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Greatest Need Of Cancer Care Givers: "Will To Work Together," ACCC President Anderson Says

Paul Anderson, a medical oncologist and director of Penrose Cancer Hospital in Colorado Springs, not only has to deal on a daily basis with the problems involved in delivering quality cancer care in the comunity. As the current president of the Assn. of Community Cancer Centers,
(Continued to page 2)

In Brief

Cancer Panel To Meet Sept. 30 In Boston; House Passes Money Bill, With $1.347 Billion For NCI

PRESIDENT'S CANCER Panel meeting, originally scheduled for June 9 in Boston and postponed when Chairman Armand Hammer couldn't attend, has been rescheduled for Sept. 30 at Dana Farber Cancer Institute. Subject matter will continue the Panel's current discussions of "Innovations in Cancer Treatment," with reports from New England area investigators. . . . **HOUSE APPROVED** the FY 1987 Labor-HHS-Education appropriations bill with little controversy and without altering NCI's total of $1.347 billion plus about $61 million for AIDS research. The Senate Appropriations Committee was scheduled to complete its action on the bill late this week. . . . **NORTHERN CALIFORNIA** Cancer Program is looking for a PI for its contract with NCI to operate the San Francisco Bay Area SEER Program. Candidates must have backgrounds in directing large scale cancer incidence reporting programs and a successful record of seeking peer reviewed funding. Send resumes to Byron Brown, PhD, NCCP, PO Box 2030, Belmont, CA 94002. . . . **NCI IS** recruiting a director for the Cancer Prevention Research Program in the Div. of Cancer Prevention & Control. DCPC Director Peter Greenwald has been running the program since William DeWys left last year. It is a Civil Service position in the Senior Executive Service with a salary range from $61,296 to $68,700, and physicians may be eligible for an additional $10,000 a year. Contact Jerry Chambers, Personnel Management Specialist, NCI Personnel Office, Bldg 31 Rm 3A32, Bethesda, MD 20892, phone 301-496-6862. Applications, with CVs and bibliographies, must be postmarked no later than Sept. 30. . . . **DONALD SQUIBB** has joined the staff of the Univ. of Texas System Cancer Center as executive director of the University Cancer Foundation to coordinate a program for private fund development.

Suggestions On How To Meet Needs Of "Cancer Industry" In 1990s Offered

(Continued from page 1)

Anderson has assumed a leadership role in developing strategies for meeting those problems.

Anderson summarized those problems and recommendations in addressing the recent meeting of the Assn. of American Cancer Institutes. Entitled, "Strategic Considerations for the Optimal Integration of the Cancer Industry into the Health Care Systems of the 1990s," the presentation first listed "Deficiencies in Cancer Industry Development for Dealing with the 1990s Health Care Industry:

"1. We have too long competed (for image, reputation and dollars) and not developed united positions on issues or plans.

"2. We have parochialized and weakened our influence.

"3. We have used the old definitions of quality care, quality physicians, quality programs, quality research too long, and without considering new definitions of quality.

"4. We have failed to cost account our specialty.

"5. We have not educated society to our real value.

"6. We have concentrated too much on the federal government, Congress, and the National Cancer Institute, and too little on state legislatures, insurance companies, business, PPOs, HMOs and other health care payers.

"7. We've made research sound too esoteric to be readily understood and supported as necessary for clinical care.

"8. We've not figured out how to optimize back and forth referrals to each other.

"9. We haven't maximized involvement of surgeons at all levels--general, thoracic, GU, gyn, neuro--in the overall cancer program.

"10. We haven't planned or developed adequate models for multisite care.

"11. We haven't adequately prioritized or limited clinical trials (lack of cost effectiveness and impact criteria).

"12. We've almost allowed high cost care to price us out of the competitive cancer care market.

"13. "We've accepted too high costs for drugs, diagnostic tests, radiotherapeutic equipment, diagnostic scanners, and too high indirect costs from our institutions.

"14. We may have trained too many oncologists, and we may have too many hospital based cancer treatment centers and programs.

