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PDQ Used Mainly For Information To Public, Not Much By Non-Oncologists, Evaluation Finds

NCI's PDQ System, contrary to the intention of its founders, was being utilized mainly to provide information to the public rather than physicians, at least through March, 1987, the recently completed evaluation of the system has found. However, average monthly usage of PDQ has more than

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In Brief

PHS Establishes Two Scientific Integrity Offices; Workshop On Ethical Issues Planned

PUBLIC HEALTH Service formally announced establishment of the Office of Scientific Integrity Review, located within the office of the assistant secretary for health, and the Office of Scientific Integrity, housed in the office of the NIH director. **Brian Kimes**, associate director for extramural programs in NCI's Div. of Cancer Biology & Diagnosis, is acting director of OSI (**The Cancer Letter**, June 23). OSI is the lead office within PHS responsible for monitoring and investigating situations that involve possible scientific misconduct (both intramural and extramural research). OSI will be the primary contact point for institutions and individuals for dealing with these matters. Policies and procedures relating to possible misconduct have been revised and will be published soon, NIH said. The Office of Scientific Integrity Review is intended to be independent from the investigative process. It will review investigations into allegations of misconduct, convene ad hoc panels to review cases when necessary, and recommend sanctions when appropriate. Inquiries about procedures and any allegations of misconduct should be directed to Brian W. Kimes, PhD, OSI, NIH, Bldg 31 Rm B1C34, Bethesda, MD 20892, phone 301/496-2624. . . . **OFFICE FOR PROTECTION** from Research Risks at NIH is sponsoring a workshop Sept. 18-19 on ethical issues involved in behavioral and biomedical research. It is open to anyone with an interest in research as well as NIH and other federal personnel involved in development of research protocols, the review of research proposals and applications, awarding of research funds, and the performance and evaluation of research. Advance registration for the workshop, to be held at the auditorium of the Uniformed Services Univ. of the Health Sciences in Bethesda, is required. Contact Agnes Richardson, OPRR, NIH, Bldg 31 Rm 5B62, Bethesda, MD 20892, phone 301/496-8101.

PDQ Use Growing, Evaluation Finds Problems, Recommends Solutions

(Continued from page 1)
doubled since the period covered in the evaluation, and NCI's intensive efforts to increase physician awareness of the service may have changed the mix of users considerably.

The evaluation was performed under an NCI contract with the Survey Research Laboratory of the Univ. of Illinois. Ronald Czaja of SRL and Clara Manfredi of the Illinois Cancer Council were coprincipal investigators. They were assisted by Debora Shaw, Indiana Univ. School of Library and Information Science, and Richard Warnecke, SRL. Edward Sondik, who heads the Surveillance Program in NCI's Div. of Cancer Prevention & Control (and is now acting deputy director of the division), was project officer, assisted by Brenda Edwards and Edward Maibach.

NCI's overall plan for evaluation of PDQ includes four main components: evaluation of procedures required to ensure that information of the highest quality is contained and maintained in the system; evaluation of PDQ's implementation by NCI and the various vendors and of PDQ's technical characteristics, as well as an assessment of the database by current users; evaluation of the diffusion of PDQ in the medical community and identification of factors that facilitate or hinder its acceptance; and evaluation of the impact of PDQ on cancer care in the community.

Impact on cancer care will be evaluated in a future activity by NCI and was not included in the Illinois contract. That group also did not address the first component, quality of information.

At the time the evaluation began in 1985, PDQ was available through the National Library of Medicine's MEDLARS system and on a limited basis through NCI's Cancer Information Service. BRS/Saunders (BRS) and Mead Data Central (MDC) were the only private search service vendors which at that time offered access to PDQ along with other medicine related databases. Since then, additional points of access to PDQ have become available through four large gateways to BRS files: the Source, Compuserve, IQuest, and Western Union's InfoMaster. The Source also offers access to NLM files. Additional sources of online access are TELMED, MediMatica, and the European Organization for Research and Treatment of Cancer. Georgetown Univ. and George Washington Univ. have online access through MUMPS.

