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CCOP Success Acknowledged, Recompetition Plans Being Made; Cancer Control May Be Added To RFA

"If the CCOPs were not already up and running, we would have to invent them." With a resounding affirmation of the

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In Brief

Anderson Assumes ACCC Presidency, Enck President Elect; Reagan Reappoints Montgomery

PAUL ANDERSON, director of Penrose Cancer Hospital, Colorado Springs, succeeded Edward Moorhead of Grand Rapids as president of the Assn. of Community Cancer Centers at the organization's 12th national meeting last week. **Robert Enck**, director of oncology at Our Lady of Lourdes Memorial Hospital in Binghamton, was elected president elect. Other new officers elected were Jennifer File Guy, Grant Hospital, Columbus, OH, secretary;and David King, principal investigator for the Greater Phoenix Community Clinical Oncology Program, treasurer. . . . **ACCC MEMBERS** approved a controversial bylaw change aimed at encouraging freestanding cancer centers to join the association. Objecting to the board's recommendation for the change, John Trombold said some of the FCCs "smack too much of entreprenurial medicine;" Herbert Kerman, while agreeing they should be admitted, argued against letting in as delegate (voting) members "these disparate, ill defined, unknown groups;" and John Travis recommended the issue be referred back to appropriate committees to draw up standards for membership. His motion to that effect was defeated after Paul Anderson, John Yarbro, David King and John Nelson argued the merits of bringing those organizations into ACCC . . . . **JOHN MONTGOMERY** has been reappointed to a three year term on the President's Cancer Panel by President Reagan. Montgomery is senior vice president of Southern Research Institute. . . . **NCI GRANT** payline for the current fiscal year, held at 159 after the White House submitted the $6.8 million rescision request to Congress, will go up two to three points when the rescision is pronounced dead next week. The rescision had to be approved by both houses to go into effect; neither has acted and probably will not by the April 15 deadline. The $55 million cut from NCI by Gramm-Rudman-Hollings will come from renegotiations in noncompeting awards, cutting awards to cooperative groups and centers five to 15% under recommended levels; and reductions in other programs.

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CCOP Bad News: No Money Available To Expand It In The Recompetition

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success of the Community Clinical Oncology Program, NCI Director Vincent DeVita enthusiastically told Assn. of Community Cancer Center members last week that it will be continued.

Those who hope to recompete their CCOP awards successfully, and others who plan to apply for new CCOPs, had their hopes somewhat diminished when DeVita gave them the bad news about funding.

NCI has been supporting the program with about $9 million a year. DeVita said that although he had hoped to be able to add more CCOPs in the next round, "Unfortunately, it will not be possible to expand." The same amount, $9 million a year, will be available for the recompetition.

Not only does that mean the program will not expand, it may well mean that fewer CCOPs will be supported this time. Increases in the budget requests, if approved by reviewers and NCI and the National Cancer Advisory Board, would reduce the total number funded.

Another major factor is the serious consideration NCI is giving to the addition of cancer control elements in the new program. ACCC and others argued vehemently for some cancer control support when the program was first established, but DeVita resisted, contending that resources should be reserved for clinical trials until the program could be established.

Some CCOPs have taken on cancer control activities without NCI support, DeVita noted. "I hope we can get some in this time."

NCI intends to issue the new request for applications in July, with letters of intent due in September. Applications will be due Oct. 15, with peer review in January and February and action by the NCAB in May, 1987.

Robert Frelick, CCOP program director in NCI's Div. of Cancer Prevention & Control, said that a planning group is working on elements of the program which will be incorporated into the new RFA. "We're looking for anyone with good ideas," Frelick said, and invited ACCC members to submit suggestions they may have.

Frelick said new CCOP issues could include such items as minority representation, cancer control activities and cancer control research, research base affiliations, standardization of data, protocol relevance and availability, protocol eligibility criteria, the infamous patient log that most CCOP participants detest, audits by research bases and payment based on credits.

