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## Administration Asking $233 Million Less For NCI In FY '88 Than Congress Is Appropriating For '87

The final NCI spending total for the 1986 fiscal year is in; the level for FY 1987 is shaping up, although the threat of Gramm-Rudman-Hollings sequestration hovers darkly over it

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*In Brief*

## Marasco New ACR President, Barbara Chick VP; Wolmark Named Surgeon In Chief Of Montefiore

**JOSEPH MARASCO**, director of radiology at the Forbes Metropolitan Health Center in Pittsburgh, was elected president of the American College of Radiology at the college's annual meeting in Baltimore. **Barbara Chick**, consultant in radiology at Glen Falls, NY, Hospital, was elected vice president, the first woman to hold an ACR office. **Thomas Meaney**, Cleveland, was elected chairman of the ACR Board of Chancellors and Franklin Angell of Baltimore was elected vice chairman. Chancellors elected to three year terms, in addition to Angell, were Carl Bogardus, Oklahoma City; and Michael Lopiano, Ventura, CA. John Tampas, Burlington, VT, and John Lohnes, Cedar Rapids, were reelected to three year terms and Tampas will serve as secretary treasurer. Elected to one year terms were Karl Wallace, Virginia Beach, VA, and Murray Janower, Worcester, MA. . . . **NORMAN WOLMARK** has been appointed surgeon in chief of Montefiore Hospital in Pittsburgh. Wolmark is director of surgical oncology at the Univ. of Pittsburgh School of Medicine, associate director of the Pittsburgh Cancer Institute, and National Surgical Adjuvant Breast & Bowel Project executive medical officer. . . . **ROBERT ENCK**, principal investigator for the Binghamton, NY, Community Clinical Oncology Program, has left Lourdes Hospital there to become director of the Riverside Methodist Hospital Regional Cancer Center in Columbus, OH. Enck is president elect of the Assn. of Community Cancer Centers. **Bruce Boselli**, of Guthrie Clinic in Sayre, PA, which is part of the Binghamton consortium, is the new PI of the CCOP. . . **TUMOR REGISTRY** Training Program sponsored by the Cancer Research Institute of the Univ. of California (San Francisco), will observe its 25th anniversary Nov. 13. It is the only regularly scheduled program of training for staff of hospital and population based cancer registries in the U.S. The symposium this year will honor David Wood, director emeritus of the Cancer Research Institute. Calvin Zippin is director of the training program.

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## OMB FY 1988 Figure For NCI Set Tentatively At $1.167 Billion

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all; the Administration's unrealistically low recommendation for FY 1988 is in; and NCI's bypass budget request, perhaps equally unrealistic, has been sent to the White House.

Little wonder that the Washington budget making process seems to defy logic. Take the tentative figure now being considered by the White House Office of Management & Budget for the 1988 fiscal year, for example. Unless NCI can, through the established appeals process, convince OMB to revise it upward, the President will ask Congress, late in January, for $1.167 billion for NCI in the fiscal year that starts Oct. 1, 1987.

That amount is $233 million less than the total being appropriated this week by Congress, which will be close to $1.4 billion. And it is a whopping $533 million less than the $1.7 billion that NCI submitted last month to the White House in its annual "bypass budget."

The President's budget is supposed to be kept under wraps until it goes to Congress, but it is widely discussed within the Administration and various advisory bodies before then. It was discussed at a closed meeting Monday of the National Cancer Advisory Board's Committee on Planning & Budget.

Nearly every category of NCI supported programs would be slashed under the OMB recommendations. Also, once again the White House has ignored the bypass budget request for substantial funding of extramural construction grants and asked for no money for construction or renovation.

The good news is that Congress usually ignores the White House budgets for NCI, and the final 1988 level most likely will be much closer to the bypass budget than to OMB's figure. The year just ended, 1986, is an example, and 1987 could be even better if the massive catchall spending bill Congress will produce this week escapes the veto and GRH axes.

NCI wound up with $1.228 billion in the fiscal year, 1986, which ended Sept. 30. That included $45 million for AIDS research. The OMB original request was $1.126 billion. The increase of more than $100 million was after NCI had taken a $53 million cut due to GRH sequestration.

