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Bailar NEJM Article "Irresponsible, Purposely Misleading," Ignored Facts, DeVita Tells NCAB

Calling the report in the "New England Journal of Medicine" by John Bailar "the most irresponsible article I have ever read," NCI Director Vincent DeVita charged Monday that it was "purposely misleading. . . I question his

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In Brief

Panel To Meet June 9 In Boston; Iverson Takes Position At U. Colo.; Namovicz Leaving NHLBI

PRESIDENT'S CANCER Panel will have its next meeting June 9 at Dana Farber Cancer Institute in Boston. The meeting, which is open to the public, will continue with the theme, "Innovative Therapies." It will start at 9 a.m. . . . **DONALD IVERSON**, associate director for the Div. of Cancer Prevention & Control's Cancer Control Science Program, will leave NCI in June to become director of research and evaluation at the Univ. of Colorado. . . . **ROBERT NAMOVICZ**, former deputy administrative officer of NCI, will leave his present position as exec officer of the National Heart, Lung & Blood Institute June 1 to become executive officer of the New Jersey Center for Advanced Biotechnology. . . . **DAVID GOLDENBERG**, president of the Center for Molecular Medicine & Immunology in Newark, has received the New Jersey Pride Award in Science and Technology. . . . **KIM REGAN**, head of program analysis and management in NCI's Cancer Therapy Evaluation Program, is leaving to become executive officer of NIH's Div. of Computer Research & Technology. . . . **DAVID SCHOTTENFELD**, chief of Epidemiology at Memorial Sloan-Kettering Cancer Center, will become chairman of the Dept. of Epidemiology at the Univ. of Michigan Sept. 1. He is also president elect of the American Society of Preventive Oncology. . . . **CORRECTIONS:** The concept statement on the new CCOP RFA published in **The Cancer Letter** last week stated the annual budget "for each award" would be $9 million. Would that it were so. That is the anticipated budget for the entire program. Also last week, the husband of new NCAB member Irene Pollin was described as owner of two Washington professional basketball teams. Actually, one of them, the Capitols, plays ice hockey. Further correction: She is executive director of the Medical Crisis Counseling Center at Washington Hospital. President Reagan made her appointment official May 16, and that of Louis Sullivan May 19.

Bailar Ignored Extensive Amount Of Prevention Research, DeVita Says

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motives and his scientific credentials to judge the entire cancer program."

DeVita made his first extensive public statement on the Bailar article at Monday's meeting of the National Cancer Advisory Board. Until then, NCI's response to the article's contention that the "war on cancer" is being lost because too much attention has been focused on treatment research and not enough on prevention had been left to Peter Greenwald, director of the Div. of Cancer Prevention & Control (**The Cancer Letter**, May 16).

The article was "purposely misleading," DeVita said, because it "pretends to use state of the art measurement (in comparing cancer mortality and survival in 1950 with 1982) when in fact it used a single yardstick, age adjusted mortality."

The main point of the article is that more should be done in prevention, DeVita said. "Without that, there was no reason to write it. We are doing a great deal in prevention, and that was pointed out to Dr. Bailar before publication of the article."

DeVita said that Bailar had sent Greenwald a copy of the article last August (it was published May 8 in NEJM). Greenwald pointed out the many errors in the article, DeVita said, but few if any corrections were made.

DeVita argued, as have other defenders of the cancer program, that use of 1982 survival data does not take into account improvements in treatment initiated in the mid-1970s, when many new therapies first went into widespread use.

DeVita pointed out that 28 percent of NCI's budget "supports good solid research in prevention. There are 26 clinical trials under way now in prevention, and (Bailar) knows that." DeVita noted that one of those trials, the low fat diet breast cancer prevention trial, commits NCI to spend up to $100 million over the 10 year study.

Board member Geza Jako, although agreeing that "NCI is doing a remarkable job in prevention," said he felt the "controversy is good" and that Bailar should be invited to a future meeting of the NCAB "to make his case."

