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NCAB Approves Bypass Budget Of $1.685 Billion For FY '88, $200 Million More Than Asked For '87

NCI's bypass budget request for the 1988 fiscal year will total $1.685 billion, an amount that would fill most if not all the gaps in cancer program funding, pay nearly half of all approved grants, restore the centers and construction programs to levels approximating needs, vastly increase

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In Brief

New Clinical Education Program Guidelines Due; Maryland Has First Mammography Screening Law

NEW GUIDELINES for NCI's Clinical Education Program will be published in June. The program, which was targeted for phase out by the NCI Executive Committee, was saved by the National Cancer Advisory Board and pressure from the American Assn. for Cancer Education and others. NCI Director Vincent DeVita agreed to continue with a revamped, scaled down version and will award $3.4 million in grants in FY 1986.... **MARYLAND GOVERNOR** Harry Hughes has signed into law the nation's first legislation requiring Medicare supplementary insurance to pay for at least part of annual mammographgy screening. The law directs supplementary insurance policies to pay up to $100 "for an annual screening by low dose mammography for the presence of occult breast cancer." Maryland also joined other states in requiring physicians to inform breast cancer patients of available treatment options. . . . **ELLIOTT STONEHILL**, NCI assistant director and executive secretary of the President's Cancer Panel, is acting associate director for program planning and analysis, the position held by the late Louis Carrese. DeVita, announcing Stonehill's assignment at last week's NCAB meeting, paid tribute to Carrese for his role in planning the National Cancer Program. . . . **BERGE HAMPAR**, NCI's general manager of the Frederick Cancer Research Facility, has retired. The new general manager is Cedric Long, who has been at FCRF with the Div. of Cancer Treatment's Biological Response Modifiers Program. . . . **KENNETH HOGSTROM**, associate physicist at M.D. Anderson Hospital & Tumor Institute, has been named chairman of the new Dept. of Radiation Physics there. . . . **ENRICO MIHICH**, director of the Experimental Therapeutics Dept. and Grace Cancer Drug Center at Roswell Park Memorial Institute, has received an honorary MD from the Univ. of Marseilles.

The Bypass Budget: All The Money To Adequately Fund Cancer Research

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cancer control efforts and double the number of patients entered into clinical trials.

In short, the bypass budget for 1988 does exactly what Congress intended it would when it was written into the National Cancer Act of 1971--present directly to the President a budget request which provides all the money needed to adequately fund the nation's cancer research efforts.

Unfortunately, the White House generally ignores the bypass budget and sends to Congress a figure which has come out of the NIH-HHS mill, where it has been chopped down drastically to fit within health research priorities developed by bureaucrats and political appointees with no allegiance to the National Cancer Program. The new bypass budget, which will go to the White House in September, has practically no chance of emerging anywhere close to the requested figure when the President sends his budget to Congress next January, unless somehow President Reagan can be convinced that it is the right thing to do.

The 1988 bypass budget (for the fiscal year which starts Oct. 1, 1987), is $235 million higher than the bypass budget for 1987. It is a 45 percent increase over the FY 1987 request in the President's budget, $1.158 billion.

Principal assumptions underlying the 1988 bypass budget are:

***Research project grants**--45 percent of approved competing grants would be funded at their full recommended levels.

***Cancer centers**--Five to 10 additional cancer centers would be funded at recommended levels in 1988, and the number of cancer centers would be increased by 50 percent by 1992.

***Cancer prevention and control**--Prevention and control activities would be supported at an increase of approximately 50 percent over the current level, with the goal of tripling that effort by 1992.

***Clinical cooperative groups**--The number of patients treated under research protocols would be doubled by 1992. Cooperative groups would be funded at full recommended levels.

***Training**--1,500 trainees would be supported through the National Research Service Award program.

***Special initiatives**--$50 million would be provided for funding of special initiatives. The current biological revolution advances scientific knowledge at ever increasing frequency so that exact support mechanisms cannot be ascertained. This fund would provide the flexibility to rapidly adjust program direction to take timely advantage of opportunities.

***Two year authority**--Increased availability of obligating authority is requested for both the special initiatives and the construction funds. Two year availability would permit more prudent planning and utilization for these program elements.

