THE CANCER LETTER

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5-FU/Levamisole A Community Success Story; Trials With Untreated Controls Revised Or Dropped

Development of a chemotherapy regimen which could produce a highly significant improvement in five year survival for some patients with one of the most prevalent solid tumors,

(Continued to page 2)

In Brief

Conference Agrees On $1.664 Billion NCI Budget; NIH Alums Bishop, Varmus Of UCSF Win Nobel

CONGRESSIONAL CONFERENCE committee agreed last week to appropriate $1.664 billion to NCI for fiscal year 1990, $18 million above the President's request, $12 million above the House recommendation, and $4 million below the Senate recommendation. The total NIH budget agreed upon by the conferees is $7.683 billion, which includes spending for AIDS . . . . **NOBEL PRIZE** for medicine this year will be shared by Michael Bishop and Harold Varmus, both with the Univ. of California (San Francisco). The award is for discovery reported in 1976 that oncogenes develop from normal growth regulating genes. Bishop, 53, and Varmus, 49, both trained at NIH in the 1960s. Varmus was a clinical associate with Ira Pastan, then at the National Institute of Arthritis & Metabolic Diseases, from 1968-70. During that time, Pastan moved to NCI and took Varmus with him. Bishop received his MD from Harvard, Varmus his from Columbia. They have been at UCSF since 1970. . . . **APPOINTMENTS** to fill two vacancies on the National Cancer Advisory Board "are at the White House," HHS Secretary **Louis Sullivan** told **The Cancer Letter** last week. One of the vacancies is Sullivan's seat, which he had to give up when he was appointed secretary; the other was created when Louis Gerstner resigned after he was hired to run RJR Nabisco. When will a new NIH director be named? Sullivan's response, in so many words: When we can find someone who will take it. The Administration's first three choices all turned the job down. One who might be the best available prospect, and who would be a popular choice among NIH personnel, would be **William Raub**, the acting director. Raub has held a number of NIH leadership positions and served as former Director James Wyngaarden's deputy. . . . **DAVID RALL**, director of the National Institute of Environmental Health Sciences, and Takeschi Hirayama, director of the Cancer Prevention Institute of Tokyo, will receive the Ramazzini award from Collegium Ramazzini at the group's meeting in Bologna, Italy, Oct. 17-25.

Untreated Arm Replaced By Two Regimens In Intergroup Study

(Continued from page 1)
a disease that kills more Americans than any other cancer except lung cancer, had for years seemed to be just beyond the grasp of clinical science.

Even if effective chemotherapy could be found, many felt not too long ago that it would involve a regimen so complicated and risky that it could only be given at the larger cancer centers.

So now it turns out that the first regimen proven in randomized, controlled trials to significantly improve survival in Dukes C colon cancer--5-fluorouracil plus levamisole--was tested for the most part in community hospitals and administered by physicians in community oncology practice.

"I think it is important that this is not treatment developed and tested only in university cancer centers so that we must have doubts about its safety or effectiveness when used in the community," Charles Moertel, chairman of the North Central Cancer Treatment Group, said at the press conference last week on the Clinical Alert issued by NCI. "Actually, 75 percent of the patients entered in our initial trial and the majority of patients entered in our larger intergroup trial were managed by cancer doctors in the community. So this treatment has already been prove to be both safe and effective in that setting."

Moertel was quoted in last week's issue of **The Cancer Letter** as saying that any Dukes C patient is "getting short shrift if he is not offered the option of levamisole/5-FU." That was not correct. Here is what he did say:

"Although levamisole and 5-FU treatment is now a new standard for management of high risk colon cancer, it certainly should not be a stopping point. We still have that two thirds of patients remaining who are not benefitted by this treatment. New clinical trials are already in operation seeking to improve results. These research protocols offer to the patient not only the very best therapy which we have established today, but also the hope of something still better.

"I feel patients with high risk cancer are getting short shrift if they are not offered this opportunity."

