THE CANCER LETTER

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CGOP Gets New Life, Will Move To DCT; DCPC May Fund More CCOPs With Money It Saves

The Cooperative Group Outreach Program, threatened with extinction unless it were moved from NCI's Div. of Cancer Prevention & Control, will be moved to the Div. of Cancer Treatment and continued indefinitely at the same level of

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In Brief

New Mount Sinai Cancer Center Gets $7 Million; Jules Harris Named Rush Cancer Center Director

MOUNT SINAI Medical Center has received a $7 million gift from industrialist Derald Ruttenberg to establish and endow the Ruttenberg Center for Neoplastic Diseases and to provide a floor in its new hospital to house cancer patients. The center will be headed by James Holland, chairman of the Dept. of Neoplastic Diseases at Mount Sinai. Ruttenberg, 70, has been a trustee of Mount Sinai for 17 years and is former chairman of Studebaker-Worthington Inc. . . . **FDA ONCOLOGIC** Drugs Advisory Committee last week unanimously approved etoposide (VP-16) for treatment of small cell lung cancer, both limited and extensive disease, and of tamoxifen as single agent adjuvant therapy for post menopausal, hormonal receptor positive breast cancer patients with positive nodes. The committee's action is advisory only, but FDA usually follows its recommendations on approving drugs for marketing. Etoposide had previously been approved for treating refractory testicular tumors; tamoxifen had been approved as palliative therapy for advanced breast cancer in post menopausal patients. . . . **JULES HARRIS**, director of medical oncology at Rush Medical College and associate director for clinical trials of the Illinois Cancer Center, has been appointed director of the Rush Cancer Center. He replaces Frederick Kittle, who has been acting director for several years. The cancer center and medical college are part of Rush-Presbyterian-St. Luke's Medical Center. . . . **OSCAR AUERBACH**, physician emeritus at the VA Medical Center in East Orange, NJ, and professor of pathology at the Univ. of Medicine & Dentistry of New Jersey, will receive the 1986 Alton Ochsner Award Relating Smoking and Health. The $15,000 award recognizes his landmark research relating smoking to lung cancer and to early changes in bronchial epithelium, and for relating the reversibility of the bronchial changes with cessation of smoking.

NCI Executive Committee Transfers CGOP To DCT; DCPC Keeps $4 Million

(Continued from page 1)

funding it is getting this year, about $4 million. That will all be new money for DCT, whose executives had resisted taking over the program if they had to fund it out of their already hard pressed budget.

DCPC Director Peter Greenwald, anxious to end his division's 10 year support of CGOP because of his own budget problems and perceptions of his advisors that it was not a true "cancer control" program, had offered to split the third year cost of the current contracts with DCT. But when the NCI Executive Committee decided to make the change, the entire $4 million was "identified" elsewhere, **The Cancer Letter** was informed.

"Money is no longer an issue," an NCI executive said.

The primary issue was whether the program should be continued. Started 10 years ago with cancer control money to encourage the cooperative groups to extend clinical trials into smaller community hospitals, it has become vital to many groups in patient accrual. Some, both in and out of NCI, had felt that with the Community Clinical Oncology Program, which costs about $9 million a year, proving to be a success, CGOP was no longer needed.

The cooperative groups vehemently disputed that view (**The Cancer Letter**, July 11). Paul Carbone and Marvin Zelen of the Eastern Cooperative Oncology Group, made a plea in a letter to NCI Director Vincent DeVita to combine CCOP and CGOP as a way of preserving the latter.

Zelen, although delighted that CGOP will be continued, said he still thinks there should be only one community clinical trials program.

CGOP barely won concept approval when it was presented to the DCPC Board of Scientific Counselors when the previous authorization had expired. The board reluctantly went along with three more years. There is almost no chance it would be approved again by that board.

Continuation of the program beyond the third year of the present authorization, which starts in December, now is up to the DCT Board of Scientific Counselors. That board, which has oversight responsibility for the cooperative groups, is much more likely to listen to the pleas of the group chairmen. CGOP is a pure clinical trials effort, although Zelen and others feel strongly that extending good therapy and patient management into community hospitals should be considered cancer control.