"I don't agree," DeVita snapped. "What he's done is irresponsible. He purposely underestimates the value of the program, he denies we are doing anything in prevention."

Jako commented that John Cairns, who has collaborated with Bailar at Harvard, had said in a presentation to the Board last year that the Year 2000 goals were unrealistic, as did Bailar in his article.

"I was totally underwhelmed by Cairns' presentation," DeVita said. He recalled that in attempting to make the point that cancer chemotherapy induces an unacceptable incidence of leukemia, Cairns used data on Hodgkin's disease, treatment for which has the highest such incidence. "When I pointed out that breast cancer chemotherapy had far less leukemia associated with it, he admitted he was using the most extreme case to make a point. . . . I question if that is an honest way to do science." Cairns and Bailar make up a "duo that has been doing a job on us, and they will continue because the press gives them so much attention."

DeVita criticized what he said was Bailar's use of "buzz words" which made the article "far from impartial." DeVita derided one of Bailar's statements, that NCI has spent "countless billions" on treatment research. "It's countless only if you can't count up to 13," DeVita said.

Annual Symposium on Progress

New NCAB member Phillip Frost, responding to a suggestion by another new member, Nancy Brinker, that a plan be developed to counter the "devastating impact" of Bailar's article, suggested that an annual symposium be held on "advances in cancer research." Frost said it should include presentations by basic and clinical researchers who made the most impressive progress during the year. It would be a public meeting, with scientific presentations each followed by a 20 minute summary for lay persons and the press. "It should be paid for by the private sector, and I would be happy to help arrange that support," said Frost, who is chairman of Key Pharmaceuticals of Miami.

Board member Helene Brown was not convinced that Bailar's article had inflicted much damage. "We're tending to make more of this than what it is," she said. "I've watched the Cancer Information Service calls closely (since the article was reported in the national media)." There has been no change in the pattern or type of calls, she said. Paul Van Nevel, director of NCI's Office of Cancer Communications, said his

staff has not detected any change, either.

Board member Enrico Mihich said "there is another dimension to this. The New England Journal of Medicine is a leading journal, a respected opinion maker. It is a peer review journal."

Board member Richard Bloch said that a letter from NCI, which many of the Board members said they wanted to sign, "should strongly criticize the journal for ignoring review. It was irresponsible."

Publication of the article "was purposely timed to impact on our budget," DeVita said in a final shot.

NCAB Accepts CCOP Recompetition, Addition Of Cancer Control Elements

When the National Cancer Advisory Board went along with initiation of the Community Clinical Oncology Program four years ago, it did so reluctantly and only after a number of acrimonious sessions. The first three years would be on a trial basis, with continuation dependent on results of the evaluation, Board members insisted.

Even last year, when NCI extended the program for one year administratively to permit more time for reshaping the recompetition and obtaining a more complete picture from the evaluation, some Board members grumped ominously.

Jerome Yates, director of the Centers & Community Oncology Program in the Div. of Cancer Prevention & Control, presented an outline of the new program and upcoming recompetition to the Board Monday. The new RFA, Yates noted, will include the requirement for cancer control research as well as continued participation in treatment clinical trials. The level budget of $9 million the first year (increasing to over $10 million by third year) and increased costs involved in doing cancer control research means that fewer CCOPs will be funded.

The changes in the program are loaded with potential controversy. What's more, the evaluation has not produced much evidence yet of the program's success in improving quality of treatment in participating communities. The "diffusion hypothesis," one of the primary justifications for the program, which holds that benefits of improved therapy for patients on protocols will spill over to other patients, has not yet been proven. Leslie Ford of Yates' staff, who heads the evaluation effort, told the NCAB that so far few if any changes in patterns of care have been found, and that there are wide variations in patterns of care within a single CCOP and among all CCOPs.

Despite the negative aspects, Board members had little to say about the makeup of the program and did not question at all whether it should be continued. Only Chairman David Korn offered anything approaching criticism.