NCI earlier this year completed negotiations with the American Medical Assn. to add AMA/Net as a PDQ vendor, making the service available to that system's 13,000 users.

CD-ROM (compact disc-read only memory) versions of PDQ are available from compact Cambridge and J.B. Lippincott. Plans are pending to provide access to PDQ through three additional CD-ROM systems and additional online systems. Among the online systems under negotiation are DIALOG, the Veterans Administration, and some overseas systems.

Only NLM, BRS, and MDC were included in the evaluation.

The evaluation involved assessment of how well vendors were carrying out their contractual obligations, monitoring searches by users and reviewing use records, phone surveys of current users, and a demonstration study in which two groups of physicians were given free unlimited PDQ searches to determine use when all barriers to access are removed.

Following are some of the findings:

* **The conclusion is that in 1987 awareness** and use of PDQ within the medical community were still low. Among physicians, both awareness and use were higher for oncologists, and especially for Community Clinical Oncology Program applicants, but were for low for community physicians not in oncological specialties. Moreover, the heaviest use of the database was by the Cancer Information Service, providing information mainly to the public, rather than by physicians and medical librarians.

Data provided by search service vendors for January 1986 through March 1987 confirm that overall use of PDQ by March 1987 was still

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limited. The major users through NLM were the CIS offices, which provide services primarily to the public rather than health professionals. Although many librarians had access to the system and were potentially in a position to introduce PDQ to physicians who requested their services, they used it an average of less than three hours each in the 15 month period studied. Average hours of use were slightly higher for physicians, but relatively few physicians with access code accounts used PDQ at all.

* **In mid-1985, 49 percent of the physicians** who had applied in 1982 for a CCOP, 36 percent of those in cancer specialties, and only eight percent of those in other specialties who were involved with cancer patients said that they were aware of PDQ. Reported use was low, with 26 percent of CCOP applicants, 16 percent of cancer specialists, and two percent of other cancer involved specialists saying that they had ever used it.

By late 1986, only the CCOP applicants (funded or unfunded) showed any change in their level of awareness of the database, with 60 percent of these physicians saying that they were aware of it. All three physician groups showed some change in terms of reported use, with 38 percent of CCOP applicants, 20 percent of cancer specialists, and three percent of other cancer involved specialists saying that they had ever used PDQ. Thus, changes between 1985 and 1986 show an increase in both awareness and use among those physicians most deeply involved in cancer care and research, the CCOP applicants. However, among other physicians who see and treat cancer patients, there was almost no change in either the level of awareness or the extent of use of PDQ. By the end of 1986, awareness and use of PDQ were still very low for the overwhelming majority of community physicians.

* **The formal agreements between NCI and** each of the search services appear to be followed in regard to most items. NCI and NLM appear to meet all obligations stated in their respective agreements.

BRS' obligations are met in regard to currency of data files, access, fees and charges, and publicity and advertising. Noncompliance was noted in two areas, one of which had been corrected by the time the report was written. That one involved BRS software, which at first did not provide access to all files. However, the evaluation report says, BRS has not fulfilled its commitments to supply detailed records of use to NCI. According to the agreement, BRS is to provide detailed quarterly reports that include the number of searches and the billable connect time for each user/bill group. In addition, BRS is supposed to report services to users who do not have electronic access and royalty free time for testing and demonstrating PDQ. These reports were not being made, the evaluation says.

MDC's obligations are met in regard to database content and description, access, fees and charges, and publicity and advertising, the report says. Noncompliance was noted in two areas. "Of serious concern is the period of two months (December 1986 and January 1987) when MDC did not meet its obligations in updating the PDQ files. An additional area of noncompliance is in MDC's failure to submit detailed records of use to NCI, an area in which it has obligations similar to those described above for BRS."

Each of the three search services was monitored to observe how quickly update files were loaded after being distributed by NCI. NLM and BRS both met their contractual obligations. NLM is committed to loading updates within seven days of receipt and averaged 4.7 days to do that. BRS has met its commitment to load updates within three working days, averaging 2.1 days. However, MDC, also committed to load updates within three working days, has averaged 4.2 days, and once did not load updates at all for two months.