Three hundred million dollars of the increase over the President's 1987 budget would support new initiatives, while restoration of previous reductions accounts for nearly $100 million. In addition to the special initiative fund of $50 million, $30 million was incorporated for additional AIDS efforts. They bypass budget assumes that the proposal to transfer all AIDS activities to the office of the assistant secretary for health would not be accepted and that the funds would remain with each institute.

It was suggested that the $50 million for special initiatives could be used to help support the proposal to map and sequence the human genome.

Bypass Budget Would Switch Directions

The bypass figure of $703 million for research grants, making possible the funding of about 45 percent of approved competing grants, would go in exactly the opposite direction taken in the President's 1987 request. That budget provides $537 million for research grants, down $26 million from the 1986 level, after the Gramm-Rudman-Hollings cut. The President's budget would fund only 30 percent or less of competing grants.

The proposal to fund from five to 10 more cancer centers compares to the stark reality of 1986, when five centers will lose their grants unless more money is added to the centers program.

The contrast is as great in other areas: Construction, skimping by with $3 million in 1986, was wiped out completely in the President's 1987 request, but is listed for $35.2 million in the 1988 bypass budget; cancer prevention and control, held at $61.1 million for 1986 and 1987, would jump to $96.2 million; and R&D contracts would go from $140.8 million in 1986 to $134 million in the

1987 request to $200.4 million in the bypass. Much of that would be used to restore cuts in drug and biologicals development, where major reductions have been made in recent years.

Cooperative groups, with $48 million in 1986 and $50 million in the President's 1987 budget, would get a whopping increase, to $78.7 million, permitting rapid expansion of clinical trials.

Intramural research, ticketed for a cut in 1987 to $190.3 million from $197.3 million in 1986, would get its first sizeable increase in years, to $237.8 million.

The breakdown by other mechanisms, for 1986, President's request for 1987, and the 1988 bypass budget:

*Cancer centers, $82.3 million, $82.3 million, $116.6 million.

*Research career program, $6.6 million, $6.9 million, $9 million.

*Organ systems, $957,000, $800,000, $1 million.

*Clinical education, $3.4 million, $2.4 million, $5 million.

*Cooperative minority biomedical program, $3.5 million, $3.4 million, $4.3 million.

*Other research, $3.3 million, $3.1 million, $4.8 million.

*NRSA, $29.5 million, $28.6 million, $36 million.

*Research management and support, $61.4 million, $58.1 million, $76.6 million.

Projections to 1992

The bypass budget includes a projection for budget requests through 1992, with the total for NCI increasing about $200 million a year, hitting $2.555 billion in 1992. The totals in that year for each of the major mechanisms would be:

Research grants, $1.2 billion; centers, $166.6 million; cooperative groups, $126.6 million; cancer prevention and control, $200.2 million; intramural research, $285.3 million; R&D contracts, $276.5 million; construction, $44.2 million; and NRSA, $46 million.

Those figures are based on projections developed two years ago in the planning effort for the Year 2000 goals. Once it was determined what resources would be needed to achieve the goal of a 50 percent reduction in cancer mortality by that date, and that most of those resources should be in place by 1992, the planners, headed by the late Louis Carrese, came up with dollar estimates of the costs. Those were incorporated into the 1986 and 1987 bypass budgets. When the final budget in 1986 and President's budget for 1987 did not provide the amounts needed to assure the Year 2000 goal requirements would be in place by 1992, those amounts were "racheted forward" (Director Vincent DeVita's term) into the 1988 bypass.

Durant Suggests Six Efforts Needed To Help Clinical Research Survive

Commenting that "scientific opportunities for further substantial progress in the diagnosis, classification, early detection, treatment and prevention of cancer were never greater," John Durant added in his presidential address at the American Society of Clinical Oncology meeting this month that "unfortunately, the obstacles along the way are more substantial than they ever were."

