THE CANCER LETTER

Vol. 13 No. 12
March 20, 1987

Subscription: $160 year North America, $175 year elsewhere

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

Only 45 CCOPs Likely To Be Funded Unless More Money Is Made Available; ACCC Goes To Congress

The picture emerging from analysis of the Community Clinical Oncology Program applications most likely to be funded is about as expected: the $10 million earmarked for the program probably will not fund more than 45, 12 fewer

(Continued to page 2)

In Brief

King Faisal Prize Next Year Will Be Awarded For Leukemia Research; Yarbro Wins Fulbright

KING FAISAL International Prize for Medicine, one of five worth $95,000 each, will be awarded next year for research which has contributed to better understanding of the biological behavior, etiology and treatment of leukemia. The award this year went to Barrie Jones of Great Britain for his work in preventing blindness. . . . **JOHN YARBRO**, chairman of the Dept. of Oncology at the Univ. of Missouri (Columbia) School of Medicine, has won a Fulbright Award to lecture at the National Univ. in Montevideo on cancer research and treatment. Yarbro headed NCI's Cancer Centers Program in the early 1970s and is a past president of the Assn. of Community Cancer Centers. . . . **ROBERT GALLO** accepted gracefully his transfer from NCI's Div. of Cancer Treatment to the Div. of Cancer Etiology (the "Yul Brynner division," Gallo called it, alluding to the hirsuteless pate of DCE Director Richard Adamson). In a letter to DCT Director Bruce Chabner, Developmental Therapeutics Program Director Michael Boyd, and the DCT Board of Scientific Counselors, Gallo wrote: "My entire scientific life was conceived and hatched in the DCT nest. Sometimes I feel it has been my whole life. Whereas I believe I now know how to fly, I have never felt more uncertain about the direction nor the altitude. I owe all of you much. I am deeply grateful for the years of patient support, for the belief in me and my coworkers during the lean years, for tolerance of some of my responses during stressful periods, and mostly for your friendship." Gallo's lab was moved to DCE to consolidate NCI's virology and AIDS research efforts. . . . **RESTORATION** of the $64 million to NCI"s FY 1987 budget which the White House had planned to move to 1988 will permit funding 116 more grants. That probably will move the payline up two to four points, still leaving it under 170. NCI (and the rest of NIH) now are paying RO1 and PO1 grants at close to recommended levels, as demanded by Congress.

CCOPs Need Reprogrammed Money, More From Congress, Or Both

(Continued from page 1)
than are currently active. A reduction of that size, more than 20 percent, would represent a major setback in the program and would severely reduce the flow of patients from communities into clinical trials.

The existing 57 CCOPs and their research bases have been getting about $10 million annually; that amount will not stretch that far in the recompetition because of the peer review approved budgets, higher this time probably because of the addition of cancer control research.

Jerome Yates, director of the Centers & Community Oncology Program in NCI's Div. of Cancer Prevention & Control, predicted earlier this year that at least $16.5 million would be required to fund 57 CCOPs. He had hoped that NCI would make up the difference by reprogramming money from other elements of the institute's budget, either within DCPC or elsewhere. DCPC Director Peter Greenwald dampened that prospect by insisting that there were no programs within the division that could be cut that much.

NCI Director Vincent DeVita, who not only would like to see the program maintained at the same level but had hoped it could be expanded, has been reasonably successful in the past in "finding" money here and there to help keep alive or beef up high priority efforts. Finding $6 million, and more if the program is to be expanded, would be extremely difficult at this time.

There is another possibility, and members of the Assn. of Community Cancer Centers aggressively explored that last week.

ACCC traditionally sets aside one day of its annual meeting in Washington for "Congressional visitation." Members fan out over Capitol Hill, buttonhole their own congressmen, senators and their staff, and press them on cancer related issues. They usually include a pitch for increasing NCI's budget, along with appeals for attention to community cancer programs.