"Not all of this will impact this RFA," Frelick said, "but we need to think about the future."

DeVita noted that when he conceived the program in 1981, he had hoped that as many as 200 CCOPs could be established. The actual number approved for funding was 63, two dropped out voluntarily and one was dropped by NCI after the first year.

"I never expected CCOPs to be perfect," DeVita said. "I have to tell you they have exceeded all our expectations. Accrual has exceeded expectations, Record keeping has been excellent." Although the diffusion hypothesis (that benefits of clinical research in communities will spread to other patients than just those on protocols) is not testable now, DeVita said, I can't believe it is not having its effect, from the data presented here."

DeVita said that if more money is made available to NCI than is presently in the budget, the program mwould be expanded in size. "To meet our goals for the year 2000, we have to expand clinical trials."

The data to which DeVita referred on CCOP performance were presented by some of the principal investigators, by cooperative chairmen, by NCI staff reporting preliminary findings on the CCOP evaluation being conducted and by ACCC which conducted its own survey of the program.

Charles Coltman, chairman of the Southwest Oncology Group, said that SWOG serves as the research base for 18 CCOPs with 23 member institutions. SWOG also contracts with 174 other hospitals and groups through NCI's Cooperative Group Outreach Program (CGOP), which also supports clinical trials in community settings.

"The CCOP research data are unequalled in quality," Coltman said. "It has been a major contribution to science. CCOPs have become an integral part of SWOG"

Coltman said the program has demonstrated that community physicians can deliver high quality cancer care and therapeutic cancer research in communities and that "SWOG is proud of its role in bringing the Community Clinical Oncology Program to fruition."

CGOP is also a successful program, Coltman said. In a review of CGOP results with protocols for acute leukemia and multiple

myeloma, "we discovered that their response rates and overall survival, everywhere, was better than the overall SWOG results. It's been said that community physicians get better patients, but that was analyzed, and the difference can't be related to pretreatment prognostic factors. My guess is that CGOP physicians are directly involved in caring for patients. At the universities, under the direction of physicians, fellows take care of the patients. It's sad, but fellows just do not do as well."

Peter Deckers, Hartford Hospital and chairman of the National Surgical Adjuvant Breast & Bowel Project's Cancer Control Network, said that community participation is vital to NSABP's programs. He noted that 59% of the group's patients are provided by the network, which includes both CCOPs and CGOPs.

Deckers said that CCOP and CGOP activities do not overlap, and he invited all those who are planning to join the CCOP recompetition to consider name NSABP as a research base.

Charles Moertel, chairman of the North Central Cancer Treatment Group, said that CCOP "represents one of the most outstanding successes of the National Cancer Program. The only problem with it is that the charge and funding have not been extended to include cancer prevention and cancer control."

Moertel said that "high quality cancer care is not equal to the best standard treatment. The only hope for some patients is research protocols. They must be available to the community."

Results of the ACCC survey were reported by Paul Anderson, incoming ACCC president. Catherine Novak and Lee Morteson participated in the survey, which found:

*Patient accrual in the second year averaged 75 per CCOP, ranging from 37 to 140, exceeding the NCI requirement of 50.

*An average of eight physicians per CCOP entered patients onto protocols, ranging from one to 20.

*CCOPs participating in the survey (22 of the 60) were split on the question of whether funding was adequate. Total funding averaged $81,650 the first year, $93,703 the second. Nine said funding was adequate, the rest that it was not.

*All agreed that their CCOPs benefitted the communities, the most important benefit being the availability of state of the art treatment. A majority said they had also benefitted themselves.

*Eighteen said their affiliations with cooperative groups and cancer centers had been a success, the rest said that some were successful, some not.

*Most valuable part of the CCOP experience: ability to offer protocol treatment to patients and availability of investigational drugs; intellectual stimulation; continuing education; data management support; cooperation among hospitals.