The White House asked for $1.158 million for FY 1987 (without AIDS); Congress will appropriate between $1.336 and $1.347 billion, plus another $61 million for AIDS. Unless next month's election radically changes the complexion of Congress, there is no reason to believe that it will not continue to provide far more adequate Cancer Program funding in 1988 than requested by the White House.

The fiscal year ended Sept. 30 without any regular approprations bill being completed by Congress. A stop gap, one week continuing resolution kept the government funded at 1986 levels while the lawmakers put together a massive, $550 billion continuing resolution to fund all agencies for the rest of the fiscal year. That wrapped up all the appropriations measures into one. The House bill called for spending at levels in the regular House passed appropriations bills, the Senate's at the levels in the Senate bills. Conferees were working out the differences at **The Cancer Letter's** press time this week. The members hoped to finish work and send it to the White House by this weekend (Oct. 10-12), so they can adjourn.

The President was threatening to veto the measure if it is not changed somewhat more to his liking. Response of Congress in that event is uncertain; the House passed its version by only one vote, so a veto override is unlikely. If Congress won't produce a bill President Reagan will accept, it could adopt another short term continuing resolution, funding the government until, say, Nov. 15, and return for a lame duck session to finish work on appropriations for the rest of the year.

### Payline Goes Up

The priority score payline for NCI competing research project grants (RO1s and PO1s for the most part) would be restored to more respectable levels under either the House or Senate figures for 1987. The payline for 1986 was 164, when 34 percent of approved competing grants were funded (a total of 951). That was down from a payline of 173 in 1985, when 1,017 competing grants, 36 percent of approved, were funded.

Under the House bill, the payline would be 175 in 1987; 172 under the Senate's. The House figure would fund 38 percent of approved grants, the Senate's, 37 percent. The House figure would support 1,060 competing grants, the Senate's 1,020.

None of those figures include grants that would be supported with the $61 million in AIDS money allocated to NCI in the Senate

bill. The House awarded the same total amount of AIDS research money to NIH, and NCI probably would get approximately the same in the distribution as called for by the Senate.

Here's how the House and Senate figures for 1987 break down by other mechanisms and categories, compared with 1986 (all without AIDS money):

*Cancer centers--1986, $88.3 million; House, $92.3 million; Senate, $93.9 million.

*Clinical cooperative groups--1986, $49.3 million; House, $50.1 million; Senate, $50.1 million.

*National Research Service Awards--1986, $124.6 million; House, $31.7 million, Senate, $31.8 million.

*R&D contracts--1986, $124.6 million; House $153.6 million, Senate $154.8 million.

*Intramural research--1986, $199.9 million; House, $208 million; Senate, $213.9 million.

*Cancer prevention and control--1986, $61.2 million; House, $66.3 million; Senate, $63.3 million.

*Construction--1986, $1.9 million (all of which went for construction/renovation at Frederick Cancer Research Facility); House, $4 million; Senate, $2 million.

*Research management and support--1986, $57.7 million; House, $59.8 million; Senate, $59.6 million.

Total funding of research project grants, again without AIDS, was $547.9 million in 1986; would be $659.5 million under the House bill, $646.6 million under the Senate's.

### Further Cuts

Two Administration proposals for FY 1987 would take further whacks out of NCI's budget. The President's drug abuse program would be supported by transferring funds from various agencies. NCI's share of the $88.3 million which would be reprogrammed out of NIH would be $15.2 million. That would come out of research project grants ($4.3 million, with a reduction of 26 in the number of awards); cancer centers ($8.6 million, with a reduction of 13 in the number of awards) and NRSA ($2.3 million, with a reduction of 94 trainees).

NIH also was proposed for an $83.1 million bite to cover transfer of funds from other programs to support AIDS projects. This would include $56 million which the various institutes would reprogram from other research to cover their own AIDS activities; of this, NCI's total would be $14.5 million. NIH also would have to give up $27.1 million to other agencies, including $600,000 from NCI.