System response times (from the time a searcher enters a command until the first character of the response is displayed) was assessed. On NLM, the average response was 4.74 seconds, with faster responses when transmission was at 1200 baud rather than at 300 baud. On BRS, the average response time was 2.96 seconds, again faster at 1200 baud. MDC is accessible only at 1200 baud, but its average response time was 3.89 seconds. Also, MDC searches conducted during prime time encountered slower responses than those done in the evening or on weekends, a difference not observed with the other services.

Manuals provided by each search service were evaluated. In general, this documentation provided by NLM and BRS was considered adequate. On the other hand, MDC did not mention PDQ in the documentation in provided for the evaluation. "This is a serious omission, given the value of written documentation in alerting researchers to the files available and

thus aiding in the dissemination of PDQ," the report says.

*** A profile of PDQ users found that nearly** 40 percent of online time on the NLM system is by CIS searchers. An average search is about 20 minutes, and the system is used for an average (by March 1987) of 458 hours per month. The report notes that updated information from NCI on usage shows that the PDQ time on NLM in 1988 totaled 10,800 hours, with an average number of users per month at 624. Current data from NLM suggest that usage may exceed 1,000 hours per month in 1989.

Records maintained by BRS and MDC show that heaviest use is for the files on cancer information (over 45 percent for BRS, over 55 percent for MDC) and protocols (over 40 percent for BRS, over 30 percent for MDC). In March 1987, BRS users logged 111.8 hours on PDQ, while MDC users had 26.8 hours of online time.

There appeared to be confusion on the part of some searchers about the nature of PDQ's content, particularly the cancer information file. Physician searchers, and especially librarians, were inclined to view it primarily as a bibliographic file. In bibliographic files, the number of records retrieved and currency of citations are major considerations in assessing the success of a search, whereas the PDQ cancer information file is a full text database, one that provides answers to question, not citations to other sources in which answers may be found.

*** A primary goal of the Current User** Survey (a part of the overall evaluation) was to determine who is using PDQ. The physicians who participated in the study were drawn from two sources. The first group comprised holders of PDQ access codes and were sampled from the usage records provided by NLM and BRS for a six month period in 1986-87. The second group was nominated by intermediary respondents (mostly librarians) who provided the survey with the names, address and phone numbers of two physicians for whom they had conducted a recent PDQ search.

The majority of physicians who participated in the survey are in oncology subspecialties. In comparison with the nononcologist users, the oncologists are younger, the majority having graduated from medical school since 1970; they tend to be medical oncologists, seeing more than 100 cancer patients yearly; they are more involved in teaching or clinical faculties and in residency training programs and are more likely to be members of cancer professional associations; they are more aware of existing clinical trials and CCOPs; the majority refer and enroll their patients in these programs; and they are more likely to participate in the planning, designing, and writing of clinical trials.

"Interestingly enough," the report says, "although the nononcologists in the Current User Survey are older than the oncologists, they are more likely to be users of computers. A higher percentage of nononcologists than oncologists use their computers for research, database inquiries, and word processing. The combination of awareness and involvement in cancer research and of computer usage may distinguish this group of users from other similar groups of physicians."

Of all the cancers listed in PDQ, the five types of cancer for which the physicians sought information most frequently are hemopoietic, breast, reproductive, digestive, and respiratory. The most frequently mentioned reasons for requesting the information are to ensure use of the most current treatment methods, to help make a clinical decision, or to find information about clinical trials. Oncologists also said that they search the database in order to make referrals, whereas nononcologists use it to confirm information obtained from other sources. Nononcologists are the most likely of the three physician groups to use PDQ to explain treatment options to their patients.

The majority of physicians feel that the information is complete. The few who said it was not suggested it lacked detailed treatment information, information on rare cancers, and more recent information. The majority said that information they received from PDQ was new to them.