"I got the sense that you aren't entirely satisfied," Korn said. "Now, you're loading the program up with a whole new set of projects. Aren't you afraid you won't be able to evaluate anything?"

Yates admitted, "Maybe we have been measuring the wrong elements. . . We have learned that it is critically important to involve surgeons. Can we move on, and add cancer control? All I know is that Chuck Coltman, Paul Carbone and Chuck Moertel (chairmen of three cooperative groups) all say it is doable."

Although Yates specifically asked for NCAB suggestions on the makeup of the new program, none were forthcoming. The CCOP recompetition, therefore, will proceed pretty much along the lines approved by the DCPC Board of Scientific Counselors (**The Cancer Letter**, May 16) and on schedule.

AACR Members Ponder Ways To Beef Up Public Support For Cancer Program

Concern over adequate funding of the National Cancer Program probably has never been more intense, as demonstrated by a symposium at the recent annual meeting of the American Assn. for Cancer Research titled, "The Cancer Budget Crisis--the Next Step."

The symposium was chaired by Enrico Mihich, Roswell Park and the new AACR president elect, who opened it with the statement, "It has become increasingly apparent that cancer research in this country is going to suffer major setbacks unless current trends in government funding of the cancer program are reversed."

Mihich cited, in addition to proposed cuts in NCI's budget, the "apportionment issue, a new subtle factor in the equation. . . the Office of Management & Budget has de facto control over the NIH budget by not allowing transfer of funds without approval from one area to another, regardless of changing priorities. There is no flexibility in expenditures."

Mihich asked a series of questions related to generating public support for increased funding and more reasonable management by OMB:

"How can we stimulate the awareness of the public to the great opportunities lying at our doorstep? How can we awaken the government to the need for support? How can we mobilize the public to exert pressures on responsible branches of government?"

After other members of the panel, which included John Durant, Fox Chase; John Laszlo, Duke; Harry Nelson, L.A. Times medical writer; and Vincent DeVita offered their opinions on the various problems (DeVita, who can't argue against the President's budget, limited his concurrence to the lack of flexibility), Harris Busch, Baylor, came up with what many felt was the best suggestion of the day:

"We need a PAC for cancer," Busch said, just like the political action committees created by other special interest groups to generate support for issues. "It would be legal. It should involve a lay committee. Physicians and scientists are the poorest people in the world to present our case. It would be seen as self serving."

Herbert Kupchik, Boston Univ., added, "The public is not aware of what is going on. We need a PAC, and an advertising program."

Irwin Krakoff, M.D. Anderson, noted that most of the major cancer centers have "well developed information offices. All of them would be happy to supply material (for public relations campaigns) and would participate in developing new material."

"Cancer can't wait until we solve the federal deficit," Laszlo said.

New Documentary On Cancer Funding Provides Strong Case For More Money

"Cancer: The Second and Final War," a documentary film on the National Cancer Program produced for PBS by Harry Mantel, makes a powerful case for dramatic increases in cancer research support.

The hour long film was sent to PBS stations this week and is now available for their programming. Whether it is used or not is up to each station.

Narrated convincingly by Pernell Roberts, the film uses many of the major figures in cancer research to describe progress made since the National Cancer Act of 1971 became

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Pancreatic Cancer Pain Reduction Concept Approved By DCPC Board

NCI's Div. of Cancer Prevention & Control's Board of Scientific Counselors unanimously approved a concept that would award five three year grants totaling $400,000 a year for prospective studies to correlate pain reduction with treatment procedures employed in pancreatic cancer patients.

The concept is the second developed by NCI's reorganized Organ Systems Program that will be issued as an RFA with set-aside funds. The first such concept was approved last fall by the Div. of Cancer Etiology and an RFA was issued for $1 million a year funding of up to five awards to study inheritance and markers of colorectal cancer and polyps (**The Cancer Letter,** Nov. 1 and March 21).

