THE CANCER LETTER

Vol. 15 No. 6

February 10, 1989

Price $185 Per Year North America
$200 Per Year Elsewhere

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

NCI, NCAB Consider Moving Basic Science Centers Out Of Core Grant Pool, Into Research Programs

NCI and the National Cancer Advisory Board are considering a major change in the funding mechanism for the Cancer Centers program. Under the proposal, made by NCI

(Continued to page 2)

In Brief

Diane Fink Moves To ACS California Div.; Preisler Named Director Of Cancer Center In Cincinnati

DIANE FINK, vice president for professional education of the American Cancer Society, has accepted the position of vice president for cancer control and professional services of the ACS California Div. Fink, who was the first director of what is now NCI's Div. of Cancer Prevention & Control, is a graduate of the Stanford School of Medicine. The California division is headquartered in Oakland. . . . **HARVEY PREISLER**, chief of hematologic oncology at Roswell Park Memorial Institute, has left after 15 years there to become the first director of the Charles M. Barrett Cancer Center at the Univ. of Cincinnati. The center provides clinical care while conducting basic and applied research into cell and molecular biology of neoplastic diseases. "We are currently seeking to recruit individuals with an interest in brain tumors, head and neck tumors, growth factors, immunotherapy and lymphomas," Preisler said. . . . **MICHIGAN STATE** Univ.'s board of trustees has approved development of a comprehensive breast cancer center, with programs on early detection, prevention, research, treatment and education. Erwin Bettinghaus and Nikolay Dimitrov are interim coordinators while a search committee seeks a director for the center. . . . **MARIAN KOSHLAND**, chairwoman of microbiology and immunology at the Univ. of California (Berkeley), will receive the FASEB Excellence in Science Award at the federation's annual meeting in New Orleans next month. . . . **BEATRICE MINTZ**, senior member at Fox Chase Cancer Center, was awarded the 1988 Amory Prize from the American Academy of Arts and Sciences, which recognizes significant advances in developmental biology. She was cited for her "outstanding work in cell development and differentiation". . . . **LOUIS SULLIVAN'S** confirmation hearings as secretary of the Dept. of Health & Human Services were postponed last week at the request of the White House. Neither the Finance Committee nor the Labor & Human Resources Committee had scheduled new dates as of Feb. 7.

NCI Considering Major Funding Change For Basic Science Cancer Centers

(Continued from page 1)
Director Samuel Broder this week, the centers that primarily conduct basic research would be transfered to the research program grant pool (ROIs and POIs), taking their portion of the Cancer Centers' budget--about $20 million--with them.

The administrative move, which would not require the approval of NIH or Congress, would protect the clinical centers from being pushed out of the program little by little, Broder told the board's Cancer Centers Committee. Basic science centers consistently get higher priority scores--on average about 20 points higher--than clinical centers.

"The situation for centers is urgent and it will become even more so in the next fiscal year," Broder told the committee. "I'm very concerned that in a time of limited resources, we are facing the possibility that because basic science centers receive higher priority scores, the centers that will go belly up will be the clinical, or comprehensive, centers.

"I see that an an enormous vulnerabilty, because Congress set up the centers program to support basic sceince, but also to provide a strong and vigorous vehicle for translating technology to their own communities," Broder said.

The centers fiscal 1990 budget is $100 million, including money for AIDS. Excluding AIDS money, the centers budget actually fell about 1 percent from the current level.

This year, three basic science centers, five comprehensive centers and nine clinical centers are up for review, and two new centers have entered the competition.

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Published forty-eight times a year by The Cancer Letter, Inc., also publisher of The Clinical Cancer Letter and AIDS update.

The move would not "transmogrify" the basic science centers into program projects (POIs), Broder said. It would merely enable him to tie funding levels for the basic science centers to the funding of ROIs and POIs.

The advantage of the move, Broder said, would be what he called "truth in advertising." It would enable him to better "package" the cancer centers program for Congress.

"We are seeing a lot of resistance to changing the cancer centers budget," Broder said. "Congress might be more receptive to the centers program if they know where the money is going, which they can't know now."

NCI could also make an argument to Congress that funding for the basic science centers should be tied to funding for the research program grants. Broder argued that the ROIs and POIs are usually protected by Congress.

"We can go to Congress and first, defend the research program grants. Then, we can tell them, please take into account that basic science centers play an integral part and should be linked to funding for the RPGs."