*Least valuable: the patient log, called time consuming, paperwork without visible benefit; paperwork in general; vagueness of the cancer control effort. In appraising the patient log, most felt it to be inaccurate, unreliable, time consuming and of little or no use.

CTEP Presents Options For Drastic Changes In Groups; Caution Urged

NCI and its advisors are deep in the throes of an issue which could have profound impact on CCOPs and all other cancer clinical trials programs, most notably the clinical cooperative groups. The outcome of this debate, which got up a full head of steam at a meeting last week, could lead to a complete reorganization of the groups.

Or it could lead to relatively minor changes; "fine tuning" of the present system, as several participants in the meeting described it.

Robert Wittes, director of the Cancer Therapy Evaluation Program in the Div. of Cancer Treatment, presented four major options, with some suboptions, which are under consideration. The presentation was made to an invited group of clinical investigators, cooperative group and cancer center representatives which was asked to comment, criticize and offer alternatives.

Wittes had previously discussed his proposals with cooperative group chairmen. The proposals are the result of an extensive survey CTEP conducted of the way the groups manage clinical trials, and the results of that management.

Culmination of the review and development of the proposals came just after four cooperative groups were disapproved by the Cancer Clinical Investigation Review Committee, joining three others cut off from NCI funding during the past year. That reduces the number of cooperative groups from about 25 (depending on the definition of a cooperative group) to about 18.

The most drastic of Wittes' options would eliminate cooperative group institutional grants, provide funds to investigators directly through groups which would be permitted to recruit and negotiate with investigators and institutions as they see fit. Investigators would be encouraged to sign up with groups that are planning studies which coincide with their (the investigators) interest and expertise. Investigators and institutions could thus belong to several groups.

"That would be an administrative nightmare," was the refrain Wittes heard most often when that option came up.

CTEP's rationale for significant changes in the groups was based on these points, the result of the survey:

*Therapeutic strategies have reached a plateu in many areas. Preclinical developmental therapeutics is moving very fast, and basic biology is moving even faster. Thus the number of worthy new therapeutic hypotheses will increase dramatically in the next 5-10 years.

*Peer review is taking a hard look at the cooperative groups this year. Federal efforts at deficit reduction make the budget outlook uncertain.

*Problems in science to consider include suboptimal coordination among groups with overlapping research agendas; duplication; many trials are too small; long gestation time for new ideas; suboptimal accrual rates and thus extended duration of many trials; general unpopularity of the intergroup mechanism; restriction of the mandate of groups to treatment, probably wasteful for NCI.

*Administrtive problems include the point that a premium for accrual in institutional awards gives incentive to idling studies; awarding of institutional grants does not clearly separate out qualitatively different kinds of contributions; rewards for accrual are inconsistent; large dollar amounts are locked up in an inaccessible noncompeting pool, making it difficult to reporgram funds within a group and virtually impossible across groups; and it is impossible to drop a relatively weak current member for a much stronger applicant with a fundable score.

*Also, there is no direct relation between dollars and particular trials, thus no good way of linking funding with studies in allocating resources; fixed relationships between institutions and groups allows little flexibility in selecting institutions to participate in trials; grant requests bear no relation to the fixed of the clinical trials budget,leaving the only solution fractional funding; there is a lack of coordination between DCT and the Div. of Cancer Prevention & Control.

*Problems in review include the feeling that reward for originality leads to the perception that intergroup trials are a liability; erratic judgments on budgets, especially institutional budgets develop because reviewers find it difficult to reward different categories of contributions with consistency; and review finds it difficult to deal with unusual requests outside the mainstream.

An ideal clinical trials program, Wittes said, should deal flexibly with the spectrum of disease sites and stages; rapidly respond to new ideas and the opportunities from NCI and industry; address only the important questions; get reliable answers; complete trials in a timely fashion, with accrual time short in relation to disease natural history and to the rate of evolution of new ideas in a particular field **("Get a reliable answer before you don't care what the answer is," is the way Wittes put it)**; serve as a clinical trials resource for any kind of cancer related multicenter study, including treatment, prevention, early diagnosis.