Congress resisted both of those schemes, although the final action had not been taken at press time. Both houses added the AIDS money without requiring reprogramming, and neither house appeared to favor the White House proposal for funding the drug abuse program.

**The spectre of GRH sequestration continues to threaten the Cancer Program.** Carried out to its worst possible scenario, it would make all the other cuts seem like peanuts.

The October deficit estimate, the second look at the FY 1987 budget as required by the GRH deficit control act, had not changed from the first estimate made in August. This week, a deficit of more than $160 billion was forecast, close to the August projection. That would trigger the automatic sequestration of funds from agencies across the board. If that is allowed to stand, NCI's total budget would be $1.112 billion, no matter what the final congressional appropriation turns out to be.

A reduction approaching $300 million would be devastating and probably would be considered unacceptable by Congress. In fact, most observers believe that Congress will do whatever it has to do to avoid sequestration this time. That still could mean some modest reductions in programs favored by Congress, with heavier cuts in more vulnerable areas. Most members probably would go for a small tax increase to avoid sequestration, but President Reagan has said he would veto that.

### The Bypass Budget

More pleasant reading is the bypass budget which NCI sent to OMB in September. This budget, which gets its name because it goes directly to the President without giving NIH or HHS a chance to cut it (although they may comment on it), is a creature of the National Cancer Act of 1971. It was intended by Congress to be the Administration's budget submission for NCI, with the White House having the opportunity to adjust it up or down, within reason. Instead, every Administration since Richard Nixon's has ignored it (as did Nixon his last two years in the White House). The budgets they have sent to Congress include amounts for NCI hammered out by NIH and HHS executives, who must deal with all the competing health demands--exactly what the framers of the National Cancer Act had thought they were avoiding. It was clearly their intention that the extra money

being directed to cancer research was to be considered as additional money added to the pot for health programs--not money for which all other health constituencies could compete.

Fortunately, Congress has paid some attention to the bypass budget, at least more than the White House has.

They FY 1988 bypass budget request submitted last month totaled $1.7 billion, up $150 million from the preliminary bypass budget presented to the National Cancer Advisory Board last May (**The Cancer Letter**, May 30). Briefly, here is what it would do:

--Fund 45 percent of approved research project grants at full recommended levels.

--Increase the number of cancer centers by 50 percent by 1992 (assuming subsequent budgets would continue to provide increasing funds for centers). Core grants would be funded at recommended levels.

--Increase support for cancer prevention and control by 50 percent over the current level, and triple this effort by 1992.

--Double the number of patients treated by clinical groups by 1992. Cooperative groups would be funded at recommended levels.

--Support 1,500 trainees through NRSA.

--Provide $50 million for starting the mapping and sequencing of the human genome.

--Provide $10 million for instrumentation grants.

--Add $30 million for AIDS research.

--Provide $35 million for construction and renovation grants.

The bypass also requests two year obligating authority for funding the genome special initiative and for construction.

Here's how the bypass budget breaks down by budget activity, with the 1986 actual figure in parenthesis:

Cause and prevention, $402.7 million ($288.3 million); detection and diagnosis, $107.7 million ($77.6 million); treatment, $520.8 million ($365.3 million); cancer biology, $312.1 million ($246.1 million); cancer centers, $118.2 million ($83.3 million); research manpower development, $52.9 million ($43 million); construction, $35.8 million ($1.9 million); cancer prevention and control, $99.8 million ($63.2 million).

The breakdown by research program, again with 1986 levels in parenthesis:

Epidemiology, $89.6 million ($66.2 million); chemical and physical carcinogenesis, $150.6 million ($108.1 million); biological carcinogenesis, $144.3 million ($105 million); nutrition, $45 million ($29 million); tumor biology, $194.3 million ($154.4 million); immunology, $116.5 million ($90.7 million); diagnostic research, $88.5 million ($62.6 million); preclinical treatment, $260.4 million ($176.8 million); clinical treatment, $248 million ($180.6 million); rehabilitation, $6 million ($4 million).