Moertel added that "through the efforts of Dr. (Samuel) Broder and his colleagues, this hopeful research treatment is available to patients nationwide and at a convenient location to their homes. These community oncology programs ensure the patient the best possible hope delivered by an oncologist who has met the high standards of qualification to participate in these research programs, whose work is monitored on a regular basis, and who cares enough about his patients to take the extra time and effort to improve the results of treatment. I feel we have very exciting prospects for much more impressive treatment advances in the years immediately ahead. If this hope is to be realized, it must be through clinical trials of sound scientific design and highest quality in conduct. If we can expand and enhance the clinical trials programs of our National Cancer Institute, I feel the nation can look forward with optimism and confidence towards major future accomplishments for the treatment of tomorrow's colorectal cancer patient."

Those other clinical trials to which Moertel referred are in somewhat of a state of flux, due to NCI's pronouncement that any trials it was sponsoring for treatment of Dukes C and poor prognosis Dukes B colon cancer may no longer include a no treatment control arm.

The intergroup study which started earlier this year, comparing combinations of 5-FU with high and low doses of leucovorin against untreated controls, had been designated as one of six new high priority clinical trials. Three groups--Cancer & Leukemia Group B, Southwest Oncology Group, and Eastern Cooperative Oncology Group--used a protocol with three arms: 5-FU plus high dose leucovorin, 5-FU plus low dose leucovorin, and observation only after surgery. NCCTG and M.D. Anderson Cancer Center randomized to surgery only, 5-FU plus low dose leucovorin, and 5-FU plus gamma interferon.

The NCCTG and M.D. Anderson study has

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been discontinued. Moertel said that interferon in the combination "seemed too speculative" and that there did not seem to be any point in going ahead with that protocol.

In a study opened only last week, NCCTG and M.D. Anderson replaced their 5-FU/leucovorin/interferon protocol with one comparing 5-FU plus levamisole (5-day course) with 5-FU plus leucovorin plus levamisole (5-day course).

The other protocol which will be continued by CALGB, ECOG, and SWOG will proceed with the high and low dose leucovorin arms. The untreated control arm will be replaced by two regimens--5-FU plus levamisole, and 5-FU plus leucovorin plus levamisole, with the leucovorin administered on the NCCTG schedule of daily times five.

ECOG has been entering patients in a randomized trial testing the "active specific immunotherapy" protocol developed by Michael Hanna at Bionetics Research Institute and Charles Hoover, then at Johns Hopkins. The treatment arm receives the BCG based vaccination after surgery; other patients have been going into an observation only arm, which has been closed. The study's investigators were in the process this week of determining whether to replace the no treatment arm with one of the chemotherapy regimens, or perhaps to close the study. It is has reached only about half of its accrual goal.

The National Cancer Institute of Canada has been entering patients in a randomized trial testing 5-FU plus leucovorin against an untreated control arm. The trial's investigators are also discussing their options. Since this study is not sponsored by the U.S. NCI, the Canadians could continue with untreated controls if they wish. Another option being considered is to join the NCCTG-M.D. Anderson study.

One trial that will not be affected by dropping untreated controls (it didn't have any) is the National Surgical Adjuvant Breast & Bowel Project's three arm study of 5-FU plus leucovorin vs. 5-FU plus levamisole vs. 5-FU plus leucovorin plus levamisole.

Broder referred to last week's press conference as "a historic event," not only because of the "very important, major progress" which was discussed, but also to the fact that Moertel was there beside him, happily talking about a chemotherapy regimen that works, agreeing that no treatment controls were no longer justifiable for Dukes C patients, and agreeing that the Clinical Alert was appropriate.

"If you know Chuck Moertel, you know that he is not easy to convince," Broder remarked to **The Cancer Letter** in what may be the understatement of the year. Over the years, Moertel--at Mayo and later with NCCTG in collaboration with Mayo--has tested one "promising" agent after another for treatment of colorectal and GI cancer. As each of them failed to show much if any benefit, Moertel's voice was the first and most emphatic in letting the world know. He was also not reluctant to express similar opinions about similar results obtained by others. That did not always enhance his popularity with some of his colleagues, but "all I ever wanted was to be shown that something works," he said.