This year those two approaches went hand in hand: more money for NCI, including a hefty increase directed to CCOP. It would not be asking too much, for Congress to add $10 million earmarked for CCOP (along with substantial increases for basic research, centers, cooperative groups, cancer control, drug development, radiation research, construction, intramural programs, etc.)

A total of $20 million would permit NCI to fund as many as 70 CCOPs, quite possibly lifting the payline to 260, the cutoff when the program was started four years ago.

With only $10 million, the payline may be down into the 220s, and some very good CCOPs could go unfunded.

More Scores

As more CCOP principal investigators called DCPC for their priority scores, they were made available to **The Cancer Letter** (through the PIs, not NCI, where staff members are rigorously abiding by the rule not to reveal scores to anyone except the PIs).

In addition to the 22 listed last week as those probably within the funding range, six others made that list: North Shore Hospital, Manhasset, NY; Marshfield Clinic, WI; Fargo, ND; Sioux Falls, SD; Duluth, MN; and Peoria, IL.

Those are not necessarily listed by their scores. Because some PIs are reluctant for their scores to be made public, **The Cancer Letter** is not publishing that information. However, one CCOP was rated so high by reviewers that it has to be revealed: North Shore, the Long Island CCOP headed by Vincent Vinciguerra.

North Shore received a score of 115, the best so far made available to **The Cancer Letter**. In the NIH peer review scoring system, the best possible score is 100, the worst 500. The CCOP review committee members were very tough, judging by some of the scores seen, and by the fact that more than 20 applications were disapproved. A score of 115 coming out of that review is exceptional.

The second best score seen so far is 131.

The 28 CCOPs identified so far as probably within the funding range all scored under 230. If no more money is made available to the program, it is possible that NCI would skip over a few to pick up others which may be considered desirable for geographic or other reasons.

Several existing CCOPs may be left out, although one PI told **The Cancer Letter** that he intended to continue the program without NCI funding if necessary. Research bases, particularly cooperative groups, probably will not allow good performers, who have been placing respectable numbers of patients on protocols, to drop out completely. They will do everything they can to encourage the good, unfunded CCOPs, to stay alive.

Antoine To Seek Dosimetry Center, Treatment Planning Project Approval

When John Antoine joined NCI last year from the Univ. of New Mexico, it ended a two year search by the Div. of Cancer Treatment for someone to head its Radiation Research Program. Another year went by before DCT was able to get the Dept. of Health & Human Services to confirm Antoine's appointment as associate director of the division and head of the RRP (he had been serving, technically, as "acting" AD).

But when he appeared before the DCT Board of Scientific Counselors last month, Antoine handled matters as if he had been on the job for years. He obtained without dissent concept approval of three RFAs for new grant supported projects which will cost an estimated $2 million a year, along with concept approval for a $150,000 a year contract (**The Cancer Letter**, March 6).

Asked by a board member what his program needed most, Antoine responded crisply, "More money. And more people."

Antoine capped his presentation by describing two new initiatives he would like to undertake, but he did not present them for concept approval at that time. One would be for a contract supported project for development of "radiation treatment planning tools." He estimated the cost at $700,000 a year for five years.

The other would be for establishing a dosimetry center for radiolabeled cancer therapy agents, probably supported through a cooperative agreement. No cost estimate was given.

The treatment planning project would involve development of computer assisted medical decision systems, with the acronym, CAMDS.

"The extraordinary advances in computer hardware and software in the last decade now make the development of CAMDS a feasible possibility," Antoine said. "While our thrust will be for particular applications to radiotherapy, our emphasis will be for the development of general tools."

Research questions for CAMDS, Antoine said, could include recognition of anatomical structures, differentiating tumor from normal tissue, physician-computer interface, choosing an optimum therapy, representation of 3-D data and evaluation of CAMDS.

