THE CANCER LETTER

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Broder Emerges As National Leader In ASCO Talk, Calls For Faster Reporting Of Clinical Trials

NCI Director Samuel Broder demonstrated in a rousing discussion with members of the American Society of Clinical Oncology that not only is he in charge of the National

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In Brief

Esparza, Young, Busch, Rush Head Oncology Societies; Hipple Center Honors Harry Eagle

NEW LEADERSHIP lineup of the oncologic societies which held their annual meetings in San Francisco last week: **Dolores Esparza** succeeded **Deborah Mayer** as president of the Oncology Nursing Society. Esparza is corporate director of oncology nursing for Salick Health Care. President elect is **Barbara Britt**, clinical nurse specialist at Childrens Hospital of Los Angeles. **Catherine Hogan** is the new secretary, and **Joanne Hayes** will serve the second year of her term as treasurer. New directors are **Pamela Hagan** and **Deborah Armstrong**. New president of the American Society of Clinical Oncology is **Robert Young**, president of Fox Chase Cancer Center, succeeding **Charles Coltman**. **Harvey Golomb**, Univ. of Chicago, is president elect. New directors are **Karen Antman** and **Robert Mayer**, both of Dana-Farber Cancer Institute. **John Yarbro** starts second year of a three year term as secretary treasurer. **Harris Busch**, Baylor College of Medicine, is the new president of the American Assn. for Cancer Research, taking over from **Lawrence Loeb**. The new president elect is **Bernard Weinstein**, director of the Columbia Univ. Comprehensive Cancer Center. **Thomas King** continues as treasurer. New directors are **Mariano Barbacid**, **Bruce Chabner**, **Peter Jones**, and **Yung-chi Cheng**. New president of the Society of Surgical Oncology is **Benjamin Rush**, chairman of surgery at New Jersey Medical School, who succeeds **Blake Cady**. **Alfred Ketcham**, Univ. of Miami, is president elect; **Charles Balch** is vice president; **Bernard Gardner** is secretary; and **Samuel Wells** remains as treasurer. . . . **HARRY EAGLE**, founding director of the Cancer Research Center of Albert Einstein College of Medicine, was recently honored when the Hipple Cancer Research Center's conference center was dedicated to him. Eagle has been chairman of the Extramural Scientific Advisory Board at Hipple, which is located in Dayton, OH. . . . **MARJORIE SMITHERMAN** has received the M.D. Anderson Cancer Center's 1989 Brown Foundation Outstanding Nurse Oncologist Award.

Broder: Congress Is Impatient, Wants Improved Results Across the Board

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National Cancer Institute, he has established himself as the leader of the National Cancer Program.

Broder addressed ASCO at the society's annual meeting in San Francisco last week.

"My agenda is to prevent and cure cancer," Broder said. His performance indicated that he is willing to stir debate and challenge convention in that quest.

The National Cancer Act states that the NCI director is also director of the nebulous entity known as the National Cancer Program, which theoretically encompasses all the federal government's cancer research activities.

The ASCO session also was an opportunity for members to ask questions of the NCI director. That gave Broder the chance to hammer in several points about dealing with Congress on the budget, the need for faster reporting of clinical trials, the importance of the bypass budget, and the gap in the cancer mortality rates between whites and minorities, and between younger persons and the elderly.

These ideas are taking shape as Broder's themes.

"Good news and bad news." Broder began by giving an overview of his testimony to Congress on the 1990 President's budget request for NCI.

"I told them there was good news and bad news in the fight against cancer," he said. He cited statistics showing that mortality rates have decreased since 1973 in many types of cancer in persons under age 65. The "bad news" is the rising cancer mortality rate for persons over age 65 for many other common cancers.

Congress is impatient. "They want to know what have you done for us lately," Broder said. At the House and Senate budget hearings, Broder said he was asked to respond to "gloomy newspaper articles" saying science is "losing the war on cancer."

Broder said he disagreed with that assessment, but that, "these are legitimate questions we must be prepared to answer," Broder said. "Several congressmen said that they thought there should be a cancer vaccine. I tried to show them that there were several problems with that. They said, 'I don't want to hear about problems, I want a vaccine.' It's their Cancer Institute, it's their money, they want results."