"15. We've concentrated too much on inhospital technology and not enough development of outpatient, nonhospital, or home cancer technology."

Anderson listed as "needs of the cancer industry for moving into the 1990s:

"1. Cooperation and mutual united support of all components.

"2. Development of stage/site guidelines especially for common cancers, including surgery, and developing these guidelines in terms of utilization review, quality assurance, cost control and risk management.

"3. Costing and pricing of cancer interventions, treatment and research.

"4. Negotiating and contracting expertise for cancer care and for clinical trials with many types of managed systems.

"5. Group support and data for resisting nihilistic or parsimonious cancer management.

"6. Greatest need: the will to work together.

"7. Actuarialization of high quality cancer care, including clinical trials, for use in negotiating with insurance companies, HCFA, HMOs, PPOs, etc.

"8. Prioritization and reduction in number of trials.

"9. Prioritization of drugs, biologicals, radiation equipment, etc. to be tested.

"10. Oncology specialists need differential market advantage over cancer care by nononcologists.

"11. High quality care must successfully compete with mediocre, poor, nihilistic, nonspecialized cancer care. Choice as to diagnosis information given to patient, treatment alternatives, etc., cannot be left strictly to nononcologist oriented primary care gatekeepers.

"12. Informed consent must be given (in addition to the usual case where treatment is recommended) to diagnosed patients when no or minimal treatment or oncology referral is recommended by the gatekeeper.

"13. Prevention, screening and early diagnosis programs must be marketed to payers, as these are rarely included in subscriber benefit lists, or paid for.

"14. Plans to remove cancer care from the gatekeeper system, either by negotiating cancer specific rates added to premiums or establishing a 'cancer gatekeeper system.'

"15. Cancer programs, whether comprehen-

sive, community hospital based, free standing, or network, must negotiate with hospitals, drug/equipment suppliers, labs, radiology, based on lower costs, perdiems, commodity approaches, competitive purchasing.

Recommendations which may be considered, Anderson said, include:

*Focusing on integrating varied components and sites, rather than competition.

*Develop coalitions or equivalents.

*Develop standards, and standardization.

*Develop cost accounting and actuarialization technology for cancer.

*Develop priorities.

*Use the task force approach.

*Integrate surgery and surgeons into the programs better than has been done.

*Do some lobbying among managed health care plans, insurance companies, HMOs, PPOs, CMPs, HCFA.

*Develop screening, prevention and early diagnostic programs for payers.

*Use the influence and reputation of centers to publicly market high quality care and clinical trials.

*Develop data for negotiating, and develop and support expert neogiating and contracting teams.

*Develop appropriateness guidelines, utilization review, quality assurance, cost control, and risk management guidelines specific for cancer.

*Credential, guide, support, and evaluate various components of the cancer industry.

*Develop plans for oncology insurance company approaches, with capitation to avoid gatekeepers.

*Develop standards for uniform use by peer review organizations nationwide.

*Develop and adopt an oncology ethics code of some sort.

*Clarify for profit and not for profit relationships and include all in a coalition.

*Have various sites exchange and/or educate management personnel to optimize collaboration and skills.

Anderson listed as an example of change characteristics of "old" HMOs compared with those of "new" HMOs. The old:

--Distinctive competence, in managed health care; salary, capitation and contracts for MD reimbursement; group and staff models; local ownership and focus; stable ownership; comprehensive first dollar coverage; low utilization and low cost; internal quality controls; little marketing; and slow growth with little access to capital.

Comparable characteristics of the new HMOs:

--Distinctive competence; capitation, modified fee for service and dividends for MD reimbursement; IPA and network models; new national owners and focus; unstable ownership (corporate and capital decisions); flexible benefits and coverage; cost conscious management, with utilization, supplies, prevention, etc.; internal and system wide quality controls; aggressive marketing; incredible growth rates, with excellent access to capital.