The pancreatic concept is the first of eight concepts developed by OSP working groups requesting set-aside funds scheduled to go before division boards this spring. The other eight include two other concepts for pancreatic cancer, two for bladder, two for breast cancer and one for large bowel. Last year, all concepts generated by the group besides that for colorectal were approved as program announcements with no set aside funding.

NCI Director Vincent DeVita told the National Cancer Advisory Board Monday that this round of RFAs recommended by the Organ Systems Program working groups "is the first real test" of the program's ability to compete for funding priority against other ideas presented to the boards of scientific counselors.

Synopsis of the concept statement:

The main goal of the initiative is to minimize pain associated with pancreatic cancer and to determine which treatments are associated with the greatest pain relief. The specific objective is to determine which treatment(s) should be used to reduce pain in pancreatic cancer by quantifying pain before, during and after treatment.

According to the concept statement, pain and weight loss are the most common presenting symptoms associated with pancreatic cancer. "In no other cancer is pain more common; eventually it is a problem in 90% to 100% of all patients with this disease. Although most patients with other cancers experience pain some time before death, the majority of pancreatic cancer patients suffer pain from the onset of their illness, and pain is often continuous and severe. Since there are no treatments to improve survival significantly (five year survival is 2%) and there is no way known to prevent the disease, methods to improve the quality of life by reduction or elimination of pain deserve high priority."

The specific objective of most pancreatic cancer treatment trials is to evaluate survival or disease free interval. The quality of life and relief from pain are seldom evaluated. Surgical radiation, and chemotherapeutic treatments have been used alone and together in the treatment of pancreatic cancer. Many medical oncologists believe that chemotherapeutic intervention results in reduction of pain in pancreatic cancer, but these claims have not been adequately documented. Varying degrees of pain relief have been reported to follow radiation therapy. Data regarding pain relief arising from such treatments are limited and require confirmation and validation. Other approaches directed specifically to relieve pain in these patients include neurolytic, neuropharmacologic, neurosurgical and psychosocial interventions. However, systematic correlations between pancreatic cancer treatment and pain relief have not been carried out. Consequently, there is considerable controversy about the most effective procedures for pain control in these patients.

The initiative proposes a prospective study of correlations between the various treatment procedures employed in pancreatic cancer patients with the resultant degree and duration of relief of pain and psychological distress with improvement of quality of life. Participants will be required to integrate pain and psychosocial assessment as part of their treatment protocols. Some treatments that might be examined include pancreatectomy/pancreaticoduodenectomy, pancreatic duct decompression, and relief of jaundice by endoscopic and percutaneous transhepatic techniques, as well as chemotherapy and radiation. Among the procedures implemented specifically for relief of pain, which may be included in this study, are alcohol or phenol neurolysis of the coeliac plexus, neuropharmacologic drugs (opioid or non-opioid analgesic) including new technologies for drug administration, neurosurgical, and psychologic interventions including hypnosis. A study of psychopharmacologic agents, including anti-depressants, are also of potential value.

Because pain and psychosocial factors play such an important part of pancreatic cancer management, they need to assessed together and serially. Specifically, pain and psychological distress will be studied serially before and during all therapeutic approaches. All of the variables will be monitored simultaneously.

Patients should be stratified as to the extent of disease at the time of treatment, and the results of specific anti-tumor therapy should be followed and assessed. The etiology of pain in each patient should be assessed by determining the apparent causes and distribution of pain. Techniques available to measure and analyze pain should include standardized algorithms to evaluate pain as soon as possible after the diagnosis of cancer and at appropriate intervals before and after initiating treatment. Analysis of these data should reveal the optimum pain relief procedures that can be tailored to address a given combination of symptoms associated with pancreatic cancer. The consequences for the quality of life for these patients should be considerable.

The study must be multidisciplinary and multi-institutional. Because of the relatively low incidence of pancreatic cancer in the U.S., a single institution would not be able to accrue enough patients for the study. Participants should meet at least once a year to discuss patient accrual, standardize methods, conduct preliminary analyses such as power analyses, and to pool data.