In response to a question from an ASCO member, Broder also noted that if the incidence rate for a type of cancer goes up, even if the cure rate increases, "we do not win."

Black-white cancer mortality rate differential. Broder showed a graph of the falling mortality rate for colon/rectal cancer among whites, compared to the rising rate among blacks.

"This shows what advances can do for people who have access to the system and can take advantage of early diagnosis and treatment," he said. Pointing to the rising line for blacks, he said, "And this shows what happens to people who do not have access to the system. I can show you this kind of curve for virtually every major tumor. I think we need to do something about it."

Faster reporting of clinical trials. "I don't think we can ask the public to wait 10 or 15 years for results. We've come to accept a year's delay in publishing of results as normal," Broder said.

"Why do you accept that? That's not peer review. That's peer delay."

Broder continued: "We cannot do clinical trials without getting informed consent. Just as we cannot withhold toxicity or the potential toxicity from a patient, we cannot withhold data, knowledge on which one can make a reasonable inference that a data base exists. Therefore a patient, in order to participate, must know that information.

"The submittal of a paper to a peer reviewed journal is prima facia evidence that a knowledge base exists. Whether there is a consensus or not is a different issue.

"Therefore, we need to do whatever we can to make sure patients are aware, even if we have to superimpose our own uncertainty on it, just as we do with toxicities for which we are not sure."

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One participant at the meeting noted that the time it takes for peer review often improves studies. Broder said he disagreed.

"How can we complacently say, 'It's okay with us if it takes a year for a clinical trial to come out'? You're sending an important message, you're sending everyone a subliminal message: Hey, what's the rush?" he said.

Broder said the journal "Science" once took only two weeks to accept an article he had written on "a basic laboratory observation." About a month thereafter, the article was in print.

"I'm not sure that we can't have a similar process for clinical trials," he said. "I think when you don't publish a clinical trial, you are setting up a disequilibrium of knowledge. In addition, you are setting up an oligarchy. You are setting up an oligarchy of doctors who are aware of the trial and know the information and you are setting up another system in which people do not have access to the information and therefore cannot protect themselves.

"In a free society, you cannot ask people to do something for a greater good. A patient's duty is to save him or herself and patients need to know those facts as much as we need to know."

Another questioner asked what NCI or others could do about getting information out faster. Broder said NCI can do some "mechanistic things," such as improving the PDQ system or other computer technology.

"But you, yourselves, are going to have to rebel against the system, if you really mean business, that says it's okay to have a clinical trial take a year to be published," Broder said. "It wouldn't be appropriate for basic science, and believe me, there's plenty of peer review for that. It's not appropriate for clinical trials."

The age differential in cancer mortality rates. "My job is to solve problems and not to make excuses. That's why I've asked the division directors not to raise the issue of biological determinism with respect to individuals over the age of 65," Broder said.

"If that's what we're saying, that if you live beyond a certain age, you must get cancer, and don't blame us, then who needs you? The bottom line is many people in this country are over age 65 and they get cancer, and many of them are very young looking. That's why we sent out notices saying, please don't use age limits per se."

NCI is the Cancer Institute for all cancer. In response to a suggestion from a participant that physicians should not take the blame for rising lung cancer rates, Broder said, "Lung cancer is in our jurisdiction. Unless you want me to ask that the National Cancer Act be modified to call it the National Cancer Institute For Everything But Lung Cancer. We have to solve problems and that's our job."

Broder told ASCO members that although he agreed that further measures to control tobacco advertising are needed, "I cannot go to Congress and blame them. You can as private individuals. We need to do better education. We need to reach young people, minorities, women, we need to find solutions to the scientific problems.

"We can't say, God, It's not our fault. It's in our jurisdiction and we have to accept responsibility for it."

The importance of the bypass budget. Robert Young, the new president of ASCO, asked Broder, "You had an opportunity to tell Congress what the National Cancer Institute is doing to solve the cancer problem. I wonder if you had an opportunity to tell them what we're not doing: that we're not funding three-fourths of the RO1 grants that are approved, that we're going to end up cutting the Cancer Centers Program by 10 percent, that we're cutting the staff of NCI by 400 positions in the last four years, that we have no construction money, and we're collapsing cooperative groups in terms of the percentage of funding, and it goes on and on. I wonder if there are opportunities for the Cancer Institute to voice these concerns or do they have to be voiced from the outside?"