Those obstacles include the "fundamental tensions between science and medicine" which are at the heart of the controversial issue of dose, Durant said. "When we behave as scientists, our principle loyalty is to truth and our resultant behavior is characterized by skepticism and openness. When we behave as physicians, our loyalty is to our patients, and our resultant behavior is characterized by compassion. These two, perfectly worthy, ethical systems are often not congruent. Fortunately, the conflicts are resolvable using the tools of clinical research. . . Our participation in clinical research as physicians is imperative if we are to resolve in a compassionate way the application of the truth to our patients' problems."

A "newly important participant" complicating clinical research is what Durant called "business"--pharmaceutical and biotechnology companies on one hand, and "the health care industry charged with funding and housing health care" on the other. "Both of these elements are fundamentally driven by the profit motive, even when they are officially chartered as not for profit. The forces driving these together are like those impelling science and medicine toward one another, i.e., that to be profitable, a product must be shown to benefit patients. Those driving them apart are ethical and economic. Clinical research costs money and often leads to even more expensive care especially, as is so often the case in oncology, where progress is gradual and results in curing only a few more at a time

but palliating many more, thus raising the costs of standard care."

The "glut" of physicians, proliferation of HMOs, PPOs "and a whole alphabet soup of organizations and insurance devices which are well on the way to reorganizing American medicine" are adding to the problem, Durant continued. Clinical oncology "will usually require a partnership with a niche provider, defined at the moment as a facility with costs much greater than normal. It will be subject to the primary physician or general internist as a gatekeeper. These gatekeepers currently with little training and knowledge of oncology and driven by powerful economic incentives for keeping the gate shut, have the potential to delay the referral of patients for appropriate care until after failure of initial therapy and, thereby, to shut down clinical research to improve results by optimizing initial management."

Another major impetus for the changes "is the declining availability of capital," including diminishing federal support "causing many good research grants concerned with ideas for the future to go unfunded, reducing research training grants necessary to replicate our bright young people, diminishing Medicare funds for training the clinical oncologist of the future, and finally causing hospitals to close beds and merge while struggling to survive. Severe as this problem is, however, there is an even greater deficit of investment capital for construction, renovation and equipment. The shortfall in operating funds can be measured in the tens of millions but that for facilities is in the hundreds of millions."

Durant offered six efforts which he said ASCO and the profession must support, "to thrive, not just survive":

"1. We must not attempt to solve fiscal problems in one arena of cancer research through rebudgeting. Reducing indirect costs to enhance direct costs will only lead to increasing deferred maintenance of the scientific infrastructure and thus its further deterioration." This, he said, is "administrative alchemy, the belief that by shifting money from one pocket to another, money will somehow be created. . . The first recommendation is, abhor administrative alchemy.

"2. We must be careful and prudent as we investigate new relationships between business, science and medicine. . . Many variations of existing models will be tried. Not all will fail. The risks are high. The second recommendation is, beware of baubles from business.

"3. Our profession must develop a strategy for dealing with the generalist as the gatekeeper. Our Society could play an important role in convincing HMOs and other insurance carriers to rely on us to develop systems to serve their gatekeeper function. Guard against the gatekeeper.

"4. The present glut of physicians is a disaster for everyone and must be addressed. Modulate medical manpower.

"5. We must expand and enhance our appeal for increasing federal support for cancer research. Joseph Early (D. MA, a member of the House Health Appropriations Subcommittee) recently advised, 'Do not play the NIH budget against the deficit; play it against the opportunities.' It is his view that we can convince Congress that the opportunities are worth the cost. He also advised us of the need to 'play to the public.' We are their defense budget when it comes to health. The fifth recommendation is, pursue public pressure.

"6. We must convince third party carriers to pay for clinical research. We have a major effort ahead of us in educating Congress, third party payers and the various HMOs that they should pay for hospitalization and other costs of research care since standard therapy often does not exist, and a research protocol is the best care available. That this is not impossible is shown by my center, the Fox Chase Cancer Center (of which Durant is president), which has convinced both the HMO of Pennsylvania and New Jersey and Blue Cross to pay for phase 1 and 2 admissions when the costs are for the ordinary care of patients receiving new therapies. We have also convinced HMO-PA/NJ, a component of US Health Care, to pay annually for 65,000 screening mammograms for those at risk for breast cancer and for testing for occult fecal blood for more than 120,000 of its subscribers who are determined to be at risk for colorectal cancer. It is hoped this type of experience will help us make the case to Medicare that they should continue to pay for the clinical research they always have but refuse now to acknowledge. Failure to accomplish this goal will surely stop progress and suspend us in a phase of cancer care analogous to that when iron lungs were the backbone of treatment for paralytic poliomyelitis. My sixth recommendation is, resume reimbursing research."