Prediction Improvements To Increase Prevention Research Need: Greenwald

The revolution in molelcular biology, particularly sequencing the human genome, will so enhance the ability for precise prediction of cancer risk that it will "bring an extreme urgency for research on prevention," Peter Greenwald told members of the Assn. of American Cancer Institutes.

The director of NCI's Div. of Cancer Prevention & Control, describing what he called "institutional barriers to prevention," cited the reduction of the cancer control line item budget since 1980 and "filtering" of NCI's messages on prevention by NIH before they reach Congress.

"For the first time a large number of individuals will know their own likelihood of getting cancer, much as they now have some understanding of their survival probabilities once they have cancer," Greenwald said.

"The window of time between when we can determine risk and when we can do something about it will be a very difficult time in medical research. That window has to be shortened. It could be something like having a great number of people know they have AIDS antibodies or a family history of Huntinggton's disease with an inevitability of getting this devastating neurological condition. This generates tremendous impetus for focused research on prevention."

Noting NCI's considerable efforts and some successes in cancer prevention, Greenwald added, "Nevertheless, we must admit there are some institutional barriers to achieving prevention." Among them are:

*Congress. "Health prevention legislation is emphasized every year. Reading NCI's legislative language leaves no doubt of congressional intent." The NIH reauthorization bill created associate directors for

prevention at both NIH and NCI. But, "there is lack of attention to detail as to where in our budget the money must be to achieve prevention. The human cancer prevention and control line item of the NCI budget has decreased nine percent since 1980, while the NIH budget has increased 55 percent. NCI as a whole rose only 21 percent in six years, cancer centers only 22 percent. Of course, this means no increase when you take inflation into account.

"I believe Congress is willing to support cancer prevention, cancer centers, and cancer clinical trials," Greenwald continued. "But it must understand that we need a strong balanced effort with support of these areas as well as the vital RO1 research."

And why hasn't Congress received that message? Greenwald offers NIH as his nominee for chief obstructionist. After first saying he was "proud to be at NIH" and fully agreed with "Time" magazine that NIH is one of America's treasures, he waded in.

"To be honest, we do sometimes have a problem with NCI's initiatives in prevention being filtered as the message is carried forward to Congress or the Administration. The resource requirements and importance at times seem to get lost, particularly when it comes to human prevention research.

"My suspicion is that this comes from the very appropriate intent to give the highest priority to basic laboratory research. But these would not suffer by also providing impetus to prevention."

Greenwald cited as a third barrier his feeling that "prestige for scientists who work in prevention has been limited." To back that up, he observed that in the annual General Motors Awards for Cancer Research, in which separate awards are giving for basic science, diagnosis or treatment, and cause and prevention, all eight awards given in treatment since the program was started have gone to Americans. A majority of those in basic science also went to Americans. But only three of those in prevention were won by U.S. scientists.

"We certainly respect and encourage this outstanding work in prevention by our foreign colleagues. But I would hope you would encourage your own scientists and let them know that there can be glory in research on prevention. . . I believe that careful assessment of human prevention research will show it to be as scholarly, as creative, and as difficult as other forms of research, and as deserving of prizes," Greenwald continued.

Prevention scientists have talked of other barriers, including attitudes, hard money positions, and the need for a stronger prevention constituency," Greenwald said. "But attitudes are changing quickly to demand more prevention research, and the constituency is large and growing.

"One attitude concerns the scrutiny given innovations in prevention compared to other areas. In prevention, people tend to ask about cost effectiveness before the research is even done, rather than allowing the development of an effective method of prevention, then later working on reducing the costs. These seem to be less of a problem in other areas of research."

Some Successes

Examples of NCI's successes in prevention include, Greenwald said:

*The Cancer Prevention Awareness Program, which "is a great success. To take just the example of being willing to have a dialogue with industry, over 92 percent of adults in the U.S. have heard NCI's message on dietary fiber and cancer, an average of 36 times each. In addition to the cereal industry, other industries are responding. Leaner choices of meats are available, nonfat dairy products are available and some fast food chains are introducing salads and other healthful choices.

