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Longer Awards, Annual Recompetition Considered For "CCOP 3;" Concept To DCPC Board In January

The next recompetition of the Community Clinical Oncology Program, which probably will be referred to as "CCOP 3," may include some four and five year awards in addition to the

(Continued to page 2)

In Brief

Owens Gives Up Hopkins Hospital Presidency, Resumes Full Time Role As Center Director

ALBERT OWENS has stepped down as president of Johns Hopkins Hospital and returned full time as director of the Johns Hopkins Oncology Center. "Because of the importance of the Oncology Center, I feel that it is in the best interest of Johns Hopkins that I spend my time overseeing the program planning and design of the new center and raising the funds that are critical to its completion," Owens said. He has served as president of the hospital since Jan. 1, 1987, and continued as Oncology Center director. Robert Heyssel, president of the Johns Hopkins Health System, will serve also as president of the hospital. Owens was named first director of the Oncology Center in 1973. . . . **F.K. MOSTOFI**, director of the Armed Forces Institute of Pathology, received a special honor at the recent International Symposium on Therapeutic Progress in Urological Cancers held in Paris. Proceedings of the three day symposium were dedicated to Mostofi in recognition of his worldwide leadership in urological cancer. Nearly 1,000 urologists and urological oncologists attended the symposium, which was cochaired by Rene Kuss and Gerald Murphy. Mostofi served for many years as the Dept. of Defense representative on the National Cancer Advisory Board, and has been with AFIP for 40 years. . . . **MICHIGAN CANCER** Foundation has added two new key staff members: **Sandra Wolman** has been named associate medical director to head a new program in genetics; she has been at New York Univ., and is a member of the American Assn. for Cancer Research board of directors. **Eric Wolman** has been appointed vice president of community programs; he has been with AT&T Bell Laboratories . . . . **GREGORY CURT**, former deputy director of the Div. of Cancer Treatment, started work this week at Roger Williams General Hospital in Providence, RI, where he is chief of clinical pharmacology and director of medical education. DCT Director Bruce Chabner announced Curt's impending departure last month (**The Cancer Letter**, June 10), but his new job had not then been finalized.

Five Year Awards, Annual Competition Seen For CCOPs Starting Next Year

(Continued from page 1)
three year awards that were used in CCOP 1 and 2. That would eventually lead to a recompetition every year, spreading out the workload and making more manageable the review and award process.

It also could possibly lead to five year awards for most of the CCOPs, easing the burden of recompetition on them as well as on NCI staff.

"That's the direction program staff would like to move," Leslie Ford, acting chief of the Community Oncology & Rehabilitation Branch in the Div. of Cancer Prevention & Control, told **The Cancer Letter**. So far, the plan is only in the talking stage; concurrence of the Div. of Extramural Activities and the NCI Executive Committee has yet to be obtained.

Ford said the proposed new RFA will go to the DCPC Board of Scientific Counselors for concept approval at the board's January meeting. The RFA would be issued next spring, a few months earlier than in the last recompetition.

CCOP 2 is just entering its second year; the third and final year will end in mid-1990.

Ford said she did not anticipate any significant changes in the CCOP guidelines. The requirement for cancer control projects was added to the program in the last recompetition.

The program's budget for FY 1989 so far remains the same, $11.5 million, as in the first year. The negotiated budgets all had built in increases for the second and third years, as the cancer control elements become operational. With the flat budget, however, control activity will be restricted, although the prospect exists that some extra money will be reprogrammed to CCOPs.

NCI Director Vincent DeVita has repeatedly said that the program should be doubled, at least. There are 52 funded programs now. Ford agreed that the potential exists for at least double that number, although only 10 to 20 of the unfunded programs from the last recompetition had priority scores that could be considered reasonably close to the funding range.

Other community organizations are participating one way or another in clinical trials, gaining experience and building expertise needed to compete for a CCOP award.

OCC To Take Over CIS Oct. 1; Cost Sharing Is Dead, Van Nevel Says

NCI's Office of Cancer Communications is one of the few, and perhaps the only, information office in the federal government with a mandate from Congress to carry out information and education programs for the general public.

