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AACI Calls For New NCI Division For Centers, Other Programs, 75 Total Core Grants By 1992

Not everyone who responded to the National Cancer Advisory Board's letter soliciting opinions and suggestions on the Cancer Centers Program expressed unqualified support for

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In Brief

St. Jude, Yale To Get Bristol-Myers Grants; Five Named For New Young Scientist Awards

BRISTOL-MYERS has announced award of two more unrestricted grants for cancer research, to St. Jude Children's Research Hospital and the Yale Comprehensive Cancer Center. Each institution will receive $100,000 a year for five years. St. Jude Director Joseph Simone said the grant there would be used for research in several pioneering areas of pediatric cancer research, including drug development and basic research in the immunotherapy of children with cancer and AIDS. Alan Sartorelli, director of the Yale center, said the grant will be used to develop therapy involving conversion of cancer cells to noncancerous state and to develop new drugs to attack oxygen deficient tumors. . . . **FIVE OUTSTANDING** young scientists have been named Bristol-Myers Cancer Research Fellows under a new program for young, clinically oriented investigators. Each will receive $120,000 for a three year period to pursue advanced study in basic research. They are Myles Brown, Massachusetts Institute of Technology; Arthur Hooberman, Univ. of Chicago; Clifford Lowell and Mark Schlissel, Johns Hopkins; and Mark Siegelman, Stanford Univ. . . . **NATIONAL CANCER** Advisory Board meeting May 9-11 will include reports from Louis Sullivan on the black leadership initiative; Barbara Bynum on NIH procedures affecting awarding of grants; John Boice on health effects of radon exposure; and Malcolm Moore on colony stimulating factor. The NCAB committee meeting schedule: Environmental Carcinogenesis, May 9, 6 p.m., Bldg 31 Rm 2; AIDS, May 9, 7:30 p.m., Bldg 31 Rm 7; Cancer Centers, May 10, 8 a.m., Bldg 31 Rm 7; Review of Contracts & Budget for the Office of the Director, May 10, immediately after the closed grants review session, Bldg 31 Rm 7; and Planning & Budget, May 10, 5:30 p.m., Bldg 31 Rm 8. All are open. . . . **ROSWELL PARK** Memorial Institute will be the first state institution in New York to totally ban smoking, effective July 4. The policy will apply to all employees, visitors, students, guests and patients other than those in private rooms with physician orders.

AACI Says Centers Underrepesented On DCPC Board, Asks For New Div.

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it. Several in fact were downright negative, with comments such as "the money would be better spent on RO1 grants," and the significance of research accomplishments in clinical and consortium centers is in doubt.

One response was anything but negative, however, in considering the accomplishments and potential of centers. As might be expected, that came from the American Assn. of Cancer Institutes, which also did not hesitate to make some suggestions on where the Centers Program should be located within NCI and how big the program should be.

The AACI response was written by an ad hoc committee established for that purpose, chaired by Richard Steckel, director of the UCLA Jonnson Comprehensive Cancer Center. Other members were Thomas Davis, Robert Hickey, Thomas King, Shirley Lansky, Alvin Mauer, Henry Pitot, Marvin Rich, William Shingleton, Joseph Simone, Bernard Weinstein and Jerome Yates. Ex officio members were Alan Sartorelli, AACI president; Ross McIntyre, vice president; John Potter, immediate past president; and Edwin Mirand, secretary treasurer.

The AACI response did not envision the plan developed by an NCI staff committee and endorsed by the NCAB Cancer Centers Committee last week, which would create a new core grant mechanism that would be used both to recognize and support comprehensive centers (**The Cancer Letter**, April 29). But there was nothing in the AACI statement which could be viewed as contrary to that plan.