Wittes listed as operational implications of those requirements:

1. Multidisciplinary involvement; 2. capability to study broad spectrum of diseases and high risk populations; 3. flexibility to shift support to new areas of emphasis as scientific priorities change, without compromising other high priority areas; 4. participation of the best clinical trials people for the conception, design, data management, and analysis of trials; 5. mechanisms for assuring access to relevant patient populations; means for deciding on important questions and the setting of priorities; 7. larger, fewer trials; 8. close integration with NCI's new agent development; 9. mechanisms for fostering constructive interactions with industry; 10. quality assurance; 11. smooth coordination and management within NCI; linking dollars to particular studies for rational budgeting.

Details of the CTEP proposals and the survey which prompted them will appear in The Cancer Letter next week.

Nixon Calls For U.S.-Soviet Union Cooperation in War Against Cancer

Former President Richard Nixon told the Assn. of Community Cancer Centers that when he signed the National Cancer Act in 1971 he said, "I hope that in the years ahead we will be able to look back and say this act will be the most important achievement of this administration." Nixon received the association's annual award for Outstanding Contribution to Community Cancer Care in recognition of his support and signing of the the National Cancer Act of 1971 at the ACCC's 12th national meeting in Washington last week.

Noting that 1971 was a year of significant achievements such as the announcement of trips to China and the Soviet Union, as well as substantially reduced casualties in Vietnam, Nixon then asked "how can I say that" signing the act was the administration's most important achievement that year?

"More people will die of cancer in 1986 than were killed in all four years of World War II," Nixon said, adding that he had "very personal reasons" for his interest in cancer. The mother of his wife, Pat, died of cancer when Pat was 12 years old, and Nixon's favorite aunt died of breast cancer when he was in high school. Other experiences with cancer occurred when he served as vice president and witnessed the deaths by cancer of Sen. Robert Taft and John Foster Dulles.

In the 15 years since the passage of the National Cancer Act, the number of comprehennsive cancer centers has grown from three to more than 20, and the number of medical oncologists has increased from 100 to more than 2,800, he said.

Nixon cited dramatic progress in survival rates for cancer patients, as well as progress in the prevention of cancer. "And that is progress.

"The progress has not been as great as we'd like," he said. "We have found no one cure [for cancer] because there may not be one cure.

"We had high hopes when this program began that we would find a cure for cancer," Nixon said. "We have not found a cure for cancer, but we're beginning to find the cause. If we find the cause, the cure is likely to come."

Nixon also called for increased international cooperation in the fight against cancer. "Today the U.S. has some differences with other countries in the world. We have particularly big differences with the Soviet Union," he said. "But we have one common interest. The Soviet Union and the United States should be allies in the war against disease, especially cancer."

While saying he believes American scientists and doctors are the best in the world, "we don't have a monopoly on wisdom," he advised. "New medical discoveries are not limited by national boundaries and never should be limited by national differences."

In waging war on cancer, "we should act not just for ourselves alone but for all mankind.

"In just 13 years, we will be celebrating the beginning of a new year, a new century ....The twentieth century has been the bloodiest in history. More people have been killed in war in the twentieth century than in all centuries before.

"By the end of this century, it is my hope and my prayer that our conquest of cancer will be our greatest victory."

Nixon also threw in a plug for ACCC representation on the National Cancer Advisory Board. "If I may do a little lobbying now of Dr. DeVita, I think you ought to be represented on the National Cancer Advisory Board," Nixon told the luncheon crowd, which responded with loud applause. Although the President makes appointments to the NCAB, the NCI director does make recommendations which sometimes are accepted and sometimes not.