In radiotherapy treatment planning, CAMDS would "provide new and powerful tools" to rapidly and automatically extract anatomical features and construct 3-D volumes of interest; to assist in the definition and delineation of tumor from normal tissue; to define target/treatment volumes from tumor contours and specific protocol recommendations for appropriate margins; to develop methods for optimizing treatment plans using 3-D representation of critical structures and tumor/target volumes; to display 3-D images and volumes of interest with superimposed dose deposition for physician evaluation; and to improve the techniques of treatment simulation and verification.

A narrative describing the rationale and justification for the project states:

"Radiotherapy is one of the most computer intensive disciplines of medical care, primarily because of the large volume of anatomical information that is required to define the tumor and treatment volume and to characterize the extent of radiation dose to the tumor and the normal tissues at risk. Computerized tomography scans now play an essential role in the radiotherapy treatment planning process. It is anticipated that the additional information available from magnetic resonance images and diagnostic tools such as PET and SPECT will be adapted to radiotherapy diagnosis and planning. Computerization of CT scans and their use in a new class of computer programs that address three dimensional treatment planning have pointed out the need for new tools in the processing and manipulation of the large volumes of data needed for the radiotherapy treatment planning process.

"This project will call for the development of computer assisted medical decision systems or expert systems 1) to rapidly extract anatomical features from multiple images needed for the definition of the treatment plan, such as the treatment volume and critical structures, including, for example, spinal cord, location of kidney, stomach, liver and other critical organs; 2) to assist the physician in the definition and delineation of tumor from normal tissue, using metabolic information available from the new imaging modalities; 3) to assist in the definition and contouring of tumor and/or treatment volumes; 4) to provide three dimensional images in rapid, interactive fashion to yield displays that assist in the organization of treatment plans; 5) to rapidly and interactively display anatomical information with the treatment plan and radiation dose

distribution superimposed in ways that help the physician choose the best plan; and 60 to provide the capability for comparison of images of treatment prots with simulation images as part of the treatment position verification process during treatment delivery. These systems will be designed with a user interface that is acceptable and useful to physicians with respect to fast response and ease of use. Physician override is essential to the system's utility for the correction of errors, faults and inconsistencies."

The dosimetry center for radiolabeled cancer therapy agents most likely would be established in a collaborative effort with the Radiation Therapy Oncology Group, with a steering committee providing guidance. Among the center's tasks would be computerized calculation from CT scans of tumor volumes and normal tissue volumes; compuerized calculation from SPECT scans of tumor dose and normal tissue dose; training of collaborators; development of software; and providing of quantitative analysis of regression, progression or stability of tumor after any treatment.

Services offered would be directed to four major areas:

*Radiation oncology and nuclear medicine--tumor remission, progression or stability (volumetrics); radiation and combined modality therapy; dosimentry for radiolabeled drugs.

*New drug development--primary dosimetry of radiolabeled antibodies and radiopharmaceuticals; and comparative dosimetry for competitive radioisotopic compounds.

*Medical oncology--tumor volumetrics (remission, progression, stable); and phase 1-2-3 studies.

*Surgical oncology--tumor volumetrics (biological response modifiers, etc.).

The FY 1987 budget for the Radiation Research Program is $75.2 million, which compares with $36.8 million for the Biological Response Modifiers Program, $117.3 million for the Cancer Therapy Evaluation Program; $108.7 million for the Developmental Therapeutics Program; and $28.6 million for the intramural Clinical Oncology Program. RRP's budget increased by about $5 million over FY 1986.

RRP is supporting diagnostic imaging grants totaling $25.7 million; other radiation grants totaling $41.8 million; and contracts totaling $5.6 million.

Enck ACCC President; King Chosen President Elect at Annual Meeting

Robert Enck, director of the Riverside Regional Cancer Institute in Columbus, OH, took over as president of the Assn. of Community Cancer Centers at its annual meeting last week. David King, Good Samaritan Medical Center, Phoenix, was chosen as president elect. King is principal investigator for the Greater Phoenix Community Clinical Oncology Program.