The NCAB committee did not take up some of the issues covered in the letter sent to more than 5,000 individuals and organizations, including where at NCI the program should be located. It was AACI members who brought the issue to a head in discussions with Director Vincent DeVita over the past two years, and the response left no doubt on the organization's position:

"The current organizational location for the NCI Cancer Centers Program [in the Div. of Cancer Prevention & Control] is considered to be suboptimal for several reasons. Chief among these are perceptions that (1) there is a limited emphasis on centers within the NCI division to which it is currently assigned; and (2) there is a lack of sufficient representation of centers on the division's board of scientific counselors."

[Ed. note: That depends on how one defines "sufficient". Paul Engstrom, chairman of the DCPC board, is vice president for cancer control of Fox Chase Cancer Center. Other members with close ties to centers are Edward Bresnick, director of Eppley Institute on Cancer Research; Frank Meyskens, associate director for cancer prevention and control of the Arizona Cancer Center; and John Ultmann, director of the Univ. of Chicago Cancer Research Center. Others on the 18 member board who are at institutions where cancer centers are located are Philip Cole, Univ. of Alabama (Birmingham); Virginia Ernster, Univ. of California (San Francisco); Donald Iverson, Univ. of Colorado; and Kenneth Warner, Univ. of Michigan].

"The best organizational location for the Centers Program," the AACI response continues, "would be within a newly formed Div. of Resources. This division could include the Centers program, construction, educating and training and the Organ Systems Program, with consideration also given to including the cooperative groups and the Community Clinical Oncology Program [the cooperative groups presently are in the Div. of Cancer Treatment, the others all in DCPC].

"The latter two programs might be included because of similarities in program activities and overlaps (with centers) in professional personnel. For example, investigators and leadership individuals at centers are active within the cooperative groups, and some centers also serve as research bases for CCOPs.

"The advantages of this newly formed division would be more effective advocacy for Centers Program activities, more accessibility to the division board of scientific counselors and the division director, better access to the NCI director, and representation on NCI's Executive Committee [which consists of DeVita, his deputy and executive officer, and the division directors]. This proposal is consistent with the longstanding position of the Assn. of American Cancer Institutes. The new division director could also serve as executive secretary for the National Cancer Advisory Board's Centers Committee.

"On a temporary basis, one alternative would be to move the Centers Program into the NCI director's office. It is recommended that a nonchartered advisory board or panel of center directors and leadership staff be set up

by the NCI director to assist in the development and evaluation of the Centers Program. While this approach could help address important short range concerns, long term programmatic goals would best be served through a new Div. of Resources."

At the present time, NCI staff favors moving centers, and possibly the other resource elements of DCPC, into DeVita's office. A new division has some appeal, but staff members do not think it would solve many problems. The Centers Program cuts across all the divisions, and its staff would have more clout in dealing with them as immediate subordinates of DeVita, rather than as a division at the same level as other divisions, NCI executives believe.

AACI's response to the question, "What is the adequate number of cancer centers and how is the number determined?:

"Core funding of 75 cancer centers by 1992 [there are now 52], at levels recommended by peer review, is viewed as adequate and would assist greatly in meeting NCI's Year 2000 goal. Ten new cancer centers could be started in 1989 if sufficient funding were made available, as requested in the NCI bypass budget. Of these, five could be consortium centers in geographic areas which are presently underserved. These estimates are based upon the fact that there are over 90 institutions which have aggregate RO1 and PO1 funding from NCI in excess of $750,000 annually, and which are regarded as candidates for core support. Conceivably, if sufficient suppert were available, the number of centers might eventually rise to a total of 135-140, particularly if there were a decision to locate additional centers at community institutions (e.g., CCOPs). However, the latter possibility poses difficult issues of increasing diversity within the Centers Program which cannot be discussed adequately here."

What is the proper mixture of the different types of centers: comprehensive, clinical, basic science and consortium?