Broder cited "the good working relationship" NCI has with clinical investigators and said the 5-FU/levamisole results demonstrate that controlled clinical trials are effective.

The NCI director does not expect to see the negative reaction generated last year when then Director Vincent DeVita issued the Clinical Alert on treatment of node negative breast cancer. "Doctor disagreement is not a problem this time." Special attention was given to notification of surgeons, "the most important group we had to reach," Broder said.

"That was an astonishingly courageous thing Vince did," Broder added. "He was proven right, and it broke the ground for us to do it again when the situation called for it."

Michael Friedman, director of NCI's Cancer Therapy Evaluation Program, wrote "to correct and expand upon aspects" of **The Cancer Letter's** report on 5-FU/levamisole results in the Sept. 22 issue.

"You imply that 5-FU/levamisole is effective for all stages of resectable colon cancer," Friedman wrote. "NCI and the responsible investigators have agreed that a post surgical observation alone (control) group is not appropriate or defensible for NCI sponsored studies of Dukes C or poor prognosis Dukes B patients. As the data mature, similar conclusions may be appropriate for other types of colon cancer patients."

[Ed. note: The lead paragraph did not identify the appropriate stages in the (probably) mistaken assumption that adjuvant therapy of colon cancer is only offered to Dukes C and poor prognosis Dukes B patients].

"On page 2," Friedman continued, "you

describe 'the first major improvement for Dukes B_2 disease. However, to date 5-FU/levamisole has demonstrated an overall survival benefit only for Dukes C patients. By contrast, only disease free survival benefits have been demonstrated for Dukes B_2 patients. With further followup, overall survival benefits may also be observable for Dukes B_2 patients."

[That was a typo. The writer had intended to include Dukes C, and did make it clear elsewhere in the article that Dukes C patients were the primary beneficiary. The writer mentioned Dukes B_2 because disease free survival improvement is not an inconsequential matter].

"Dr. Moertel was fully cooperative in the NCI application for Group C designation for levamisole/5-FU, but he did not initiate the suggestion to NCI and FDA [as stated in the article]. The application was submitted in April and approved on May 4 (not July). It is NCI practice to make a promising therapy available as quickly as possible consistent with solid efficacy and safety data.

"Unfortunately, NCI has not been 'deluged with requests for the drug.' In fact as of Sept. 21, only 506 inquiries have been made and only 122 patients treated. This is regrettable since many more patients could have been appropriately considered for this therapy."

[That is why Broder decided to go ahead with the Clinical Alert. In July, sometime after **The Cancer Letter's** story on 5-FU/levamisole results had been picked up by newspapers around the country, NCI staff members said that Cancer Information Service personnel had received hundreds of calls, and that NCI's Investigational Drug Branch which handles Group C requests through its Drug Management & Authorization Section had been swamped with calls. Evidently, the "deluge" quickly dropped to a trickle].

"Dr. Moertel has contributed to the identification of the activity of 5-FU and levamisole but he did not originate the idea," Friedman continued. "Hence, his being 'reluctant to take credit for it' is understandable. He has properly cited the earlier work of investigators who first utilized this combination."

[**The Cancer Letter** misunderstood Moertel's response to the question, "Who should get credit for this?" He thought the question was directed at the issue of whose idea was it for NCCTG to organize and carry out the clinical trial, and he emphasized that the credit should go to the community physicians in the group].

John Durant, vice president for health affairs at the Univ. of Alabama, mentioned the 5-FU/levamisole results in a presentation at an American Cancer Society workshop on clinical trials recently. It is an example of what NCI and the oncologic community face when a new treatment is proven effective.