Maybe it is, but the key buzzword at DCPC for the past several years has been "cancercontrolresearch." If it doesn't have a research element, it is service and not true cancer control, the philosophy goes.

The CCOPs are finding that out as they gear up for the recompetition. They will have to include cancer control research in their applications this time. That was certain to increase their budgets, which coupled with NCI's position that the program would be funded at the same level ($9 million) as this year, would inevitably lead to fewer CCOPs being funded.

That picture may have changed somewhat with DCPC's unloading of CGOP while keeping the $4 million. Some, and perhaps all, of that money may be added to the total CCOP budget, although no one is making any promises now.

"We'll have to wait and see what the magnitude is," said Jerome Yates, director of DCPC's Centers & Community Oncology Program. "If we get top quality applications, with quality ideas for cancer control, we can make a case for using the money freed up by the CGOP transfer."

CCOP Meeting

Yates hopes that a meeting of CCOP representatives and their research bases Sept. 8 in Bethesda will shed some light on how they are approaching the cancer control research requirement. The meeting will be held in Bldg 31 Room 4, from 10 a.m.-4 p.m.

Yates expressed his admiration of "the great job" performed by two of his staff members, CCOP program director Robert Frelick and program specialist Wilma Dunlap in pulling together all the elements involved in the new RFA and getting it through the NIH bureaucracy and into the hands of applicants. "They really have been outstanding," Yates said.

Waxman Hearing Generates Support For Bill Banning Tobacco Advertising

Emotional appeals from the grandson of the founder of one of the largest cigarette manufacturers and the daughter of a famous victim of cigarette smoking, backed by testimony of a variety of health professionals, presented

a strong case for legislation to ban all forms of tobacco advertising and promotion at a hearing last week held by Congressman Henry Waxman (D.-CA), chairman of the House Subcommittee on Health & Environment.

Patrick Reynolds, whose grandfather founded R.J. Reynolds Tobacco Co., said his awareness of the danger of cigarette smoking began when his father died of emphysema at age 58. He has been actively campaigning with antismoking organizations, Reynolds said. Although he has long since sold his stock in the company and never worked for it, he is frequently criticized for "biting the hand that feeds me. If the hand that once fed me is the tobacco industry, then that same hand has killed many millions of people."

Victoria Brynner is the daughter of actor Yul Brynner, who died last year of lung cancer. She said he started smoking at age 12, developed a five pack a day addiction, and stopped only when throat problems occurred, "much too late."

Charles LeMaistre, president of the Univ. of Texas System Cancer Center and current president of the American Cancer Society, said four issues should be considered. "First, that tobacco advertising and promotion have as their primary purpose to expand the market for tobacco products. Second that market expansion is aimed primarily at our most vulnerable population, America's youth. Third, that the vast advertising and promotion expenditures of the tobacco industry dominate our economy and overwhelm the relatively small amount spent on our best efforts to educate the public. Fourth, that tobacco advertising and promotion are so effective in perpetuating tobacco use among our nation's youth that congressional action is now mandatory."

Kenneth Warner, chairman of the Dept. of Public Health Policy at the Univ. of Michigan, disputed tobacco industry claims that its advertising is not meant to increase cigarette consumption and that it does not do so. Recent studies show that advertising does encourage smoking, he said. Moreover, "the industry annually loses more of its customers than any other product." An average of 1.5 million Americans stop smoking each year, and another 300,000 to 500,000 are killed by cigarettes each year, he said. Added to the smokers who die of other causes, that means about 2.5 million Americans "must start smoking each year for the industry simply to maintain the size of the smoking population." Since 90% of new smokers are under age 21, "the industry has a powerful incentive to use whatever tools it has available to assure that kids become smokers."

The bill was introduced by Congressman Mike Synar (D.-OK), with broad bipartisan support. Legislation restricting print advertising generally has been considered unconstitutional, as a violation of the First Amendment. However, the recent Supreme Court decision permitting Puerto Rico to ban the advertising of casinos, which are legal there, has been a powerful stimulus to legislation to ban all tobacco advertising and promotion, which Synar's bill would do.

The tobacco industry, supported by the American Advertising Federation, contends that the Puerto Rico case and Supreme Court decision is not applicable to a tobacco advertising ban. They also claim that advertising bans in other countries not only have not worked but that at least in Italy, Taiwan and Iceland, per capita consumption of cigarettes has doubled despite ad bans.