NCI, GW Scientists Report Blocking HTLV-3 Invasion Of Human Cells

Viral Technologies Inc., a Washington DC area firm, announced last week that scientists at George Washington Univ. and NCI have successfully inhibited the AIDS associated virus, HTLV-3/LAV from invading human cells in a series of in vitro experiments utilizing antibodies against thymosin alpha$_1$.

The studies' results are immediately applicable to the development of an AIDS vaccine, the company said.

Viral Technologies is a joint venture 50 percent owned respectively by Interleukin-2 Inc. of Alexandria, VA, and Alpha 1 Biomedicals of Washington.

Allan Goldstein, chairman of the Dept. of Biochemistry at GW, said at a press conference called to discuss publication of the findings in the May 30 issue of "Science" that in vitro evaluations conducted at NCI since last December confirm an antiserum against thymosin alpha$_1$ effectively neutralized the AIDS associated virus and blocked its replication in H9 cells.

The "Science" article is by Prem Sarin, Daisy Sun and Arthur Thornton of NCI and Goldstein and Paul Naylor of GW.Interleukin-2 Inc. is the exclusive licensee of IL-2 production technology; Alpha 1 is engaged in commercial development of peptides and other products of the immune system.

Biomedical Computing Support Contract Recompetition Approved

The Div. of Cancer Prevention & Control's Board of Scientific Counselors has approved the recompetition of a support contract for biomedical computing for its cancer prevention and control activities. The five year contract will be managed through the use of the task order mechanism, with first year funding of $1.4 million expected for the award. The concept statement and another concept for supermarket interventions and shoppers' behaviors approved by the board follow:

Biomedical computing support for cancer prevention and control. NCI expects to award one five year contract with estimated first year funding of $1.4 million.

DCPC currently procures biomedical computing support through a contract managed by the Surveillance & Operations Research Branch. The contract will end in September 1987, therefore the competitive selection process for a new contract is scheduled to be completed for award in September 1987.

The project centers around needed services in four major functional areas:

1. Design and development of systems and procedures for managing, processing, analyzing and reporting cancer control surveillance information. Much of this information will be in the form of large scale national data bases.

2. Development and maintenance of analytical tools, such as mathematical models and statistical techniques, which can be used to evaluate and plan cancer control program activities and their impact in a community, and plan resource allocation to achieve optimal public health objectives for the nation.

3. Application of state of the art computer technology to the design and development of computer system networks for cancer control surveillance, information dissemination, population based community intervention studies, and dietary assessment.

4. Research data management, such as data coordinating activities, file management, and statistical analysis for research projects and for feasibility/pilot studies of population based community intervention trials conducted by DCPC staff.

Statistical analysis is an essential component in each of these activity areas. Such analyses typically involve large data bases and complex file management, and require advanced statistical techniques, including graphical analysis. All work must be accompanied by adequate and complete documentation, an inventory of all computer programs and files created, flowcharts, documentation of program algorithms, and data coding conventions.

The type of support needed from the contract is heavily influenced by the changing state of computer technology. In 1984, all of DCPC's computer support was derived from the NIH DCRT mainframe computers, an IBM 370 (models 3081, 3084, and 3090 dyadic processors) and a DEC 10. Use of microcomputers instead of mainframes was introduced early in the current support contract resulting in a steady increase in the number of applications using personal computers.

Microcomputer applications typically support an interactive user interface and have the potential for great cost savings since the hardware is relatively inexpensive and recurring costs are minimal for remedial maintenance and software upgrades. During the course of the next contract, a substantial conversion to state of the art microcomputer technology should be anticipated. Most DCPC applications will be run on a distributed network of microcomputers with automatic gateway as to the DCRT mainframes. The network will include mass storage devices, such as CD-ROMs, to accommodate the cancer control surveillance data bases, graphics work stations for graphical analysis, and laser printer for high quality output.

