THE CANCER LETTER

Vol. 13 No. 47

Dec. 4, 1987

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

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NCI To Implement Plan For Stepped Up Patient Accrual Despite Reservations Of Group Chairmen

Cooperative Group chairmen gave NCI's plan for stimulating patient accrual lukewarm approval this week and also went along somewhat reluctantly with the selection of high

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In Brief

DCPC Still Looking For Yates' Replacement; New Jersey Commission Offers New Fellowships

PETER GREENWALD, director of NCI's Div. of Cancer Prevention & Control, is still seeking candidates for the job of associate director for centers and community oncology programs. The position has been vacant since Jerome Yates left Oct. 1 for Roswell Park Memorial Institute. Greenwald feels it is crucial to fill the job as soon as possible, with the intensive examination of cancer centers under way by the National Cancer Advisory Board, the evolution of CCOPs and their expanding role in cancer control, and other vital issues facing the new AD. Those interested, either for themselves or on behalf of others, may contact Greenwald at NCI, NIH, Bldg 31 Rm 10A52, Bethesda, MD 20892, phone 301/496-6616. . . . **PAUL DURAY**, director of autopsy pathology at Yale Univ. School of Medicine, has been appointed chief of anatomic pathology at Fox Chase Cancer Center. . . . **WOMEN'S HEALTH** Trial ad hoc committee which will take one last (maybe) look at the question of whether the trial should be continued will meet Dec. 15-16 in Bldg. 31 Rm 4A48. It will be open 9 a.m.-noon the first day, closed the rest of the day, with a report to be written on the final day. . . . **ALBERT DEISSEROTH**, chief of hematology/oncology at San Francisco VA Medical Center and professor of medicine at Univ. of California (San Francisco), has been named chairman of the Dept. of Hematology at M.D. Anderson Hospital & Tumor Institute. . . **DAVID BALTIMORE**, Nobel laureate and director of the Whitehead Institute for Biomedical Research, has been elected vice chairman of the Scientists' Institute for Public Information Board of Trustees. . . . **NEW JERSEY** Commission on Cancer Research is offering pre and postdoctoral fellowships. The predoctoral program will provide a $10,000 stipend and participating institutions will waive tuition. Postdoctoral fellows will receive awards of $18,000, $19,000 and $20,000 for the first, second and third years, plus $5,000 for fringe benefits and travel.

Groups Go Along With Increased Accrual Plan, Balk On Specific Trials

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priority clinical trials which will be targeted as the first beneficiaries of the plan.

Group chairmen and other group representatives met Monday with Div. of Cancer Treatment staff, including Robert Wittes, director of the Cancer Therapy Evaluation Program; Michael Friedman, chief of the Clinical Investigations Branch; and Richard Ungerleider, CIB deputy chief and director of the Clinical Trials Cooperative Group Program.

The plan evolved from deliberations CTEP has carried on with the groups and other clinical trials participants over the last two years. Wittes and NCI Director Vincent DeVita have lamented, in editorials, lectures, informal discussions and any other forum they could find, what they call the "dismal, disgraceful" fact that so few cancer patients are enrolled in clinical trials. Slow accrual stretches out the time required to complete trials and get answers to the questions being asked, they point out.

Group representatives and CTEP agreed at their previous meeting that a plan be developed for payment per case to stimulate accrual (**The Cancer Letter**, Aug. 21). Monday, Ungerleider presented a draft of guidelines for the new program. Objections to certain aspects of the guidelines, primarily whether existing group members and affiliates will be eligible for the capitation funds, are being incorporated into revisions which will be made before implementation.

CTEP's selection of the particular trials which will be earmarked for the program failed to win the wholehearted endorsement of group representatives. Those will be presented to the DCT Board of Scientific Counselors, which has already approved in principle the capitation plan, in February.