LeMaistre and others argued that those bans were ineffective because they contained too many loopholes and were not accompanied by aggressive education efforts. In Norway, where the ban was total and strictly enforced and where strong public education programs against tobacco are in place, substantial reductions have occurred.

Sen. Bill Bradley (D.-NJ) and Congressman Fortney Stark (D.-CA) appeared at the hearing to plug their bill (HR 3950) that would disallow tobacco advertising and promotion costs as deductible business expenses. That would skirt the First Amendment issue, and even if it did not reduce the amount of advertising, at least would return $1 billion a year to the U.S. Treasurery, Stark pointed out. The cost of advertising would be passed on to smokers, further discouraging consumption by making it more expensive, he said.
Stark and Bradley agreed that Synar's bill is preferable but noted that their bill has been determined by legal advisors to be constitutional.

The White House created a stir by forbidding Surgeon General Everett Koop from testifying in favor of the bill. Waxman denounced that action and insisted that top Administration officials appear to explain why. He read a response in which it was agreed that Koop and others would appear at a later date. NCI Director Vincent DeVita was not asked to testify.

Medicare Adjustments Critical For Diffusion, Innovation, ProPAC Says

Adjustments to Medicare's prospective payment system are critical to the effective diffusion of new medical technology as well as innovation and scientific advancement, the Prospective Payment Assessment Commission stressed in a recent letter to Health Care Financing Administration head William Roper.

"The Medicare prospective payment system [PPS] should be a flexible and evolutionary system responsive to changing health technology and practice patterns and to the distributional impacts of payments within the system," ProPAC said. "We believe that adjustments are critical to the effective diffusion of new medical technology. Adjustments are also critical to maintaining an environment that fosters innovation and scientific advancement."

The 32 page letter, signed by ProPAC Chairman Stuart Altman, contains the commission's comments on HCFA's notice of proposed rulemaking concerning fiscal year 1987 changes to the inpatient PPS published last month (**The Cancer Letter**, June 20).

Stating that it has "a number of concerns" regarding the department's response to the commission's recommendations made in April, ProPAC said, "Our review of the NPRM leads us to believe that ProPAC's approach to updating and maintaining the Medicare prospective payment system and that of the department are diverging in significant ways."

ProPAC maintained that the department's response to its recommendations "indicates a belief that averaging solves the problems of the prospective payment system. Thus, adjustments carefully designed to meet specific needs are unacceptable because they add to the complexity of the system." While ProPAC agrees "that it is appropriate to be concerned with the level of complexity," it believes that "the continued viability and success of the program is more dependent upon flexibility than upon maintenance of the status quo."

In addition, the commission said it did not believe that HHS' response to its recommendations "always gives full consideration to the detail and extent of the problems we have identified." It also doesn't "believe the response exhibits the flexibility which we believe is necessary to update and maintain the system.

"In order to encourage the confidence of beneficiaries, providers, suppliers and taxpayers, we hope that the [HHS] Secretary [Otis Bowen] will reconsider the details of our analysis in developing the final fiscal year 1987 PPS regulations."

The HHS proposal would establish an update factor of 0.5%. ProPAC recommends that the update factor be set at 1.9%, or 2.2% if capital payment is included in PPS. HHS proposes to incorporate capital into PPS beginning Oct. 1. Federal capital payments would be phased in over a period of five years, with the federal payment portion increasing by 20% each year. The federal capital payment would be based on FY 1983 Medicare cost report data adjusted to offset interest income earned on funded depreciation. The hospital specific payment would be based on the lesser of the hospital's indexed 1986 capital costs or actual capital costs during each year of the transition.

ProPAC asserted that "several components of the Secretary's capital payment proposal are unduly harsh." It specifically objects to the selection of 1983 as the base year for calculating fixed capital payments, reduction of capital payments to offset interest earned on funded depreciation and payment of the lesser of actual or trended historical costs in the hospital specific portions.