The bypass budget also includes a breakdown by funding mechanism, including $713.3 million for total of research project grants, compared with $549.8 million in 1986; $78.7 million for cooperative groups; and $96.2 million for prevention and control.

The 113 page document includes a brief description of each program area, the current state of each, accomplishments and impending plans. The narrative makes a strong scientific case for additional funds in each of the program areas.

"The achievements and progress directly attributable to the National Cancer Program constitute a record which is a source of great pride to all those involved in the entire cancer research effort," NCI Director Vincent DeVita wrote in a preamble to the budget.

"The sections which follow tell a detailed story of progress over the recent past which has resulted from painstaking probing of the very foundations of life itself. But NCI's investment in fundamental biomedical science has begun to pay off in very practical terms; the whole question of cancer has been transformed from a complex, unintelligible enigma to a lively and exciting area of pursuit and is tantalizingly close to being a solvable problem.

"I firmly believe that much of the credit for having reached this level of opportunity, and for the revolution in technology and biology which has brought it about, belongs squarely to support from NCI, made possible through the Congressionally mandated National Cancer Program. NCI's commitment to basic biological research is obvious when one considers that, although NCI represents only 23 percent of the total National Institutes of Health, it supports over half of all molecular biology supported by NIH. . . Although the precise time when we will reach the outright ability to cure or prevent all cancer is not firm, a solid foundation exists for this confidence that we are quickly and inexorably approaching that point."

## Sixty CCOPs Could Cost $16 Million; DCPC Staff Thinks It Could Get It

NCI staff is now estimating that to fund 60 Community Clinical Oncology Programs in the recompetition now under way, considering that cancer control research has been added as a required activity in addition to the primary mission of placing patients on treatment protocols, a total of $16 million a year will be required.

That is about $7 million more than the program has been costing, for the same number of CCOPs. NCI previously had indicated that funding would be held at the same, $9 million a year level during the first four years of the program. The number of awards would have to be reduced, depending on the additional cost of the cancer control components.

That still is all that is listed in the Div. of Cancer Prevention & Control budget for CCOP, but DCPC staff feel that (1) they will get enough good, strong, applications with high priority scores to (2) convince the NCI Executive Committee that $7 million should be "reprogrammed" (or "identified") so that at least 60 awards can be made.

After reviewing 130 letters of intent, and meeting with representatives of potential CCOP research base applicants, CCOP Coordinating Program Director Robert Frelick found that some were still unclear about certain aspects of the competition and that several questions had been raised.

Some of the letters "reflected a lack of understanding of the 'critical mass' of patient resources, investigators, facilities and data personnel typically found in a successful CCOP," Frelick wrote in memo sent to applicants. "It is unlikely that a CCOP will be able to accrue to research studies more than 7-10 percent of the number of new cancer patients seen per year in the CCOP institution(s). Patient resources may be expanded through consortial arrangements with other institutions, especially if there has been a previous working relationship."

Answering a question on research bases, Frelick wrote, "An affiliation with a pediatric research base will not count toward the five affiliations allowed in the RFA. Thus, a CCOP may affiliate with one national multidisciplinary cooperative group, a total of four specialty groups or cancer center bases, and a pediatric group. In selecting a research base, consideration should be given to whether it has protocol resources appropriate for the patient mix seen by the CCOP participants."

Frelick said that most of the clinical cooperative group0s listed in the CCOP RFA are expected to submit research base applications. Also, letters of intent to submit a CCOP research base application have been received from the following cancer centers and state health departments, who gave permission that there intentions could be made public:

Cancer centers (with PIs and phone numbers):

Yale Univ., Carol Portlock, 203-785-4110; Illinois Cancer Council, Shirley Lansky, 312-346-9813; Dana-Farber, Brad Patterson, 617-732-3480; Univ. of Rochester, John Bennett, 716-275-4915; Columbia Univ., Rose Ruth Ellison, 212-305-6730; Ohio State Univ. (cancer control only), C.J. Cavalaris, 614-422-1382; Fox Chase, Paul Engstrom, 215-728-2986; Fred Hutchinson, Fred Appelbaum (treatment), 206-467-4412, and Maureen Henderson (cancer control), 206-467-4678; Univ. of Texas M.D. Anderson, Rodger Winn, 713-792-2370; UCLA (cancer control only), Ellen Gritz, 213-825-8444; Memorial Sloan-Kettering, Jon Kerner, 212-794-6998; Northern California Cancer Program, Theodore Phillips, 415-591-4484; Bowman Gray, Robert Capizzi, 919-748-4464; Univ. of Southern California, Franco Muggia, 213-224-6677.