Elected secretary of the association was Irvin Fleming, Methodist Hospital of Memphis, where he is chairman of the Cancer Committee and president of the medical staff. Elected as trustees were Vincent Caggiano, Sutter Community Hospital, Sacramento; Albert Einstein, Virginia Mason Cancer Center, Seattle; Marcia Fountain, Memorial Medical Center, Springfield, IL; and James Ungerleider, St. Elizabeth Medical Center, Dayton. Ralph Scott, Christ Hospital, Cincinnati, was elected to his second term as trustee.

Frelick, Mortenson Honored

Robert Frelick, former ACCC president and CCOP program director for the National Cancer Institute who will retire in July, was given the annual award for "Outstanding Contribution to Community Cancer Care." In a surprise presentation, ACCC Executive Director Lee Mortenson was given the "Edward L. Moorhead Award of Special Merit for Service to ACCC", named for the recently deceased former ACCC president and longtime advocate of community physician participation in national clinical research. Both awards were made at the Saturday luncheon meeting.

Frelick's acceptance speech was a gentle, somewhat self deprecating account of his extensive career as a physician, oncologist, surgeon and sometime radiotherapist, and the development of oncology and cancer treatment during that period. During that time he worked with many of the major figures in cancer research, and was a participant in the development of a number of techniques and drugs.

"I've spent 40 years leading up to this," he said.

He had his first contact with clinical trials as a medical student; the group next door was treating syphilis with penicillin, and Frelick noted that this was the first time long term IVs were given.

During his medical internship, where he

worked with both surgeons and radiotherapists, he realized, he said, "the internists' job was to keep the patients alive after being treated by the surgeons and radiotherapists." He became interested in electrolytic balance.

In practice in Delaware, he said, "I got talked into giving radiotherapy. I knew enough to get consultants" from Memorial Sloan-Kettering, who would go down to Delaware from New York periodically. He even coauthored a paper, with John Hynes, in 1953, on "Roentgen Therapy of Malignant Lymphomas with Special Reference to Segmental Radiation Therapy." They were aggressively treating nodes not obviously involved.

"People didn't want to treat Hodgkins with radiation," Frelick said, in order to "save something for when it comes back."

Frelick said he got an idea for early detection of cancer in 1950, encouraging physicians around the state to take Pap smears and other tests. "We didn't catch many cancers, but we trained a whole generation of Delaware doctors in doing Pap smears."

Frelick said he was probably one of the first to use 5-FU. He was working with a drug company on the protocol. He also observed that he had given some 10 autologous bone marrow transplants, but "gave it up because I thought I wasn't getting results."

He played a role in bringing tamoxifen to approval for use in the U.S. He said while doing consulting work for ICI he was asked to evaluate the drug, which was in the literature in Great Britain. He encouraged the company to go ahead with U.S. development.

He wrote an early protocol using cisplatinum, which was turned down.

He was also a pioneer in using multiple drug combinations, citing work with liver cancer patients during the era when common thinking was "one drug at a time." "We melted down some livers," Frelick said, but renal failure was a serious problem.

He worked with NSABP, was in the Central Oncology Group, and later switched to CALGB.

Frelick, who has spent the last five years as an administrator of a government grant program, had his share of experience with proposal writing as a researcher and community oncologist. He said he was the "victim of my first NCI site visit" while in a medical residency at Memorial Hospital in New York. His first try for a grant, while in practice in Wilmington, was also his first failure: a proposal for a "saturation program" contract during the early demonstration project days after the National Cancer Act was passed in 1972. "We didn't get the review I thought we should, so I rewrote it as a PO1 and got funded."

When the three Wilmington hospitals merged, he was named chief of oncology, "a good position to be in in these circumstances."

Prior to going to NCI, he said he realized "we were mainly treating end stage patients, and not really having much results," and wanted to do more for prevention and early diagnosis.