All the others were established by their agencies to handle press queries and take some of the burden of dealing with the press off their staffs; to help with responses to congressional inquiries and drafting congressional testimony and speeches; and to maintain a positive image for the agency and its staff members.

OCC does all that, and very well, but its public information and education work goes far beyond the usual PR range of activities. The print and electronic media messages it generates, the hundreds of thousands of pamphlets and booklets it distributes and phone calls it answers have been responsible at least in part for changes in health related lifestyles and the attitude Americans have toward cancer.

Those activities were written into the National Cancer Act when it was renewed in 1974, and reaffirmed and expanded in subsequent renewals.

With the decision to move the Cancer Information Service from the Div. of Cancer Prevention & Control to OCC (**The Cancer Letter**, June 24), that role will be expanded further.

The CIS budget of more than $5 million a year will be transferred Oct. 1, the start of the 1989 fiscal year, to OCC, along with the portfolio of contracts with 16 organizations, most of them cancer centers, to operate CIS offices around the country.

OCC also will deal with the eight unfunded CIS offices, which receive literature for distribution to the public and use of the CIS toll free phone service (1-800-4-CANCER) but no money from NCI. They are permitted to identify themselves as NCI affiliated or NCI supported CIS offices.

DCPC had proposed, in the concept it presented to the division's Board of Scientific Counselors, that all CIS offices be placed on a cost sharing basis, with the local institutions picking up 25 percent of the costs, to free up money which could be used to help support the unfunded offices. That would have gone into effect in recompetition of the contracts, with

the new awards to be made at the start of FY 1990.

The DCPC board voted down cost sharing, although approving the recompetition. But what about the proposal now that CIS is being moved out of DCPC and out from under oversight by that division's board?

"Cost sharing is dead," OCC Director Paul Van Nevel said. The NCI advisory body asked to rule on that concept made its decision and it will stick, even with the recompetition carried on outside that division.

If the CIS budget remains level, at about $5 million, in 1990, NCI probably will be able to support only 13 or 14 offices. Whether those left unfunded in that case would continue with their own support remains to be seen. Even if they do not, it seems likely that the number of participating but unfunded CIS offices will grow, as centers become more aware of the visibility and marketing potential inherent in the program. NCI has made it clear that no blatant or overt use of the system to sell the host institution's services will be tolerated, but the value is there anyway, without any extra hype.

In the current fiscal year, $4.7 million is going directly the the contractors, and NCI spends another $700,000 for the phone service. OCC is spending another $500,000 on its health education program.

CIS has a three person staff, headed by Kate Duffy, which will be transferred to OCC Oct. 1. Van Nevel would like to locate them in NIH's Building 31, where his offices are, but space there is so limited that that may not be possible.

Van Nevel also is trying to squeeze a new slot out of NCI's limited number of positions to add a fourth person to the CIS staff, to handle training of CIS personnel and oversee quality control. If he can't get that slot, Van Nevel said it possibly could be done through a contract.

COMMIT, Massive Antismoking Effort, Moving Into Implementation

The Community Intervention Trial for Smoking Cessation (COMMIT), probably the most intensive and best organized antismoking effort ever undertaken in this country or anywhere else, is moving rapidly into the impementation phase following approval by the Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control (The Cancer Letter, May 13).

COMMIT also may be one of the most costly antismoking campaigns ever, at $42.7 million over the 99 month life of the program. If it can achieve its goal of effectively aiding heavy smokers in the 11 participating communities to stop smoking and maintan cessation on a long term basis, it could have a major impact on cancer incidence.

The program is being carried out under the overall direction of Joseph Cullen, DCPC deputy director and head of NCI's Smoking, Tobacco & Cancer Program. The project officer is Terry Pechacek, STCP program director for community trials.

A COMMIT Steering Committee has been organized, chaired by Erwin Bettinghaus, dean of the College of Communication Arts & Sciences at Michigan State Univ. Bettinghaus last year completed a term as chairman of the DCPC board, and was recently appointed to the National Cancer Advisory Board. The committee consists of the 11 principal investigators.