Concerning perceptions of PDQ's role in cancer treatment over the next five years, the majority of all surveyed physicians think that it will be a reliable source for information on cancer treatment, clinical trials, and physicians and organizations providing cancer care, and that it will increase physicians' knowledge of available clinical trials. At the same time, only a minority think that it will alter existing referral and consultation patterns. The majority feel PDQ will have a positive impact on the physician-patient relationship because it enhances the patient's treatment options and helps the patient better understand his/her condition.

The evaluation found that barriers to use

of PDQ by community physicians include lack of awareness of PDQ and unfamiliarity with it, difficulty with accessing it, cost (of equipment as well as the $16-23 per hour for online time charges), and lack of a perceived need for it. "Many physicians are very satisfied with their current sources of information and, moreover, do not believe that a computerized system is necessary or can replace their existing sources," the report says.

NIH To Clarify Policy Statement On Jackson Laboratory Fund Request

NIH probably will clarify statements it made in a draft position paper released earlier this month on the fire at the Jackson Laboratory, **The Cancer Letter** has learned.

In the position paper, NIH said it did not support federal funding to help the nonprofit laboratory rebuild its central production facility, which was destroyed by fire on May 10.

While it is not clear whether the agency will change its position, officials have indicated that factual errors contained in the one page statement would be clarified.

The NIH policy paper was released in response to a bill, since passed by the Senate Aug. 4, that would provide $25 million in a single grant for construction of a mutant mice production facility at a nonprofit institution.

The bill does not mention the Jackson Laboratory by name, and funding is open to competition. However, as a practical matter, no other institution is likely to compete successfully against Jackson for the award.

The bill was introduced by Sen. Orrin Hatch (R-UT) and Sen. Edward Kennedy (D-MA).

The Jackson facility was the largest mutant and inbred mouse resource in the world and provided U.S. researchers with 1,700 mutant mice strains, or 33 percent of all mice used for research in this country. Costs to rebuild the facility, including temporary space during construction, and to replace lost animals and equipment are estimated at $40 million.

Kenneth Paigen, director of the Jackson Laboratory, and his assistant, Kenneth Trevett, met with NIH Acting Director William Raub last week and other NIH officials to discuss the fire and its implications for research.

Trevett described the meeting as "long and productive." Other participants in the hour and 45 minute meeting were Katherine Bick, deputy director for extramural research; Joseph (Edward) Rall, deputy director for intramural research; Ruth Kirschstein, director of the National Institute of General Medical Sciences; and representatives from NCI and the National Institute of Allergy & Infectious Diseases.

"They heard a lot of information about the national resource that Jackson Laboratory is, and they got a greater sensitivity to the national impact of the fire," Trevett said.

In the NIH draft position paper, there were three statements that the agency apparently agreed to clarify as a result of the meeting. (For a full text of the NIH draft policy, see **The Cancer Letter,** Aug. 11.)

First, NIH called the laboratory a "commercial organization." That is incorrect. The laboratory is a nonprofit, tax exempt organization.

Second, NIH implied that the laboratory's situation was analogous to that of other research institutions that have been struck by natural disaster or by animal terrorist groups.

"While those are serious problems, the effect is felt within the institution," Trevett said. "Whereas our situation represents an issue of national resources."

Third, the NIH policy stated that the laboratory could use earnings from the sale of mice or "redirect current resources" to rebuild its production facility.

Trevett noted that the laboratory doesn't have "current resources" to redirect. Though the laboratory was fully insured, the insurance will cover only $16 million of the rebuilding cost. The laboratory expects to have deficits of $4.5 million a year for the next two years.

"There was a very positive reaction," to the laboratory's position, Trevett said. "We felt we had increased their awareness of the concerns." The NIH officials indicated they would issue a final policy in the next few weeks.

"We hope that clarifications are made in the near future and some positive support is given," Trevett said. "At this point, we can't make a commitment on construction of permanent facilities, beyond the initial design work."

He stressed that the laboratory is seeking to replace only the square footage that was lost in the fire.

The Senate bill has a difficult road ahead. The Senate Labor-HHS-Education Appropriations Subcommittee will conduct its markup of the NIH appropriations in early September. If the bill is included in the markup, the subcommittee's counterpart in the House would have to agree to the funding

request. Then the appropriations bill will have to be reconsidered in the House and the Senate.