*"The tide of public opinion about smoking has changed. People no longer are willing to breathe the carcinogens from the smoke of others. A nationwide smoking intervention network has been established by NCI, consisting principally of the investigators of the cancer prevention and cessation intervention trials supported through the Smoking, Tobacco & Cancer Program. In this program, over $10 million was expended in FY 1985 with 49 percent of it going to projects conducted at institutions with cancer centers.

*"This year the women's health trial will intensively study the effect of a low fat diet on breast cancer incidence in a vanguard group of 300 women at high risk of breast cancer. Nine hundred more will be entered into the study this year and if the feasibility can be documented, the trial later will be expanded to 30,000 women. Investigators at Fred Hutchinson Cancer Center play a lead role in this program, which is a multi-institutional project.

*"Studies of the chemistry and function of dietary fiber, vitamin A and the carotenoids

in humans are under way. Studies are being designed to develop reliable biological markers to measure dietary compliance or earlier endpoints in chemoprevention trials. In all, 75 percent of the DCPC human and laboratory research projects in chemoprevention are projects in cancer centers.

*"A strong network for cancer control research in black populations has begun and the initial steps taken for a Hispanic cancer control program. Drew Univ. has received an award for a consortium planning application. In addition, contracts have been awarded for community studies in the black population to address health services access and utilization (avoidable mortality) and primary prevention (smoking).

*"The Div. of Cancer Etiology under the leadership of Dr. Richard Adamson has continued to maintain a very strong and innovative program in viral oncology, and in chemical and physical carcinogenesis. A strong tie has been encouraged linking biochemical and epidemiological research. This is a tie that I hope you will encourage at your own cancer centers."

Award Fee System Indicates How NCI Thinks FCRF Contractors Are Doing

Competition for the renewal of NCI's contracts at Frederick Cancer Research Facility has developed into a wide open affair, with NCI anticipating multiple entries in all five categories and with the major incumbent admittedly on the verge of being out of the running after firing its top two employees there (**The Cancer Letter**, Aug. 8).

A key feature of four of the five contracts--determining the profit each firm has received through an "award fee" system--offers some insight into the reason for all the competition: the stakes.

It also provides some indication on how well each of the contractors have been performing, although certainly not the only indicator in that regard.

Under the award fee system, costs covering specified services are paid separately, based on negotiated amounts. In addition, certain sums are established as available for the award fees. Every six months, an NCI group reviews the contractors' performances and authorizes payments of fees from the available sums for that six month period.

The contract for basic research, with Bionetics Research Inc., pays a fixed fee.

Here's how each of the award fee contractors have fared since the inception of their contracts in September, 1982.

Program Resources Inc. This is the big one, for operations and technical support, which will total $181 million over the five years of the contract. During the first three and a half years, ending with the last six month period at the end of March, a total of $8,287,901 was available for the award fees. PRI received $5,116,209, or 62 percent of the available money, leaving a little over $3 million on the table.

PRI started slowly, receiving only 53 percent of the available award fee in the first six month period, but steadily improved. During the last complete six month period, which ended March 31, PRI received 73 percent of the available fee.

The other three award fee contractors did considerably better, in terms of percentages, although their contracts were far smaller. The best performance on that basis was turned in by the smallest--**Data Management Services Inc.**, for scientific library services. DMS received $121,078 out of $133,886 available over the three and a half years, 91 percent.

Harland Sprague Dawley Inc., with the animal production contract, received $323,355 out of $398,897 for the same time period, 81 percent.

Information Management Services Inc., with the computer services contract, received $179,624 out of $220,921 available, also 81 percent.

IMS and DMS are small businesses, and the computer and library services contracts are small business set asides. Both have been determined as still qualifying as small businesses, permitting them to join in the recompetition.

To be fair in comparing PRI's performance with the others, the operations contract is so much larger and more extensive, with far more opportunities for things to go wrong. Also, with that much money at stake, NCI gave it intense scrutiny and probably was more critical of any problem areas.