"While the commission agrees that capital payment under PPS should be initiated soon, it must be done with payment policy that will not jeopardize beneficiary access to facilities that are able to provide services that are safe and of high quality." It also agrees that a transition to all inclusive prospective prices, combining operating and capital components in a single prospective payment per case, should be initiated in FY 1987. However, it believes that fixed capital expenditures differ substantially from moveable capital expenditures and that the differences should be reflected in new capital payment policy.

It added that "with appropriate adjustments, Medicare cost report data are adequate for determining the national and hospital specific proportions of fixed and moveable capital." It recognized, however, "that for the purpose of paying hospital specific rates, fixed/moveable capital assignments on the cost report would need to be more closely monitored in the future."

Annual Recalibration Required

ProPAC also asserted that annual recalibration "is necessary and required in order

for PPS to keep pace with recent changes in the delivery of medical services." It stated that it "strongly believes" that HHS should recalibrate DRG weights using fiscal year 1985 patient billing data.

"The commission believes that DRG prices should reflect the most recent data available, and therefore, the weights should be recalibrated annually." While agreeing that the difference between weights based on FY 1984 data and FY 1985 data would be insignificant for most DRGs, it said that recalibration could make a difference for DRGs experiencing significant practice pattern changes.

"Because most weights would change very little each year, annual recalibration would be less disruptive than a schedule as infrequent as every four years, as allowed under the statute," it said. "In addition, recalibration avoids the need to compute individual weights for each DRG that is reclassified."

In addition to the benefits of using more recent data, ProPAC maintained that an annual recalibration schedule is important so that the hospital industry can anticipate when changes will occur. The HHS proposal did not indicate any planned schedule for recalibration, except to note that it must be carried out at least every four years.

"The commission believes that recalibration should be carried out on a schedule known in advance to the hospital industry rather than on an ad hoc basis," it said. "Such a schedule is consistent with the PPS goal of increasing the predictability of Medicare payments."

It also noted that HHS' justification for rejecting ProPAC's recommendation regarding payment for magnetic resonance imaging is that recalibration would take care of the problem. "Since the secretary does not plan to recalibrate, the DRG weights will not automatically reflect the resources associated with MRI as the NPRM states."

Recalibration of the DRG weights using more recent data would also "afford an opportunity to establish new cutoff points for day outliers," it said. "given the decline in length of stay referred to...in the NPRM, new outlier cutoffs might be justified to ensure that hospitals in the aggregate are not underpaid for outlier cases because of declines in length of stay."

ProPAC also maintained that "it is very important that the coding system and the DRGs be flexible enough to incorporate new technologies at fair payment levels." HHS "has refused to accept an add on payment for MRI, to recalculate labor/nonlabor portions of DRGs with expensive devices, and to recalibrate the DRGs annually.

"These refusals, together with a reluctance to assign clinically heterogeneous cases to unique DRGs, seem to reflect a lack of concern for the inequities and problems the current DRGs pose for new technologies."

ProPAC is also concerned that HCFA "does not have a consistent and comprehensive strategy to identify and promptly correct deficiencies. For example, some problems are addressed on an incremental basis while for others 'detailed analysis of...the impact on the DRG logic system' is advisable before 'piecemeal changes are implemented,'" ProPAC said, citing HCFA's position.

In the areas of coding and case mix issues, ProPAC cited two basic concerns: a diagnosis versus procedure classification system, and generic versus individual adjustments to DRGs.

Although the NPRM emphasized that the DRG classification system is a diagnosis based system, not procedure based system, ProPAC noted, "Yet, one of the initial steps in grouper logic is to sort patients by whether an operating room procedure was performed or not." More than 200 of the 471 current DRGs are surgical.

"The commission believes that the avoidance of grouping patients by procedure is conceptually attractive but not always feasible," it said. "In supporting the use of procedures to classify patients for payment purposes, there are a number of non operating room procedures or therapies that are resource intensive and should receive similar consideration in the grouper logic."

Although ProPAC acknowledged that the establishment of the ICD-9_CM Coordination and Maintenance Committee "may help to maintain and update the ICD-9-CM system," it "continues to be concerned that there is no official involvement by nonfederal users and coding experts in activities, no advance agenda for public meetings, and no opportunity for public comment on proposed changes prior to adoption." Such input is especially important since ProPAC does not vote or make final decisions in the public forum.