"The old saying, 'Nobody expects community doctors to participate in clinical trials because they're too busy treating patients is no longer true, he said. Wearing his "CCOP hat," a blue baseball type cap, Frelick expressed confidence that the program would, with cooperation between ACCC, the local physicians and NCI, grow and succeed. "I think we can achieve the Year 2000 goals."

In introducing Frelick, Gale Katterhagen, former ACCC president and one of the organizers of the association, called Frelick a man of integrity. He said that when he called Frelick ostensibly to get some information for his introduction, "I knew and Bob knew the real reason I was calling was to get my CCOP score. We smooshed for a while, but I never got the score."

Frelick was praised by Katterhagen as "a very young man--67 is just his chronological age."

Paul Anderson, Colorado Springs, another past president, made the new Moorhead award to Mortenson, who he said has done more at the practical level than anyone else for the association. The award will be given intermittently, he said.

Mortenson, in accepting, expressed his appreciation for the award being named after Moorhead, affectionately calling him "a crazy man who brought a lot of delight into our lives."

Apportionment Report Ordered By Congress On Its Way: Wyngaarden

An NIH report on the impact of apportionment requested by Congress by Jan. 1 is on its way, NIH Director James Wyngaarden told the House HHS Appropriations Subcommittee at its hearing on the NIH budget.

"Apportionment" is the term the Office of Management & Budget uses to describe how it

distributes funds to the institutes at NIH. It restricts the flexibility of the institute directors in reprogramming funds, and leaves much of that power in Wyngaarden's hands. It removes much of the power and flexibility in how NCI spends its funds, power originally given in the National Cancer Act of 1971 but omitted, supposedly in error, in the most recent renewal of the Act.

Last year, after hearing the vociferous objections of NCI (indirectly) and Cancer Program supporters, the House subcommittee directed Wyngaarden to report on how apportionment was working.

Rep. Joseph Early (D-Mass.) asked Wyngaarden about the status of the report, which Congress has not received in spite of its request last summer that it be submitted by Jan. 1. The committee's appropriations report requested the report because of "numerous complaints to the effect that the new methods for apportionment of appropriations by the Office of Management & Budget are placing unnecessary restrictions on NIH program management and are creating excessive paperwork."

The Apportionment Issue

Both Early and committee member C.W. Young (R-Fla.) asked NCI Director Vincent DeVita about the effects of apportionment on the institute's operations, and ways in which Congress could assist in alleviating problems associated with the process.

Young specifically asked DeVita "how difficult is it to move [money] within your institute to fund promising research.?"

DeVita said that "more recently we have had more difficulties," noting that apportionment "has caused some lack of flexibility" in the institute's ability to transfer funds according to program needs.

"Sometimes we need to move monies in the middle of the year," he said, adding that that authority is needed on a day by day basis.

Moving funds is more difficult "when you need permission" to move funds one way, and then move them back again, he said.

Asked by Young if Congress can take any steps to make such actions easier, DeVita noted that last year's committee report contained language addressing the issue.

The issue of apportionment is currently under discussion at NIH, he said. "I have always agreed that at any given level, apportionment separates authority and responsibility," he said, adding, "I'm satisfied that we're addressing the issue internally."

[At the last meeting of the National Cancer Advisory Board, DeVita told board members that Wyngaarden would be making the report to Congress on apportionment, and that "it is my guess he will say it is working fine. I can't sit next to him [at the Congressional appropriations hearings] and say it is a bunch of hooey" (**The Cancer Letter**, Feb. 13).]

Early also asked DeVita to submit for the record an accounting of how much he believes could be effectively spent by NCI. Under the Administration's FY 1988 budget request for NCI, the institute would actually receive $1.302 million in FY 1988 funds, a $100 million decrease from its 1987 budget. The official FY 1987 budget request is $1.875 billion, $64 million of which would be taken from NCI's 1987 appropriation and moved to the FY88 year, and another $508.3 million that would be reserved for outlying years of grants awarded in 1987.