Bionetics Research Inc. has received, through last March, $2,495,115 under its fixed fee contract. That works out to about $500,000 every six months for a total contract cost of about $3.8 million each six month period. The five year total will be $38 million.

How do the performances of the four award

fee contractors stack up against that of Litton Bionetics Inc. (now Bionetics Research Inc.), which held the contract for all services at FCRF during the first 10 years of NCI's presence there?

A complete comparison is not yet possible, since three performance periods remain on the present contracts. If PRI's steady improvement continues, that would lift the overall percentage for the current contractors. IMS also improved substantially, leaving only $3,500 of the available money in the last period after leaving $7,000 during the first six months. Harlan Sprague Hawley has left about $9,000 during each six months, although the percentage improved a bit. Likewise, DMS has left about the same amount, $2,000, each six months, but it isn't likely anyone will get much more than 91 percent out of the system.

Overall, the current contractors have received 63 percent of available award fees during their first three and a half years. Litton, during its last five years, from 1977 to 1982, received $4,013,393 out of $5,565,565 available, for a 72 percent record.

Hatch Committee Clears Bill Blocking OMB's "Apportionment"

Technical amendments to the National Cancer Act, one of which will block the White House and its Office of Management & Budget from micromanaging NCI through what has become known as "apportionment," were approved last week by the Senate Labor & Human Resources Committee.

Originally, the National Cancer Act of 1971 contained a provision which stated that NCI "shall" receive its annual appropriations directly from the President and OMB. When the Act was renewed in last year's biomedical research reauthorization, "shall" was changed to "may." That permitted OMB to lump NCI's appropriations with those of the rest of NIH, giving OMB and the NIH director the opportunity to play games with the money. For instance, they have decreed that funds may not be transferred from one budget category to another without OMB's permission. That has tied Director Vincent DeVita's hands and reduced his flexibility in moving money around to take advantage of new research opportunities or to make the best use of funds left over near the end of the fiscal year.

DeVita and his staff have been so outraged by the whole thing that they have been moved to campaign openly for a remedy, a risky business when you hold your job at the pleasure of the person you are, in effect, campaigning against. OMB is an office reporting directly to the President.

The bill reported out of Sen. Orrin Hatch's committee changes "may" to "must." That should do the job, if the legislation makes it all the way through. There is some doubt about that--the White House, HHS and probably NIH will oppose it, and it still must clear the full Senate and the House. Congressman Henry Waxman (D.-CA), chairman of the House Health Subcommittee, reportedly will go for it only if it is made applicable to all NIH institutes, and that would generate even stronger opposition on the part of NIH brass and HHS.

The Hatch "technical" amendments also clarify a few other issues created in the renewal authorization. It specifically gives NIH institute directors authority to appoint members of their peer review groups, an authority clearly given in the Cancer Act originally. Without it, appointments to NCI review groups would have to clear the NIH director, a process that could add delays and other hangups.

Another amendment would make it clear that ex officio members of the National Cancer Advisory Board are nonvoting members. That problem came up at the last NCAB meeting, when it was noted that the new authorization would permit them to vote. Ex officio members are all representatives of government agencies with some interest in cancer research, and most NCI executives and their advisors do not feel it is appropriate to let them vote, particularly on grants.

Finally, an amendment will add a representative of the Dept. of Energy, the director of the Office of Energy Research, as an ex officio NCAB member.

Those wishing to help generate support for the amendments should contact their own senators and representatives as well as Waxman, other members of his subcommittee, and Chairman John Dingell (D.-MI) of the parent Energy & Commerce Committee.

Another bill with special importance to cancer centers will be considered when Congress returns from its recess in September.

This is a measure supported by the Assn.

of American Cancer Institutes which would amend prospective payment legislation to broaden exemptions for cancer centers.

The legislation creating Medicare prospective payment in 1983 contained a provision requiring HHS to make exceptions for hospitals involved extensively in cancer treatment and research. HHS did not follow the express intent of Congress and instead severely limited exceptions, resulting in exemption of only eight institutions.