It added that the current annual schedule for publication and implementation of proposed changes to the ICD-9-CM system "will

not be timely enough for the commission to carry out its responsibilities to consult with the [HHS] secretary before rulemaking."

ProPAc also expressed concern that the proposed elimination of periodic interim payments (PIP) "may compromise the ability of certain hospitals to maintain an adequate cash flow." PIP has allowed hospitals to manage Medicare cash flow despite frequent changes in federal Medicare payment and utilization review policies, problems with claims submission, and delays in intermediary processing and payment of claims, it said.

The commission agreed with HHS that hospitals should be provided incentives to submit claims in a more timely fashion and that they are increasingly capable of doing so because of electronic submission. It is concerned, however, that "recent Administration policy to slow the claims processing and payment cycle may exacerbate cash flow problems. Thus, while hospitals may be improving the timeliness of their claims submission, they may face difficult cash flow problems due to delays in payment."

The incorporation of capital into PPS payments may further exacerbate cash flow problems for many PPS hospitals, it said.

ProPAC advised that "prior to elimination of PIP, it is necessary to assess the combined impact on hospital cash flow of this action together with changes in the payment cycle and incorporation of capital into the prospective payment rates." The assessment would provide a basis for policies to alleviate cash flow problems beyond the control of individual hospitals that arise from changes in federal policy. It added that the proposed 45 day length of stay exception provision and the provision for accelerated payments "may not be adequate to address these concerns."

Congress Reaffirms GRH FY 1986 Budget Cuts, Including Those For NCI

Congress reaffirmed last week the FY 1986 Gramm-Rudman-Hollings budget cuts, which had been declared illegal by the Supreme Court. That ruling, in effect, declared that the cuts would have to be achieved through votes by both houses of Congress; bills to that effect sailed through with little discussion.

Thus, NCI's $56 million share of the cuts will stand, ending any hopes that some of the canceled contracts and grant reductions might be restored.

NCI Advisory Group, Other Cancer Meetings For August, Sept., Future

Early Treatment of Breast Cancer--Aug. 1, Marriott West Hotel, Denver. 40th annual Rocky Mountain Cancer Conference. Contact Jiri Tvrdik, RN, Professional Education Director, American Cancer Society, Colorado Div., 2255 S. Oneida, Denver 80224, phone 303-758-2030.

Cancer Therapeutics Program Project Review Committee--Aug.7-8, NIH Blg 31 Rm 6, open Aug. 7 8:30-9 a.m.

International Society for Experimental Hematology--Aug. 10-14, Hyatt Regency, Buffalo. 15th annual meeting. Contact Dr. Michael McGarry, Roswell Park Memorial Institute, 666 Elm St., Buffalo, NY 14263, phone 716-592-9348.

Congress on Research in Lymphokines and other cytokines--Aug. 10-13, Marriott Copley Place, Boston. Contact Scherago Associates, 212-730-1050.

SV40, Polyoma and Adenoviruses--Aug. 13-17, Cold Spring Harbor. Contact CSH Laboratory, Box 100, Cold Spring Harbor, NY 11724, phone 516-367-8343.

Cancer Biology & Immunology Contracts Review Committee--Aug. 15, NIH Bldg 31 Rm 4, open 2-2:30 p.m.

New Advances in Internal Medicine: Clinical Applications--Aug. 17-22, Hyatt Regency, Monterey, CA. Contact Office of Continuing Medical Education, Univ. of California (Davis) School of Medicine, 2701 Stockton Blvd., Sacramento 95817, phone 916-453-5390.

Molecular Genetics of Bacteria and Phages--Aug. 19-24, Cold Spring Harbor. Address above.

14th International Cancer Congress--Aug. 21-27, Budapest. Contact Congress Bureau MOTESZ, PO Box 32, H-1361 Budapest, Hungary.

Hepatitis B--Aug. 28-31, Cold Spring Harbor. Address above.

3rd Annual Endocurietherapy Symposium--Aug. 29-31, Gatlinburg, TN. Contact CME Office, Univ. of Tennessee, 800 Madison Ave., Memphis 38163, phone 901-528-5547.

5th Annual Workshop on Papillomaviruses--Sept. 3-7, Cold Spring Harbor. Address above.