"The NCI Centers Program, by supporting the professional leadership, shared resources and facilities at cancer centers and by promoting interdisciplinary research collaborations, offers comparable benefits to all types of centers. As in the past, there may be no 'proper mixture' of cancer centers other than that which comes about spontaneously in response to the opportunities and specialized resources available at each institutional site. Specific questions relative to review have been raised concerning certain types of centers, however. The basic science centers have been perceived by some to fare better during peer review for their core grants because they encompass a more cohesive body of investigations which can be assessed by a more homogenous peer review group. On the other hand, some feel that centers with broader programs which are scientifically diverse in nature and which have clinical research as well as regional activities, are at a disadvantage when peer reviewed by a parent review committee dominated by laboratory investigators.

Salmon "Enthusiastic" About Plan For New Comprehensive Center Core Grant Program

The intensive review of the Cancer Centers Program, particularly the role and characteristics of comprehensive centers, was instigated by a letter to NCI Director Vincent DeVita written in May, 1987, by Sydney Salmon, director of the Arizona Cancer Center in Tucson, indicating that the center was interested in achieving NCI recognition as a comprehensive cancer center.

Since it had been over eight years since the last such recognition had been bestowed by NCI following a review by the National Cancer Advisory Board, DeVita felt it was time to reconsider whether the exercise was worthwhile and whether the criteria for determining if a center were comprehensive should be updated. The NCAB Centers Committee, chaired by John Durant, undertook the task of conducting the review.

Salmon told **The Cancer Letter** this week that he was pleased his letter had been a "catalyst" for review of the program, which he said was "overdue."

The proposal to tie recognition as comprehensive to a new core grant mechanism also appealed to Salmon. "I'm enthusiastic about the idea. Bringing this process into peer review is a reasonable approach." The prospect of waiting for as much as two years, the time it probably will take to implement the new program, does not bother him. "I think it is likely that a number of centers will be interested in competing," he said. "The program overall will benefit."

"Fourteen of the 52 core grant supported centers are currently of the basic science type, and in the opinion of some this ratio may be high. If the total number of centers

were to increase to 75 while the number of basic science centers remained relatively constant, it is felt that the Centers Program might be in better balance. There is also a perception that advances in basic science are occurring rapidly at this time while clinical applications of basic science discoveries may be occuring less rapidly than is desirable. This situation could be addressed by increasing the number of qualified clinical and comprehensive centers, if sufficient resources can be made available to fund them adequately."

As for suggestions that management of the basic science centers be moved to the Div. of Cancer Biology & Diagnosis, that basic science centers be supported through the program project mechanism rather than center core grants, and that centers be expected to develop other sources of core funding after a specified time such as 10 years, AACI answered with a resounding "No" to each.

"Basic science centers should be kept within the same division as the other cancer centers. It is important that cancer center programs be considered as a group to facilitate the development of collaborative research within institutions as well as between cancer centers of different types, where appropriate. . . Core funding for basic science centers should continue to be available through cancer center support grants. Current program project guidelines do not offer core support for independently peer reviewed (RO1 supported) cancer research at an institution nor do they provide sufficient developmental support to stimulate new program initiatives. . . Careful peer review will assure survival of the best and most effective centers. It would be dangerous to threaten the stability of these centers by imposing a requirement that core funding may be reduced drastically or even disappear after 10 years."

A summary of the 95 responses was presented to the NCAB committee. Excerpts follow:

What is the greatest contribution of each type of cancer center?

In general, the development of multidisciplinary collaborations and expertise, shared facilities, increased public awareness, kexpanded research opportunities, enhanced technology transfer, provision of bridge support for investigators temporarily without funds, critical mass of scientists focused on one research area, developmental funds. By center type:

Comprehensive--An increase in the number and qualifications of oncologic specialists, fostering multidisciplinary growth within an organization, lay education programs, complete approach to cancer problems in a geographic area.

Consortium--Contribute more to cancer control than other centers, coordinate/promote research on regional basis, affect larger population than other centers.

Clinical--new treatment modalities are brought to clinical trials more rapidly, increased patient accrual, increased public awareness of cancer issues, trained oncologists are brought to the community, truly interdisciplinary research.