The draft of the guidelines, which are subject to further revision, follows:

I. Objective

The objective of the process to be described is to promote accrual of additional patients onto specific clinical trials. Bringing additional patients into a clinical trial will speed the resolution of the experimental question. The procedures outlined below will provide incentive to physicians to enter additional patients by providing financial support proportionate to the number of patients recruited.

II. Selection of High Priority Trials

Cooperative clinical trials which are of high priority to the Institute will be identified by CTEP staff. Approved trials in progress or those undergoing CTEP review will be eligible. The criteria for selection will reflect prevailing scientific circumstances and national requirements, and will involve such considerations as prevalence of the disease, urgency of the experimental question, and biologic importance of the anticipated findings. CTEP selections will be brought before the Group Chairmen's Committee for endorsement, with subsequent ratification by the DCT Board of Scientific Counselors.

III. Allocation of Funds by DCT

The Cooperative Group(s) conducting the selected trial(s) will develop and submit proposals to CIB which contain a projection of the number of patients to be accrued through existing programs along with a projection of the number of <u>additional</u> patients to be recruited through this mechanism. The sources of these additional patients should be specified (unfunded members, affiliates, or nonaffiliates). A capitation plan specifying and justifying the amount to be awarded to participating institutions per additional patient must be included. Justification for funds requested for quality assurance, or to cover additional operations office or statistical office costs associated with the increased flow of data must be provided.

The following will not be eligible to receive additional capitation awards through this mechanism: Member institutions holding current DCT clinical trials cooperative agreements, institutions holding NCI CCOP awards and utilizing one of the Cooperative Groups as its research base, and physicians who receive capitation payments through the Cooperative Group Outreach Program mechanism.

(Ed. note: CTEP agreed to modify the eligibility requirements--see below).

Proposals will be evaluated by staff of CIB and the Grants Administration Branch and may be modified after review.

Upon acceptance of a proposal by CIB/GAB, funds will be awarded through administrative supplementation of the proposing Cooperative Group's operation office U10. Awards will be made on an annual basis, and will be restricted on the award notice to the costs necess-

ary to support additional accrual to the specific protocol. Funds will be disbursed by the group operations office to participating institutions or practices.

IV. Evaluation of Performance

Evaluation by NCI staff will occur annually at the time of the operations office noncompeting renewal (T5) application, with adjustments to requested budgets as appropriate. Evidence of a net increase in total accural of evaluable pataients (i.e., an increase over baseline accrual rates) must be provided. This mechanism must not be used simply to pay for patients who would have been entered on study through an existing mechanism.

The awardee will be subject to peer review for the group's capacity to increase accrual at the time of the operations office's next regularly scheduled competing application. The funds for continuing these activities must be requested in the competing application. Funds will be awarded only as long as an identified high priority protocol is active within the group. The level of the award will be adjusted annually based on performance in this area.

V. Application Procedure

A formal application utilizing PHS form 398 should be prepared by the group operations office. An original and one copy should be sent to the grants management specialist associated with the parent Cooperative Group, NCI, Westwood Bldg Rm 8A14, Bethesda, MD 20892. An additional four copies should be sent to Richard Ungerleider, MD, Director, Clinical Trials Cooperative Group Program, NCI, Landow Bldg Rm 4A20, Bethesda 20892.

A. The face page of the application must be completed, and signed by the principal investigator and by the business official of the submitting institution.

B. The abstract of the research plan should specify the goal of increasing the patient accrual to specifically identified clinical trial(s).

C. A detailed budget for the first budget period, and a projection for the remaining years in the project period, should be supplied. The first budget period should be from the requested start date until the next Type 5 anniversary date of the parent U10 award. This will differ among applications (e.g., if the start date is anticipated in June, 1988, and the operations office award will recycle in December, 1988, the first budget period would be six months).