State health departments:

Main, Greg Bogden, 207-289-5378; and Minnesota, Don Bishop, 612-623-5000.

Frelick addressed issues and questions raised at the meeting of research base representatives:

1. Will the initial review group be responsible for review of the science of the proposed cancer control studies included in the research base applications?

A. The initial peer review will be concerned primarily with the potential for the research base to conduct multi-institutional trials, availability of appropriate expertise to develop cancer control protocols, ability to provide the necessary data support and statistical analysis for studies which seem to be appropriate for CCOP use, and the ability to attract CCOPs willing to work with them. A study must be approved by NCI (DCPC/DCT) before the protocol is implemented.

2. Review of cancer control concepts, protocols, and companion studies to current treatment protocols A. All new concepts and

protocols will be sent to Linda Hogan, head of the Protocol and Information Office, CTEP, Div. of Cancer Treatment, NCI Landown Bldg Rm 4C33, Bethesda, MD 20892.

Concepts or protocols which include only cancer control will be triaged by the Protocol Information Office to DCPC for review. Treatment protocols will be reviewed by the Cancer Therapy evaluation Program of DCT, as they are now. Mixed or companion studies will, as a rule, be reviewed by CTEP with participation by appropriate DCPC personnel.

3. Cancer control protocol review in DCPC.

A. An intramural protocol review committee will review the protocols for cancer control studies referred to DCPC. Extramural consultants will be utilized when additional expertise is needed for a specific protocol. Protocol design, feasibility, quality of the study, significance of the questions, and possible duplication of research already in progress will be considered by the review committee.

Cancer control concepts will be accepted for review after Dec. 1, 1986. Cancer control protocols will be accepted for review after Jan. 15, 1987.

4. Will concept review of proposed cancer control protocols be similar to the letter of intent/concept review system now in use by CTEP?

A. Yes. The acceptability of a proposed intervention for a cancer control research project will be determined when the concept is reviewed. The CCOP program staff will be responsible for the review of concepts. A format for submission of concepts will be available.

5. If a cancer control protocol has already been developed, does a separate concept have to be prepared or can the protocol itself be submitted for the preliminary concept review?

A. If the protocol has already been developed, it may be submitted for concept review in lieu of writing another document. If the concept is approved, the usual procedure for protocol review will be followed.

6. Will the protocol review committee review NCI approved studies already implemented through other funding mechanisms?

A. After a research base has been approved for funding, one list of currently active studies may be submitted prior to Aug. 1, 1987, with a request for approval for CCOPs. Subsequent reviews will be prospective.

7. What about the review of cancer control pilot studies?

A. In order to monitor progress in development of cancer control research and assign appropriate credit, concepts for all cancer control pilot studies must be approved by DCPC. The format for submission will be the same as for other studies. It should be recognized that the primary purpose of CCOP is participation of physicians in phase 2 and 3 treatment studies and NCI approved cancer control protocols.

8. Protocol credits.

A. When a protocol is submitted for review, the protocol authors and research base staff will be expected to suggest the appropriate credit for accrual, based on the time and effort needed to conduct the study. The credit assignment should be a reflection of the data manager requirements, type of intervention, physician time, and duration of the study. Guidelines included in the CCOP RFA--1 credit for a phase 3 study, .7 for a phase 2 study, and up to 2 credits for a complicated pediatric acute leukemia study. When each treatment or cancer controlo protocol is approved, DCPC program staff will review the credit suggestions and assign the allowable credit. This process should assure comparable credit for protocols from the various research bases.