9th Annual Oncology Nursing Conference--Sept. 4, Marshfield, WI. Contact Mary Seehafer, Education Dept., St. Joseph's Hospital, Marshfield 54449, phone 715-387-7587.

Role of Rehabilitation in Cancer Care--Sept. 5-6, Portland, OR. Contact Suzanne May, Cancer Rehabilitation Service, Good Samaritan Hospital & Medical Center, 1015 NW 22nd Ave., Portland 97210, phone 503-229-7283.

Fourth International Conference on Cancer Nursing--Sept. 7-12, New York. Contact the conference, 404 Park Ave. South, Ninth Floor, New York 10016.

Modern Approaches to New Vaccines Including Prevention of AIDS--Sept. 9-14, Cold Spring Harbor. Address above.

Double Stranded RNA Virus Symposium--Sept. 9-13, Oxford, UK. Contact D.H.L. Bishop, Institute of Virology, National Environment Research Council, Mansfield Rd., Oxford, OX1 3SR, UK.

6th Annual Soft Tissue Tumor Symposium--Sept. 15-17, New York. Contact Dr. Steven Hajdu, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York 10021, phone 212-794-5902.

Critical Molecular Determinants in Carcinogenesis--Sept. 16-19, Stouffer's Hotel, Houston. 39th Annual Symposium on Fundamental Cancer Research. Contact Conference Services, M.D. Anderson Hospital & Tumor Institute, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

National Conference on Gynecologic Cancer--Sept. 17-19, Hilton Hotel, Atlanta. Contact American Cancer Society, conference, 90 Park Ave., New York 10016.

Biological Effects of DNA Topology--Sept. 17-19, Cold Spring Harbor. Address above.

2nd Annual Clinical Hyperthermia Symposium--Sept. 18-20, St. Louis. Contact Bahman Emami MD, Div. of Radiation Oncology, Mallinckrodt Institute of Radiology, 4511 Forest Park Blvd., Suite 411, St. Louis 63108, phone 314-362-8500.

8rg Annual Diagnostic Cytopathology Course--Sept. 18-20, New York. Contact Robin Nager, Cytology Service, Memorial Sloan-Kettering, 1275 York Ave., New York 10021, phone 212-794-5903.

Weekend of Oncology--Sept. 19-21, Sawmill Creek Lodge, Huron, OH. Contact Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Rm TT3-301, Cleveland 44106. Phone (local) 444-5696; (in Ohio) 800-762-8172; (outside Ohio) 800-762-8173.

Current and Future Contributions of Chemistry to Health: The New Frontiers--Sept. 22-26, Heidelberg. Contact Gesellschaft Deutscher Chemiker, Abteilung Tagungen, Varrentrappstr. 40-42, Postfach 90 04 40, D-6000 Frankfurt am Main 90, Federal Republic of Germany.

Div. of Cancer Prevention & Control Board of Scientific Counselors--Sept. 22-23, NIH Bldg 1 Wilson Hall, 8:30 a.m. Closed Sept. 22 3 p.m.-adjournment.

Urologic Cancer--Sept. 22-24, Westin Hotel, Boston. Contact Dept. of Continuing Education, Harvard Medical School, Shattuck St., Boston 02115, phone 617-732-1525.

Molecular Mechanisms in the Regulation of Cell Behavior--Sept. 22-26, Hershey, PA. Contact Executive Director, Tissue Culture Assn., 19110 Montgomery Village Ave., Suite 300, Gaithersburg, MD 20879, phone 301-869-2900.

Oncology Nursing Conference VII--Sept. 23-26, Westin Galleria Hotel, Houston. Contact Conference Services, M.D. Anderson, 6723 Bertner Ave., Houston 77030, phone 713-792-2222.

Breast Cancer: Therapeutic Dilemmas--Sept. 24, Cedarwood Hall Auditorium, New York Medical College, Valhalla, NY. Contact CME, NYMC, Valhalla 10595, phone 914-993-4487.

American College of Epidemiology--Sept. 24-26, New Haven, CT. Annual meeting. Contact Curtis Mettlin PhD, Secretary, ACE, Roswell Park Memorial Institute, 666 Elm St., Buffalo 14263.