D. A detailed budget and justification for each item requested must be provided:

1. If capitation costs are requested as reimbursement for patient accruals, the cost per patient must be broken down and justified, e.g.:

a. Estimate of physician time spent on research (to obtain informed consent, to fill out data forms, etc.) and the resultant cost. Time spent delivering standard medical care is not allowable.

b. Estimate of data manager or nurse time to meet research requirements (e.g., compiling and mailing data, specimens, etc.) and the resultant cost.

c. Cost of mailing or of handling research related patient specimens, forms, materials (slides, X-ray).

d. Other consultant costs (e.g., pathology, radiology, etc.).

2. Justification must be provided for operations or statistical office costs claimed relaative to increased patient accruals. Such claims might include the costs associated with quality assurance, additional Office for the Protection against Research Risks assurances, handling the increased volume of data, training sessions for physicians and staff new to the clinical trials process, and travel and per diem for new participating physicians (do not include travel in the capitation costs).

3. Be certain tht funds which have been budgeted in other NCI awards are not included in the calculation of per capita or ops/stat office reimbursements ("In other words, no double dipping," Ungerleider said).

4. Principal investigators should explore with their institution whether the institution would consider waiving or reducing the indirect costs associated with this subcontracts. If the institution agrees to a waiver or reduction, it should be stated in the application.

E. A narrative of the research plan, specifying baseline accruals supported by existing NCI awards, and distinguishing projected additional accruals to be supported by this mechanism, should be provided. Baseline accruals should be established through presentaiton of information regarding entry of patients with the relevant disease/stage onto group clinical trials in the three previous years. Documentation should be provided for justifying any stated estimates of increased accrual. Plans for recruiting new sources of patients should be described.

Data demonstrating the existence of recruitable patients should be provided in the form of patient logs, hospital registrations, tumor registries, letters of intent by potential physician participants, or other evidence to validate the existence of a substantial recruitable patient population. Plans for data management and quality assurance to guarantee the evaluability of the patients accrued from these new sources should be provided.

Friedman commented that many of the additional patients which might be brought in might be available from the "large pool of previously funded organizations." That would include the Community Clinical Oncology Programs which were not funded in the recent recompetition and the Cooperative Groups which were dropped from the funded ranks last year.

Although agreeing that "generally" the Cooperative Group system is functioning effectively and "asking important questions and getting answers," Friedman presented figures which indicate that phase 3 studies are not being completed as fast as they should: Of the 163 presently active studies still in the accrual phase, 30 percent will require more than five years to complete accrual, 43 percent will need four years, and the median time of accrual is 36 months. More than 50 percent will need nine months or more past the original estimate.

Friedman mentioned "some bright spots." The intergroup adjuvant colon study recruited more than 500 patients within a year, with "excellent evaluability and followup." The intergroup Hodgkins disease study is adding patients more than 50 percent faster than estimated.

"There is adequate evidence that when the system is harnessed properly, more than enough patients are available to answer the questions in a timely fashion," Friedman said.

Paul Carbone, chairman of the Eastern Cooperative Oncology Group, pointed out that the exclusion of funded institutions by the new mechanism's guidelines would preclude bringing nonparticipating subspecialists into the system.

Ungerleider said CTEP "is not philosophically opposed" to permitting those so affected to participate but "from our point of view it would seem difficult to account for those funds, and difficult to demonstrate an increase in accrual" resulting from that participation.

"The money could go to the physician directly. There could be rules, as long as he is not on the (cooperative group) grant, or not getting any other funds," Carbone said.

"That's an issue we'll have to consider," Friedman said. CTEP staff agreed to develop more flexible eligibility requirements.

Charles Moertel, chairman of the North Central Cancer Treatment Group, questioned the practicality of the plan. The physicians at which the new mechanism is aimed "are people not currently involved in cooperative group activities," Moertel said. "They have no recent experience in clinical research, by and large. They will have to locate a large pool of patients. People will have to be trained, and then they have one year of accrual and then they're out. To me, that seems like a terribly inefficient way to do something. It would seem a lot better to enhance the existing systems."