Broder responded, "No, they can be voiced and they can be voiced in a document I wish everyone would take a little more seriously--the bypass budget.

"I think the bypass budget has not received the support and the respect it deserves from the academic and practicing community. It is an astonishingly important right, a statutory requirement that is given to the Cancer Institute. This year we asked for approximately $500 million more than what is in the President's budget. I'm required to prepare this document.

"The bypass budget is a professional needs budget, not a political needs budget. We need at least $20 million more for cooperative groups, we need at least $30 million more in our Cancer Centers Program, and so on. When some of you tell me that the bypass budget is unrealistic, think what you are saying."

Looking ahead to the reauthorization of the National Cancer Act, which gives NCI the authority to prepare the bypass budget, Broder said, "You should support the bypass budget, and you should be prepared to defend and argue for the reauthorization of the National Cancer Act. It cannot be done with only the director of NCI running around alerting people that there's a problem. It's your concern, it's your Cancer Institute."

Karen Antman, chairman of ASCO's Public Issues Committee, noted that the society testified in Congress in support of the bypass budget.

Another participant asked Broder, "How can we help you?"

"There are a number of things you can do," Broder said. "For example, those of you who work in cancer centers or direct them: I personally believe that you should make a great effort to involve elected officials at a local, state and federal level, to come to your centers. We have run into situations where we have tried to arrange such visits but have been told by cancer center directors that they're busy. That is as important as almost any activity you can do. Congressmen should see at first hand what a cancer center is, what it means in the community, what a loss of a core grant is likely to mean in real terms."

"I told Congress that we will lose four or five center core grants this year and a comparable number next year with the current budget projections. There can be no doubt about what the implications of the budget are: We can do research, we can be productive, we're not going to take our bottles and go home, but everybody's on notice that we will have significant problems. But it's up to you to work with us to make sure that people understand what it means, what the term 'comprehensive' means to a community."

Cancer and AIDS patient advocacy. Sydney Salmon, director of the Univ. of Arizona Cancer Center, asked Broder about the role AIDS patient advocates have played in getting funding for research. "AIDS patient advocates have picked up a number of themes (on faster drug development) from the National Cancer Institute, but have implemented them," Broder said.

The attitude of the cancer research community, Broder said, is "Go ahead, you want to make a big deal of things like group C, getting things out, speeding experimental drugs, that's fine, but you do it, not us.

"The AIDS activists have said, 'Hey, we want to know, we want to act. Why does it take so long for a drug to be approved? What is the process? We don't want to use death rate as an endpoint, because that's our death rate.'"

Broder continued: "Call it what you want, but survival is the same thing as death rate, and death rate is a very severe standard. I'm not saying it should not occasionally be the only standard we can endure, but patients want to live, they want to act, they do not feel that they have to be used for somebody's else's purposes. AIDS activists have taught us that. I think it would be good if we had more cancer patient advocacy in a positive sense, who would demand things."

Broder's fantasy. Speaking to reporters before his speech, Broder was asked about his goals as director. "I'll tell you my fantasy," he said. "My fantasy is to be able to hold a press conference to announce the dismantling of the National Cancer Institute because cancer is no longer a problem."

Mortality, Survival Still Improving For Some, But Bad News For Others

NCI's annual statistics review, this year covering the period from 1973-1986, as in the past falls into both the good news and bad news columns. There is more than a hint that the trend is leaning toward the good side, especially for those who are white and under age 65. For others, the continuing bad news outweighs the good.

The review was released by NCI at the recent meeting of the National Cancer Advisory Board. A summary of the major findings:

*** Annual mortality rates (deaths per 100,000 persons for the period 1973-86**

--Improvement is evident in the large reductions in the annual cancer rates among persons under age 65. Bladder cancer mortality has decreased 29 percent; ovary, 24 percent; colorectal cancer, 14 percent; oral cancer, 17 percent; children's cancers, 35 percent; and cervical cancer, 38 percent. However, other cancers have shown increases--melanoma, up 17 percent; multiple myeloma, up nine percent; esophageal cancer, up six percent. The mortality rate for all cancers combined for persons under 65 decreased 10 percent if lung cancer is excluded, and nearly all lung cancer can be prevented by eliminating smoking. All

cancers combined decreased three percent in persons under age 65.