John Durant, chairman of the centers committee, said he favored the proposal.

"There is an increasingly serious funding problem," Durant said. The change might make the centers program "a more comprehensible package for Congress to understand. We could go back to Congress and say, fellows, if you really want to see science turn into medicine, the centers need some support." He noted that the clinical centers may be more appealing to the public than basic science centers.

Whether or not the board endorsed the proposal, Durant said, it ought to give Broder some direction on the centers program.

Durant outlined three options the board could take:

Option 1: Leave the centers program alone and continue the present funding process. That would result in funding 12 centers this year at 85 percent of the recommended funding level. If that carried on, the ratio of clinical to basic science centers would change dramatically in just a few years.

Option 2: Create a more spartan program by fully funding fewer centers. If this option were tried this year, eight centers could be fully funded, dropping nine existing centers and two new centers. That would also lead to a net transfer of funds out of clinical centers into basic science centers.

Option 3: Broder's proposal of separating the centers into two categories, basic science

and clinical, and tying the funding of the basic science centers to the research program grant pool.

"The success of Option 3 is unproven," Durant said, but the other options are not very attractive.

David Korn, NCAB chairman, asked whether there might be an Option 4, of funding centers at less than 85 percent in the hopes of keeping a few more centers alive. He said Broder's proposal "smacked a little bit of a protective earmark for basic science centers."

If funding levels were at about 80 percent, only one more center would be funded, said Lucius Sinks, chief of the Cancer Centers Branch in NCI's Div. of Cancer Prevention & Control. The other drawback to that option, Sinks said, is that it "tells the scientific world that peer review doesn't matter.

"When you start funding far below the recommended level, those centers that have done well are penalized," Sinks said.

If NCI were to fund all of the 17 centers, they would be funded at only 68 percent of the recommended level.

Broder said his proposal would not make much difference in the actual funding in the next year. In the second year, however, NCI could make the argument that basic science centers should not have to take a funding decrease and that the clinical centers are an important part of the nation's overall effort for early detection and prevention of cancer.

"I'm not saying there's no risk," Broder said. "I'm saying it will be worse if we do nothing. I could be wrong."

Broder also cautioned that NCI cannot assume it will get the full budget proposed by the Reagan Administration. In fiscal 1989, NCI got $20 million less than the President's budget proposed.

"Officially, I must defend the President's budget, but I will do everything I can to signal that we need more money," he said.

Board member Helene Brown said she leaned toward supporting Broder's idea. "While it's risky, it gives us an interim measure," she said. "It doesn't have to be permanent if the funding situation changes."

Durant agreed, saying the situation could be monitored and changed back to the present system if necessary.

Board member Enrico Mihich, while saying he had reservations about the proposal, said the basic science centers and the clinical centers "were two bedfellows that didn't fit together."

Broder urged the committee to take action this year and not to wait. "If you are prepared to say the centers budget should be totally committed to basic science, then you should say it up front."

Board member Samuel Wells said, "I don't think anyone in this room would want that."

Board member Roswell Boutwell said he was concerned that the move would be "a first step to phasing out" the basic science centers.

"I'm not suggesting that," Broder said. "It might protect basic science centers better because Congress usually protects research program grants.

"The current situation is the first step toward to significant damage to our comprehensive centers--that's a certainty, that's not hypothetical," Broder said.

"We want to be in a position where we can ask comprehensive centers to participate with us in important national efforts that are maybe not as glamourous as cloning genes," Broder said, mentioning prevention of cervical cancer, smoking cessation, and cancer prevention for minorities.

The issue comes down to "what is the best science," Broder said. "I would argue that if you could get everyone in the U.S. to stop smoking, that's as valid as basic research."

One danger of the proposal, said Korn, is that by declaring the clinical centers "an instrument of public health, then you never can close one no matter how bad it is. Then you have useless monuments."

Peter Greenwald, director of the Div. of Cancer Prevention & Control, said that the proposal would not affect the peer review system.

"I don't think we have to worry about funding bad centers," Greenwald said.

Board member Louise Strong asked what would happen to clinical centers with a very strong basic science component.

Sinks said that the clinical centers that receive higher priority scores are those that have good basic science programs.

The committee endorsed Broder's proposal and presented it to the full board. Part of the proposal also was to ask the clinical centers to accept added responsibilities in prevention in exchange for additional funding, if more funding becomes available. Possibly, all of the clinical centers would be declared "comprehensive."