Individuals involved in ongoing clinical trials could include pain assessment in their protocols and apply for funds through this initiative. Less funding would be required if pain studies could be included within the framework of an ongoing clinical trial at an institution that has the resources and expertise required to carry out the study. Board Chairman Erwin Bettinghaus suggested that the inclusion of pain studies within ongoing clinical trials could be written into the RFA for "extra brownie points."

Other concepts approved by the board are:

Cancer Control Research Small Grants Program. NCI expects to make up to 30 awards in fiscal 1987 for total funding of approximately $1 million per year. The application should contain a budget that does not exceed $15,000 in direct costs for dissertations and $35,000 in total costs for other studies.

Originally approved in 1983, the small grant program is intended to stimulate the growth of a nationwide cohort of scientists with a high level of scientific research expertise in the field of cancer control. Its major objectives are to encourage scientists from a variety of academic disciplines to apply their skills to scientific investigations in the field of cancer control intervention research and to have these scientists build upon their small grant research results to successfully develop larger intervention research projects. The specific objective is to recruit up to 150 new principal investigators (30 per year for five years) into Cancer Control Research.

NCI funded 10 grants under the program in 1984, and 20 grants in 1985. While the number of awards to be made in 1986 under the small grants program have not yet been announced, NCI received 70 applications this year, and believes that the program, which originally operated under three RFAs, is meeting its original objective of soliciting proposals from new investigators and pilot projects from experienced scientists.

Applicants may request support for human intervention research in cancer control areas defined by "DCPC's Grant Guidelines for Cancer Control: Areas of Programmatic Interest." These will usually be phase 2 or 3 cancer control studies.

Applicants may include established researchers from other disciplines, new investigators, and pre-doctoral degree students. The only exclusions are individuals who have ever been principal or co-principal investigators on an NCI funded cancer control grant or contract, or who have been a paid staff member on an NCI funded cancer control grant or contract for more than two years.

Dissertation research is allowed with a statement of approval by the applicant's full dissertation committee before funding.

The total program duration is five years. An RFA will be issued once per year for new small grant projects. Each approved grant is usually for one year, but may be up to two years, if the funding restrictions are not exceeded.

Home Care of Cancer Patients. NCI expects to award three two-year grants totaling $500,000 in the first year of funding for research to describe current practices regarding the home care of cancer patients and to evaluate interventions to improve home care. The concept is the first of a two phase program, the second of which will be reviewed at a later date.

The specific objective of the concept is to assess the patterns of referral, growth, quality and effectiveness of existing home care service systems in providing care for cancer patients at varying times in the course of their disease (diagnosis, remission, relapse and advanced disease).

The purpose of the project is to determine the adequacy of the care cancer patients receive in the home. Specific aims are: 1) examine care in terms of referral sources, initial planning, number and kinds of services provided; 2) describe whether health care

needs and provision of care fluctuate over a year during which patients receive intermittent treatment; 3) to determine the quality of care (i.e., the result or outcome) of patients receiving care at home; 4) analyze underlying causes (when possible) of any trends identified in the study; and 5) develop recommendations to improve existing home care efforts.

The research has four components: 1) identification of patients and periodic in-home data collection from patients and their families about their health care problems, home health services and other medical services received; 2) documentation of the providers' evaluation of what health care problems exist, what services they are providing and why; 3) when patents receive care in a hospital or clinic, review of the medical record to determine the reason; and 4) analysis of quality of care, quantity (number of providers and number of services), outcome and fluctuations over time.

Researchers should identify a population and target community in order to conduct this patient-level tracking study. The sample population should include adult cancer patients having a life expectancy longer than one year, who are receiving initial or intermittent therapy for their cancer and are living at home. Emphasis will be on newly diagnosed patients who can be followed through the course of their disease.

Researchers should specify the geographical areas in which patients will be followed and establish interagency capability to follow patients through the variety of available community-base services, e.g., proprietary and non-profit home care agencies. A common entry point for patients into the study, such as discharge from the hospital after initial diagnosis, should be identified. The study design should include a method to retrieve information directly from patients and their families as well as from health care professionals, providers of hospital, clinic and home care services.