--Cancer mortality in children has declined 34.8 percent in the 14 years between 1973 and 1986 (60.3 percent since 1950) which is recognized as due to treatment, particularly treatment through the nation's network of clinical trials and cancer centers.

--Some significant decreases in cancer mortality rates among persons 65 and over have occurred since 1973. Cervical cancer is down 39 percent; bladder cancer, down 18 percent; and colorectal cancer, down five percent. On the other hand many cancer sites have shown increases in mortality--all sites combined, up 12 percent, and all sites combined excluding lung cancer, up three percent; lung cancer among females, up 141 percent; melanoma, up 47 percent; and brain cancer, up 54 percent.

--The lung cancer incidence rate (cases per 100,000) in males has begun to decrease. Lung cancer in females continues to rise but more recently at a much reduced rate of increase, down from 6.3 percent per year increase to 2.8 percent per year.

--The lung cancer mortality rate in white males has leveled off after a rise since 1973 of 16 percent. In contrast, the rate among all females increased 94 percent since 1973 and continues to grow at over four percent per year.

--The age adjusted annual mortality rate from all cancers excluding lung is down 2.1 percent since 1973, and attesting to the magnitude of lung cancer, mortality from all cancers combined including lung cancer is up 5.4 percent.

*** Disproportionate cancer rates among blacks**

--Black males have a mortality rate 40 percent higher than white males. Blacks have more than three times the mortality rate of whites for esophageal cancer. The mortality rate for black women is over 16 percent higher than the rate for white women. The differences between five year relative survival among whites and blacks by sex is particularly striking--females, 56 percent for whites against 44 percent for blacks; males, 46 percent for whites against 33 percent for blacks.

--For many cancers, black rates are increasing in contrast to decreasing rates among whites. Colorectal cancer mortality has fallen nine percent in whites, but has increased by 11 percent in blacks.

*** Cancer survival 1973-86**

--There is an increase in five year relative survival among white cancer patients. Survival has increased from 49.9 percent for patients diagnosed in 1974-76 to 51.1 percent for 1980-85. This is the largest such increase in the history of the SEER Program.

--There is an increase in five year relative survival from all cancers combined from 48.9 percent for patients diagnosed in 1974-76 to 49.8 percent for all cancers combined for patients diagnosed during the 1980-85.

--Among blacks, however, there has been a decrease in five year relative survival from 38.6 percent for patients diagnosed in 1974076 to 38.1 percent for patients diagnosed during 1980-85.

Other trends include:

The dismaying news that lung cancer continues to climb among women despite all that is known about preventing the disease. Now lung cancer mortality among women has finally overtaken breast cancer as the leading cancer killer among white women. Trends indicate the same will be true by the end of this year for all women.

While concern is high over rising breast cancer incidence rates, the increases may be due more to better and earlier detection than to a real change in prevalence. Nonetheless, breast cancer incidence rates have increased 15 percent from 1982 through 1986. The rates are now higher than for any year since data collection began in 1973. Many experts feel that the large increase also apparent in in situ breast cancer cases signals that early detection is taking place.

Breast Cancer mortality shows essentially no change from the preceding year in women over 50. On the other hand, for women under 50 the rate declined slowly from 7.0 deaths per 100,000 in 1973 to 6.0 in 1983 and has increased slowly from that point to 6.4 in 1986.

CCOP RFA Generates Huge Interest; Q&A Session Jammed At ASCO

A crowd of about 60 potential applicants for NCI's recompetition of the Community Clinical Oncology Program packed a room designed to seat 30 at the George Moscone Convention Center in San Francisco last week to glean what information they could from NCI staff about the $12 million program. The briefing was held during the annual meeting

of the American Society of Clinical Oncology.

The amount of interest generated by the program far exceeds the number of grants would like to award, 80. Since the RFA was released May 19, more than 2,000 copies have been sent to potential applicants, according to Leslie Ford, chief of the Community Oncology & Rehabilitation Branch. More copies were distributed at the ASCO meeting.