9. Will epidemiological studies be appropriate?

A. Purely descriptive studies are considered phase 1 cancer control hypothesis development and will only be acceptable if the epidemiological study points to specific interventions for subsequent studies. Such proposed interventions should be economically and socially feasible.

10. Are studies in health practices and economics appropriate for cancer control interventions?

A. Yes, if specific and the results are usable (e.g., how frequently should bone scans be done in following women with breast cancer and does this information influence the behavior of physicians?). A study of how to improve the measurement tools in quality of life studies in order to use the results to persuade Blue Cross to change overall payment policies would not be specific enough.

11. Research base budgets for add on operational and statistical costs for managing CCOP accrual should be based on anticipated funding of approximately $400 (direct costs) per credit. Although the initial review com-

mittees will consider the appropriateness of budget requests, final funding decisions for the research bases will be made by program staff after determination of expected accrual from the funded CCOPs.

12. How will cooperative group members and other research base affiliates be able to participate in the cancer control studies being proposed for the CCOPs?

A. Participation of funded members and affiliates will be supported through the research base cancer control committee. Cancer control committee budgets may include requests for funds for development of pilot stsudies, administrative staff (not more than 10% FTE), travel and consultant resources, and funding for non-CCOP investigators eligible to participate in cancer control stsudies.

13. Can a cancer center apply to be a research base for cancer control only?

A. Yes. A cancer center may be a research base for treatment and/or cancer control research. They cannot be a research base for only treatment research. A CCOP may affiliate with more than one cancer center.

14. Can a CCOP be recruited to participate in a study that is especially appropriate for that CCOP, even though it is not affiliated with the research base sponsoring the study?

No. A CCOP can enter patients on study only through its affiliated research bases. Cancer control inter-research base sstudies will be encouraged. If desirable, DCPC will assist in establishing communication links.

15. How will the Clinical Cancer Investigation Review Committee look at cooperative groups which become involved in cancer control research efforts? Will this have an adverse effect on a group's performance evaluation?

A. CTEP is in the process of revising the current CCIRC guidelines and will take the above into consideration. It is recognized that additional disciplines sensitive to cancer control issues may be needed on the CCIRC; they may be added by the use of ad hoc members for a specific review or regular members of the committee as membership rotation occurs.

## Eleven Contracts Awarded For Big Community Project On Heavy Smokers

Eleven contractors have been selected for participation in the first phase of NCI's $30 million, seven to eight year project aimed at helping heavy smokers kick the habit.

The project is being supported by the Div. of Cancer Prevention & Control because (1) most of the smoking related malignancies occur among those are considered heavy smokers, and (2) heavy smokers have far less success in cessation efforts than do those who are light to moderate smokers.

Phase 1 of the project will be a one year planning period, with the results then to be presented to the DCPC Board of Scientific Counselors. That Board will decide then whether to proceed with the second, implementation phase, "where the realy money will be spent," according to DCPC Deputy Director Joseph Cullen. Implementation will involve large community trials, "the largest ever done in smoking," Cullen said.

Phase 2 will require five to six years, and followup and analysis will require one to two years.

Eight of the 11 contractors received multimillion dollar awards, but only $50-80,000 will be initially committed to each for the planning phase. Three more received only the one year planning commitment; they could receive implementation awards if the project is taken into phase 2 and if the funds are available.

Each contractor in phase 2 will conduct clinical trials in two matched communities. DCPC would prefer that 22 communities be involved, but would settle for 16.

The eight with the full awards are American Health Foundation, New York, $4.4 million; Univ. of Iowa, Iowa City, $3.2 million; Kaiser Foundation Research Institute, Oakland, $3.6 million; Univ. of Massachusetts, Worcester, $4.3 million; Oregon Research Institute, Eugene, $3.1 million; Research Triangle Institute, Research Triangle Park, $4.1 million; Roswell Park Memorial Institute, Buffalo, $3.4 million; and Univ. of Waterloo, Ontario, Canada, $3 million.

The three with the planning awards are Univ. of Medicine & Dentistry of New Jersey, Newark, $53,750; Lovelace Medical Foundation, Albuquerque, $65,768; and Fred Hutchinson Cancer Center, Seattle, $78,876.