Because of new technology developed under the National Cancer Act, an additional four million Americans who get cancer this year will be cured, John Yarbo, past president of ACCC, told the luncheon in introductory remarks. In 1971, "we would have been able to cure only 21 million of the more than 50 million destined to get cancer" with the 42% cure rate at that time, he said, whereas now the cure rate is probably over 50%.

"Without the support of the man we honor today, that legislation would not have been possible," he said. Yarbo quoted Washington journalist Daniel Greenberg on Nixon's dedication to cancer research. "'The record shows that he was the first and last President to give cancer research personal attention and budgetary backing.'"

ACCC's award for service to cancer patients was presented to Nixon "on behalf of [the association] and the thousands of practicing oncologists all across the land, and on behalf of over 50 million Americans

now alive who will develop cancer in their lifetimes, and most especially on behalf of the at least four million more of them who will be cured because of the research that your signing the National Cancer Act made possible."

After signing the Act, Nixon directed that an additional $100 million be given to NCI in 1972, an almost 50% increase in the institute's budget at that time, Yarbo said. "The explosion in funding and resources provided by the National Cancer Act is perhaps best illustrated when I tell you that 80% of all of the dollars spent on cancer research have been spent since its passage in 1971."

Previous recipients of the ACCC award include: Sen. Robert Dole, for his interest in the potential negative impact of DRGs on clinical research; Sen. Birch Bayh, for his support of community cancer programs and their involvement in clinical research; B.J. Kennedy for his involvement in the foundation of medical oncology as a medical specialty; and Harold Amos, for his leadership in science and as a member of the NCAB and President's Cancer Panel.

FCC Special Interest Group To Address Definition, Reimbursement Issues

A new special interest group for freestanding cancer centers is being established by the Assn. of Community Cancer Centers. One of the first tasks of the new group will be the establishment of subcommittees to address such questions as the definition of FCCs and reimbursement issues associated with the centers. Group members hope to have the subcommittees operational and a draft definition developed before ACCC's fall meeting in New Orleans in September.

One of the first issues to be addressed by the subcommittees is the definition of a freestanding cancer center.

Although some participants in an April 2 meeting of the FCC Special Interest Group were concerned about excluding existing centers by creating too strict a definition, the majority seemed to agree that a broad definition is needed as a first step in the development of standards and eventual accreditation for the centers.

Most agreed that the definition should allow for a broad interpretation of a freestanding cancer center, but generally felt that a cancer center should optimally include all services that might be required by a cancer patient on an outpatient basis.

Participants also appeared to agree that the concept of a freestanding center should not necessarily exclude centers that are physically linked with a hospital, but that the term should be interpreted to mean administrative freedom in managing the center's affairs.

Participants also agreed that the centers should have some kind of accreditation and quality control. Although the potential for duplication of efforts currently underway by the American College of Surgeon's Commission on Cancer to address the two issues was raised, many participants seemed to believe that an effort by an ACCC special interest group could serve a complementary role and allow for the inclusion of the group members' special expertise in the area of freestanding cancer care.

Other issues identified as meriting further attention included indigent care, clinical research, and group affiliations with groups such as ACCC.

The meeting and a subsequent workshop on FCCs was led by Thomas and Carolyn Sawyer, who run a network of four radiation therapy centers in the Orlando area.

Thomas Sawyer is scheduled to meet with ACCC officials to discuss the establishment of subcommittees. He told the meeting that he hopes to devise a list of subjects to be addressed by the subcommittees with ACCC officials, and will contact persons who attended the meeting of the Special Interest Group for their help in establishing the subcommittees. Sawyer hopes to have a draft definition of FCCs to bring to the New Orleans meeting in September. One possibility raised at the session was the term freestanding cancer system that would encompass total care of cancer patients while excluding smaller units that could be considered centers.

Other potential subcommittees include one to examine the financial structure of the centers, and another to deal with reimbursement issues.