Ford emphasized the eligibility requirements: community based groups, single hospitals, HMOs, physician groups all are eligible. Centers with NCI funded core grants through the Cancer Centers Program and university based major teaching institutions are not eligible as CCOPs, although centers may apply to serve as research bases for one or more CCOPs.

Research base applicants can be NCI funded clinical cooperative groups, NCI funded cancer centers, and public health departments with cancer control expertise.

"Some people ask, 'We haven't done cancer control research, what should we say in the application?'" Ford said. "You should clearly document any experience you've had, your ability to access the population, and give two examples of the research you plan to do."

She stressed that cancer control research should involve intervention, not merely surveys. She said the definition used by the Div. of Cancer Prevention & Control is, "Intervention research aimed at reducing the incidence and mortality of cancer."

One participant asked whether the reviewers would consider the scientific experience of currently funded CCOPs in the application process.

"Absolutely," Ford said. "The best thing a (currently funded) CCOP can do is show what you've done since 1983 (when CCOP first began)."

Another participant asked how currently funded research bases should proceed since all of them will be recompeted. "How will we make allowances for the changes in costs, etc.?"

Ford said the grants for research bases are renewed every year. "We will know the new CCOPs before next May, so the renewal for research bases will reflect the new CCOP pool," she said.

A separate RFA for the new minority CCOP will be released on June 2, according to Carrie Hunter, program director and cancer control research coordinator for CCOP. That program will make about $1.2 million available for an estimated eight awards to involve more minority patients in clinical trials and improve minority access to state of the art cancer care (**The Cancer Letter**, Feb. 3).

Letters of intent for the minority CCOP will be due July 14, and the application receipt date will be Oct. 13, Hunter said.

The minority CCOP is limited to hospitals, HMOs, clinics, physician groups or consortia, and university hospitals that are major teaching institutions, Hunter said. All must demonstrate access to a large pool of minority patients by showing that more than 50 percent of new cancer patients are minorities.

Hunter said documentation of that percentage may be through the tumor registry or admission and discharge records. There is no specific requirement for the number of years for which the percentage must be documented, but being able to demonstrate greater than 50 percent "for several years would be desirable."

Other important information would be the percentage of minority patients already entered on clinical trials, she said. The 50 percent cutoff "is a fixed number," Hunter said. "We are trying to get groups with access to large numbers of minorities."

One participant asked whether composite organizations may split off their minority components in order to meet the 50 percent requirement.

"We cannot say to you how to structure your organization," Hunter said. "It's up to you how to put together the consortia.

Funded cooperative groups cannot apply for the minority CCOP, but unfunded ones may, Hunter said. If their funding goes through, they must withdraw their application. In addition, a group would not be able to apply for both CCOP and the minority CCOP.

One participant asked whether a research base could develop a protocol for any or all of the eight minority CCOPs. Hunter and Ford noted that the research base would have to eventually form a link with one of the CCOPs. "We see DCPC as being the broker for ideas, linking CCOPs with research bases, but that would have to be worked out," Ford said.

Hunter also advised applicants to "go back and look at how CCOPs were reviewed. You and your research base are what you're evaluated against."

"Reviewers have only what you tell them in the application," Ford said, with the exception of the most recent review of current CCOPs.

Excerpts of the CCOP RFA follow:

RFA Number: 89-CA-13
Title: Community Clinical Oncology Program
Letter of Intent Receipt Date: June 15.
Application Receipt Date: Aug. 22.

The Div. of Cancer Prevention & Control of NCI invites applications from domestic institutions for cooperative agreements to continue its Community Clinical Oncology Program. New applicants and currently funded programs are invited to respond to this RFA.

Utilizing the national resource of highly trained oncologists in community practice, the CCOP: 1) provides support for expanding the clinical research effort in the community setting; 2) stimulates quality care in the community through participation in protocol studies; 3) fosters the growth and development of a scientifically viable community cancer network able to work closely with NCI supported clinical cooperative groups and cancer centers, and public health departments; 4) supports development of and community participation in intervention cancer control research, including prevention, early detection, patient management, rehabilitation, and continuing care; 5) involves primary care providers and other specialists in cancer control studies; and 6) increases the involvement of minority and underserved populations in clinical research.