Diet and Cancer: Public Health Messages in Product Advertising--Sept. 24-26, Washington Hilton Hotel, Washington DC. Sponsored by the American Institute for Cancer Research. Speakers will include Peter Greenwald, director of NCI's Div. of Cancer Prevention & Control; Sanford Miller, director of FDA's Center for Food Safety & Applied Nutrition; Michael Jacobson, executive director of the Center for Science in the Public Interest; Charles Carey, president of the National Food Processors Assn.; and various other scientists, retailers and regulators. Contact AICR Symposium Headquarters, 655 15th St. NW, Suite 300, Washington DC 20005, phone 202-639-5164.

Physiological MRI Spectroscopy: From Isolated Cells to Man--Sept. 24-26, Vista International Hotel, New York. Contact Conference Dept., 212-838-0230.

Poxvirus/Iridovirus--Sept. 24-28, Cold Spring Harbor. Address above.

Diagnosis and Therapy of Bone Marrow Abnormalities --Sept. 25-26, San Francisco. Contact Extended Programs in Medical Education, Rm 569-U, Univ. of California, San Francisco 94143, phone 415-476-4251.

Immunology of Malignant Disease--Sept. 27, Ireland Cancer Center, Cleveland. Contact Barbara Guy, Ireland Cancer Center, Lowman Bldg 211, Univ. Hospitals of Cleveland, 2074 Abington Rd., Cleveland 44106, phone 216-844-7856.

Interaction of Radiation Therapy and Chemotherapy--Sept. 28-Oct. 1, Fort Magruder Inn, Williamsburg, VA. Contact Suzanne Bohn, American College of Radiology, 925 Chestnut St., Philadelphia 19107, phone 215-574-3181.

Breast Issues, 1986--Sept. 30-Oct. 3, Marriott Mark Resort, Vail, CO. Contact Joan Camp, 8200 E. Belleview, Suite 218, Englewood, CO 80111, phone 303- 788-6966.

FUTURE MEETINGS

Oncology Nursing Symposium: Cancer Implications Throughout the Life Span--Oct. 1-3, Cleveland. Contact Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Rm TT3-301, Cleveland, OH 44106.

Challenge of Cancer to the Community--Oct. 17-18, Tampa. Contact Joseph Sinkovics MD, Medical Director, St. Joseph's Hospital Community Cancer Center, PO Box 4227, Tampa, FL 33677, phone 813-870-4242.

Current Trends in Head and Neck Cancer Nursing--Oct. 22-23, Baltimore. Contact Pamela Macedonia, Office of Continuing Education, Johns Hopkins Medical Institutions, Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-6085.

Oncology Today: Toward 2000 II--Oct. 30-31, Fox Chase Cancer Center, Philadelphia. Contact Peggy Conners, Conference Coordinator, 215-728-3110.

Curative Treatment Strategies 1986--Nov. 6-8, Century Plaza Hotel, Los Angeles. Annual oncology review sponsored by Cedars-Sinai Medical Center and Comprehensive Cancer Center. Contact Lore Kahane, Cedars-Sinai, Rm 2049, PO Box 48750, Los Angeles 90048, phone 213-855-5547.

New and Future Technology in Cancer Treatment--Dec. 5-6, Bunts Auditorium, Cleveland Clinic. Contact CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave. Rm TT3-301, Cleveland 44106.

Organ Directed Toxicities of Anticancer Drugs--June 4-6, 1987, Burlington, VT. First international symposium. Contact Miles Hacker PhD, Vermont Regional Cancer Center, One S. Prospect St., Burlington 05401, phone 802-656-4414.

Critical Issues in Tumor Microcirculation, Angiogenesis and Metastases--June 8-12, 1987, Carnegie Mellon Univ., Pittsburgh. Contact Hilda Diamond, Biomedical Engineering Program, Carnegie Mellon Univ., Pittsburgh 15213, phone 412-268-2521.

Program Announcements

Title: Development of new methods to couple cytotoxic agents to monoclonal antibodies

Deadline for applications: Oct. 1, Feb. 1, June 1

The Biological Response Modifiers Program of NCI's Div. of Cancer Treatment invites grant applications for basic and applied studies on new methods to couple cytotoxic agents to monoclonal antibodies. This program announcement is intended to foster research to develop standardized efficient procedures to couple drugs or toxins to MoAbs directed against tumor associated antigens.