In the area of data from the patient, a method to assess the level of severity of health care problems experienced by both the individual patient and the family should be developed. Assessment of health (physical, psychological and social) care problems should encompass broad categories of problems common to cancer patients such as nutrition, elimination, mobility, self care and independent patient activities and family/home characteristics.

Researchers should develop methods of monitoring the quality of home care during the periodic visits to collect data from the patients. Indices for monitoring can be developed using guidelines such as the Oncology Nursing Society's Outcome Standards of Oncology Patient Care or the American Nurses Assn.'s Standards for Community Health Nursing. Patients should also be queried about what health care was received, to include specific information such as who provided services, why they were rendered, where they were obtained and the source of funds to pay for services (e.g., insurance or personal funds).

Data from the home care providers should include the home care agencies evaluation of what health care problems exist in a specific patient/home situation. Researchers should also note what care the agency is providing and the rationale for the choice of intervention (e.g., home health aide provided only three mornings per week because that is the extent of service paid by the patient's private insurance). Data should also be obtained from the perspectives of the home health care nurses actually responsible for the management of cancer patients regarding factors that limit optimal care and those that enhance care.

Data from other health care providers other than home care services should also be obtained.

An examination of the relationship between the numbers and kinds of services and their quality is an important part of phase 1. Quality of care encompasses a variety of outcome measures such as appropriate utilization of home care services, health care system components and cost. The quality of care is measured both on the patient/case level and the community level. Researchers should also examine possible explanatory influences such as reimbursement or the passage of time. For example, reimbursement constraints might severely reduce the number of home health care services rendered six months after diagnosis while high level health care problems remain.

Based on the analysis, researchers should propose models for development of optimal home care and recommend priorities for home health service interventions to improve existing cancer patient home care. The recommendations should specifically focus on ways to assure long term impact on home care, and not merely to improve care during the time of an intervention study.

NCI staff will review the research and recommendations generated by the initiative in order to set priorities for testing home health care models and interventions in the second phase of the initiative. Those applications might be directed to develop, implement and evaluate models of interagency administrative mechanisms to track patients between courses of cancer treatment; home health care directed by specialized multidisciplinary cancer care teams,; or educational programs in treatment related phenomena for all home health care aides and family members. A variety of research designs such as cohort, case control, experimental or cross sectional can be used. Rigorous methodology is expected as in integral part of the proposal.

Small Business Innovation Research Program DCPC has submitted 15 SBIR concepts for the September 1986 solicitation, all of which were approved by the board.

1. Development of specific biochemical markers for monitoring dietary status and/or compliance.
2. Development of materials and strategies for achieving dietary change in targeted populations.
3. Development of analytical methodology for the measurement of carcinogen loads in human diets.
4. Development of software for cancer control-related sets from Hispanic Health and Nutrition Examination Survey (HHANES).
5. Development of a users guide for health risk assessment for cancer prevention and control.
6. Health promotion intervention strategies.
7. Development of an eating behavior screening tool for cancer risk appraisal.
8. Aiding teachers to facilitate school re-entry among child and adolescent cancer patients.
9. Software for managing cancer patient home care.
10. Enhancement of understanding of cancer and its treatment among pediatric oncology patients and their siblings.
11. Development of matched skintone breast prostheses.
12. Development of consumer-oriented materials regarding cancer care in the home.
13. Data management systems for clinical studies.
14. Integrated demographic analysis system.
15. Identification and evaluation of literature in the area of relative health risk of tobacco use.

Support contract for special population initiatives. NCI expects to award one five-year contract with first year funding of approximately $300,000. The contract is intended to provide technical and logistical support to DCPC's program directed at intervention research in special populations (e.g. minorities). The contract will enable the program to continue to expand its efforts

directed at population based intervention research, generate research interest and capabilities in the representative academic, clinical and public health environments for these populations, and to respond to situations where special needs are to be met.