Awards also have been made in another multiyear, multimillion project for research on avoidable mortality from cancer in Black populations:

Michigan Cancer Foundation, $1.9 million; Univ. of Texas Medical Branch, $2.9 million; Charles R. Drew Medical School, $1.3 million;

Cornell Univ. Medical College, $1.8 million; Bowman Gray School of Medicine, $1.2 million; and Morehouse School of Medicine, $1.4 million.

Four awards were made for primary prevention of smoking in Black populations:

Hektoen Institute for Medical Research, Chicago, $$2.5 million; Univ. of Kentucky, $1.7 million; Univ. of Massachusetts, Amherst, $2.5 million; and Illinois Institute of Technology, $589,487.

Westat Inc., Rockville, MD, received A five year, $1.2 million contract for minority research programs analytic support and quality control.

In another big DCPC project, 13 contracts were awarded for chemoprevention animal studies:

DMBA induced epidermal tumorigenesis, Eppley Institute, $113,135; esophageal and forstomach cancer using 4-HPR and sodium molybdate, IIT Research Institute, $142,052; MAM induced colon cancer, Eppley Institute, $260,497; lung cancer using 4-HPR, selenium and vitamin E, IIT Research Institute, $129,496; lung carcinogenesis using B-carotene and retinol, IIT Research Institute, $116,255; DMBA mammary tumors, IIT Research Institute, $138,179; MNU induced lung tumors, IIT Research Institute, $251,501; OH-BBN induced bladder cancer, IIT Research Institute, $285,965; colon cancer by sulfasalaziine, American Health Foundation, $153,782; Balb/3T3 sarcomas, Eppley Institute, $82,188; DMBA induced epidermal tumorigenesis, SRI International, $147,693; breast carcinogenesis by 4-HPR, selenium and vitamin E, American Health Foundation, $146,125; and breast and bladder carcinogenesis by various retinoids, IIT Research Institute, $329,030.

Other chemoprevention contracts were awarded to Microbiological Associates Inc., $49,936 for in vitro screening system for identification of new chemopreventive agents; Regional Service Center Inc., $738,715 for calendar pack packaging of chemopreventive agaents; and ERCI Facilities Service Corp., $1,699,870 for a centralized chemopreventive agent source.

Various other DCPC contracts were awarded to:

Knowledge Access Inc., $49,952, and I.S. Grupe Inc., $49,978, for personal computer based information systems for cancer control; Information Management Services Inc., $1,582,470, for computing support for the Biometry Branch; and Whalen Biomedical Inc., $48,262 for breast protheses for subradical surgical and radiation therapy cosmesis.

## 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-71011-21

Title: Biomedical computing--design and implementation
Deadline: Approximately Dec. 12

The Biostatistics Branch of the Epidemiology & Biostatistics Program in NCI's Div. of Cancer Etiology, is recompeting an ongoing project for research and development and data processing support. The contract is currently being performed by Information Management Services Inc.

Under this proposed acquisition, the contractor shall provide computer related research and services for the scientific activities of the Biostatistics Branch. This will involve (a) research and development in computer science to develop specialized software; (b) use of existing software and systems for supporting Branch projects; and (c) development of computer programs and systems.

This is not a contract for statistical consultation service. This contract will require close contact between the Branch investigators and the contractor's staff. Performance will be monitored by means of frequent working meetings, progress reports and site visits.

Prospective offerors must have expertise in biomedical/biostatistical computing. The estimated level of effort will be 28.5 staff years over a three year period. All development and production processing will be done using the NIH Computer Center and the contractor will be expected to use this facility by remote access. The contractor shall be available to operate a remote job entry facility housed in government space from 7:45 a.m. to 4:45 p.m. and provide for up to four daily deliveries between the NIH Computer Center and NCI offices to transport computer materials. The NCI facility is located in the Landow Building in Bethesda.

This acquisition will be a total small business set aside with a size standard of $7 million.

Contracting Officer: Barbara Shadrick
RCB Blair Bldg Rm 114
301-427-8888

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

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