Procedures should provide the best ratio of antibody to cytotoxic agent that preserves both antibody specificity and agent toxicity. Assays performed on potentially useful conjugates should include stability, antibody specificity, immunoreactivity and cytotoxicity. Innovative approaches using recombinant DNA technology to couple the toxic agent to the antibody would also be appropriate. In order to be responsive to this announcement, the applicant should demonstrate that the studies are designed to develop therapeutically useful conjugates. At the least, some experiments using a therapeutic end point should be proposed.

Title: Neuroendocrine effects on the immune system for cancer therapy

Deadline for applications: Oct. 1, Feb. 1, June 1

BRMP invites grant applications for basic and applied studies on the application of neuroendocrine

effects on the immune system for cancer therapy.

There is a need to assess the effects of mediators that act between the immune system and nervous system, the cells they act upon, their receptors, and target cell effects to determine possible application for enhancement of the immune response for cancer therapy. Studies directed toward a therapeutic endpoint may involve, but not be limited to, identification of responsiveness of immune cells to neuroendocrine mediators in vitro and in vivo, administration of mediators to animals bearing spontaneous, transplantable, and autochthonous tumors for therapeutic evaluation, and direct intervention to inhibit tumor growth promoting activities of neuroendocrine mediators by administration of antibodies directed against neuroendocrine peptides or cell receptors.

For further information on either of the above two program announcements, contact Dr. Carl Pinsky, Chief, Biological Resources Branch, BRMP, Div. of Cancer Treatment, NCI, Frederick Cancer Research Facility, Bldg 426 Rm 1, Frederick, MD 21701, phone 301-698-1098.

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-CP-71000-13
Title: Pre-1979 death index extension

Deadline: Approximately Dec. 20

The Epidemiology & Biostatistics Program of the Div. of Cancer Etiology is soliciting proposals from qualified organizations to implement an extension of the National Death Index to cover the period 1963-78 (approximately). The successful offeror shall establish contact with appropriate individuals in each of the 56 U.S. registration areas, as well as with the Assn. for Vital Records & Health Statistics to establish feasibility. To be considered for award, offerors must include in their proposals letters of intent from at least 70% of such offices of vital statistics expressing willingness to cooperate.

This project will be divided into two distinct phases. Phase 1 shall be a detailed feasibility study to provide NCI with options (varying in their cost, coverage and degree of completeness) to expand the National Death Index for years prior to 1979. Phase 2 would implement the option selected by NCI to carry out the death index extension activities.

Contract Specialist: Sharon Miller
RCB Blair Bldg Rm 114
301-427-8888

RFP NIH-NIAID-MIDP-87-10
Title: Development of antiviral drugs for treatment of human cytomegalovirus infections, particularly in AIDS and other immunosuppressed patients

Deadline: Sept. 25

The Development & Applications Branch of the Microbiology & Infectious Diseases Program of the National Institute of Allergy & Infectious Diseases has a requirement for the development of antiviral drugs for the treatment of human cytomegalovirus infections. The successful offeror must have capabilities, appropriate technical approach and facilities to chemically synthesize one or more compounds which will inhibit the replication of human CMV.

To receive a copy of the RFP, send two self addressed mailing labels to Jacqueline Holden, NIAID, NIH, Westwood Blvd Rm 707, Bethesda, MD 20892.

NCI CONTRACT AWARDS

Title: Preclinical investigations of antitumor agents
Contractors: Ohio State Univ. Research Foundation, $489,197; Mayo Foundation, $650,735; Southern Research Institute, $777,735.

Title: Services in support of the Developmental Therapeutics Program
Contractor: Technical Resources Inc., $519,139

Title: Support services to develop a computerized comparison population for occupational studies
Contractor: ORI, $324,723

Title: Support service for Diet & Cancer Program
Contractor: Information Management Services Inc., $402,376

Title: Synthesis of congeners and prodrugs
Contractor: Research Foundation of State Univ. of New York, $830,732

Title: Cancer Communication Program support
Contractor: Prospect Associates Inc., $6,065,785

Title: Nutrition intervention trial in Linxian, China
Contractor: Cancer Institute, Chinese Academy of Medical Sciences, $392,186

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