Initially, support will be used for expanding intervention activities in the black populations program, while developing the foundation for intervention research for the other target population segments, especially Hispanics.

The contractor will be expected to provide technical consultation to researchers or interested organizations; technical assistance in producing training programs on cancer control research for the representative communities; general administrative support, including preparation of responses to routine requests for programmatic information, graphics preparation, report writing, etc.; and translation of materials to and from English and Spanish and other languages as necessary.

The contractor will also be expected to locate and summarize data to characterize the cancer control related needs of special population segments; assist in identifying potentially viable intervention methods or assessment instruments; conduct a process evaluation to identify the major strengths and weaknesses of the special population initiatives; and conduct a variety of working group meetings to identify research needs and opportunities.

To date, the program has placed emphasis on developing a program of intervention research directed at black populations, "and this effort alone has more than exhausted available staff resources," the concept statement says. The effort has been successful in generating interest where there was little before, Knut Ringen, special expert with the division, told the board. For example, NCI received 41 responses to three current RFPs from primarily black, almost entirely new investigators not previously associated with NCI, he said. Excellent rapport has been established between the representative academic/ medical communities and NCI. The acceptance and expression of principles of cancer control research is increasing impressively, evidenced by the award of small grants to black investigators and a planning grant for a consortium cancer center to three predominately black medical schools. "These achievements have been made by seriously overextending staff, using ad hoc arrangements with consultants and existing division support contracts and often relying on the interest and personal commitment of volunteers," he said. Ringen told the board that existing activities will have to reduced in scope and initiating additional activities in current programs or starting new programs with other special populations will not be possible without additional support.

Problems that need to be remedied in special population initiatives include: a limited research base on which to build because few valid studies have been undertaken in the past; in general,intervention methods and assessment instruments have not been validated for use in special populations; and the paucity of current researchers with sensitivity to the needs of these populations who also have access to and credibility among the populations.

Leukemia Society Offers Two New Grants, Three Others For 1987

The Leukemia Society of America is now accepting applications for 1987 grants, and for two new awards providing immediate funding to encourage basic and clinical research in leukemia and related diseases. The Society offers three other awards which are a primary source of salary support for investigators whose work is concentrated on seeking the causes and cures for leukemia, lymphomas, Hodgkin's and multiple myeloma.

The new President's Research Development Award is a one year, $50,000 grant open to senior investigators on tenure track. Projects must represent unique research opportunities which cannot and should not wait for implementation of a lengthy funding mechanism. This award may not be used to supplement salary support of the principle investigator or for travel expenses.

The other new award is the Short Term Scientific Exchange Award which is open to Leukemia Society fellows, special fellows and scholars to travel to another laboratory or clinic for the express purpose of learning a specific technique or to share specific information which has been developed by the PI there. A maximum of $5,000 will be awarded to cover transportation, lodging and out of pocket expenses. The award may not be used to attend scientific symposia, workshops, etc. or for salary support.

The the two awards are made on a quarterly basis, Jan. 1, April 1, July 1 and Oct. 1.

The other Leukemia Society awards are:

--Five year scholar grants for a total of $200,000 to researchers who have demonstrated over a period of not less than five years their abilities to conduct original investi- gations in the specified fields.

--Three year Special Fellow grants for a total of $87,000 for those investigators in the intermediate stages of career development.

--Three year Fellow grants for a total of $70,500 for promising investigators with no or minimal prior experience assisting and training with scientists and physicians in the related fields.

In all categories, candidates should hold a PhD, MD or equivalent degree but not have attained tenured status at the time the grant is to become effective.

Applications deadline is Sept. 2, 1986, for the 1987 awards. Proposals will be evaluated on a competitive basis by the Leukemia Society's Grant Review Subcommittee, which is chaired by Werner Kirsten. Funding will begin July 1, 1987. For application forms and additional information write to Research Grant Coordinator, Leukemia Society of America, 733 Third Ave., New York 10017.

