advisory Council, which is headed by Lloyd Old, Memorial Sloan-Kettering Cancer Center. Associate directors are Edmund Klein, Roswell Park Memorial Institute; and Benvenuto Pernis, Columbia Univ.

Last year, when it seemed that NIH might be restricted to awarding only 5,000 competitive grants rather than 6,500 as provided for by Congress, CRI offered an emergency program which would have picked up a few of the high quality immunology grants that would have been out of the priority score funding range (**The Cancer Letter**, April 19). CRI had committed $1 million to this program.

CRI asked NCI and the National Institute for Allergy & Infectious Diseases to inform grant applicants with scores between the expected cutoff and 200 of its emergency effort and suggest they provide CRI with copies of their pink sheets. A panel of the Scientific Advisory Council reviewed them and selected 34 for further, in depth review. While this was going on, the situation at NIH improved with the compromise on funding (later upheld by a congressional override of the President's veto), and 24 of the 34 were informed they were being funded after all.

That left 10 competing for the emergency awards,

seven from NIAID and three from NCI. Three were finally selected, all of them from NIAID. They are receiving $50,000 a year for two years—not a lot by NIH standards but enough to help hold their projects together until they can recompete at NIH.

Although the situation at NIH could be even worse as the effects of the deficit reduction legislation take hold, CRI has no plans for any further emergency support of unfunded NIH immunology grants, an Institute spokeswoman said. Present and planned new programs will require commitment of all available funds.

SEVEN NCAB VACANCIES TO BE FILLED, DECISION TO BE MADE ON CHAIRMANSHIP

The terms of six members of the National Cancer Advisory Board will expire following the board's February meeting, and another seat, that of the late Angel Bradley, is also vacant, leaving President Reagan with seven appointments to make.

NCI Director Vincent DeVita has submitted his nominations for the vacancies, and other recommendations have poured into the White House, some with congressional support.

Those whose terms are up are Robert Hickey, executive vice president of M.D. Anderson Hospital & Tumor Institute; Gale Katterhagen, director of oncology at Tacoma General Hospital; Rose Kushner, patient advocate and executive director of the Breast Cancer Advisory Center in Kensington, Md.; Ann Landers, newspaper columnist, Chicago; LaSalle Leffall, chairman of surgery at Howard Univ. Hospital; and William Powers, chief of the Radiation Oncology Center at Wayne State Univ.

Kushner, Landers and Bradley were appointed as lay members. The person appointed to Bradley's seat will serve out the remaining two years of her term; the other six will be appointed to six year terms.

The Assn. of Community Cancer Centers has been lobbying hard for Katterhagen's reappointment and also for the appointment of John Yarbro, Univ. of Missouri professor of oncology, former ACCC president and former head of the cancer centers program as an NCI staff member in the early 1970s. Katterhagen is also a former ACCC president and is presently cochairman (with Leffall) of the NCAB's Committee on Cancer Control & the Year 2000. Hickey is chairman of the board's Committee on Organ Systems Programs.

The Oncology Nursing Society is working just as hard for the appointment of two of its members—Marilyn Stromborg of Illinois and Joyce Yasko of Pittsburgh.

Rep. Rose Mary Oakar (D.-Ohio), who has been initiating and promoting various legislative efforts on behalf of cancer patients, has urged Kushner's reappointment.

NCAB members generally are not reappointed except in cases where they have been filling out unexpired terms of someone else. There have been exceptions: Powers has served on the Board since it was established in 1972.

DeVita has not publicly discussed his preferences for the open positions, but the NCI leadership in general, and some NCAB members, feel that perhaps the most pressing need, with Leffall's departure, will be for a strong, creditable academic surgical oncologist. Most of them also feel that there has been a major deficiency in the area of public health -epidemiology-cancer control since Maureen Henderson of the Univ. of Washington left the Board two years ago.

Another perceived need is for a strong research oriented academic medical oncologist. And finally, most agree the Board could use another basic scientist.

One appointment related issue which has caused considerable controversy in the past is the provision in the National Cancer Act that requires at least five members of the Board to be experts in either environmental carcinogenesis or nutrition and cancer.

That provision was written into a renewal of the Act by former Congress Andrew McGuire at a time when he and others felt NCI had been neglecting those fields. President Carter attempted to follow that directive but it has been all but ignored in the Reagan appointments, although the White House disputes that point.