Cancer control computer applications in the field are expanding rapidly. Centralized data processing and secondary data analysis, which dominated DCPC computing support activities in previous years, are yielding to an emphasis on microcomputers for study support in the field with software provided by DCPC. All large scale intervention trials and other cancer control efforts can be expected to utilize this approach in the near future.

DCPC will continue to be the focus for cancer control surveillance activities that center about the SEER program. Assistance to state and local non-SEER cancer surveillance data base development, maintenance and analysis must be provided. Data on cancer treatment, patient outcome, and costs of care must be collected and analyzed. Computer support for these activities will be derived from the support contractor.

Trends in technology and in cancer surveillance impact on the nature of support required from the recompeted contract. The contractor must be experienced in state of the art microcomputer technology, mainframe applications, and especially integration of multifaceted computer networks designed around the appropriate interface of both types of systems. The design and analysis of complete microcomputer software systems and their communications with mainframes will be developed with sophisticated off the shelf support packages. Advanced systems analysts and senior programmers will be needed far more than junior programmers or coders.

Estimates of level of support and expected costs have been built on the following assumptions: First, utilization of the existing support contract was projected for the remainder of the contract period and beyond using current usage adjusted only for a 5 percent annual increase in costs due to inflation.

Second, an option was added for four types of expansion of cancer control surveillance activities that require substantial computer related support in future years: consortium arrangements with members of the proposed American Assn. of Cancer Registries for data processing, editing and analysis of non-SEER registries; use of extant data bases containing information on clinical treatment of cancer patients; use of national data bases such as those available from the Health Care Financing Administration on costs of cancer treatment; and analysis of data obtained from the 1987 Health Interview Survey on cancer risk factors and dietary assessment. Approximately $216,000 per year plus a 5 percent annual inflation factor was added for this option.

Third, a contingency option was included to allow substantial computer-related activities for central data coordinating center support of a future cancer prevention trial conducted by the intramural Cancer Prevention Studies Branch. The sequel to the China Tin Miners Pilot Trial is the most likely choice. Approximately $200,000 per year plus a 5 percent annual inflation factor was added for this option.

The Surveillance and Operations Research Branch and other DCPC staff members will exercise direction and control over the research and application projects and will closely monitor performance. Proposals will initially be reviewed by an ad hoc technical review committee, and a source evaluation group will be formed later to review recommendations for the ITEG. The SEC will develop questions for the offerors, consider and recommend the competitive range, and recommend final selection.

Examples of the specific DCPC projects supported by the current contract follow:

SEER: Central data processing; computer systems maintenance and enhancements; data analyses; and production of monographs and manuals.

The NCI Annual Cancer Statistics Report

Systems and software development for the state based Year 2000 cancer control model

Multifactorial analyses of cancer risk factors using NHANES-II data base

Microcomputer software system development for dietary assessment data capture and analysis

Development of a prototype distributed data processing system for the Occupational Cancer Network

Data management for NCI-USDA human nutrition studies

Data coordinating center activities for China Tin Miners Pilot Study

Data coordination and central management for CCOP Quality of Life Feasibility Study

Key, edit, update and tabulate information for CCOP patient log data

Final data analysis of Psychological Aspects of Breast Cancer Study

Data management and analysis for the multi-center Childhood Cancer Survivors Study.

Shopper Intervention Study Okayed

The board also approved a noncompetitive contract with Giant Foods to study the effects of supermarket interventions on food shoppers' knowledge, attitudes and behaviors related to diet and cancer. The three year project will include a general mass media campaign directed to residents of the metropolitan Washington DC area, and will include monthly brochures offering background on diet and cancer issues, shopping and cooking tips, recipes and practical advice. Giant will include fiber labeling to its current nutrition shelf labeling program and will emphasize low fat, high fiber food products and the cancer risk reduction and prevention message in its in store signs and posters. In the second year of the program, some stores will receive new interventions designed to expand the range of popular, low fat, high fiber prepared food options available in the store.