"The episodic nature of this will not be as frequent as you suggest," Friedman responded. "They will have reasons to participate in subsequent trials. We don't underestimate the effort it takes to train people, but it can be a successful effort. CCOPs are an example, and they have recruited huge numbers of patients."

"You're talking about groups brought in on a sustaining basis," Moertel said. "They have been enormously successful. But this is not CCOP or CGOP. This is one year and out."

Friedman and Wittes pointed out that the payments would continue as long as the physician is placing patients into the study, and that when that study is completed, he could go onto another.

"You can't hire anyone with a guarantee of funding for one year," Moertel insisted. "You need sustained support."

"You're suggesting an obligatory expansion of the Cooperative Group mechanism," Wittes answered. "We can't make that commitment now considering NCI's budget situation."

Carbone noted that the new mechanism "is not much different than the existing CGOP mechanism. We could do it if you give us the flexibility."

"There is a disagreement here that we can't paper over," Wittes said. "The purpose of these funds is not to provide brain power for enlarged urologic cancer activities. The purpose is to support increased entry of patients into trials of high priority."

Carbone suggested that a greater potential for additional patient accrual might be with HMOs and the unfunded CCOPs. Those could be exploited, "if you could give the Cooperative Groups more money specifically for high priority trials. You would get more bang for the buck."

"You're talking about increasing funding for existing participating institutions," Wittes said. After further discussion on that point, the always cool Wittes displayed some exasperation.

"What bothers us is, if a group like ECOG is accruing only 10 to 30 percent of eligible patients, why should we give you more money to follow the same system? Ten to 30 percent stinks." He added that at the August meeting, group chairmen generally agreed that that ratio could be improved with the existing system.

"There is a lot more to accrual than funding," Moertel said. "I agree that 10 to 30 percent stinks."

The High Priorities

CTEP offered as the trials which meet the criteria for special emphasis with the new mechanism those for cancers of the colon, rectum, breast and bladder, and lymphoma.

CTEP also suggested some specific protocols:

*Dukes B_2 and C colon cancer, NSABP's C-03 protocol comparing the combination of methyl CCNU, oncovin and 5-FU (MOF) with the combination of 5-FU and leucovorin. The hypothesis is to determine the value of 5-FU modulation by leucovorin compared to the best prior treatment arm.

*Dukes B_2 and C rectal cancer, NCCTG's protocol 86-47-51, with four arms--MeCCNU, radiotherapy, infusion 5-FU followed by MeCCNU + 5-FU; MeCCNU and 5-FU, RT, bolus 5-FU followed by MeCCNU and 5-FU; 5-FU, RT, infusion 5-FU and 5-FU; 5-FU, RT, bolus 5-FU and 5-FU. This study will test the value of MeCCNU and the value of infusion vs. bolus schedule of 5-FU during radiation therapy.

*Negative node breast cancer, intergroup study in which patients undergo surgery and radiation therapy and are randomized to six cycles of CMFP (cyclophosphamide, methotrexate, 5-FU, prednisone) or to no further treatment. The accrual goal is 380, but CTEP would like to increase that to 800.

*Diffuse large cell lymphoma, Southwest Oncology Group protocol 85-16--CHOP vs. M-BACOD vs. Promace/Cytabon vs. Macop B.

*Efforts are being made to organize an intergroup study in bladder cancer.

Group chairmen expressed serious reservations about endorsing any of the protocols for the new mechanism at this time.

"I feel very uncomfortable coming to you and saying we will do this or that," Moertel said. "We work in groups, with people who may be more knowledgeable about specific areas than we are. I think we should defer these decisions until our group meetings."

"To move this along, it is important at least for this body to endorse disease areas," Friedman said, mindful that the DCT Board meeting is in Febuary, the next one in June.

"What do I know about lymphoma, or bladder cancer?" Moertel responded.

"Not all groups have to agree to everything," Friedman said.