Basic--specific scientific discoveries were cited, enhanced teamwork on cancer related problems, a "profound catalytic role in mobilizing research on the cancer problem."

Other comments--basic centers need to be hooked up to the commmunications network and interact with clinical activities; the centers program is responsible for only modest progress in treatment; research productivity should be the main criterion for success; cancer control activities are deficient; the significance of research accomplishments in clinical and consortium centers is in doubt. One respondent distinguished centers' highly successful coordinating function, which transcends departmental and institutional boundaries, from their operating activities which "would probably occur in the absence of centers."

How important is the core grant to the basic research effort or how could it be improved?

Shared resources were frequently emphasized. Core grants improve the communal organization and infrastructure of science. They provide the major motivating factor to institutions to provide space and resources for cancer research. They need to provide more support for various types of collaborations between basic scientists and others. Construction money is needed. More developmental funds are needed. The core grant ceiling should be removed. Research in basic centers can't survive without core grants. More flexibility should be provided for budgeting between categories.

On the other hand, one responder said that center directors are frequently without power and the core grant has been fragmented and ineffective.

Are there issues extraneous to NCI policy that inhibit the function of centers?

Uncertainty of appropriations for biomedi-

cal research; struggles over control of resources; unfavorable policies for third party reimbursement, especially for therapy considered "experimental;" FDA constraints on new drug approval; FDA paperwork; internal institutional politics (especially by the parent medical center); lack of uniform state incidence reporting for cancers; local land use and construction policies; high cost of new drugs; animal welfare concerns; patterns of medical practice (town/gown conflict); lack of regulatory authority inhibits centers from sustaining regional cancer control efforts; local politics.

The NCAB Centers Committee and NCI staff discussed various ramifications of the proposed comprehensive cancer center core grants, which will be known as P60 grants (regular center core grants are P30s).

"If you have a high powered P30 and are doing well, and you apply for a P60, you're putting your P30 at some risk," Durant commented.

Staff members had suggested that centers planning to compete for P60 grants should not do it at time of renewal of their P30s. Those that fail in P60 competition would still have their P30s.

Lucius Sinks, chief of the Cancer Centers Branch, pointed out that those with creditable P30s, with their basic science and clinical programs already having passed peer review, would not need to have those elements reviewed in their first P60 competition. "But the second time around, they would do the whole thing."

"There are all kinds of options," said Brian Kimes, director of the Extramural Research Program in the Div. of Cancer Biology & Diagnosis. "Those that fail in competition for a P60 would not have to shut down the P30 portions of their programs."

Durant noted that some centers have a P30 and a cancer control grant. With the new mechanism, "you're taking core elements of the cancer control grant, incorporating them in the P60 and make the research elements of the cancer control grant fly on their own."

"That's not necessarily true everywhere," DCPC Director Peter Greenwald said.

"Another aspect of the P60 is that it will have actual funds for research," Kimes said. "It will have a budget for research projects that will allow a center to get projects started, get people together, who then can compete for other support."

"How will that differ from developmental grants?" Durant asked.

"More money," Kimes said. "We're talking about real research projects, not just developmental."

"The track record for use of developmental funds has been reasonable," Durant said. My point is, will core elements of cancer control grants go into the P60 core?" The staff consensus was that they would.

NCAB Chairman David Korn asked if training funds "can be tucked into the P60?"

"It looks that way," Durant answered. John Abrell, executive secretary of the Cancer Center Support Grant Review Committee, added that it would not affect other training.

Durant asked if the P60 would require all elements now required for the P30, plus the cancer control, outreach, education, regional activities and clinical trials requirements for comprehensive status. "That's what we really had in mind," Greenwald responded.

"Some centers do zero in cancer control," committee member Enrico Mihich said. "They have no machinery for cancer control. This means they would have to set it up."

"If they want to be comprehensive," Greenwald said.

Durant referred to the emphasis on clinical trials participation. "If NCI takes that seriously (in requiring that for comprehensive awards), will accrual rise? My guess is yes."