The laboratory conducted a quick survey last week of NIH laboratories to determine the impact of the shortage of Jackson mice.

"Several laboratories have had to stop a component of their program, while others had to delay experiments," Trevett said. "That same situation that exists at NIH exists throughout the country."

The shortage of mice has hit immunology research the worst, Trevett said. In addition, the supply of mutant mice used in neurobiology and autoimmune disease research has been interrupted.

Several neurobiologists have written letters in support of the Senate bill, Trevett said. In addition, members of the American Society of Clinical Oncology and the American Assn. for Cancer Research have been urged to write letters in support of the bill.

Jackson Laboratory was destroyed by fire once before, in October 1947, when forest fires were raging all across New England. Though the fire just missed the town of Bar Harbor, the laboratory and many vacation homes in the area were burned.

The American Cancer Society donated $50,000 for rebuilding the laboratory after the 1947 fire.

Mass. Congressman Was Instrumental In $1.5 Mil. Proton Beam Funding

The House Labor HHS Education Appropriations Subcommittee's 1990 budget bill that was sent to the floor of the House earlier this month contained few surprises for NCI.

Except one.

The committee provided $1.5 million for NCI to "conduct planning and development of a very limited number of referral centers" for treatment of inoperable brain tumors through proton beam therapy.

The appropriation essentially overrides a decision by NCI's Div. of Cancer Treatment Board of Scientific Counselors not to reopen funding for facilities or equipment for heavy particle accelerators.

The board's action in February was taken because of a request by the Harvard Cyclotron Laboratory, Massachusetts General Hospital and the Massachusetts Eye & Ear Infirmary. The three institutions collaborate on cancer therapy using the Harvard cyclotron, which needs to be replaced. Harvard is raising money to pay for the unit's replacement (**The Cancer Letter**, Feb. 24). Thus, it comes as no surprise that a Massachusetts congressman, Rep. Joseph Early, was instrumental in pushing the idea for proton beam referral centers through the committee.

Under the appropriations bill, the grants to institutions for proton beam therapy would be competitive, and the number of centers is up to NCI.

However, the competition for "a very limited number" of grants will not be stiff, since there are few institutions in the U.S. that have proton beam equipment dedicated to medical research and therapy. Harvard and Loma Linda Univ. are the only two doing extensive cancer research and therapy with the machines. The proton beam unit at Lawrence Berkeley Laboratory is used for physics as well as medical research.

A spokesman for Early said the subcommittee does not earmark funds for specific institutions.

"The money is there so that NCI can pursue this avenue. We would assume that NCI would proceed in competitive manner."

The spokesman noted that Massachusetts "has a large number of research centers," and the congressman frequently talks to researchers and is very supportive of biomedical research.

"Evidently, this appears to be a very promising opportunity," the spokesman said.

The appropriation still must get Senate approval. The Senate Labor-HHS-Education Subcommittee will conduct its markup of the budget in September.

Harvard, Massachusetts General and MEEI had asked the DCT Board to reconsider its policy discouraging funding requests for construction of heavy particle accelerators. That policy has been in effect since the funding, beginning in 1978, of four neutron generators.

Herman Suit of Massachusetts General's Dept. of Radiation Medicine appeared before the Board to ask for "approval to apply" for NCI support for replacement of Harvard's cyclotron. The machine, intended for physics research, was built in the 1940s and is nearing the end of its useful life.

Suit asked the Board whether NCI would be receptive to an application for partial support of a new proton beam unit. A new unit costs nearly $21 million, and Suit estimated the yearly cost of operating the unit and for patient support would be $5 million.

The Harvard Board of Trustees said it would allocate land and start a capital campaign for a new building to house the unit if the group got independent peer review of its work and some outside funding.

The $1.5 million in Early's proposal is not nearly enough to cover the cost of a new cyclotron. However, if the group does receive part of the funding through an NCI grant, it would lend federal authority and support to the fundraising effort.