Combining the expertise of community physicians and other health care professionals with NCI approved treatment and cancer control clinical trials provides the opportunity for the transfer of the latest research findings to the community level.

The issuance of the CCOP RFA seeks to build on the strength and demonstrated success of the CCOP over the past six years by: 1) continuing the program as a vehicle for supporting community participation in treatment and cancer control clinical trials through research bases (clinical cooperative groups and cancer centers supported by NCI, and public health departments); 2) expanding and strengthening the cancer control research effort to equal that of cancer treatment; 3) utilizing the CCOP network for conducting NCI assisted cancer control research; and 4) evaluating on a continuing basis CCOP performance and its impact in the community.

It is anticipated that up to $12 million in total costs per year for 5 years will be committed to specifically fund applications which are submitted in response to this RFA. It is anticipated that up to 80 awards will be made. This is dependent on the receipt of a sufficient number of applications of high scientific merit. NCI program staff will take into account demographic and geographic distribution of peer reviewed and approved applicants in the final funding selection process to assure inclusion of minority and underserved populations. Multiple CCOP applicants approved for funding who are competing for the same patient population will be considered, but all may not be awarded unless warranted by the population density.

The total project period for applications submitted in response to this RFA may not exceed three years for new applicants and five years for applicants previously supported under this program. Previously supported applicants will be funded for three, four, or five years depending upon priority score/percentile, review committee recommendations, and programmatic considerations.

The earliest feasible start date for the initial awards will be June 1, 1990. Although this program is provided for in the financial plans of NCI, the issuance of awards pursuant to this RFA is also contingent upon the continued availability of funds for this purpose.

Prospective applicants are asked to submit by June 15, 1989, a letter of intent that includes a descriptive title of the proposed research, the name and address of the principal investigator, the names of other key personnel, the participating institutions, and the number and title of the RFA in response to which the application is being submitted.

The letter of intent should be sent to, and copies of the RFA obtained from Leslie Ford, M.D., Community Oncology & Rehabilitation Branch, Div. of Cancer Prevention & Control, NCI, Executive Plaza North, Room 300-D, Bethesda, MD 20892, phone 301/496-8541.

NCI Advisory Group, Other Cancer Meetings For June, July, Future

Div. of Cancer Treatment Board of Scientific Counselors--June 5-6, NIH Bldg 31 Rm 10, 8:30 a.m. Closed June 6, 8:30-9:30 a.m.

Critical Issues in Tumor Microcirculation, Anglo-genesis and Metastasis--June 5-9, Carnegie Mellon Univ., Pittsburgh. Biological significance and clinical relevance. Contact Hilda Diamond, Associate Director, Biomedical Engineering Program, Carnegie Mellon Univ., Pittsburgh, PA 15213, phone 412/268-2521.

Centennial of Johns Hopkins Medicine--June 7-11, Baltimore. Contact Johns Hopkins Office of Public Affairs, Suite 1100, 550 N. Broadway, Baltimore, MD 21205, phone 301/955-6680.

Spirituality: A Neglected Dimension in Patient Care--June 8, Rochester, NY. Oncology Nursing Society, Genesee Valley Chapter. Contact Michele Haller, RN, Strong Memorial Hospital, 601 Elmwood Ave., Rochester, NY 14642, phone 716/275-2171.

Cancer Management Course--June 8-10, Little Rock, AR. Contact Cancer Dept., American College of Surgeons, 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

Acrylonitrile Oversight Committee--June 8, Executive Plaza North Rm H, Rockville, MD, 9 a.m., open.

16th International Congress of Chemotherapy--June 11-16, Jerusalem. Contact Scientific Secretariat, 16th Congress of Chemotherapy, POB 983, Jerusalem 91009, Israel.

Drug Delivery of Proteins--June 12-14, Boston. Contact Technology Management Group, Conference Div., 25 Science Park, New Haven, CT 06511, phone 203/786-5445.

Biology & Immunology Contract Review Committee--June 12-13, NIH Bldg 31 Rm 2, open June 12, 9-9:30 a.m.