The committee decided to table discussion of the criteria for comprehensive cancer centers. Durant said such a discussion "would

be almost meaningless" given the current funding situation.

Durant presented the funding proposal to the full board Tuesday, and although there had been extensive discussion of it at the committee meeting, there was none whatever then.

"We agreed that we didn't like any of the options, but the best was to continue funding at 85 percent, which would result in some centers being pushed out," Durant said.

"My view and that of others is that our committee should be involved in strategic planning on the future of the centers program," he said. An interim meeting of the Centers Committee may be held prior to the May board meeting, with further discussion of the Broder proposal, the comprehensive center issue and the appropriate location of the centers program.

The Institute of Medicine Committee on the Cancer Centers Program is scheduled to deliver its report on the centers program at the end of March. The committee meets for the last time on Feb. 22.

FDA And NCI "In Substantial Agreement" On Approval Criteria

FDA and NCI are "in substantial agreement" on criteria for approval of experimental cancer drugs, FDA Office of Drug Evaluation Director Robert Temple told the second meeting of the National Committee to Review Current Procedures for Approval of New Drugs for Cancer and AIDS.

Temple said the agency agrees with most points made in recommendations by the Div. of Cancer Treatment's Board of Scientific Counselors last year, and that FDA will make a formal written response soon. "We agree with almost all of them, and would say that what they describe is approximately what our policy is."

He characterized recommendations made at the previous meeting by DCT Director Bruce Chabner, however, as "to some degree at odds" with those submitted by the division's board. The board's recommendations, for example, did not assert that partial responses of 20 percent "should be a basis for approval," he said. "They may have meant to say that, but that isn't what they said."

Discussing Chabner's assertion that complete responses should provide a basis for approval, Temple said he would agree "except in the case of carboplatin, where survival data exists" on cisplatin for ovarian cancer.

Temple said the agent will soon be approved for patients with refractory disease. He expressed reservations about approval for front line therapy, however, without knowing how the agent compares to cisplatin in survival. FDA's Oncologic Drugs Advisory Committee recommended approval as second line therapy and indicated it would support approval for first line treatment without survival data if there were improved response rates, but that because the agent demonstrates comparable response rates, survival data was needed.

Following persistent questioning by committee members about carboplatin, Temple said, "I don't understand why anybody hoping to use carboplatin wouldn't want to know how it compares" with cisplatin. "I think the reason is that people think they do know."

"No Standard Therapy"

Chabner disagreed with Temple's assertion that "it's important to compare" carboplatin "against standard therapy. I don't agree because I don't think we have good therapy for ovarian cancer. Our cure rate is only 20 percent at the most, and these are in somewhat selected patients, I can't consider a disease where 80 percent of the patients are dying of that cancer as having a standard therapy. To me, approval of a drug that demonstrates activity is an important step toward achieving an effective therapy. I think that having carboplatin approved for first line therapy is warranted."

He also commented on Temple's statement that "'well, the drug is available for refractory use, so if you want it you can use it for patients in first line therapy.' This is true, you're not going to be put in jail for doing this, but you're not going to get reimbursed."

Lack of support for research trials and third party payment "is a growing concern of ours. For this reason, I think that early approval for first line use is very, very important. I think that's another important aspect of our disagreement."

Committee Chairman Louis Lasagna asked Temple about "significant delays" between advisory committees' recommendations for approval and FDA approval.

Temple said FDA has had only one disagreement with its advisory committee in recent years, in the instance of mitoxantrone for breast cancer. While the committee recommended approval in 1986, FDA disagreed

because it knew of additional data. When brought back before the committee in December of 1987, only one member recommended approval. The drug has still not been approved because of poor survival data, he said.

"I don't understand why it's important to compare mitoxantrone to adriamycin, when single agent adriamycin produces a survival benefit of a few months in a small fraction of the treated population," Chabner countered. "I think what is important is to encourage development of mitoxantrone and to explore its uses. That will come after approval."

Noting the agent's lower cardiac toxicity as compared to the dose limiting cardiac toxicity seen with adriamycin, he said the decision not to approve the drug when it first went to FDA in 1985 "may have had serious adverse consequences in developing autologous bone marrow transplant regimens that would be more effective."

Charging "basic differences in philosophy about drug approval," Chabner said, "I don't think that it should be the FDA's role to define standard therapy for diseases for which we don't have cures."