"What is the ethical answer to how we decide when to give the Good Housekeeping Seal of Approval to some new therapy as the new standard?" Durant asked. "Consider the 5-FU/levamisole adjuvant therapy of colon cancer. Two trials now report initially significant survival advantages for this therapy. Do we now declare partial victory and tell new patients that this is now standard therapy? If we do, what will be the effect if, upon further maturation of the data, something is amiss with the analysis of the early results? If a physician is skeptical and doesn't tell his new patient about the results, is he guilty of malpractice? Do we want juries deciding this?"

NIH Office Of Scientific Integrity On 'Front Line' Of Investigations

The NIH Office of Scientific Integrity is now the "front line office" that will conduct investigations of scientific misconduct in the intramural and extramural community and will deal with institutions that conduct investigations.

Brian Kimes, acting director of the OSI, gave an overview of the role of the new office and its new regulations at the recent meeting of the National Cancer Advisory Board.

Kimes, associate director for extramural programs in NCI's Div. of Cancer Biology & Diagnosis, is on temporary detail to NIH and is scheduled to return to NCI on Nov. 1. Kimes told the NCAB he was reluctant when former NIH Director James Wyngaarden asked him to take the post.

"My first reaction was, 'Why me? Science corrects for itself. This office isn't needed,'" Kimes said. "Very grudgingly I accepted this position after Dr. Wyngaarden personally convinced me that this really was an important issue and there was much more at stake here. Perhaps the credibility of science wasn't as high, the credibility of institutions wasn't as high, and the credibility of government managers wasn't as high."

Kimes then became involved in Congressional hearings on scientific misconduct this

summer. One was held by Rep. John Dingell (D-MI), chairman of the Oversight and Investigations Subcommittee.

"It was clear that Mr. Dingell did not believe that institutions that received HHS support had enough resolve to truly investigate allegations of misconduct," Kimes said. The subcommittee is investigating eight or nine cases in parallel to investigations being conducted by institutions and by the OSI.

Other hearings were held by Rep. Robert Roe (D-NJ) and Rep. Ted Weiss (D-NY). The Office of the Inspector General also asked Kimes to prepare a report.

Kimes called the sudden interest by politicians and the Inspector General's office "very alarming."

"These are very powerful forces that seem not to want to really understand science or the need to maintain creative, open environments where individuals can test their ideas without fear," Kimes said. "It would be nice if the scientific establishment had greater advocacy in this area. Right now it seems that we're reacting to the adversaries. That's why I became convinced that we do have a serious problem."

Prior to 1982, the Public Health Service had no provision for investigating scientific misconduct, Kimes said. In 1986, NIH published policy and procedures for dealing with misconduct. There were 11 cases in which individuals were "debarred" from receiving PHS support for having committed misconduct. However, each agency had their own system in following the guidelines.

"There was a tremendous political debate about how misconduct would be handled," Kimes said. "Part of that debate was whether the role of monitoring investigations of institutions and conducting investigations would be centered at the departmental level or the agency level like NIH."

Wyngaarden was concerned that he never could become associated with an investigation going on in an institution, Kimes said, because it was his role in the old system to sign a "decision memorandum" determining whether the investigation was fair and thorough.

Kimes said NIH won that political debate, which led to the creation of the OSI, which is housed in NIH.

"It is the front line office that will deal with institutions, and it will conduct its own investigations," Kimes said.

The Office of Scientific Integrity Review is another office at the departmental level. Instead of a decision memorandum being signed by the NIH director, now recommendations are sent from OSI to OSIR for review and then passed up to the HHS assistant secretary to be signed.

Kimes outlined the role of OSI:

--To receive allegations, including anonymous allegations.

--To monitor the investigations of institutions that receive PHS support.

--To conduct investigations of extramural and intramural misconduct.

In addition, he said he hoped the office would become more involved in the promotion of responsible conduct of research.

OSI has the responsibility to conduct these functions for the entire PHS, including the Alcohol, Drug & Mental Health Administration, FDA and the Centers for Disease Control. OSI is now the process of establishing procedures for dealing with FDA and CDC, Kimes said.