The Board's negative vote, taken in a closed session, was based on the limited DCT budget and the relatively small number of tumors demonstrated so far as better treated by proton beam therapy. The decision was made in the face of an enthusiastic recommendation for approval by an ad hoc committee established to review the request.

The vote did not mean that institutions cannot submit grant applications for support of proton beam development.

Until the appropriation committee's action, however, it would have been unlikely that any of those applications would have been funded, considering the Board's opposition. The reviewing study section and the National Cancer Advisory Board have the final say in approving applications.

In its report, the committee, chaired by James Cox of M.D. Anderson Cancer Center, commended the Harvard group's work.

Since 1974, the group of physicians, physicists and engineers from the three institutions have conducted clinical investigations of proton beam therapy. As of February, they had treated 1,880 cancer patients.

In its report, the committee said, "It is difficult to justify a nonreceptive attitude towards a grant application when replacement of a technologically out of date, existing facility is involved, and when the research group involved has a record of substantial contributions. Over the past two decades, the Harvard group has treated as many patients as all other proton facilities in the world combined.

"They have pioneered in treatment planning and delivery techniques for protons, including development of patient positioning techniques, dosimetric methods, 3D treatment planning and sophisticated beam delivery techniques."

The report noted that some of those techniques are now used on conventional radiation therapy.

The group's clinical trials demonstrated "highly successful local control and survival" in several tumor types, the report said. The report listed seven tumor types, including 80 percent five year control and survival in a trial of 105 patients with base of skull chordoma and chondrosarcoma; 85 percent local control in 65 patients with soft tissue sarcoma; and 100 percent local control with no radiation myelitis in paraspinal sarcoma. A trial involving 1,000 patients with uveal melanoma achieved 98 percent local control, 95 percent eye retention and an 80 percent five year survival rate.

Last year, Loma Linda Univ., with the help of Rep. Jerry Lewis (R-CA), got a $5 million grant from the Department of Energy to support a clinically dedicated proton beam facility. The department also provides funding to the Fermi Laboratory in Illinois.

Biotech Firm Plans Clinical Trials In USSR To Test Antineoplastic Drugs

A U.S.-Soviet collaborative effort arranged by a San Diego cancer biotechnology firm would give pharmaceutical companies access to a large number of cancer patients for clinical trials and at the same time give Soviet physicians and patients access to experimental therapies.

AntiCancer Inc., has signed agreements with three cancer hospitals in the USSR that give the firm access to patients and their records for clinical trials the firm would custom design for pharmaceutical companies.

Emphasis will be on experimental antineoplastic agents that have been tested by AntiCancer's advanced preclinical drug evaluation technologies, thereby giving pharmaceutical companies a "fully integrated" evaluation of new cancer drugs from preclinical to clinical phases, said Robert Hoffman, AntiCancer's president.

Such trials would take advantage of the large number of patients available in the three hospitals. The largest of the three, the All Union Cancer Research Center in Moscow, has 1,000 beds for cancer patients. Altogether, the three hospitals have about 2,000 beds for cancer patients.

The other two hospitals that have agreed to work with AntiCancer are the All Union Scientific Center for Hematology and the Herzen Moscow Cancer Research Institute, both located in Moscow.

Hoffman said clinical trials at the three Moscow institutions could accrue patients more

quickly and could proceed faster than trials in the U.S.

"Accrual takes a long time, and treatment may not be uniform," because U.S. trials can be spread among several institutions, he said.

The All Union Cancer Research Center also has agreed that if it does not have enough patients with certain types of cancer needed for a trial, the hospital would recruit patients from other parts of the country.

Since the center is considered one of the best cancer hospitals in the USSR, patients, who otherwise might be treated in provincial hospitals, probably would be willing to participate, Hoffman said.

Each protocol would have to be approved by the hospital's institutional review board.

"I think it would be mutually beneficial for all sides," Hoffman said.

The arrangement offers the Soviet hospitals the opportunity to work with American scientists and offers Soviet cancer patients experimental therapy they would not get otherwise, Hoffman said.