FDA's role "is to ensure that a drug has activity and that it is safe to use. Beyond that, I think it is up to the research community to define the role of drugs."

A number of committee members expressed concern about what they perceived as FDA's insistence on too low starting dosages in phase 1 trials. "There is an implicit assumption by the patient and by the physician that there is some expectation of usefulness, that this is not purely a self sacrifice exposure to risk without potential gain," committee member Samuel Hellman said. "I think we're all comfortable with phase 1 trials if at the bottom end of the scale, there is some reasonable expectation. It may be small, but reasonable. When it is so low as to not be reasonable," it is difficult for investigators to ask patients to participate.

"I don't believe we're wedded to any particular escalation stage or" starting dose, Temple said. He emphasized that protocols may be modified, but that FDA must be notified if safety issues are involved.

To charges by committee member Peter Hutt that there seemed to be a great deal of confusion about FDA policy, Temple said the rules are clear, and that sponsors worried about FDA's reaction should call agency staff. He also stated that problems such as IND modification more often refer to biologics and AIDS drugs than cancer agents.

Temple also said that endpoints other than survival can be used for approval. For example, sponsors "don't need a mountain of data" for approval of agents for refractory illnesses.

"If you really care, you come in early and meet" with FDA staff, he said.

Bills To Lift $50 Mammography Cap Are Planned; Other Cancer Measures

Legislation lifting the $50 cap on Medicare reimbursement for screening mammography will be introduced in Congress next month, **The Cancer Letter** has learned.

Congresswoman Barbara Kennelly (D-CT) plans to introduce the measure in the House around March 1, and Sen. Christopher Dodd will introduce the companion measure in the Senate.

The legislation would set the screening mammography rate equal to the diagnostic mammography rate, which is reimbursable under Medicare up to a "reasonable limit."

The Catastrophic Coverage Act passed last year imposed the cap on fee reimbursement. Since the test for screening and diagnostic mammography is the same, the fees should be similar, a spokesman for Kennelly said. The cap defeats the intent of the legislation, which was to increase the number of women screened for early signs of breast cancer, Kennelly believes.

Many physicians and clinics do not offer the test for $50, and most charge between $80 and $200. The average charge for diagnostic mammography is between $100 to $120.

Estimates are that 5 to 15 percent of women over age 40 are getting the screening mammography, a Kennelly spokesman said. Ideally, every woman over age 40 should get one.

Lifting the cap would make it more likely that doctors would invest in the equipment, thus making the test more available, Kennelly believes.

Under the last year's Medicare payment schedule for mammography, the legislation would cost $124 million in 1990 and rise to $229 million in 1993, the Congressional budget office estimated. That estimate is based on an average cost for the test of $107, and an assumption that 35 percent of eligible women would get the test each year.

However, since radiology is coming under a new payment schedule this year, it is not clear what would happen to those figures.

The General Accounting Office is currently studying the mammography reimbursement issue and is scheduled to release a report late this summer.

In a related development, Mary Rose Oakar (D-Ohio) has introduced a bill, HR 209, that would amend the Social Security Act to provide for annual coverage of screening mammography for women over age 64 and to increase the base payment limit from $50 to $60.

Oakar also has introduced a bill, HR 200, that would require states to enact laws which require physicians and surgeons to inform breast cancer patients of alternative effective methods of treatment for breast cancer in order to quality for certain federal funds.

Sen. Daniel Inouye (D-HI) has introduced a bill, S67, legalizing the prescription of parenteral diacetylmorphine (heroin) to terminally ill cancer patients for relief of intractable pain.

The bill, titled the Compassionate Pain Relief Act, authorizes HHS to establish demonstration projects and regulations for the safe use and storage of the heroin. The program would be in force for five years.

Inouye said his bill "has more than adequate safeguards to prevent the drug from being introduced to the general public."

The patient's physician would have to make a diagnosis approving the use of the drug, and his decision would have to be approved by a medical review board of the hospital dispensing the drug. The heroin to be used would come from the supply confiscated by police.

For the second year in a row, Sen. Lloyd Bentsen (D-TX) has sponsored a resolution designating the third week in April "National Minority Cancer Awareness Week." Introducing the measure, Senate Joint Resolution 34, Bentsen said, "One way that Congress can help the medical community in dealing with the minority cancer problem is by promoting public awareness of the cancer crisis in the minority and economically disadvantaged community."