Donald Iverson, director of research and evaluation at the Univ. of Colorado Health Sciences Center and a member of the DCPC board, chairs the COMMIT Policy Advisory Committee. Other members are David Burns, Univ. of California (San Diego); Richard Carleton, Pawtucket Heath Health Program; Virginia Ernster, Univ. of California (San Francisco); William Friedewald, associate director for disease prevention at NIH; and Kenneth Warner, Univ. of Michigan. Ernster and Warner are also members of the DCPC board.

The primary hypothesis being tested in the trial is that the implementation of a defined intervention protocol, delivered through multiple community channels and using limited external resources, will result in a smoking cessation rate in heavy smokers that is at least 10 percent greater than that observed in the comparison communities.

The primary trial goal is to design and conduct community based interventions that will effectively aid heavy smokers in 11 communities in achieving and maintaining long term cessation of cigarette smoking.

The primary trial objective is to assess the effect of this community based intervention program by comparing, in communities randomly allocated to receive active intervention vs. matched communities not receiving this specific intervention, the smoking cessation rates among cohorts of heavy smokers.

Some secondary trial objectives are:

--To determine in the intervention communities vs. the comparison communities the effect of this community based intervention on smoking cessation rates among cohorts of light to moderate smokers, differences in prevalence of heavy smoking, and differences in prevalence of overall smoking.

--To investigate the effects of this community based intervention program in subgroups of smokers selected according to demographic factors, smoking history and other individual factors, and to develop a risk model to predict smoking behavior and cessation based on such factors.

--To perform exploratory analyses to suggest the contributions of specific intervention channels to smoking cessation, and to study possible trends over time in the effects of the community based interventions.

--To document and prepare the resulting intervention protocol for subsequent large scale applications in various locations.

In phase 1, the trial design, sample size, survey requirements and timeline were developed; intervention activities identified and protocols and materials prepared; implementation and evaluation plans developed; and key investigators and professional staff at all 11 sites identified.

Bettinghaus told the board that the group includes "some very strong investigators who have their own idea how to do things." Iverson added, "They are strong people. Everyone knows how the world should be run. Cooperation at first was difficult," but after the Policy Advisory and Steering Committees started having an impact, the group moved ahead and phase 1 goals were met.

Heavy smokers are those who smoke 25 or more cigarettes a day. Studies have shown that they have a much higher cancer incidence than light and moderate smokers, and have much more difficulty quitting smoking. Although the percentage of adults who smoke has steadily declined since 1965, the proportion of heavy smokers has increased.

The trial design includes 11 pairs of communities which are matched within each pair by size and demographics and range from 52,993 to 166,824 in total population. Communities within each pair have been randomized to either intervention or comparison. Telephone surveys have been done to collect baseline data on the prevalence of smoking and heavy smoking in the communities and to identify and recruit cohorts of smokers for long term followup.

The protocol consists of standardized activities to be used in all intervention sites. Community mobilization will begin this summer, followed by phase 2 intervention which will start in early 1989 and continue until the end of 1992. The primary intervention channels include health care settings, mass media, worksites, community organizations, schools, telephone hotlines and a smokers' network. Community wide coalitions and task forces will be formed to coordinate and plan the community wide intervention efforts. Cessation strategies will include periodic community wide cessation campaigns, as well as sustained activities involving groups and individuals.

The primary endpoint of the study is the smoking cessation rate among heavy smokers in each community, using the rates in randomly selected cohorts of heavy smokers as representative of the community as a whole. Self reports of smoking cessation will be validated by appropriate biochemical tests during the final survey. No smoking cessation efforts will be directed toward the members of the cohorts per se; their identities will not be made available to any of the local principal investigators or staff conducting the interventions.

Intervention strategies

Results from NCI's current STCP trials have defined numerous strategies for inclusion in this trial. The most promising include programs offered through physicians and dentists, mass media, worksites, community organizations, and telephone hotlines. These strategies will be coordinated into a four year intervention effort. Intervention efforts will target environments where heavy smokers can be reached most efficiently and effectively. Intervention activities will promote both an increased frequency of quit attempts as well as greater maintenance of cessation.