"Yes, but it is more complicated than that," Michael Friedman, chief of the Clinical Trials Branch, said, pointing out that some centers are already heavily involved in clinical trials.

An RFA Or PA? Competitive Or Not? Drug Group Announcement Confusing

The announcement in the "NIH Guide for Grants and Contracts" (April 15) appeared to be a recompetition of NCI's original National Cooperative Drug Discovery Groups, initially awarded through an RFA in 1983.

What it really was supposed to be, however, was a program announcement, but in this case, it wasn't even that. Program announcements are invitations for investigators to submit applications in suggested areas of research, in competition for RO1 or PO1 grants.

The April 15 announcement on drug discovery groups was intended only for those groups already funded by NCI. It will be competitive only in that the groups will have to come through peer review with fundable priority scores. No new groups will be

permitted to join in the competition. The mechanism of support will still be cooperative agreements, rather than ROIs or program projects.

The announcement that looked like an RFA but was supposed to be a program announcement was necessary because there had been a problem with language in the original awards dealing with renewals.

Meanwhile, initial review was wrapped up last month on 33 applications for new groups. The Div. of Cancer Treatment's Developmental Therapeutics Program had hoped to complete review in time for final action by the National Cancer Advisory Board next week. If that cannot be done, NCAB review will be done by mail, since these awards must be made before the end of the current, 1988 fiscal year, Sept. 30.

The DCT Board of Scientific Counselors will hear presentations from the first four drug discovery groups at its meeting in June. A new RFA for natural product drug discovery groups is awaiting concept approval by the Board, which decided at its February meeting that that decision would depend on progress reports from the existing groups, which are headquartered at Univ. of California (San Francisco), Roswell Park Memorial Institute, Memorial Sloan-Kettering Cancer Center and Univ. of Florida (Gainesville).

Board members indicated in February that they leaned toward approval of concept, but would like to hear the progress report first.

Idaho Senator Pressures DeVita About Proposed INL Reactor Use

An Idaho senator is pressuring NCI to take over the state's INL reactor for use in boron neutron capture therapy. As NCI Director Vincent DeVita appeared before the Senate HHS Appropriations subcommittee, Sen. James McClure (R-ID) questioned DeVita repeatedly about the institute's plans to convert the facility for use in treatment.

The Dept. of Energy is preparing to close INL, which has been used to produce isotopes for the military. DOE is willing to pay conversion costs if NCI will pick up the costs of the facility thereafter (**The Cancer Letter**, March 25). While the conversion would cost about $10 million, $60 million would be required "to turn it back into sagebrush," Div. of Cancer Treatment Deputy Director Gregory Curt has said.

McClure repeatedly extolled the virtues of the Idaho facility and its promise in the treatment of glioblastomas.

NCI officials are concerned with the problems of transporting patients to a remote facility for treatment. INL is approximately 60 miles away from the closest hospital. McClure countered, however, that many U.S. patients are seeking treatment in Japan, where research with boron neutron capture is underway. The therapy involves depositing boron in or near the tumor. It emits alpha particles, attacking the adjacent tumor cells while sparing normal tissue outside the tumor.

The Idaho facility is considered uniquely capable of producing the necessary materials for the therapy.

Although acknowledging that the Idaho facility is unique and its "quality of medium range neutrons is unmatched anywhere else in the world," DeVita expressed reservations about its treatment promise in glioblastoma.

"I am not very enthusiastic that this method will work unless we have a better compound to use along with the machine," he said. "I think the INL reactor is unique and it can be used effectively for other kinds of tumors, but for glioblastoma alone, which is why the proposal got into trouble, there are alternative experimental approaches that patients could go to with a better chance of success than the INL boron neutron capture."

DeVita said he hoped INL will modify its proposal to include other types of tumors, especially malignant melanoma that has metastasized to the brain. NCI originally thought the facility's initial proposal would include that disease as well. "There is some hope for readdressing the issue and coming back with a different proposal," he said.