Board OKs Nutrition Research Concept, STCP Support Contract Recompetition

The concept for new, five year program project grants for research on the role of nutrition in cancer prevention was approved by the Div. of Cancer Prevention & Control Board of Scientific Counselors at its last meeting.

The board also approved recompetition of the support services contract for the Smoking, Tobacco & Cancer Program, which would raise the annual budget of the contract to about $1 million from the current $472,000. The present contract is held by Prospect Associates.

A noncompetitive $104,00 five year program of cancer surveillance in Alaska for Native Americans was approved as an interagency agreement between NCI, the Indian Health Service and the Arctic Investigations Laboratory of the Centers for Disease Control.

The goal of the nutrition and cancer prevention research program, to be directed by the Diet & Cancer Branch, will be to develop a multidisciplinary, extramural research effort that would provide insight into the role of nutrition in cancer control and prevention, said Carolyn Clifford, chief of the branch. Two grants of $550,000 each would be awarded under the program.

Several board members said the nutrition program could be, as Johanna Dwyer said, "a way to keep nutrition research going" despite the lack of construction funds for a nutrition lab at the Frederick Cancer Research Facility.

It is also a recognition of the fact, said board member Frank Meyskins, that "nutrition has not amalgamated itself well with modern biology."

Presentations on the three concepts included the following:

Nutrition and Cancer Prevention Research Program.

During the past decade there has emerged a profound interest in the role of diet and nutrients in cancer risk. Present knowledge about the relationship of diet to cancer incidence and mortality is based on epidemiologic and experimental studies. Epidemiologic or observational studies offer interesting potential approaches to intervention studies but leave much to be desired with respect to causal relationships between dietary components and some types of cancer.

Increased emphasis on the science of both nutrition and carcinogenesis and the relationship of these two fields accelerate and expand understanding of the role of diet in cancer prevention. Knowledge of the mechanisms of carcinogenesis at the molecular level will be helpful in designing nutrition experiments for the purpose of cancer prevention. Conversely, data obtained from nutrition experiments that reveal effects of specific dietary components on cancer incidence can provide evidence for the molecular processes that are obligatory for carcinogenesis.

In 1983, the NRC Committee on Diet, Nutrition & Cancer recommended that future research central to further progress in defining the role of nutrition in cancer prevention should include fundamental research into the ways diet affects cancer, taking advantage of recent advances in molecular biology, improvement of methodological shortcomings, including animal models and development of biological markers.

To address these recommendations and the knowledge gaps, a broadly based, multidisciplinary, extramural research program with both short term and long term goals will be essential in advancing the nutrition and cancer research efforts.

To meet this challenge effectively it is now

necessary to build stronger intellectual and active research bridges between the disciplines that relate closely to clinical research, basic research and the process of carcinogenesis and its prevention. Current research thrusts and funding do not provide a framework within which this multidisciplinary approach to nutrition and cancer prevention research can be effectively fostered.

The nutrition and cancer prevention research program is a new initiative which will complement the other multidisciplinary research programs supported by the Div. of Cancer Prevention & Control. It will also provide added dimensions and new opportunities for nutrition and cancer research. Increased cooperation, communication and collaboration among participating investigators will accelerate the acquisition of knowledge and should result in a greater contribution to the program goals that if individual research projects were pursued separately.

The nutrition and cancer prevention research program is an attempt to establish high quality, long term research programs in nutrition and cancer and will be supported by the NCI program project grant (PO1) mechanism. The NCPRP concept envisions a multi-disciplinary environment of scientists interacting closely in the research program. These can include new as well as experienced investigators in relevant fields and disciplines, such as nutritional sciences, biochemistry, molecular biology, genetics, physiology, disease prevention and control, medicine, public health, epidemiology and biostatistics.

The NCPRP will require a major program theme to focus the research efforts and form the basis for multidisciplinary and interinstitutional collaboration and synergism. The intent is to establish NCPRPs in institutions that have a critical mass of resources and qualified investigators who can focus or redirect efforts into nutrition and cancer research.

The NCRU should include the following components:

--A qualified leader with an appropriate time commitment for coordination and integration of NCPRP components and activities.

--A multidisciplinary group of prevention oriented scientists who can conduct basic and clinical research in the area of nutrition and cancer.

--One major specific research theme to focus the NCPRP efforts, and at least three research projects including both laboratory and clinical research.