Becuase heavy smokers represent a relatively small and physically dispersed group within the community at large, community intervention channels that are capable of reaching a reasonable proportion of heavy smokers (i.e., worksites, medical practices and community organizations) will be particularly targeted. Data from ongoing community analysis, the baseline survey, and input from local community leaders will help refine the intervention plan for each community.

The interventions will consist of standardized activities to be implemented in all intervention sites. The activities will be implemented using a variety of institutions and

structures that already exist in the communities. In addition, some new community organizational and intervention structures will be developed to coordinate the intervention efforts, including a community board comprised of community leaders representing a variety of institutions.

Intervention activities fall into four general categories:

*Health care provider programs, utilizing physicians, dentists, pharmacists, their allied health providers, and the settings in which these professionals work.

*Worksite and organizational programs, emphasizing both cessation programs and smoking policies.

*Coordination of cessation resources and services, including group and self help programs, a telephone hotline, and a smokers' informational network.

*Public education campaigns, promoting smoking as a public health problem, and community wide cessation campaigns.

The COMMIT protocol includes 62 required intervention activities and 10 optional activities. Initial activities focus on community mobilization and training. Task forces will be formed in each community to organize and implement activities in the four categories listed above. As the local community resources and skills increase in all of these areas, activities across task forces will be combined into semiannual community events and campaigns.

An increasing proportion of smokers and heavy smokers in each intervention community should be reached and involved in these coordinated efforts each year. The ultimate intervention objective for the final year of the trial is to have more than half of the heavy smokers in each community reached and involved in at least one major cessation program activity with many of these smokers reached and influenced by more than one category of cessation activity. Through the coordinated activities developed in multiple intervention channels during community wide cessation events and campaigns, the trial will seek to make cessation influences persistent and inescapable for heavy smokers in each intervention community.

Implementation of interventions

Implementation of the intervention protocol will be achieved through community mobilization, which is the means by which the community and diverse intervention channel resources are activated to undertake or expand smoking control activities. The goal of mobilization is to complement and enhance existing community activities, not to compete with ongoing programs.

A central and standard feature of the implementation plan is the formation of a community board. This board will be a senior policy and management body. In an evolving collaboration with the trial investigators, the board will devise a community smoking control plan to implement all aspects of the protocol defined intervention.

Examples of intervention activities

Health care providers--Physicians, dentists, pharmacists and allied providers will be assisted in expanding cessation programs at health care facilities. These will include seminars and consultation.

Worksites--Support for cessation programs will be provided, including self help manuals and creation of incentives for cessation.

Organizations--This will include presentations at meetings and in organizational media, featuring promotion of community cessation resources and self help organizations, promotion of smoke free meetings, and organizational competitions during magnet events.

Cessation resources (hotline)--Includes oral and written information on health consequences, quit resources, maintenance, passive smoking, telephone counseling, distribution of self help materials, referall to cessation programs; (network)--newsletter for smokers and their families, information on quit resources, promotion of self help and cessation resources, publicity of local smoking policy changes.

Public education (media)--Kickoff event, publicity for magnet events and other activities, media training for local advocates, local amplification of national events, referrals to self help information and cessation resources, publicity of passive smoking issues; (schools)--Curricula, materials for students and parents, facilitation of teacher training, promotion of parental cessation through youth, combined programs of parent cessation and adolescent prevention, promotion of smoke free policies at schools, sports events and other public events, community action to reduce tobacco sales to teenagers.

Evaluation

The impact of the intervention protocol will be assessed primarily by monitoring the smoking cessation rates in cohorts of heavy smokers in intervention and comparison communities. This will be accomplished by the

baseline survey and annual endpoint followup surveys. To monitor the secondary trial objectives, two other categories of surveys will be performed, called the evaluation surveys and the special population surveys.