Sawyer told the workshop that ACCC will have to address the issue of different accreditation for FCCs. He added that he believes the association should allow a form of voting membership by FCCs, but that he does not think a FCC should have an equal vote for a delegate membership. (See In Brief, page 1, for the report on members' decision to offer FCCs full voting rights).

Persons attending the meeting ranged from representatives of hospitals contemplating the establishment of freestanding cancer centers, operators of local and regional cancer centers and representatives from firms specializing in the development of FCCs such as CDP Associates and Salick Health Care.

Salick Health Care has recently opened a new division, SHC's Health Resources Group, in Washington. The office is headed by Kathie Bowing, vice president and general manager of the Washington D.C. Division, and Nancy Bookbinder, director of planning and economic analysis. Both Bowing and Bookbinder worked for La Jolla based CDP Associates before joining Salick several weeks ago.

The new Washington division will offer consulting services to some select clients in addition to helping the internal development of new centers within the Salick system, Bowing told **The Cancer Letter.** Those services include oncology reimbursement expertise, oncology data system assessment and cancer center service assessment and program development.

While the consulting service represents a new function for Salick Health Care, the office's main purpose will be cancer center assessment, and the development and implementation and establishment of Salick's out patient networks of cancer care centers that provide 24 hour care.

NCI's Supercomputer Undergoing Government Acceptance Testing

NCI's supercomputer has been installed at the institute's Frederick Cancer Research Facility. The highspeed computer is currently undergoing "acceptance testing" and will probably be accepted by the government within the next week. One of NCI's first priorities will be the establishment of a communications system with the NIH campus in Bethesda.

NCI is still exploring the best way to involve outside investigators in obtaining computer time with the system, and the most beneficial communication system to promote access by outside investigators.

The institute has still not developed a formal application procedure for use of the supercomputer by outside investigators.

Investigators interested in using the supercomputer have been contacting Jacob Maizel, chief of the Div. of Cancer Biology & Diagnosis' Mathematical Biology Laboratory (**The Cancer Letter,** Nov. 15). Some investigators are currently using projects they earlier proposed to NCI as part of its acceptance testing on site.

Although the highspeed computer will be the first supercomputer designed for and devoted primarily to research in the biomedical sciences, biomedical researchers do have access to supercomputer time at one of six National Science Foundation Supercomputing centers or three resource centers.

A joint NSF and NIH program makes peer reviewed awards of up to 25 hours of supercomputer CPU time to promote the exploratory use of supercomputers by researchers, including those with little or no experience with supercomputers, but who anticipate that supercomputers might make a significant impact on their research.

The program is designed to encourage the broadened use of supercomputers by biological, biomedical, behavioral, social and economic scientists.

Investigators should submit a brief proposal outlining the nature of the problem to be studied and the potential advantages of supercomputer usage. The proposal should include a cover page (with appropriate institutional signatures), a short abstract, a list of current research support, curriculum vitae (including publications during the past five years), and up to a five page justification of the proposed use of supercomputer time.

This section should describe the investigator's relevant research program, the level of current computational usage/involvement, and the proposed new activity/advance to be made possible by the use of a supercomputer.

Access to a particular type of supercomputer or to a particular center may be requested. Researchers who anticipate an immediate need for more than 25 hours of supercomputer time are encouraged to discuss their needs with NSF.

The deadline for receipt of proposals is April 18. Fifteen copies of the proposals should be sent to: Dr. John C. Wooley, BBS: Advanced Scientific Computing , National Science Foundation, 1800 G Street N.W., Room 325, Washington, D.C. 20550.

For further information about the competition call: Ms. Brenda Flam, NSF Biophysics Program at 202-357-7050 or Dr. Suzanne Stimler, NIH Biomedical Research Technology Program at 301-496-5411.

RFPs Available

Requests for proposals 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.