Food purchase data will be monitored for 40 stores, 20 intervention and 20 selected as matched control stores in the Baltimore area, which is a separate media market. The major dependent variable to be compared will be the proportion of the market share devoted to higher fiber-containing products and fats and oil category considered a good indicator of shifts in products containing fats. The second element of the evaluation is the collection of personal interview data from shoppers on their awareness and knowledge of the aims of the program and changes in knowledge, attitudes and food-related practices. NCI will spend approximately $215,000 for its share of the study.

Pain Relief For Hospitalized Patients Should Be Part Of Quality Assessment

Examination of the adequacy of pain relief for hospitalized patients should be made a part of existing quality assurance programs, an NIH Consensus Conference on The Integrated Approach to the Management of Pain recommended at the conclusion of a two and half day meeting. Panel Chairperson Laurel Copp told a press conference following the meeting that pain control is part of quality control assessment in licensed hospices and suggested that hospitals include assessment of the adequacy of pain relief in their quality assurance programs as well.

The panel concluded that data presented suggests that hospitalized patients with acute pain tend to receive inadequate treatment for pain whereas those suffering from chronic nonmalignant pain tend to receive high doses of drugs with limited efficacy and significant side effects. "There are many parallels in the inadequate treatment of cancer pain with the inadequate treatment of acute pain," it found. Reasons for low doses or doses given infrequently for patients with acute pain include incorrect assessment, insufficient knowledge of the pharmacology of the prescribed drug, personal attitudes of the care givers and the patients

themselves about narcotic analgesics and concern about the problems of addiction and respiratory depression that is greater than the actual risk. "Approaches to addressing these problems include education of health care professionals about the analgesic drugs and sensitization of these professionals to the roles their personal attitudes may play in their use of narcotic analgesics," as well as public education. The panel cited patient controlled analgesia (PCA) as "one of the innovative ways that may provide effective individualized analgesia and comfort" for patients.

The panel also emphasized the need for an integrated approach to pain management, and concluded that the nurse "may be identified as the coordinator of patient care." Nurses "have well-established pivotal roles in the assessment and management of pain which will increase in importance."

Future research should be directed to identify the factors that facilitate or hinder the dissemination and implementation of up to date information in clinical practice in the treatment of pain, the panel recommended. Other recommendations for future research include:

Determine the appropriateness of using existing research measures in clinical settings and to evaluate their validity as adjuncts to clinical judgments in pain assessment. Investigators should consider the special issues related to children in pain that have received less attention in the past.

Identify the specific factors associated with outcome within treatment modalities.

Discover and develop more effective analgesic drugs with larger margins of safety.

Assess more fully the potential value of each of the nonpharmacological approaches to pain in acute and chronic pain states through controlled studies in specific populations.

Continue research on endorphins, enkephalins, and narcotic receptors that show promise of producing better analgesic drugs. This research may also contribute to a better understanding of the mechanisms of such nonpharmacological therapy as acupuncture.

Develop and evaluate methods of drug delivery including PCA, sustained release formulations, epidural administration, and transdermal absorption of narcotic drugs to improve pain management with presently available narcotic drugs.

Describe studies of the nature and meaning of pain in a variety of settings and with a broad range of populations as the basis of ethnoculturally and contextually appropriate assessment tools.

The conference was jointly sponsored by NCI, the NIH Clinical Center, the National Institute of Neurological & Communicative Disorders & Stroke, the National Institute of Dental Research and NIH.

NCI Advisory Group, Other Cancer Meetings For June, July, Future

National Tumor Registrars Assn.--June 3-6, Park Plaza Hotel, Boston. Annual meeting. Contact Shirley Foret, Eilliot Hospital, 955 Aurburn St., Manchester, NH 03103, phone 603-669-5300 ext. 2147.

Hormonal Manipulation of Cancer: Peptides, Growth Factors and New (Anti)Steroidal Agents--June 4-6, Rotterdam. Contact Trial and Data Dept., Dr. Daniel den Hoed Cancer Center, PO Box 5201, 3008 AE Rotterdam, The Netherlands.

President's Cancer Panel--June 9, Dana Farber Cancer Institute, Boston. Innovations in cancer treatment, 9 a.m., open.