"We have a broader responsibility than we had in the past," he said.

OSI first set out to define "scientific misconduct." The proposed definition was: "The fabrication, falsification, plagiarism, deception or other practices that seriously deviate from those that are commonly accepted within the scientific community for proposing, conducting or reporting research."

Subsequently, the word "deception" was removed because there are some forms of behavioral research where deception is a necessary part of the research protocol. Also, an addition was made saying that misconduct can occur in the way information is proposed in an application to PHS. Finally, a clause was added to say that honest error or honest differences of opinion in interpretation or judgments of data are not misconduct.

"I think most of the scientific community can accept this definition," Kimes said.

In the extramural community, the responsibility for receiving and investigating allegations of misconduct lies with the institutions that receive PHS support, Kimes said. "Our main role is to monitor the fairness, thoroughness and objectivity of those investigations."

This is a two step process. First, every institution has 60 days to conduct an inquiry, a preliminary investigation of the facts to see if a further investigation is justified. At this stage, NIH does not know about the allegations.

Second, when an institution decides a full investigation is warranted, the institution must

notify OSI. The institution must complete an investigation within 120 days.

OSI requires the institution to submit an inquiry report, and at end of investigation, a final report.

A clause in final rule gives the PHS the authority to ask for information retrospectively. "We can go back to an institution as ask for documentation on inquiries they did that did not result in an investigation," Kimes said.

Kimes also said there will be an "assurance requirement" from the institution, similar to human subject assurances and animal welfare assurances, without which an institution cannot receive PHS support. By Jan. 1, 1990, every institution will have to sent these assurances to OSI.

Institutions also will be required to report generic data on misconduct such as the number of allegations received, the number of inquiries and investigations conducted.

"Every time we go before Congress and defend the extent of misconduct in science, we have no data," Kimes said. "Some in the scientific community think that this is going to be a nightmare when we get that data, but I personally don't believe that will be true."

Kimes also discussed what he called the "strategy and philosophy" of OSI.

"We don't want to project the image of being a policeman. The reason we're housed at NIH is to maintain a close relationship with institutions and scientists. We want to project the role of a collaborator and facilitator in what we regard as a mutual responsibility. What we do see as a main problem in complying with that responsibility is that institutions for the most part are not experienced at investigations. Over the last eight years, we have only 180 documented cases of investigations. That's not a whole lot of experience. We hope we can provide some assistance to institutions on the front end on how to conduct an investigation."

Kimes discussed five issues he said were of "extreme sensitivity and importance":

--The timeliness of the process. "It is very important that individuals who are not guilty of misconduct get a timely resolution before rumor can destroy their career."

--The maintenance of absolute confidentiality, at the institutional level and the governmental level. OSI policy with the news media or anyone who asks is not to confirm whether an investigation is being conducted of any scientist. "We are trying not to reveal anything about an ongoing investigation, and I would recommend institutions to follow the same procedure."

--What to do when a finding of no misconduct has occurred. "We're not sure how to handle this at this point," Kimes said. "If somebody has been under investigation and no misconduct has been found, we're not sure we want the public to know about that. That could still have an effect on somebody's career."

--Protection of the whistleblower vs. protection of the accused. "We're striving very hard to maintain objectivity in this process."

--Following up on the publications of those who have been proven to have committed misconduct. "That is probably one of the most difficult aspects to follow up on," Kimes said. In many cases, discredited articles still are being cited by other researchers, even when the articles have been retracted. "We want to prevent the use of analysis that is false."

Most journal editors won't retract a multi-author article unless every author agrees, because of the fear of litigation, Kimes said. Even though one researcher may have been discredited, the other authors can claim that their section of the research is still correct.

"What we need is some legislation to make journal editors immune to that sort of thing," Kimes said.