--Specific developmental projects are allowed as an optional category for up to 15 percent of the direct costs of the NCRU. These projects will undergo peer review as part of the overall NCPRP application review process.

--Research or administrative core units or shared resources necessary to more efficiently conduct the research program. (Optional)

Smoking, Tobacco and Cancer Program Support Services Contract.

This is a recompetition to provide NCI's Smoking, Tobacco & Cancer Program with support services essential to the continuing development of intervention research in smoking prevention and cessation, and dissemination of results from the trials within a national research strategy to reduce cancer mortality caused by tobacco use.

STCP serves as the focal point for NCI's research, disease prevention and health promotion activities related to tobacco use and cancer. Although research and control activities are the responsibility of several divisions and offices, central coordination of STCP is provided by the office of the director of the Div. of Cancer Prevention & Control. DCPC, in collaboration with the Div. of Cancer Etiology and the Office of Cancer Communications, is responsible for STCP's research and control efforts to reduce deaths caused by or related to the tobacco use. STCP collaborates with other NCI units, NIH, federal, state and local governments and private organizations.

STCP administers an aggressive extramural, interdisciplinary, applied research program to investigate intervention programs that can successfully modify smoking and tobacco use behavior. This program currently encompasses 60 intervention trials involving over 10 million people in 30 states and 250 communities. As these trials enter their last phases in the early 1990s, a consensus of the most active ingredients and the most effective strategies must be defined.

In addition, the hundreds of educational and informational products and documents which are being developed in these trials need to be collected and evaluated for national dissemination. Finally, the research knowledge from the more than 200 scientific papers already published from these trials need to be collected and evaluated. The whole process of completing and preparing the focused STCP trials for national dissemination is expected to substantially increase the demands on the support contract function.

In addition to these focused trials, STCP has begun full implementation of the Community Intervention Trial for Smoking Cessation. Throughout the early 1990s, results from the initial phase of the trial must be considered for potential dissemination. Finally, STCP has now added the program that should serve as the culmination of the national research strategy. Approval has been received to initiate the American Stop Smoking Intervention Study, which will mount community based tobacco control coalitions in up to 20 states and major metropolitan areas.

The demand upon STCP has escalated rapidly in recent years and is expected to continue its escalation as the program moves from its externally managed grant research program to an internally managed national applications program for the dissemination of proven results.

The current support contract has provided DCPC and STCP with invaluable logistical and technical support to maintain the STCP research network across the 60 research trials. Additionally, the support contract has been invaluable in the development of scientific consensus meetings focusing on physicians and dentists interventions, school based interventions, self help strategies and media intervention strategies.

It is expected that the level of these types of services will continue to grow as the 60 STCP funded trials reach maturity in the early 1990s. The increased demand projected for DCPC and STCP is appropriate to be addressed through the contractual support services contract and is critical to the overall effort to meet NCI's year 2000 goals related to tobacco use control.

The support services contract will provide STCP with scientific, technical and logistical support in the following areas:

Conference meeting support: The support contractor will assist STCP in the conduct of conferences, meetings, workshops and seminars by providing a strategy and operational plans for conduct of the meeting; preparing and distributing to participants necessary background and orientation materials; providing assistance with lodging and travel arrangements; and providing onsite conference service functions.

Planning, data management and data analysis support: The contractor will provide support for the development and updating of STCP operational plans including the preparation of issue and background papers and tracking progress toward program goals. The contractor will assist in the design and conduct of small studies; the identification and organization of national and international numeric and bibliographic data on smoking, tobacco and cancer and assist STCP with the design of analyses of that data.

Writing, editorial and graphics services: The support contractor will assist STCP with: preparation of scientific and technical reports; identification and acquisition of scientific expertise specific to the topic to be addressed; and literature searches, scientific writing and editing, copy editing, the preparation of graphics for tables and figures and slides and charts for presentation.

Access to content specific scientific expertise: The contractor will assist with the start up and implementation of STCP's major research and applications program. Implementation of these efforts will, from time to time, require specific scientific expertise in the areas of smoking intervention and cessation, biomedical and behavioral expertise related to tobacco use and cancer. Over the years proposed in this renewal, the support contractor selected will be expected to meet the needs of STCP by providing these and additional support services necessary to fulfillment of STCP and DCPC objectives.

The approximate annual budget, contingent upon availability of funds is $950,000 in 1990, $1 million in 1991, $1.05 million in 1992, $1.1 million in 1993, and $1.15 million in 1994.