"There are probably only a thousand or so patients with that type tumor, (glioblastoma)" DeVita said. "On the other hand, that is not the only type of clinical trial the facility could be used for."

When McClure cited the use of a former DOE facility at Los Alamos for clinical trials, DeVita said the facility accrued only 322 patients over a decade at a cost of $22 million.

"I think this is different, though, and I'm quite optimistic about the capacity to treat this way and I think we need to show whether or not we can do it or whether it will be effective. We don't need to say that forever more, you have to go to INL to get it. If we can prove that it's a useful way of dealing with brain metastases, then we can expand the

program," DeVita said.

"I hope we'll be able to convince them to come in with a different kind of proposal and then proceed."

The best use of the facility is not to run independent clinical trials, "but to be part of a program that is a national program," he said.

In addition to noting the group's lack of expertise in running clinical trials, he cited potential problems in transporting patients to Idaho for treatment, and from the closest hospital to the reactor.

Discussing metastatic melanoma, he said, "We can control metastatic melanoma outside of the brain." If boron capture neutron therapy were shown to be effective for both glioblastomas and brain metastases from malignant melanoma, "it would be a major advance." Japanese scientists "have already found a compound that can be collected in the melanoma tumor, but we don't have that in the primary tumor." Approximately 27,000 patients are diagnosed with malignant melanoma per year, about 6,000 of whom die. Of the 6,000 who die, about 80 percent die with brain metastases.

McClure also criticized a recent report's recommendation that the facility be held in standby for five years, stating that keeping the reactor idle would cost the same as converting it for patient use.

Pointing out that the report should be considered advisory, DeVita said, "I don't think we have to wait five years to decide."

Although the two other competing reactors at MIT and Brookhaven are located in the more densely populated Northeast, they are not as good as the INL facility, he said.

NCI officials and representatives from the three major reactor groups are meeting together in Annapolis "to discuss plans for protocols for refurbishing machinery so we can get some data on them", he said.

A full scientific report will be made to DCT in June.

Since testifying before the House Appropriations HHS subcommittee in March, five NCI supported studies have turned positive, DeVita said. NCI is currently putting together a public service announcement to publicize the results of its trial involving stage 1 breast cancer, he said. In addition, the institute's Biological Response Modifiers Program has had several positive studies involving colony stimulating factor.

Noting that cancer is now the Number 2 killer in the U.S., DeVita said that, even if the goal of the Year 2000 to reduce cancer mortality by 50 percent were met, "cancer will move from the Number 2 killer to the Number 1 killer because of the aging of the population, the decline in mortality from cardiovascular disease and because, unfortunately, AIDS is also influencing the incidence of certain types of cancers and may drive the incidence upward."

Subcommittee Chairman Lawton Chiles (D-FL) asked about the many different cancer statistics being cited, and about the progress of NCI's panel convened to evaluate cancer statistics. The panel report is due out in June, DeVita said.

He said NCI is "impressed by age specific mortality," specifically the significant decline in mortality in persons under 65. If smoking related cancers were pulled out from the mortality figures, the decrease would be seen in persons under 85, he said.

Chiles also expressed "great concern" about the Government Accounting Office's report that two thirds of cancer patients are not receiving state of the art treatment. Noting that the $71.3 million spent on efforts for technology transfer represent less than five percent of NCI's budget, he asked, "Shouldn't we spend more on making sure that" treatment already discovered is used?

"We agree with that," DeVita replied. Noting that 38 clinical trials are underway in the area of prevention, he said, "When one of these studies becomes positive, there's going to be a revolution."

He also pointed out that NCI "has no control over the way medicine is practiced. All we can do is jawbone." Citing breast cancer as an example of problems in changing treatment practices when optimal treatment for a disease changes, he said such problems are especially severe if the treatment goes to another specialty than that that traditionally cared for those patients.