The new bill would specifically exempt any institution recognized by NCI, presently and in the future, either as a comprehensive cancer center or clinical cancer research center, which would include about 38 institutions. It would direct that those institutions be reimbursed, without limitation, for the actual reasonable cost of inpatient hospital services.

The bill will be introduced by Sen. Daniel Moynihan (D.-NY), who plans to attach it to a package of other items put together by the Finance Committee, which has jurisdiction over Social Security and Medicare legislation. A Moynihan aide said the package would be brought to the committee in September.

NIH Investigating Leak Of Cohn's Medical Records To Jack Anderson

NIH officials are investigating how the "Washington Post's" syndicated columnist Jack Anderson and his associate Dale Van Atta obtained copies of attorney Roy Cohn's NIH medical records.

Best known for his role as the prosecutor of Julius and Ethel Rosenberg and then chief aide to Sen. Joseph McCarthy during his investigations of alleged communist subversion in the 1950s, Cohn died Aug. 2 at the NIH Clinical Center, one week after Anderson and Van Atta reported that he was receiving the investigational drug azidothymidine given patients with acquired immune deficiency syndrome.

NIH gave the cause of Cohn's death as cardiopulmonary arrest, with dementia and underlying HTLV-3 infections listed as secondary causes.

Headlined "NIH Treated Roy Cohn for AIDS," the July 25 Anderson column quoted from Cohn's medical record from the Clinical Center, giving details such as the time and date of his first admission, and the name of his attending physician. It also quoted from his records for readmission June 2, stating that Cohn was receiving 20 mg per day of the drug azidothymidine, "approved only for use on AIDS patients." It also cited a June 6 discharge planning summary that reportedly advised he be "given ample time for processing of information" and should "be given one command at a time."

The article also noted that "more than 70 percent of adult AIDS victims have been homosexuals or bisexuals."

NIH has not yet determined who leaked the medical record, but has assigned an investigator to try to find out. Although an article appearing in the "Washington Post" reported that unnamed NIH officials were considering bringing charges against Anderson and Van Atta for publishing the records, an NIH spokesman told **The Cancer Letter** that NIH there are no plans for such action now. The Post" article quoted Van Atta as saying he would welcome legal action by NIH because he thinks it would set a precedent for allowing journalists to quote from medical records, especially those of public figures.

Once Anderson obtained the medical records, he was protected by the First Amendment, Art Spitzer, legal director of the American Civil Liberties Union of the National Capital Area, told **The Cancer Letter.** "Doctor-patient privilege is an important thing," he said. "Maintaining the confidentiality of medical records is of significant civil liberties' interest." Spitzer said that if NIH discovers that someone from its staff turned the medical records over to the columnists that NIH can then take action against the person for violating patient confidentiality rules.

In the column, Anderson and Van Atta explained their reasons for the breach of confidentiality by saying that Cohn had tried to avoid being disbarred by New York in June by saying he was dying of liver cancer. The article in the "Post" quoted Van Atta as saying, "If I had all the records of all the people that have AIDS, I wouldn't print a word of it. But Roy Cohn is a special case because he made a public issue of his dying."

At NIH, only persons directly involved in a patient's care are supposed to have access to medical records. When a patient is on a unit at the clinical center, only authorized personnel may obtain the chart from the nursing station. Medical records are available to patients who show their patient identification cards, and may be released to others only with a release signed by the patient.

Title: Application of shuttle vectors and related technology to study the mechanisms of DNA damage, repair, and cell sensitivity to ionizing radiation

Application receipt date: Oct. 15

NCI's Div. of Cancer Etiology invites grant applications which utilize recent developments in recombinant DNA techniques to investigate the mechanisms of damage, repair and sensitivity of mammalian cells to ionizing radiation.