Of the 500 heavy smokers identified in each of the 22 communities, 400 will be randomly assigned to the endpoit cohort, which will be monitored annually to assess the impact of the intervention. These annual telephone followups will include only questions to determine smoking status and residency in order to minimize the impact of repeated contacts. Successful cessation will be confirmed biochemically only at the end of the study.

Participating communities

The community intervention centers, principal investigators and participating communities are:

American Health Foundation, New York City, Ernst Wynder. Yonkers, intervention; New Rochelle, comparison.

Fred Hutchinson Cancer Research Center, Seattle, Maureen Henderson. Bellingham, intervention; Longview/Kelso, comparison.

Kaiser Foundation Research Institute, Berkeley, Lawrence Wallack. Vallejo, intervention; Hayward, comparison.

Lovelace Medical Foundation, Albuquerque, Neill Piland. Santa Fe intervention; Las Cruces, comparison.

New Jersey Univ. of Medicine & Dentistry, Newark, Norman Hymowitz. Patterson, intervention; Trenton, comparison.

Oregon Research Institute, Eugene, Edward Lichtenstein. Medford/Ashland, intervention; Albany/Corvallis, comparison.

Research Triangle Institute, Research Triangle Park, NC, Tyler Hartwell. Raleigh, intervention; Greensboro, comparison.

Roswell Park Memorial Institute, Buffalo, Michael Cummings. Utica, intervention; Binghamton/Johnson City, comparison.

Univ. of Iowa, Iowa City, Paul Pomrehn. Cedar Rapids/Marion, intervention; Davenport, comparison.

Univ. of Massachusetts Medical School, Worcester, Judith Ockene. Fitchburg/Leominster, intervention; Lowell, comparison.

Waterloo Research Institute, Waterloo, Ontario, Allan Best. Brantford, intervention; Peterborough, comparison.

The communities were matched for size, demographic and smoking characteristics. David Byar, chief of DCPC's Biometry Branch, determined which of the two in each case would be the intervention by lottery.

Cullen says COMMIT is the "best program NCI has" but there is more to come.

"Smoke Free America" is what Cullen and his colleagues are calling a new concept they will be presenting next. "It will reach 50 million Americans. We will take what we have learned from all the smoking related trials, including COMMIT, and applying it to entire states."

The new program is scheduled to go into the planning phase in 1990 and implementation in 1992, just as COMMIT is winding up implementation. The American Cancer Society and state health departments may participate.

Wisconsin Funds Cancer Control Program With $450,000 Appropriation

Wisconsin recently joined the ranks of more than two dozen states which fund cancer control programs. The state legislature approved $450,000 for the 1988-89 fiscal year to begin developing the Wisconsin Cancer Control Initiative.

The Wisconsin Cancer Council, a group of 23 cancer related agencies, worked with the governor to develop this initiative to cut the state's incidence, morbidity and mortality of cancer.

Specific objectives include:

*Developing innovative cancer prevention and control programs.

*Collaborating with health care providers, researchers, local public health agencies and health care organizations to develop statewide cancer prevention and control activities.

*Transferring new information and technology for treating, diagnosing and preventing cancer to Wisconsin residents and health care providers.

*Increasing the number of patients receiving the most advanced diagnosis and therapy available.

Qualified organizations will compete for the bulk of these funds by submitting project proposals. Cancer control experts will review the proposals and award grants based on merit and how closely they ascribe to the goals of the Wisconsin Cancer Control Initiative, according to Paul Carbone, chairman of the Wisconsin Cancer Council.

Possible proposals might include screening programs, smoking prevention studies and cancer education efforts.

"The plan is simple," Carbone said. "By applying current methods to prevent and treat cancer, we can decrease deaths significantly.

Wisconsin is well known for its excellent cancer researchers and treatment facilities, but these accomplishments are funded mostly by federal dollars, which cannot be used to promote the application of such findings within Wisconsin communities.

"Thanks to Gov. Tommy Thompson and the legislature, the Cancer Control Initiative can now help disseminate this valuable information throughout the state, and help save lives."