"That is not an issue this time," one source told **The Cancer Letter.** The White House contends that five of the holdover members meet the environmental carcinogenesis-nutrition requirement: Board Chairman David Korn, Roswell Boutwell, Gertrude Elion, Enrico Mihich and Louise Strong.

That may be stretching the definition a bit; although each of those is certainly qualified to discuss with considerable knowledge most environmental issues, only Boutwell is presently working in those areas. Boutwell, with the Univ. of Wisconsin, is on a two year assignment as chief of research at the Radiation Effects Research Foundation in Hiroshima.

Korn, a pathologist, is dean of the School of Medicine at Stanford; Elion is scientist emeritus with Burroughs Wellcome; Mihich is director of experimental therapeutics at Roswell Park; and Strong is associate professor of pediatrics and medical genetics at M.D. Anderson.

Korn's two year term as chairman of the Board is also up this year. With one exception, previous chairmen have always been reappointed for second terms. The exception was two years ago, when the White House announced that Korn would replace Tim

Lee Carter "in line with the policy of rotating the chairmanship."

Korn's stewardship has been steadying, and the Board has recovered much of the prestige and scientific direction it had lost under Carter, the former congressman who never understood what his role as chairman should be. The improvement was made easier by Reagan's 1984 appointment of such solid scientists as Strong, Elion and Mihich.

The present lineup of lay members is the strongest in the Board's 14 year history. Richard Bloch made a major contribution in coming up with the concept of PDQ and then contributing much of his fortune to the building that houses it. Helene Brown, codirector of cancer control at UCLA, is more knowledgeable than most professionals about many issues with which the Board deals. Kushner sometimes antagonizes NCI staff and colleagues on the Board with her aggressively presented views but she probably has been the hardest working member of the Board during her tenure and has made major contributions in the evolution of the organ systems program and the Community Clinical Oncology Program. Landers generally does not have much to say and is present only for the first day of the three day meeting, but she has used her column to powerful effect on two or three occasions.

The schedule calls for the new appointments to be made sometime in March. NCI plans to bring the new members in for an orientation session sometime before the Board's May meeting. They will meet with the NCI Executive Committee and undergo briefing on their duties and responsibilities.

NEW CCSP AND CCRU AWARDS APPLICATIONS UNDER REVIEW

NCI has made its Cancer Control Science Program a continuing effort. To date, five awards have been made under the program, most recently to the Illinois Cancer Council for a five year CCSP in head and neck cancer rehabilitation.

First year direct costs for the Illinois award are approximately $650,000. The award is the second CCSP won by the Illinois Cancer Council. Other institutions that have received CCSP awards are the Fox Chase Cancer Center, UCLA, and Memorial Sloan-Kettering. Three applications for CCSPs are currently under review.

Another cancer control mechanism established by the Div. of Cancer Prevention & Control, Cancer Control Research Units, has generated two more applications currently under review. NCI made one award to the Univ. of Washington in 1984, then reissued the RFA. OCI currently has no plans to reissue the RFA again, at least for the next six months.

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. 20892. 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.

NCI-CM-67873-18

Title: Large scale production of monoclonal antibodies

Deadline: March 20

The Biological Response Modifiers Program of the Div. of Cancer Treatment seeks a contractor to produce large scale, pharmaceutical grade quantities of specific monoclonal antibodies for preclinical testing and clinical trials. The contractor will be expected to have the requisite capability to produce a monoclonal antibody by either ascites production in mice or currently available cell culture techniques. The contractor shall produce 10 to 50 grams of a given monoclonal antibody upon receipt of a given hybridoma. It is anticipated that five to 10 different monoclonal antibodies will be required in the stated amount annually.

The principal investigator shall have a minimum of five years of extensive experience in immunology and cell biology, and should devote at least 25% of his/her time annually to this effort.

In addition to the PI, the support staff should have experience directly relevant to (a) production and purification of monoclonal antibodies; (b) characterization of monoclonal antibodies by immunological and biochemical methods; (c) testing of monoclonal antibodies by FDA approved procedures; and (d) preparation of clinical use products under GLP and GMP procedures.

The concept from which this RFP was derived was approved last fall by the DCT Board of Scientific Counselors and was reported in The Cancer Letter Oct. 11, page 4.

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