The goal of this RFA is to encourage research that will result in new techniques, approaches, and information which will advance knowledge about the specific mechanisms of radiation induced damage and repair, and the relationship of such processes to cell killing, developmental changes, and neoplastic transformation. Emphasis is placed on sensitive and specific quantitation of various DNA lesions(e.g., base substitutions, deletions, rearrangements, etc.) and the ability to carry out experiments on various cells in culture such as normal human fibroblasts, cells from patients with various radiation sensitive syndromes (including ultraviolet sensitivities), or mouse cells from inbred strains that are radiation sensitive or resistant.

Objectives would include but not be limited to the use of shuttle vectors and related technology as follows:

1. To determine the damage to shuttle vector marker genes when they are irradiated inside or outside of the cell and in the presence or absence of agents which alter their physicochemical response to radiation.

2. To measure the dependence of damage/repair processes on dose, dose protraction, and radiation quality, or to measure the combined effects of ionizing radiation with other agents such as promoters, other chemicals, or nonionizing radiation.

3. To devise methods to distinguish between mutations arising at the point of DNA damage from mutations which arise in initially undamaged areas of DNA as a consequence of DNA damage elsewhere in the genome.

4. To investigate physiologic and genetic factors of host cells that influence mutagenesis or transformation such as host cells which have a genetic susceptibility or resistance to radiation, or cells which manifest cancer proneness.

Awards will be made as traditional NIH research project grants. The maximum period for application is three years. It is anticipated that at least three individual research project grants will be awarded for the first year assuming the applications are of high scientific merit.

The concept from which this RFA was derived was approved by the DCE Board of Scientific Counselors at its winter meeting and reported in **The Cancer Letter** Feb. 28, page 2.

Copies of the complete RFA and additional information may be obtained from Raymand Gantt PhD, Low Level Effects Radiation Branch, DCE, NCI, Landow Bldg Rm 8C-19, Bethesda, MD 20892, phone 301-496-5266.

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-EB-71002-21
Title: Mortality study of workers exposed to methylene chloride

Deadline: Approximately Oct. 25

The Epidemiology & Biostatistics Program in NCI's Div. of Cancer Etiology is seeking a contractor to provide technical support to abstract occupational history data, perform vital status tracing, obtain death certificates, conduct industrial hygiene monitoring, develop historical exposure estimates, obtain pathology materials, conduct interviews, collect samples for biological monitoring and provide data management services.

A minimum population of 10,000 workers exposed to methylene chloride is being sought for this study. The subjects will come from approximately 15-20 plants located throughout the U.S., Canada (Edmonton) and England (Runcorn, Bexford Falls). The primary objectives are:

A. To determine the cancer mortality experience of workers exposed to methylene chloride and to compare this with cancer mortality of both the U.S. general population and with an industrial group with little or no methylene chloride exposure.

B. To obtain sufficient exposure estimates to allow an evaluation of dose response relationships for causes of death. This will require industrial hygiene sampling of current levels of methylene chloride and othr solvents in the workplace as well as obtaining monitoring data done in the past and describing historic conditions.

C. To evaluate the role of methylene chloride taking into consideration the effects of other chemical exposures which may be present at the workplace, as well as factors such as age, sex, race, cigarette smoking and alcohol consumption upon cancer mortality.

D. To evaluate the delivered tissue dose by examining blood levels of methylene chloride and carboxyhemoglobin, which is formed from carbon monoxide, the major metabolite of methylene chloride.

This contract will be a 100% small business set aside with a size standard of 500 employees.

The concept from which this RFP was derived was approved by the DCE Board of Scientific Counselors at its spring meeting and reported in the June 27 issue of **The Cancer Letter**, page 4.

Contract Specialist: Barbara Shadrick
RCB Blair Bldg Rm 114
301-427-8888

CORRECTION

The synopsis of RFP NCI-CP-61064-60, Laboratory rodent and rabbit facility for the Laboratory of Cellular Carcinogenesis & Tumor Promotion, published in **The Cancer Letter**, Aug. 8, should have been listed as a 100% small business set aside, with a size standard of 500 employees.

The Cancer Letter _Editor Jerry D. Boyd Associate Editor Patricia Williams

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