"Your proposal leaves something to be desired," said John Ruckdeschel, Lung Tumor Study Group. "With the adjuvant colon cancer trial, you're basically taking one group's trial and emphasizing it. You agree that no clear answer is likely. I'm afraid you will stultify creativity, and that we'll shut everyone down for a few years."

Emil Frei, chairman of Cancer & Leukemia Group B, said he thought it was all right to take one regimen and designate it as a high priority. But he added that there was no colon-rectum adjuvant protocol now which meets the criteria for high priority emphasis under the new mechanism.

Friedman responded that the proposed studies "represent a distillation of opinion," and that other studies such as ECOG's vaccination trial for colon cancer would still be supported. "We're only limited by our vision. There are enough good ideas out there, and enough patients. There is not enough money."

"This is a good first cut," Charles Coltman, chairman of the Southwest Oncology Group, said. "We can take it from here. Getting new institutions involved will be a big challenge."

"I'm willing to try other mechanisms if you (NCI staff) think they will work," said National Surgical Adjuvant Breast & Bowel Project Chairman Bernard Fisher.

Pressed by Friedman on how soon they could put together applications for the supplemental funding, most of the chairmen were noncommittal.

"If your instrument includes funding for participation of CALGB members not partici-

pating in those trials, then we can move fast, certainly within a month," Frei said.

"I would need more time. Two to three months," Coltman said.

Friedman suggested that "for operational purposes" three months would be the target, or March 1.

Ungerleider pointed out that the supplemental applications would not involve site visits or review by the Cancer Clinical Investigation Review Committee, the Cooperative Groups' study section. As supplements to existing grants, they would be reviewed by CTEP staff and Grants Administration Branch and would be funded administratively. The CCIRC review would take place when the group's operational grant is up for competitive renewal.

Carbone did some quick calculating and determined that the new mechanism could be expected to bring in an additional 1,000 to 1,500 patients a year. Friedman said that CTEP's estimate was between 1,000 and 2,000.

Carbone noted that at an average cost of $1,000 per patient, the cost to NCI would be between $1 million and $2 million a year.

James Cox, Radiation Therapy Oncology Group, asked what CTEP expects "from those of us who are not high accruers in those areas (selected for high priority studies)." Friedman said that RTOG member institutions might participate through physicians who are not themselves members of RTOG.

Cox suggested it would be inappropriate for him to vote on selection of specific protocols for emphasis about which he had little expertise. "If Chuck Moertel has reservations about an adjuvant chemotherapy trial, why should I vote on it?"

Friedman, referring to Moertel's well known conservative view of chemotherapy, said to Moertel's delight, "If you fail to vote on everything Chuck Moertel has reservations about, you would never vote on anything."

Coltman offered a motion that the chairmen adopt the selection of disease sites for emphasis "as a principle, and leave it to the individual groups to work out details of specific protocols."

Coltman added, "When Dr. DeVita says the Cooperative Group system is broken (**The Cancer Letter**, Nov. 20), it is up to us to demonstrate that it is not broken, or that it can be fixed." The motion was approved, with a few scattered affirmatives, no vote against it, and Moertel abstaining "because it would not be fair to the people I represent."

St. Jude Begins Massive $100 Million Expansion Doubling Present Size

St. Jude Children's Research Hospital in Memphis has broken ground on a five year, $100 million expansion of its facilities and research programs.

"St. Jude has made significant research findings during its first 25 years," said founder Danny Thomas who turned the first shovel with assistance from 34 year old Susan Bailey Bramlett, one of St. Jude's longest term survivors of childhood leukemia.

"When we began our efforts to find a cure for leukemia, just four percent of children afflicted lived," Thomas said. "With the curative therapy developed at St. Jude, more than 50 percent now are considered cured. The ground breaking signals our intention to broaden the scope of our work and attack catastrophic diseases of children on many fronts."