Although the Administration seems to have backed down on its efforts to "extend the availability" of FY87 funds into FY88, the request remains in the fiscal 1988 budget proposal sent to Congress, and HHS executives have said the request will be pursued. OMB Director James Miller recently wrote to HHS Secretary Otis Bowen stating that there would be "no Executive Branch action to defer or otherwise restrict the funds currently available until after Congressional enactment" of the "extended availability" proposal (**The Cancer Letter**, March 6). In asking HHS to advise OMB of "any further steps which you believe are necessary in light of the Impoundment and Control Act," the agency essentially gives the go ahead for NIH to obligate its appropriated funds under its normal schedule.

Committee Chairman William Natcher (D-Ky.) indicated that Congress may consider increasing the NIH budget, asking Wyngaarden if NIH would have to add additional positions "if Congress gives NIH 6,400 new grants and 560 centers." Wyngaarden indicated that additional staff would not be required, which would be hotly denied in private by most NIH executives. Position reductions have cut deeply into NIH staff, and most offices are short on support staff and some program managers.

Natcher also asked Wyngaarden to submit an account of what funds he thinks could be

effectively spent at NIH as a whole.

Other questions to be submitted for the record include the issue of a recent decision to stop the provision of toll free telephone service for patients at the NIH Clinical Center, estimated to cost more than $500,000 per year.

Natcher also asked about staffing at the NIH Clinical Center. Wyngaarden said that 75 positions have been added in the last year, bringing the total number of employees at the Clinical Center to 1,909 full time equivalents in 1987. The number of nurses at the Clinical Center is projected to be 690 FTEs in 1987. In 1985, nurses accounted for 653 FTEs; that number dropped to 644 in 1986.

The chairman also asked if the new pay system for nurses at the Clinical Center has been implemented yet. Wyngaarden said that the first phase of flexible weekend scheduling, increased weekend pay, on call pay and overtime has been implemented, but that the second phase of higher general pay provisions is under review in the department.

Natcher instructed the NIH director to provide a detailed account of the plan for the record. He also asked about occupancy rates at the hospital. The occupancy rate at the clinical center is expected to be about 59 percent in 1987, the same as last year. That rate is still down from the 1985 occupancy rate of 62 percent.

He also questioned the lack of construction funds for NCI, the National Eye Institute and the National Heart, Lung & Blood Institute. Last year, the three institutes shared approximately $9 million in such funds, but construction funding was felt to be of lesser priority than support for basic biomedical research in this year's budget, Wyngaarden said.

Natcher asked DeVita to describe the impact on researchers of downward negotiations of approximately 17 percent required in FY 1987.

Some labs are finding it very hard to make adjustments, and are finding it necessary to lay off people, DeVita said. "I would prefer funding fewer grants."

Natcher also asked DeVita about reported increases in the incidence of cancer. He requested the NCI director to provide the committee with a detailed report on the incidence of cancer, the number of deaths, survival rates, and related data over the last 25 years on every major kind of cancer. He also asked that NCI submit the executive summary of the soon to be released Government Accounting Office report on NCI, and the institute's written response.

During his appearance before the Senate HHS Appropriations Subcommittee, DeVita was asked by Chairman Lawton Chiles (D-Fla.) about NCI efforts towards the Year 2000 goals.

Emphasizing that the Year 200 plans are goals, not estimates, DeVita explained that half of the mortality reduction would be due to prevention, with the major effort being smoking prevention.

"I personally believe we're ahead of schedule on the smoking prevention," he said, citing recent antismoking ordinances and legislation in Florida, Beverly Hills, and Cambridge.

These "are all signs that the public mood is to reduce exposure to smoking," he said. "We need to reduce smoking by about 50 percent of what it was in 1984, to achieve the prevention goals, and we need to make some dietary changes, too" to achieve the Year 2000 goals.

The other half of the mortality reduction would come from treatment. NCI is making attempts "to double the number of patients who are going into our clinical trials program, so that we can capture a larger proportion of the population in what we consider the state of the art experimental protocols," he said. He also noted that cancer mortality can be reduced by 10 percent with existing treatments. "I think we're on target," he said.