Five Year Cancer Surveillance of Alaskan Natives

The primary goal is to provide a set of baseline cancer incidence, mortality and survival data against which the results of intervention programs can be measured. Some examples may include: increased use of Pap smears for early detection of cervical cancer; reduction of lung cancer and the reversal of increasing lung cancer trends through smoking cessation and prevention programs; monitoring the effectiveness of liver cancer mortality through vaccination for hepatitis B and alpha-fetoprotein screening for individuals at high risk and leading to detection of the disease at an early stage; providing staging information to assist in evaluating the effectiveness of screening programs.

The program has the following objectives:

1. To initiate and maintain a system of cancer surveillance for the five years 1989 through 1994 which will assure the identification and registration of all Alaskan Natives who are Alaskan residents and who are newly diagnosed with cancer. Data collection will be retroactive to 1984 diagnoses. Information of epidemiologic importance to Alaskan Natives will be included. These include ethnicity to linguistic subgroup, quantum of Native blood, village of birth and village of diagnosis. Other data to be collected will include stage of disease at diagnosis, treatment and other demographic and tumor descriptors. To the extent possible, information on the cancer patients' diet, use of tobacco and alcohol will be collected. Information of cancers detected by screening will be collected.

2. To update existing cancer incidence records on Alaskan Natives from 1969 to 1983 with follow up data to enable survival analyses on this older data. This includes the assessment of 1980 through current mortality.

3. To analyze and report on the cancer incidence, mortality and survival experience of Alaskan Natives as determined through the registry. To perform analyses of temporal trends and rate comparisons with other racial and ethnic groups in Alaska and elsewhere.

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 Executive Plaza room number shown, National Cancer Institute, NIH, Bethesda, MD 20892. Proposals may be hand delivered to the Executive Plaza, 6130 Executive Blvd., Rockville, MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CN-95162-41

Title: Support contract for special populations initiative
Deadline: Approximately March 6

NCI's Div. of Cancer Prevention & Control is soliciting proposals from small business organizations interested in furnishing all necessary personnel, facilities, equipment, materials and supplies, except as may be otherwise provided by the government, to provide necessary research and logistical support to the Special Populations Studies Branch in the conduct of planning, data management and analysis; scientific review; report, manual and article preparation; conference management; editorial services; graphic services; administrative support; and liaison.

This procurement is a 100 percent set aside for small businesses. For the purpose of this procurement, a small business is defined as one whose average annual receipts for the preceding three fiscal years do not exceed $3.5 million.

Contract Specialist: Susan Hoffman
RCB Executive Plaza South Rm 635
301/496-8603

RFP NCI-CP-71106-56

Title: Record linkage studies utilizing resources in population based tumor registries (master agreements)
Deadline: Approximately April 14

This is an annual notice issued by NCI in seeking qualified firms with population based cancer registries in the U.S. and in other countries in order to collaborate in the conduct of record linkage and subsequent analytic studies. The master agreement currently consists of 20 master agreement holders, under a four year master agreement which expires March 14, 1992.

Offerors should have cancer incidence data for all patients diagnosed within a defined geographic locale during the decade 1976-1985. Offerors must have experience in the collection of cancer data from a variety of medical sources and multiple institutions. Offerors must have experience in obtaining information on vital status of cancer patients years after initial diagnosis.

Offerors must have the legal authority to collect medical data within the given geographic area or else be able to demonstrate the willingness of all medical facilities within that area (including hospitals, clinics, private pathology laboratories, private radiotherapy facilities, and nursing homes with diagnostic services) to participate in data collection and patient followup activities. Offerors must have the ability to obtain, access to existing population based registries of exposed groups of individuals in the geographic areas covered by the cancer registry. Offerors must be willing to conduct collaborative research studies and analyses with the Epidemiology & Biostatistics Program and must be willing to permit the pooling of data with other cancer registries for combined analyses.

Master agreements will be awarded to all offerors whose technical proposals are considered acceptable. The initial master agreement award is nonmonetary, and is exclusively for the purpose of establishing a pool of contractors who are qualified to perform services for epidemiologic studies of cancer utilizing the resources of population baased cancer registries. Each master agreement holder will be eligible to compete for awards of master agreement orders to carry out specific record linkage and subsequent analytic studies.

Contracting Officer: Sharon Miller
Contract Specialist: Donna Winters
RCB Executive Plaza South Rm 620
301/496-8611