Ovarian Cancer: Problems but Progress--June 14, Cleveland. Contact Cleveland Clinical Educational Foundation, Dept. of Continuing Education (TT31), 9500 Euclid Ave., Cleveland, OH 44195, phone (local) 444-5696; (Ohio) 800/762-8172; (elsewhere) 800/762-8173.

The Other Side of Cancer--June 14, Los Angeles. Cancer Management Network of Southern California. Contact RoseAnn Cadena, phone 213/224-7368.

Biometry & Epidemiology Contract Review Committee--June 20, NIH Bldg 31 Rm 8, open 10-11 a.m.

Clinical Applications of Chronobiology--June 20, NIH Lipsett Auditorium, Clinical Center, Bethesda. Contact Kirt Vener, PhD, NIAMS, Westwood Bldg Rm RM5A07, Bethesda, MD 20892, phone 301/496-0754.

Div. of Cancer Biology & Diagnosis Board of Scientific Counselors--June 22, NIH Bldg 31 Rm 2, 8:30 a.m.

Assn. of American Cancer Institutes--June 22-23, Puerto Rico. Annual meeting. Contact Maria Neris, 809/751-6242, or Dr. Edwin Mirand, 716/845-3028.

Scientific Foundations for Clinical Progress--June 26-27, Senate House, Univ. of London. Euro-Oncology 89. Contact BDI Conferences Ltd., 3 Beaconsfield Terrace Rd., Kensington, London W14 OPP, England.

Fifth Annual Meetng on Oncogenes--June 27-July 1, Frederick, MD. Contact Margaret Fanning, FACS, PO Box 249, Libertytown, MD 21762, phone 301/898-9266.

Div. of Cancer Etiology Board of Scientific Counselors--June 29-30, NIH Bldg 31 Rm 10, 8:30 a.m.

N-Nitroso Compounds, Mycotoxins and Tobacco Smoke: Relevance to Human Cancer--July 2-7, Beijing, China. Contact IARC, 150 cours Albert Thomas, 69372 Lyon Cedex 08, France.

British Assn. of Surgical Oncology--July 6-7, Reading, Berks, UK. Contact BASO, Royal College of Surgeons, Lincoln's Inn Fields, London WC2A 3PN, UK.

Ninth Sapporo Cancer Seminar--July 6-8, Sapporo. Contact Atsuko Suehiro, Laboratory of Pathology, Cancer Institute, Hokkaido Univ. School of Medicine, Sapporo, Hokkaido 060, Japan.

Conservative Treatment of Breast Cancer--July 11-13, Venice. Contact Secretariat, Rm FA89, European School of Oncology, Via Venezian, 1, 20133 Milan, Italy.

Treating the Drug Resistant Cancer Patient--July 13-15,

Disneyland Hotel, Anaheim. Fourth Annual UCI Cancer Conference. Contact Univ. of California (Irvine) Cancer Center, UCI Medical Center, 101 City Drive South, Bldg 44, Rt. 81, Orange, CA 92668, phone 714/634-5081.

National Conference on Breast Cancer--July 19-21, Chicago. American Cancer Society conference for health professionals. Contact ACS, 1599 Clifton Rd. NE, Atlanta, GA 30329.

Cancer Management Course--July 21-22, St. Louis. Contact Cancer Dept., American College of Surgeons, 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

FUTURE MEETINGS

Oncology Social Work: A Clinical Focus--Sept. 21-22, Clearwater Beach, FL. Florida Society of Oncology Social Work Sixth Annual Conference. Contact Linda Scott, 813/972-8407.

Prospects of Oncological Clinical Research 1989--Nov. 13-14, Paris. European Organization for Research & Treatment of Cancer Foundation. Contact Pr. S. Khoury, Hopital de la Pitie--Urology Service (Pr. Chatelain), 83, Bd de l'Hopital, 75013, Paris, France.

Radiation Research Society--April 7-12, 1990, New Orleans. 38th annual meeting, along with 10th annual meeting of the North American Hyperthermia Group. Contact Radiation Research Society, 1101 Market St., 14th Floor, Philadelphia, PA 19107, phone 215/574-3153.