New NCI Journal To Be All New, The "Science" Magazine Of Cancer

The new journal NCI is planning will not be a merger of the two existing journals it publishes, "Journal of the National Cancer Institute" and "Cancer Treatment Reports," as it had been described by NCI Director Vincent DeVita at last month's meeting of the National Cancer Advisory Board (**The Cancer Letter**, Feb. 6).

Rather, it will be an entirely new journal, with a new approach and schedule. NCI still has not (or had not, when last heard from) selected a name, but favors "The Cancer Journal."

DeVita did not use the term "merger." What he said was that the two existing journals "will be collapsed into one." What he meant was that "JNCI" and "CTR" each will be

Why not call the new journal "Phoenix"?

collapsed into nothing--they will cease publication at the end of this year.

In their place will arise the all new journal. It will be published twice a month, whereas the two headed for oblivion are each published once a month.

How else will it differ from its predecessors?

"It will be a cancer magazine that is the equivalent of 'Science,'" according to Jean Baum, who as marketing coordinator for NCI's International Cancer Information Center is responsible for sales of the publication, as well as the center's other products, including PDQ.

The new journal probably will not exceed 100 pages per issue, and hopefully will appeal to a broader audience, Baum said. It will be "dynamic. . . quick," with a turn around time of eight weeks which "should appeal to readers and contributors."

It will not be an NCI house organ, and great efforts will be made to solicit articles from a broad base of contributors. Articles still will be peer reviewed, by non-government reviewers.

The subscription price has not yet been established. "JNCI" costs $54 a year ($73.75 foreign), "CTR" $29 ($36.25 foreign). "JNCI" has about 12,000 subscribers, although not all are paid. "CTR" has 5,000 subscribers, but 2,500 of those are complimentary, exchanges, and otherwise unpaid. About 25 percent of subscribers to "JNCI" are foreign.

ICIC publishes a booklet, "Scientific Information Services of NCI" which describes each ICIC product or service, including the scientific journals and specialized current awareness publications and on line data bases. To obtain copies of the booklet, write to ICIC, NCI, Bldg 82 Rm 123, Bethesda, MD 20892.

The specialized publications include "Cancergrams," which had been chiefly distributed at no charge until this year. NCI stopped sending free copies but slashed the annual subscription price to $7.50-11 (25% more for foreign addresses). Baum said that sales have been coming in well.

Other specialized publications:

"Oncology Overviews," retrospective bibliographies containing selected abstracts of recent articles on cancer research topics. Over 200 titles are available, at prices ranging from $4-18. Lists of titles and ordering information are available from ICIC.

"Recent Reviews," with separate publications for diagnosis and therapy, carcinogenesis and virology, immunology and biology. Prices range from $4-8.

"NCI Monographs," timely reporting of proceedings of key cancer conferences or a related group of papers on a specific cancer subject. Priced from $5-20. "Monographs" replaces two previously published supplements, "Cancer Treatment Symposia" and "NCI Monograph Series." Current listings of available back issues of the two former supplements as well as the new titles are available from Monography Editor, address above.

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-CO-74106-10

Title: OCC community support
Deadline: Approximately May 1

NCI is soliciting proposals for a master agreement on projects to supprt the planning, development, and implementation of public information projects which require application at the regional or local level.

Contract Specialist: Jean O'Brien
RCB Blair Bldg Rm 314
301-427-8745

RFP NCI-CO-74107-40

Title: Cancer prevention awareness: the black college as a resource
Deadline: Approximately May 1

This project is to develop and implement effective diffusion strategies which utilize a black college/ university in the dissemination of information about cancer to the black population. The offeror's proposal must include a letter of commitment from a black college or university.

Contract Specialist: Teresa Baughman
RCB Blair Bldg Rm 314
301-427-8745

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

Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.