When the expansion is completed, St. Jude Children's Research Hospital will be nearly six times larger than the original facility and will have twice the square footage of today's hospital, according to Director Joseph Simone. The expansion includes additional laboratories, enabling St. Jude researchers to intensify their efforts in numerous areas.

"The expansion will enable use to double our efforts in the areas of childhood cancers, blood diseases such as hemophilia and sickle cell anemia and infectious diseases like influenza. It will also enable us to further develop a genetics research program that we hope will lead to significant achievements in unlocking the mysteries of catastrophic childhood diseases," Simone said.

Simone announced that the hospital will imeediately begin preparations for a pediatric AIDS research program (see **AIDS update**, this issue).

In addition to the expanded research facilities, the expansion will include a surgical suite, a magnetic resonance imager building and large inpatient and outpatient facilities.

Baddia Rashid, executive director of American Lebanese Syrian Associated Charities, St. Jude's funding body, said the construction costs would reach $83 million with the remainder earmarked for the purchase of medical equipment and hospital furnishings.

Part of the expansion cost will be covered by funds raised by the "Mission for Memphis" drive which raised more than $18.2 million for St. Jude and the Univ. of Tennessee Medical School, Rashid said.

The project will be completed in five phases beginning immediately and continuing through July 31, 1992.

St. Jude physicians see more than 1,000 patients yearly, most of whom are treated on an outpatient basis as part of ongoing research programs. The hospital also maintains 48 beds for patients requiring hospitalization during treatment.

Nursing Education Should Emphasize Decision Making: Swedish Educator

Clinical nursing education should encourage students' abilities to make value based, clinical judgments and decisions based on diagnostic reasoning regarding complex patient care, Gertrud Grahn told the Fourth European Conference on Clinical Oncology and Cancer Nursing in Madrid.

Noting that the "core of any profession lies in its practice," Grahn said the "ability to make value based, clinical judgments and decisions based on diagnostic reasoning regarding complex patient care problems demands that the student's abilities for analyzing and synthesizing, for fragmenting and integrating, are further developed." Grahn has a background in nursing education and administration in Sweden, and is currently involved in nursing research. She delivered the keynote address and chaired a session on cancer nursing education and training.

Education in the clinical setting, "even if of extremely high quality, could be ruled more by discretion than by specific teaching/learning strategies," she said. "It is what the students learn here and now in actual clinical situations that will form their identity at a professional level. Education and training in the clinical setting is the heart of educational endeavors."

The ability for diagnostic reasoning "will increase according to development and formation of abilities for conceptual logical reasoning and abilities that emphasize a caring ethos and the attainment of an ability for empathetic, ethical-moral reasoning," she said.

The identification of criteria at different levels of logical reasoning and moral reasoning, in cancer nursing education "would facilitate efforts to provide experiences conductive to growth and development."

Grahn also said that nursing education should be guided by "the nature and scope of nursing practice" and that nursing education should "contribute to the development of nursing practice."

Although the nature and scope of nursing practice "is still frequently conceived as task performance and not as using independent thought or decision making," it is changing, she said. Nursing is "slowly developing a body of knowledge that will be recognized by virtue of being scientifically researched, which will be known and utilized by every nurse in providing competent treatment and care carried out with empathy, respect for the patient's integrity, and due attention to the patient's need for security, and based on autonomous clinical judgments and decisions regarding patient care.

"The nature and scope of nursing practice and the responsibilities nurses are assumed to take for developing the nature and scope of nursing practice--whether in terms of holistic patient care or in terms of diagnosis and treatment of human responses--should not only be mentioned in the curriculum, but be the determinant of how nursing education is planned and accomplished," she said.

"Of utmost importance is how education in the clinical setting--how training--is carried out."

Grahn noted that staff members in clinical settings who are responsible for most of the supervision and education in nursing practice "are seldom requested to have a special preparation for teaching, and they seldom have opportunities for penetrating the aims, content and methods outlined in the curriculum."