Platinum and Other Metal Coordination Compounds in Cancer Chemotherapy--Jan 23-26, 1991, San Diego. Sixth International Symposium, sponsored by Univ. of California (San Diego) Cancer Center. Contact Cass Jones, Cancer Chemotherapy Conference, Meeting Management, PO Box 179258, San Diego, CA 92117, phone 619/453-6222.

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

RFP NCI-CP-95625-61
Title: Support services in virology, tissue culture and immunology
Deadline: Approximately July 20

NCI is interested in proposals from contractors to perform karyotypic analysis, immunofluorescence assays, Elisa assays, preparation of monoclonal and polyclonal antibodies against purified retroviral proteins, to supply small quantities of purified viral antigens and retroviruses, to prepare tissue culture cells and to maintain a nude mouse colony.

Offerors must meet mandatory qualification criteria which require that they have (or provide evidence that they can establish prior to contract award) facilities from which the freshly prepared specimens can be delivered to the NIH campus in Bethesda within one hour after harvest. This is necessary because fresh preparations of cells, viruses and virus infected cells are needed within one hour after processing for cell and molecular biology studies to avoid degradation of ribo-nucleic acid needed for these studies.

Offerors also must have biocontainment facilities (P_2) with P_3 capability available to carry out the work with human viruses (leukemia-lymphoma and AIDS) at the time of award.

The incumbent contractor is Biotech Research Laboratories Inc. A four year award is anticipated. This will be a 100 percent small business set aside.

Contract Specialist: Charles Jackson
RCB Executive Plaza South Rm 620
301/496-8611

RFP NCI-CP-05609-76
Title: Biomedical computing design and implementation
Deadline: Approximately July 31

The Radiation Epidemiology Branch of NCI's Div. of Cancer Etiology seeks computer related support for its biostatisticians, epidemiologists and others in the branch in the form of data management and analysis of large sets of biomedical data.

This computer related support falls into three main categories: 1. Data management activities consisting of keying, formatting, and editing data collected from field studies; 2. Systems design and development consisting of defining technical specification requirements and developing the program language code required to implement automated solutions; 3. Statistical analysis and modeling consisting of using standard software packages and specialized software to carry out analyses under the general guidance of branch personnel.

This is a recompetition of a contract currently providing computer related services for approximately 15 studies per month. It is a 100 percent small business set aside.

Contract Specialist: Michael Miller
RCB Executive Plaza South Rm 620
301/496-8611

RFP NCI-CN-95124-41
Title: SEER/surveillance quality control unit
Deadline: Approximately July 20

The Surveillance Program of NCI's Div. of Cancer Prevention & Control is interested in soliciting proposals from organizations for maintaining a quality control unit for the program. The purpose of the QCU is to assess and ensure the completeness, accuracy, and timeliness of data that are available to NCI and used to measure the progress of cancer control.

A secondary purpose of the QCU is to reduce the variability in procedures and interpretation of data collection and abstraction conventions by individuals responsible for collecting and managing cancer surveillance information through education and communications.

A third purpose of the QCU is to provide a research and evaluation component focused on assessment of the quality of surveillance data and the efficiency of existing surveillance systems to assure that they continue to serve NCI program needs.

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

NCI CONTRACT AWARDS

Title: ADP support services for DEA and OD
Contractor: Washington Consulting Group, $1,684,837

Title: Exposure assessment methods for pesticides
Contractor: Univ. of Iowa, $426,802

Title: Endpoint cohort tracking survey for community intervention trial for smoking cessation
Contractor: Westat Inc., $197,320

Title: Preclinical pharmacology investigations of antitumor agents
Contractors: Ohio State Univ., $617,141; Mayo Foundation, $394,041; Univ. of Southern California, $609,973

Title: Support for NCI/NICHD local area networks
Contractor: Universal Hi-Tech Development Inc., $429,098

Title: Procurement of data developed in the study of breast cancer in Oriental Americans
Contractor: Univ. of Southern California, $74,799

Title: Dosage form development of new agents for the treatment of AIDS
Contractor: Univ. of Utah, $430,598

Title: International scientist to scientist exchange program
Contractor: The Union International Centre Le Cancer, $625,000