Carbone, Univ. of Wisconsin (Madison) Medical School professor of human oncology and medicine and director of the UW Clinical Cancer Center, also pointed out that the existing Wisconsin Cancer Reporting System is a focal part of the plan. The WCRS, started in 1976, collects data on all newly diagnosed cases of cancer to determine incidence rates and matches data with death records to determine mortality rates.

Initiative funds will increase WCRS capabilities to better collect and analyze data for planning, coordinating and evaluating resources to curb cancer in Wisconsin, Carbone said.

Tobacco Research Council Grants Now Total 3,348, $120 Million

The Council for Tobacco Research, which was in the news recently in connection with the landmark New Jersey lawsuit involving a lung cancer patient and cigarette manufacturers, noted in its annual report for 1987 just released that the total number of published scientific documents supported by the Council is 3,348, at a cost of $120 million.

Although the Council's support comes from the tobacco industry, it contends that it is totally independent and that its support of research is based entirely on scientific merit and relevance. Grant applications undergo peer review by the Council's Scientific Advisory Board, which consists of 14 scientists.

Leon Jacobson, professor of medical and biological sciences at the Univ. of Chicago, is chairman of the advisory board. Other members are Richard Bing, Huntington Medical Research Institutes, California Institute of Technology and Univ. of Southern California; Roswell Boutwell, McArdle Laboratory and Univ. of Wisconsin; Drummond Bowden, Univ. of Manitoba Health Sciences Center; Michael Brennan, Michigan Cancer Foundation and Wayne State Univ.; Joseph Feldman, Scripps Clinic & Research Foundation; Jeffrey idle, St. Mary's Hospital Medical School, London; Manfred Karnovsky, Harvard Medical School; Alfred Knudson, Fox Chase Cancer Center; Henry Lynch, Creighton Univ. School of Medicine; Barry Pierce, Univ. of Colorado Health Sciences Center; Gordon Sato, W. Alton Jones Cell Science Center; Sheldon Sommers, College of Physicians & Surgeons of Columbia Univ.; and Peter Vogt, Univ. of Southern California School of Medicine.

Hammer Agrees To Bush Request For Probe of FDA On Cancer, AIDS Drugs

Armand Hammer, chairman of the President's Cancer Panel, has authorized the release of the letter he received last month from Vice President George Bush, asking the Panel to investigate the Food & Drug Administration's regulation of anticancer drugs (The **Cancer Letter**, June 17).

Bush also asked in the letter to Hammer that AIDS drugs be included in the probe. Hammer has agreed to undertake the study.

Bush noted that he has been in charge of the Presidential Task Force on Regulatory Relief. He said he was concerned that barriers may exist to rapid development and deployment of effective treatments for cancer and AIDS.

"I would like to suggest that the President's Cancer Panel...undertake a systematic study of drug regulation as it affects progress in developing and making available therapies for cancer and for AIDS, and make recommendations for improvements.

"The Panel could provide valuable assistance by conducting such a study and providing a report...on such questions as:

*Should approval criteria for investigational new drugs (IND) and new drug applications (NDA) for cancer or AIDS be modified?

*What should be the appropriate endpoints for assessing effectiveness of new agents for the treatment of cancer and AIDS?

*What degree of flexibility should clinical investigators have in modifying approved investigational studies that would accelerate the IND process based on early findings, and to what degree should protocol modifications require new approvals?

*In what ways should the roles of affected institutions (FDA, NCI, private institutions) be modified to improve the process?

*Could the activities of commercial organizations in conducting research be better organized and integrated so as to enhance their contribution to the research endeavor?"