"In the spirit of glasnost, the agreement includes absolute access to all patient records," he said.

Under the agreement, AntiCancer could arrange phase 1, 2 and 3 trials. A pharmaceutical company would pay AntiCancer a fee for access to the hospitals and to design and carry out the trials.

AntiCancer's medical staff will not be stationed in Moscow, but will make frequent trips to check on the progress of trials, Hoffman said.

The Soviet clinical trials should enhance a pharmaceutical company's chances of receiving FDA approval for a new agent, Hoffman said.

FDA usually will not approve a new agent based only on foreign data. However, the data could be submitted with data on U.S. trials as supporting evidence of a new drug's safety and efficacy.

The agreements with the hospitals came about because of Hoffman's 15 years of experience working with Soviet oncologists. He has made six trips to the Soviet Union, including one visit of almost a year, while he was an exchange scientist with the National Academy of Sciences.

No pharmaceutical company has entered a contract with AntiCancer to start trials in the USSR, but there has been much interest, Hoffman said.

"We are ready to go," Hoffman said. "The key thing is to have some promising agents."

RFAs Available

RFA 89-CA-14
Title: Data based intervention research for public health agencies
Application receipt date: Nov. 15

NCI's Div. of Cancer Prevention & Control invites applications for cooperative agreements in support of projects that will serve as models of data use in the planning and evaluation of statewide cancer prevention and control programs.

This RFA is designed to stimulate the development of cancer prevention and control intervention programs on the state and local level based on a thorough analysis and evaluation of a variety of data sources related to cancer control which exist in the state. The four phased project includes (1) identification, appraisal, and analysis of existing population specific data sources related to cancer control; (2) the development or modification of a cancer control plan; (3) initiation of new or modification of existing cancer prevention and control programs as specified in the plan; (4) a period for evaluation of process and outcome.

Applicants must be state or territorial health departments. Local health departments or agencies within the jurisdiction with primary responsibility for cancer control activities may apply through the state or territorial health department. Health departments currently funded under the NCI grants, "Cancer control technical development in health agencies," "Data based interventions for cancer control," or previous issues of "Data based intervention research for public health agencies" are not eligible to apply.

Funding is limited to a maximum of seven years. Approximately six awards are anticipated depending on the quality of applications and the availability of funding.

Copies of the complete RFA and additional information may be obtained from Dr. Leslie Boss, Program Director, Executive Plaza North, Rm 233D, NCI, NIH, Bethesda, MD 20892, phone 301/496-8584.

NCI CONTRACT AWARDS

Title: Single photon radiopharmaceutical for function, metabolism, and tissue localization
Contractor: Univ. of Massachusetts, $551,583

Title: Laboratory support for processing and storage of biological specimens from persons at high risk of cancer
Contractor: Biotech Research Laboratories Inc., $2,407,575

Title: Tracing through credit bureaus to determine vital status and current address for patients treated in Minnesota hospitals
Contractor: Johns Holding Co., $2,025

Title: Tracing through other sources and resources to determine the vital status, phone numbers, and current address of chemical industry workers
Contractor: Equifax Inc., $58,078

Title: Phase 1 clinical trials of biological response modifiers, Task A and Task B
Contractors: Task A--Univ. of Alabama Comprehensive Cancer Center, $4,793,691; Memorial Hospital for Cancer & Allied Diseases, $3,232,645; Univ. of Texas M.D. Anderson Cancer Center, $2,628,234. Task B--UCLA, $2,973,305; Cleveland Clinic, $2,502,559; Memorial Hospital, $1,792,144; Univ. of Wisconsin, $2,213,462.

Title: Primary rodent production centers
Contractors: Charles River Laboratories, $7,763,314; Harlan Sprague Dawley Inc., $3,913,231; Simonsen Laboratories Inc., $2,787,699

Title: Maintenance of NCI diagnosis serum bank
Contractor: Mayo Foundation, $1,242,792

Title: Procurement of prostate cancer cell lines
Contractor: Stanford Univ., 843,820; and Northwestern Univ., $796,694