Kimes suggested that the definition of misconduct could include scientists who have "demonstrated a long history of basic negligence in their research. In the PHS, we might not want to see that individual have a grant because everything he publishes never seems to be true."

NCI Director Samuel Broder took exception to that statement. "I think scientists should be allowed to be wrong, and being wrong per se is not in any way scientific misconduct," Broder said. "There are examples of individuals who are perceived to be wrong consistently for a decade or more. Some eventually become Nobel laureates."

Kimes noted that differences of opinion is covered in the definition. "I'm giving you that as a hypothetical situation."

"Well, I just expressed my hypothetical concern, then," Broder said. "I think what we're talking about is the need to respond to the public's demand that scientific performance being done with its tax dollars is legitimate and appropriate. Therefore, misconduct is something we cannot accept in the scientific arena because it would violate public trust. But I think that to go beyond

that to have a hypothetical situation where we would be treating some difficult to define and difficult to interpret standard of when someone's behavior met the standard in retrospect, when there was no intent to deceive, is a great concern to me."

Kimes noted the definition includes "practices that seriously deviate from those that are commonly accepted within the scientific community. I can assure you that particular area would be a judgment of scientists, not a government standard."

Board Chairman David Korn said he and other scientists worked to try to eliminate that phrase in the definition. "It was considered vague, undefinable and an invitation to mischief," Korn said. "The best we were able to accomplish was disclaimer on error. In my point of view the scientific community lost that battle. Otherwise, I think the guidelines are not bad at all and could serve the purpose well if they are administered sensibly."

In another development, NIH has drafted conflict of interest guidelines that would prohibit investigators whose research is funded by NIH or ADAMHA from owning options or personal equity holdings in a company that could be affected by the outcome of the research or that produces a product being evaluated by the research project.

The proposed guidelines were published in the Sept. 15 "NIH Guide for Grants and Contracts." Comments may be submitted by Dec. 15 to Katherine Bick, Deputy Director for Extramural Research, Shannon Bldg Rm 144, 9000 Rockville Pike, Bethesda, MD 20892.

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-CO-03851-35
Title: Editorial services to the International Cancer Information Center
Deadline: Dec. 15

NCI solicits proposals from organizations to perform editorial services to the International Cancer Information Center. This RFP is a 100 percent small business set aside. The "Journal of the National Cancer Institute" is both a biomedical journal and a cancer news and issues magazine, published twice monthly and averaging 100 pages per issue. Original manuscripts from clinical and basic researchers from around the world are edited, typeset, proofread, and correct; and each issue is designed, printed and delivered within eight weeks of acceptance of the manuscript.

Contractual services required include technical proofreading and review, technical and nontechnical substantive editing, copyediting and both technical and editorial cold reading and review. In addition, original writing of promotional copy is required for brochures, advertisements, booklets, catalogs, direct mail letters, news releases, flyers, scripts and articles describing products and services to target audiences of health professionals and the lay public.

Contracting Officer: Robert Townsend
RCB Executive Plaza South Rm 608J
301/496-8628

RFP NCI-CN-95164-42
Title: ASSIST/2000 coordinating center
Deadline: Oct. 30*

The purpose of this procurement is to provide a coordinating center for the American Stop Smoking Intervention Study (ASSIST/2000), a cooperative effort between NCI and the American Cancer Society aimed at the development and implementation of a six to seven year tobacco prevention and control demonstration throughout the U.S.

Responsibilities of the coordinating center will include the following: developing training and instruction modules, delivery of a specific training program to ASSIST sites, development and production of promotional and training videos, coordination of programs and projects across and between ASSIST sites, developing and implementing a studywide communication system, providing conference management and support services, establishing and maintaining a centralized information and resource center, providing analytical expertise for various project tasks and assisting the NCI program office in the daily operations and management of the ASSIST project sites.

One award is anticipated and a 9.5 year incrementally funded cost reimbursement completion contract will be awarded.

*This RFP was issued in August, but NCI did not send a copy to The Cancer Letter until Oct. 2, apparently due to a mailing problem.