"I hear what you say that you can't tell a doctor how to practice medicine," Chiles said. "On the other hand...I think we do have a responsibility up here...we've got to figure out how to do that.

"To think that we're spending this money discovering all these new ways, yet we've got literally maybe thousands of people dying because they're not getting the ways that are out there now, I don't believe it's acceptable for us to say that we can't affect the private practice of medicine. I don't believe that's a good enough answer."

DeVita cited the 20 percent per year increase in the use of PDQ by physicians, but noted that problems remain among doctors who have complained that NCI is trying to change referral practices as well as the practice of medicine.

Chiles and Sen. Lowell Weicker (R-CT) also expressed concern about the continued discrepancy in cancer survival between blacks and whites.

The Administration's budget request for NCI in FY89 is $1.468 billion, a 6.4 percent increase over its FY88 budget. That figure does not include NCI's $125 million share of NIH AIDS funding, which is once again proposed for consolidation within the office of the assistant secretary for health.

Asked by Weicker about his view on the consolidation of AIDS money in OASH, DeVita said, "There are two parts to that answer. Everybody feels that we need to have a national policy on how to deal with AIDS and the only way you can deal with making policy is to make sure that someone very high up in the system has some control over where the resources are being allocated, how they're being allocated and whether or not there are big gaps...and that speaks in favor of centralizing the budgets.

"The other side of the coin is that my own personal view is that you should keep authority and responsibility very closely linked. People who have to make their decisions on a day to day basis should not be forced to go through a whole series of a chain of command to people who don't know as much about a particular problem. To the extent that you centralize the budgets and do that, then you have a downside risk. We don't know, in fact we have been assured and we have to accept that" centralization would not interfere with institute directors being able to conduct their work on a day to day basis.

Weicker also asked if NCI was utilizing the full capacity of its supercomputer, and what plans have been made to upgrade the computer.

NCI's supercomputer is being used at full capacity, DeVita said, adding that although NCI has already upgraded its memory, it believes additional upgrading will be needed in the future.

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-8564756
Title: Resources for xenotransplantation and evaluation of human tissue injected into athymic mice
Deadline: Approximately July 1

The Laboratory of Human Carcinogenesis of the Div. of Cancer Etiology is recompeting a requirement to provide a barrier facility for breeding and experimental management of nude mice that will be given transplants of human tissues and cells which is currently being performed by Hazleton Laboratories Inc.

Proposals are now being solicited from qualified firms to provide the necessary resources for an enclosed, barrier facility with controlled in and out sterilization of materials and supplies, in and out anti-bacteriological showers for personnel, and laminar flow housing for breeding stock and experimental mice. A pyrogen free, self sustaining, unshared colony of athymic nude mice (800-1,000) is required as a source of the experimental recipients of the human tissues. The contractor should have proven capabilities for performing animal surgery, long term maintenance of experimental mice, and preparation of tissues for high resolution and electron microscopy. The contractor's staff should be trained and experienced to use applicational development (ADL) and the interactive language DBASE III PLUS (Version 1.1).

The RFP contains a mandatory requirement that offerors must demonstrate in their proposal their ability to facilitate rapid pick up and transplantation of fresh tissues from NIH and its collaborators. To ensure the successful complete of the project, this process should be completed within 90 minutes.

A four year cost reimbursement, completion type contract will be awarded as a result of this solicitation.
Contract Specialist: Donna Winters
RCB Blair Bldg Rm 114
301/427-8888

NCI CONTRACT AWARDS

Title: Antibody mediated detection systems for acrolein: DNA adducts
Contractor: Biological Research Faculty & Facility Inc., $499,960

Title: Tracing through motor vehicle bureaus to determine vital status and current address of patients treated for thyroid disorders
Contractor: Equifax Inc., $16,644

Title: Production and testing of human LAK cells
Contractor: Bionetics Research Inc., $3,353,553

Title: Breast and other cancers after scoliosis x-rays
Contractor: Westat Inc., $1,440,195

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