Toxicology Update '86--June 9-11, Turner Bldg, Johns Hopkins Medical Institutions. Contact Program Coordinator, Office of Continuing Education, 720 Rutland Ave., Turner 22, Baltimore 21205.

Normal and Neoplastic Blood Cells: From Genes to Therapy--June 10-13, Rome. Sponsored by Fondazione Internationale Menarini; Istituto Superiore di Sanita; and World Health Organization.

Div. of Cancer Etiology Board of Scientific Counselors--June 12-13, NIH Bldg 31 Rm 10, open June 12 1 p.m.-adjournment and June 13, 9 a.m.-adjournment.

American Conference on Hospice Care--June 14-17, San Francisco. Contact 2nd Annual Conference, Stephen DiTullio, 470 Boston Post Rd., Weston, MA 02193, phone 617-899-2702.

Critical Care of Leukemia Patients--June 14, Greater Baltimore Medical Center auditorium, Towson, MD. Contact Leukemia Society of America, Maryland Chapter, #1 Spinners Court, Randallstown, MD 21133.

Second International Symposium on Prostatic Cancer --June 16-18, Hotel Inter-Continental, Paris. Contact Dr. Saad Khoury, Clinique Urologique (Pr Chatelain), Hopital de la Pitie, 83, Bd. de L'Hopital, 75 013 Paris, France.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--June 18, NIH Bldg 31 Rm 11A10, open 9-11 a.m.

Society for Oral Oncology and the ACS Cancer Conference for the Dental Profession--June 19-21, Seattle. Contact Ann Pomerinke, ACS Washington Div., PO Box C19140, Seattle, WA 98109, phone 206-283-1152.

Biometry & Epidemiology Contract Review Committee--June 19-20, NIH Bldg 31 Rm 9, open June 19, 8:30-9 a.m.

Cancer Research Manpower Review Committee--June 19-20, Bethesda Marriott, open June 19 1-1:30 p.m.

Supportive Care of the Cancer Patient--June 20-21, Holiday Inn, Pensacola. Physicians seminar. Contact Dolly Partridge, Director of Education, Baptist Hospital, PO Box 17500, Pensacola, FL 32522, phone 904-434-4819.

Cancer Clinical Investigation Review Committee--June 23-24, NIH Bldg 31 Rm 6, open June 23 8:30-9 a.m.

Assn. of American Cancer Institutes--June 27-29, Hotel del Coronado, San Diego. Annual meeting. Contact

La Jolla Cancer Research Foundation, Attn. AACI, 10901 N. Torrey Pines Rd., La Jolla, CA 92037, or phone Sondra Bernhardt, 619-455-6480.

New Concepts and Developments in Immunology Vaccines--July 14-17, Hyatt Regency Hotel, Buffalo. 10th International Convocation. Contact Ernest Witebsky Center for Immunology, Rm 210 Sherman Hall, State Univ. of NY (Buffalo), NY 14214.

Clinical Cancer Program Project Review Committee--July 17-18, Bethesda Hyatt Regency, open July 17 8:30-9 a.m.

Cancer Center Support Review Committee--July 31-Aug. 1, Holliday Inn Crown Plaza, Rockville, MD. Open July 31, 8:30-9:30 a.m.

FUTURE MEETINGS

Expanding Role of Rehabilitation in Cancer Care--Sept. 5-6, Hilton Hotel, Portland, OR. Contact Suzanne May, Cancer Rehab Service, Good Samaritan Hospital, 1015 NW 22nd Ave., Portland 97210, phone 503-299-7283.

Cancer Nursing: An International Perspective--Sept. 7-12, Hilton Hotel, New York. Contact Secretariat, Fourth International Conference on Cancer Nursing, 404 Park Ave. South, Ninth Floor, New York 10016.

Breast Cancer--Therapeutic Dilemmas--Sept. 24, Cedarwood Hall Auditorium, New York Medical College, Valhalla. Update on concepts regarding behavior and treatment alternatives. Lecturers will include Anne Carter, Maurice Black, Stephen Carter, Joseph Cimino, Bernard Fisher, Samuel Hellman and Ruth Spear. Contact Office of CME, New York Medical College, Valhalla, NY 10595, phone 914-993-4487.