Contract Specialist: Joanne Feldman
RCB Executive Plaza South Rm 635
301/496-8603

NCI-CP-05619-56
Title: Resource to support the chemical, economic and biological information needs of the Div. of Cancer Etiology
Deadline: Approximately Nov. 13

This notice cancels a procurement notice for "Resource to support the chemical, economic and biological information needs of the Div. of Cancer Etiology" and reissues this acquisition under a sources sought synopsis using SIC code 8732 ($3.5 million). The specific qualification data, including capability statements, will be analyzed by NCI staff to determine if there are qualified sources using SIC code 8732. The following information explains the sources sought procurement requirements.

DCE is seeking qualified sources for the development of information on environmental and occupational cancer which consists of four tasks:

Task 1: Support of the chemical selection and nomination process consists of two class studies per year, for a total of 10, during this five year acquisition. The contractor shall review classes of chemical substances, as directed by the project officer, and prepare a report for review by the Chemical Selection Planning Group and the Chemical Working Group. One of the reasons for conducting class studies is the selection of candidate chemicals on which summary sheets shall be prepared for consideration by the CSWG for ultimate nomination to the National Toxicology Program. Suitable class studies shall be published in the open literature. Summary sheets will be prepared in accordance with a specific formal.

Thirty summary sheets per year are planned, for an approximate total of 150, during this five year period. Plan, support, attend and prepare minutes of three to four CSWG meetings and eight CSPG meetings per year. Prepare and submit data packages containing the summary sheets and CSWG recommendations for those chemicals selected for nomination for

carcinogenicity bioassay. Support the nomination of approximately 25-30 chemicals to the DCE short term testing program. Continue maintenance and updating of NCI's Chemical Tracking File which is a computerized file that tracks the status of all chemicals considered for nomination for carcinogenesis bioassay.

Task 2: Support of the chemical information needs of the International Agency for Research on Cancer entails coordinating activities with IARC staff and the NCI project officer. For the five year period of this contract, 15 IARC working group meetings are expected, requiring submission of information for Section 1 (Chemical and Physical Data) and Section 2 (Production, Use, Occurrence and Analysis) of the IARC monographs on the evaluation of carcinogenic risks to humans on 250 to 300 chemicals. Material is furnished to IARC no later than 90 days prior to each working group meeting. A contractor representative (professional chemist or toxicologist to be approved by NCI) shall attend up to three IARC meetings per year. The contractor is expected to be familiar with chemical industry economics with emphasis on patterns of production, including chemical process flow distribution, intermediate use and end products, on a world wide basis, which emphasis on the U.S., Eastern and Western Europe and Japan, and have access to reliable national and international reference sources.

Task 3: Chemical Carcinogenesis Research Information System consists of maintaining and enhancing the CCRIS data base which resides and may be searched in the NIH, National Library of Medicine's TOXNET system. The contractor shall survey pertinent sources and evaluate data in accordance with the evaluation criteria furnished by NCI. After final review by a senior toxicologist and project officer, the contractor shall enter suitable studies on chemicals into the data base. For the five year period, accrual of studies on approximately 250 to 300 discrete chemicals per year, or a total of 1,250 to 1,500 chemicals, may be anticipated with some overlap on data for carcinogenicity, mutagenicity, cocarcinogenicity, etc.

Task 4: Special studies entails the continued updating of the NCI Bioassay Report Summary Handbook by preparing summaries, following the established format, of NCI/NTP Carcinogenesis Bioassay Technical Reports. There will be an average of 20 to 25 summaries per year. The contractor will respond to ad hoc inquiries, at the direction of the project officer, at the rate of approximately five per month.