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-CM-67906-30
Title: Large scale isolation of antitumor agents from natural sources
Deadline: July 16

The Developmental Therapeutics Program of NCI's Div. of Cancer Treatment is interested in receiving contract proposals from, and establishing master agreement order contracts with, offerors with the capability to extract, isolate and purify antitumor agents from plant and animal materials on a pilot plant scale.

The successful offerors must provide a pilot plant facility capable of storing and processing up to 5,000 kg of bulk crude material and must have experience in process development of natural products isolations. The government will supply the plant and animal materials to be processed. The successful offerors will supply all equipment, solvents, reagents and other materials needed for the project. The antitumor agents isolated must be of high purity suitable for subsequent manufacture of clinical dosage forms, and all work must be carried out under current good manufacturing practices standards. A minimum mandatory requirement is that the contractor be registered as a manufacturer of bulk drugs with the Food & Drug Administration at the time of award.

This is a resolicitation of the RFP in an attempt by NCI to secure additional sources for this project.

Master agreements are competitively negotiated and awarded to more than one contractor. It is planned that such agreements will be awarded on or about Jan. 10, 1987, for a two year period, but will not be funded per se. After award, groups of qualified master agreement holders will be invited to bid competitively on appropriate master agreement orders as they are issued. Each master agreement order will be designed to accomplish a specific task as promptly as possible and will be awarded on a completion or level of effort basis, as determined by the contracting officer.
Contracting Officer: Clyde Williams
RCB Blair Bldg Rm 228
301-427-8737

RFP NCI-CM-67885-68
Title: Preparation and supply of fresh and cultured mammalian cells
Deadline: June 16

(This is the second announcement of the availability of this RFP. The first, published May 2 inThe Cancer Letter, did not result in any proposal submissions.)

The Developmental Therapeutics Program of NCI's Div. of Cancer Treatment is seeking an organization qualified to provide large quantities of well characterized normal and neoplastic mammalian tissue culture cells and receive, process, distribute, store and maintain fresh human leukemic cells and tissues. It is anticipated that 100 grams of fibroblastic cells grown as monolayer and 100 grams of suspension cultured cells will be required each year. The contractor should also be able to process up to 125 samples of human leukemic blood and supply the leukocytes to the government. The contractor should be able to freeze fresh cells in a viable state.

It is anticipated that a cost reimbursement incrementally funded type contract will be awarded as a result of the RFP for a period of 60 months beginning March 30, 1987. This RFP represents a recompetition of a project currently performed by Biotech Research Laboratories of Rockville, MD.
Contract Specialist: Karlene Ruddy
RCB Blair Bldg Rm 212
301-427-8737

RFP NCI-CO-64090
Title: Clinical protocols analysis and tracking
Deadline: Approximately July 20

This competitive acquisition is for the continued building and updating of the clinical cancer therapy protocols file which becomes the CLINPROT data base and the protocol file of the Physicians Data Query (PDQ) system. This clinical information dissemination activity involves the collection, abstracting and indexing of ongoing research protocols.
Contracting Officer: Barbara Mercer
RCB Blair Bldg Rm 314
301-427-8745

New Documentary On Cancer Funds

(Continued from page 4)
law, and to argue for more money for cancer research.

The film presents accurately and in detail the history of NCI funding since 1971, zeroing in on the efforts by the White House under Presidents Carter and Reagan to hold down or cut the cancer research budget. It also points out the fact that since 1976, in constant dollars, NCI's budget has suffered about a 25 percent decline.

Those looking for answers to questions posed by Enrico Mihich (on how public support can be generated) should make certain this film is seen in their communities. If no local PBS station uses it, videotape cassettes are available from Mantel in either beta or VHS for $75 per copy. Contact him at 20522 Attica Rd., Olympia Fields, IL 60461, phone 312-747-1725.

Mantel spent much of the past four years producing the film, with the help of donated labor, transportation, hotels and $25,000 of his own money.

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