Pediatric Oncology--Oct. 17, Battenfeld Auditorium, Univ. of Kansas Medical Center, Kansas City. Contact Carole Rosen, Office of Continuing Education, UK Medical Center, 39th and Rainbow, Kansas City KS 66103, phone 913-588-4480.

American Assn. for Cancer Education--Nov. 11-14, LeCentre Sheraton, Montreal. Annual meeting. Contact Henry Shibata MD, S10.22, Royal Victoria Hospital, Montreal, PQ, H3A 1A1, Canada.

Innovative Cancer Chemotherapy for Tomorrow-- Nov. 12-14, Sheraton Centre Hotel, New York. Chemotherapy Foundation Symposium VII. Postmenopausal breast cancer, polychemotherapy, differentiation chemotherapy, chemoimmunotherapy and new phase 2 drugs. Contact Director, Page & William Black Post Graduate School of Medicine, One Gustave L. Levy Place, New York 10029, phone 212-650-6737.

Monoclonal Antibodies and Breast Cancer--Nov. 20-21, San Francisco. Latest advances in preparation and use of monoclonal antibodies in diagnosis, prognosis and future treatment of breast cancer. 2nd international workshop. Contact Dr. Roberto Ceriani, John Muir Cancer & Aging Research Institute, 2055 N. Broadway, Walnut Creek, CA 94596, phone 415-943-1167.

Gastrointestinal Oncology--1986--Dec. 4-5, Memorial Sloan-Kettering Cancer Center, New York. Contact CME Conference Planning Office, Box 458, MSKCC, 1275 York Ave., New York 10021, phone 212-794-6754.

American Radium Society--April 6-10, Portman Inter-Continental Hotel, London. 69th annual meeting. Contact Suzanne Bohn, Executive Secretary, American Radium Society, 925 Chestnut St., Philadelphia 19107, phone 215-574-3179.

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-67879
Title: Development and production of parenteral forms of anticancer agents
Deadline: Approximately Aug. 1

The Pharmaceutical Resources Branch of the Developmental Therapeutics Program, Div. of Cancer Treatment, is seeking a contractor to develop and manufacture parenteral dosage forms of anticancer agents in support of DCT's clinical trials program. The project also will involve complete quality control evaluation of the products.

Offerors may propose on one or both of the following annual project levels:

Level A--The number of freeze dried projects required annually will be approximately 16 consisting of single batch sizes averaging between 5,000 and 20,000 vials (usual vial size 20 to 30 ml). All production for freeze dried products shall require simple aqueous solution, sterile membrane filtration, fill volume 12 ml per 30 ml vial or 4 ml per 10 ml vial, an average of 96 hours freeze drying cyle and 100% inspection, labeling and packaging. The number of sterile liquid projects will be approximately eight annually consisting of single lot sizes of 10,000 to 30,000 ampules/vials. All production assignments for sterile liquid fills shall require simple aqueous solution, fill volume 10 ml per 10 ml ampule, terminal autoclaving and 100% inspection, labeling, packaging.

Level B--The number of freeze dried projects required annually will be approximately eight consisting of single batch sizes averaging between 3,000 and 15,000 vials (usual vial size 20 to 30 ml). All production assignments for freeze dried products shall require simple aqueous solution, sterile membrane filtration, fill volume 12 ml per 30 ml vial or 4 ml per 10 ml vial, an average of 96 hours freeze drying cycle and 100% inspection, labeling and packaging. The number of sterile liquid projects will be approximately four annually consisting of single lot sizes of 5,000 to 10,000 ampules/vials. All production assignments for sterile liquid fills shall require simple aqueous solution, fill volume of 10 ml per 10 ml ampule, terminal autoclaving, and 100% inspection, labeling and packaging.

The new drug substance will be supplied by NCI. The contractor will provide all other ingredients, containers, stoppers, boxes, labels, etc.

The principal investigator should have at least three years experience in the preparation of sterile freeze dried products.

Contract Specialist: Elizabeth Moore
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301-427-8737

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