The sources sought acquisition is 100 percent setaside for small businesses with a small business size standard of 8732 for Commercial, Economic, Sociological and Educational Research. This announcement is not a Request for Proposal and does not commit NCI to award a contract now or in the future. No RFP is available at this time. Interested parties are requested to respond to this announcement by forwarding sufficient information to demonstrate technical approach, background and experience of staff, management approach and facilities and equipment capabilities. Requesters should limit the capability statements to 15 to 20 pages. Nine copies of this document must be submitted to the contract specialist.

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

RFP NCI-CN-05221-20

Title: Large bowel adenomatous polyp dietary intervention study --data and nutrition coordinating center

Deadline: Approximately Jan. 4, 1990

NCI's Div. of Cancer Prevention & Control is soliciting proposals to provide a data and nutrition coordinating center for a multicenter randomized controlled dietary intervention study that will involve 2,000 participants, the Large Bowel Adenomatous Polyp Dietary Intervention Study. The center will be responsible for central study coordination, overall medical data management and monitoring, and coordination of nutritional intervention of this study. The center will act as a liaison between NCI, clinical centers, and other study consultants.

Offerors will be required to demonstrate in their technical proposals, in a separate section entitled "Mandatory Qualification Criteria," how they will satisfy the following requirements of this project:

A. Requirement for senior personnel assigned to this study to meet on a daily basis with the project officers in the Executive Plaza North Building in Rockville, MD.

B. Be available for the daily receipt and delivery of reports and materials to Executive Plaza North.

Contract Specialist: Charles Lerner
RCB Executive Plaza South Rm 635
301/496-8603

RFP NCI-CN-05220-20

Title: Large bowel adenomatous polyp dietary intervention study --clinical centers

Deadline: Approximately Jan. 4, 1990

NCI's Div. of Cancer Prevention & Control is soliciting proposals for clinical centers to conduct a large bowel aenomatous polyp dietary intervention study. This multicenter randomized controlled intervention study will examine the effect of a low fat, high fiber, vegetable and fruit enriched diet on the recurrence of adenomatous polyps of the large bowel. It is expected that each centeer will randomize participants at a minimum rate over seven per month, or 170 patients over the two year randomization period.

General requirements include identification and accrual of eligible participants, nutritional education and counseling, participant followup, and endpoint assessment. Intermediate endpoints specimens will be collected. Data maintenance and reporting and quality control systems will be supported.

Contract Specialist: Charles Lerner
RCB Executive Plaza South Rm 635
301/496-8603

RFP NCI-CO-94395-40

Title: NCI/NICHD LAN hardware and software

Deadline: Approximately Nov. 12

It is anticipated that a negotiated fix price, indefinite quantity, requirements contract will be awarded. This contract will involve supplying the hardware and software for local area networks for NCI and the National Institute of Child Health & Human Development.

In addition, the contractor shall provide the maintenance for the equipment provided under this contract. The local area networks will use both Token Ring/IEEE 802.5 and Ethernet/ IEEE 802.3. The hardware and software must be fully compatible with and properly interoperate on the same cable plant (both Token Ring and Ethernet) with the existing 3Com 3+Open and the 3Com 3+ operating systems. All responsible sources may submit proposals which will be considered.

Contracting Officer: Gloria Dahl
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NCI Contract Awards

Title: Studies on environmental cancer utilizing prepaid health plans.
Contractors: Kaiser Foundation Research Institute, Oakland, CA, $1,194,691; Kaiser Foundation Research Institute, Portland, OR, $1,348,693; Kaiser Foundation Research Institute, Los Angeles, CA, $876,288.

Title: Second cancer following treatment for uterine corpus cancer.
Contractor: Swedish Cancer Registry, $78,785.

Title: Breast cancer in women under the age of 45: field centers.
Contractors: Emory Univ., $1,194,434; Fred Hutchinson Cancer Research Center, $803,582; New Jersey State Dept. of Health, $581,357.

Title: Radiation dosimetry for epidemiologic studies.
Contractor: Univ. of Texas M.D. Anderson Cancer Center, $1,062,276.

Title: Coordination of a case control study of renal cell cancer.
Contractor: Westat Inc., $994,491.