Although many oncology nurses can serve as role models for improving the quality of patient care, they often "lack the ability to transfer or share this knowledge in educational situations," she said. "They have learned by time and experience and student nurses are supposed to do it the same way.

"Do we really want this pattern to be repeated over and over again?

"I strongly believe that if education at basic or advanced levels, and not only time and experience, are used as a means, a key, a quality improvement can reach out and saturate all encounters in cancer patient care.

Grahn used the concepts of journeyman, foreman and master to distinguish between levels of competency and performance.

"Change and development toward mastery--a commitment to act at a certain level of excellence--implies change toward professional nursing practice."

While both the master and the foreman are skilled practitioners in the way they interact with the patient, the difference is "the master's ability to grasp a situation in a holistic, integrative way, still differentiating alternative aspects and values.

"Where judgments are required, it is the ability to use relevant information, be authorized to make clinical decisions on the basis of diagnostic reasoning and to be accountable for what is decided.

"This is, however, very seldom considered in teaching learning situations in clinical settings," she said.

Grahn also noted that it is "still a question in many countries of distinguishing between nursing as an occupation and nursing as a profession."

Citing American nursing leader Margretta Styles, she said nursing scores moderately well when comparing criteria for an occupation versus a profession except in the areas of theory and autonomy. "That is a scientific body of knowledge as a means to acquire autonomy and to provide a basis, control and direction for nursing practice and nursing education.

"In the years to come, European nurses have to reach consensus regarding the nature, scope and standards for cancer nursing practice in terms of nursing as an occupation or a profession and thus regarding appropriate level and type of preparation for entry into practice."

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-074111-10

Title: Cancer Information Dissemination and Analysis Center (CIDAC) Carcinogenesis and Cancer Biology
Deadline: Approximately Jan. 20

NCI is seeking organizations with scientific and technical capabilities to assume the operation of a CIDAC for the International Cancer Research Data Bank, International Cancer Information Center. One contract will be awarded in the subject area of carcinogenesis and cancer biology. Major activities include:

1. Assuming regular monthly production of over 60 series of "Cancergrams," monthly current awareness bulletins containing 30-100 abstracts of recently published cancer research. For each "Cancergram" topic, a CIDAC staff member (subject specialist) screens monthly abstracts retrieved from compuertized searching of an ICRDB database and prepares a package of some 50-100 abstracts for review by a consultant (identified by the CIDAC) who is currently involved in research pertinent to the "Cancergram" topic area and who need not be an employee of the organization.

2. Producing annually 10 different "Oncology Overviews," retrospective compilations of 150-500 selected abstracts on high interest cancer research topics. The publications are developed by the subject specialists in consultation with researchers (identified by the CIDAC) who are recognized as experts in the subject area of each "Oncology Overview."

3. Responding rapidly to request for information in specific cancer research subject areas. Subject specialists must be able to interact knowledgeably and professionally with scientists requesting information, and formulate and use computer search strategies for retrieving the needed information from ICRDB data bases.

The organization must have previous experience in analysis and processing of cancer research information or similar biomedical information as well as involvement with cancer research (preferably in house or via a teaming arrangement). The project director must have a PhD or MD and one or more research publications in a biomedical subject directly relevant to cancer research areas covered by the CIDAC. Consultants and outside reviewers must have a PhD or MD degree and one or more research publications in a biomedical subject area direclty relevant to the specific "Cancergram" which they were to review. Collectively, they must cover all "Cancergram" topics within the CIDAC's purview and should be located in sufficiently close proximity to the CIDAC office or provision must be made for overnight courier delivery to provide rapid turn around in their review of "Cancergram" materials.

This procurement is a total set aside for small business.

A small business, for the purposes of this procurement, is a firm, including its affiliates, that is independently owned and operated, is not dominant in the field of operations in which it is bidding on government contracts, and whose average annual sales or receipts for its preceding three fiscal years do not exceed $3.5 million.

Contracting Officer: Joan O'Brien
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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.