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-CM-97569-23
Title: Selective acquisition of compounds for anticancer and anti-AIDS screening
Deadline: Approximately Sept. 20

The Drug Synthesis & Chemistry Branch of NCI's Developmental Therapeutics Program in the Div. of Cancer Treatment is responsible for the acquisition of selected novel synthetic compounds for evaluation as potential anticancer and anti-AIDS agents. To fulfill this responsibility, DS&CB must provide a large number of selected compounds per year for evaluation in the anticancer and anti-AIDS testing programs. In addition to the acquisition of selected synthetic compounds, DS&CB is responsible for the development and implementation of compound selection criteria, management of samples and related correspondence to and from compound suppliers, and creation of the chemical data base by direct input to the automated NCI Drug Information System. Continued monitoring of past and current published literature (including patents) in chemistry, biochemistry and biology is an essential part of this project. The contractor shall support the overall program objectives of DS&CB by accomplishing the following interrelated tasks:

A. Provding DS&CB with a suitable volume and variety of "new" chemical structures of synthetic compounds from which DS&CB can select the ones it regards as the best candidates for evaluation in the anticancer and anti-AIDS screening program. At least 20,000 structures per year become a major portion of the pool of structures available through contribution of this project, NCI's European Liaison Office and submissions directly to NCI.

Selections of compounds to be acquired for screening are made only among those structures known to be "new" to the NCI automated data base. Thus, the structure must be entered into a temporary file in the data base. The staff of this project prepares the structures provided by all DS&CB structure sources for computerized selection. The number of structures at this point may be as high as 40,000 per year. The preparation is done by entering in the DIS the chemical structure along with specified nonstructural data to identify each structure. The selection process is an evolving science performed by experienced medicinal chemists.

Once the selections have been made, the contractor acquires samples of the synthetic compounds in quantities adequate for evaluation. Sample sizes of 50 mg or more are usually required. The sample acquisitions are performed by this project using a combination of methods including field operations by the contractor and/or correspondence with potential suppliers.

Reacquisition, i.e. the acquisition of samples previously tested, is the responsibility of this project. This activity involves the receipt of requests for reacquisition, the gathering of facts related to the reacquisition, and initiating the correspondence to achieve the reacquisition. Part of this responsibility includes tracking these reacquisition attempts through successful reacquisition or until the decision is made to terminate the request. The Drug Information System requires input related to reacquisitions.

B. Registration of the acquired compounds into a permanent automated chemical data base. "Registration" is the process by which each new sample to be tested by NCI is entered into NCI's permanent data base and identified with a serial accession number, the "NSC number."

Control is obtained by requiring that a fixed number of compounds are registered per year. It is expected that each year 5,000 to 6,000 synthetic compounds will be needed for anticancer evaluation and 10,000 to 12,000 will be registered in the anti-AIDS screening program. In addition, a much smaller number (approximately 200 to 400) of natural products will be registered per year. It is also expected that a majority of the compounds will be tested in both screening programs giving an estimate of 13,000 to 16,000 total registrations per year. Since it is very important to minimize the length of time from receiving a sample to the issuance of printed screening results, it is further required to regulate the rate of registrations on a weekly basis. The goal is to keep the number of registrations made weekly as constant as possible throughout the year and still end up with the required yearly total. Maintaining the permanent data base as accurately as possible will be this project's responsibility.

C. Providing complete correspondence and record keeping services required to maintain the overall DS&CB acquisition effort.

D. For literature surveillance, utilize a very broad base of past and current primary literature sources, published abstract services, and online information systems to continually monitor published works (including patents) in chemistry, biochemistry and biology.

The contractor's facilities must be suitably located to provide uninterrupted flow of daily services required by the project. These include (1) a minimum of one round trip to the DS&CB offices in Rockville, MD; (2) coordinating the transfer of incoming samples with appropriate documents to the storage contractor (currently located in the Rockville area); and (3) the transfer of program related materials (documents, structures, computer generated output, samples, etc.) within NCI facilities.

The procurement is a total small business set aside. It is anticipated that an incrementally funded contract will be awaarded for a period of five years, beginning on or about April 15, 1989.
Contract Specialist: Nancy Carrick
RCB Blair Bldg Rm 228
301/427-8737

NCI Contract Awards

Title: Multidrug resistance patterns in human tumor cells
Contractor: Integrated Genetics Inc., $777,905
Title: Maintenance of the NCI Drug Information System
Contractor: Fein Marquart Inc., $1,980,873
Title: Special studies of toxicology and pharmacology of anti-AIDS drugs
Contractor: Southern Research Institute, $510,844

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