RFP NCI-CB-61023-55
Title: Transplantation, induction and preservation of plasma cell tumors in mice and the maintenance of a colony of special strains of mice
Deadline: Approximately June 15

The Div. of Cancer Biology & Diagnosis is seeking proposals for provision of a support facility for studies on the genetic basis of susceptibility to cancer. This contract will provide for a closed (quarantine protected) conventional mouse colony in which mice can be observed for plasmacytoma development and in which various congenic strains of mice can be developed and bred for induction studies. Specific tasks under this contract shall be (1) the induction of plasma cell tumors in mice that includes conventional mouse colony containing inbred and congenic strains of mice; (2) the transplantation, preservation and distribution of plasma cell, lymphocytic macrophage and mast cell tumors in a frozen tumor bank; (3) characterization of myeloma proteins; (4) development of congenic strains of mice, using biochemical, seriological and karyological markers; and (5) the maintenance of a wild mice colony as a resource for new genetic markers and a facility for observing wild mice for the development of leukemia and mammary tumors. Approximately 8,000 mice shall be maintained under this contract. All animals will be supplied by the government.

Offerors need to demonstrate their ability to provide for rapid exchange of animals and materials between their facility and the NIH campus in Bethesda. A five year contract is anticipated.

This announcement represents recompetition of a contract currently being performed by Hazleton Laboratories America Inc. of Vienna, VA.
Contract Specialist: Mary McGarvey
RCB Blair Bldg Rm 114
301-427-8888

RFP NCI-CB-61024-55
Title: Maintenance and development of inbred and congenic resistant mouse strains
Deadline: Approximately June 15

The Div. of Cancer Biology & Diagnosis is seeking proposals for provision of a support facility capable of (1) maintaining a colony of approximately 75 strains of inbred mice by strict pedigreed brother/sister matings; (2) breeding and developing new congenic mouse strains using inbred and wild derived mice; (3) making selective crosses and backcrosses for immunologic and linkage analyses; (4) producing and maintaining transgenic mice; (5) freezing and recovering embryos from inbred, congenic, backcross and transgenic mice; (6) producing antisera by immunization between these strains and with other antigens; (7) producing, maintaining and characterizing hybridomas from appropriately immunized animals; and (8) performing quality control testing by serology, skin grafting and DNA hybridization studies on pedigreed animals in the colony. Approximately 6,000 mice shall be maintained under this contract. All animals will be supplied by the government.

Offerors will need to demonstrate their ability to provide for rapid exchange of animals and materials between their facility and the NIH campus in Bethesda. Other minimum facility, equipment and personnel requirements will be included in the RFP. A six year contract is anticipated.

This announcement represents recompetition of a contract currently being performed by Hazleton Laboratories America Inc.
Contract Specialist: Mary McGarvey
RCB Blair Bldg Rm 114
301-427-8888

NCI CONTRACT AWARDS

Title: Preparation of radiolabeled materials
Contractor: Research Triangle Institute, $973,813.

Title: Epidemiological investigations in Utah--the SEER Program
Contractor: Univ. of Utah, Utah Cancer Registry, $528,000 (modification)

Title: Biomedical computing--design and implementation
Contractor: Capital Systems Group, $5,611,629

Title: Use of hemoccult screening techniques as a means of detecting early cancer of the bowel
Contractor: Univ. of Minnesota, $5,505,486

Title: Preclinical toxicology of sodium selenate
Contractor: International R&D Corp., $153,731

Title: Preclinical assessment of monoclonal antibodies
Contractor: NeoRx Corp., $1,543,238

Title: Extramural utilization of the immunodeficiency cancer registry
Contractor: Univ. of Minnesota, $47,661

Title: BCB repository for storage and distribution of research resources
Contractor: Microbiological Associates, $1,904,951

Title: Preclinical toxicology of S-selenomethionine
Contractor: International Research & Development Corp., $192,380

Title: Support services for Diet, Nutrition & Cancer Program
Contractor: Prospect Associates, $403,190

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