THE CANCER LETTER

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Eight Probable Minority CCOP Awardees Listed; NCI May Award As Many As 12, With 220 Payline

NCI has not yet released the list of awardees in the new Minority Clinical Oncology Program, but **The Cancer Letter** has identified eight who are almost certainly in the funding range. They are, in no particular order, with the principal investigator listed in some cases to distinguish the awardee from another CCOP in the same city:

(Continued to page 2)

In Brief

Golomb, Weinstein Head ASCO, AACR; Abeloff, Moses Presidents Elect; Sackett Heads AUR

HARVEY GOLOMB and **BERNARD WEINSTEIN** assumed presidencies of the American Society of Clinical Oncology and American Assn. for Cancer Research, respectively, at last week's annual meetings in Washington. Golomb, chief of hematology/oncology at the Univ. of Chicago, succeeded Robert Young; Weinstein, director of the Columbia Univ. Comprehensive Cancer Center, took over from Harris Busch. ASCO members named **MARTIN ABELOFF**, Johns Hopkins Univ., president elect. AACR's new president elect is **HAROLD MOSES**, Vanderbilt Univ. New AACR directors are John Mendelsohn, Peter Nowell, June Biedler, and Nancy Colburn. New ASCO directors are Frederick Appelbaum, Nancy Kemeny, and Daniel Von Hoff. . . . **KATHERINE PAVLOVNA GOLDBERG** was born May 27 at Georgetown Univ. Hospital, weighing in at 8 lbs 10 oz. Mother, Associate Editor Kirsten Goldberg, and daughter are doing fine. Her father, Cancer Economics Editor Paul Goldberg, and grandparents Sonia and Boris Goldberg and Julie and Jerry Boyd, will recover eventually. . . . **JOSEPH SACKETT,** Univ. of Wisconsin, is the new president of the Assn. of University Radiologists. Other new officers for 1990-91 were named at the group's recent annual meeting in Minneapolis. **Albert Moss**, Univ. of Washington, is president elect; and Kay Vydareny, Univ. of Michigan, is secretary treasurer. The association also announced two Gold Medal Award winners: **John Campbell** of Los Angeles, and **John Juhl** of Madison, WI. . . . **NATIONAL CANCER** Survivor's Day is June 3. For the third consecutive year, there will be celebrations around the country to commemorate personal victories over cancer and advancements in research. . . . **GARTH NICOLSON,** Univ. of Texas M.D. Anderson Cancer Center, was awarded the 1990 Burroughs Wellcome Visiting Distinguished Professor Award from the Royal Society of Medicine of Great Britian. He will spend two to four weeks in Britain lecturing, visiting colleagues and providing a text for publication in the society's journal.

Eight Probable Minority CCOP Awardees Identified; NCI Mum

(Continued from page 1)

USA Cancer Center, Mobile, AL; Univ. of Illinois, Chicago (Thomas Ladd); Newark Inner City CCOP (Thomas Hall); San Antonio (Santa Rosa Hospital) CCOP; Medical College of Virginia, Richmond; Tulane Univ.; San Juan City CCOP (Luis Baez); and Grady Memorial Hospital, Atlanta.

Priority scores in that group ranged from 160 to 213. Although NCI originally had determined that the $1.2 million set aside for the new program would fund no more than eight minority CCOPs, there were indications last week that as many as 12 awards might be made in this round. The budget could be stretched by reducing the budgets of all awardees to figures under those recommended in peer review, picking up additional CCOPs and lifting the payline to about 220. Some exceptions could be funded above the established payline, if the NCI Executive Committee decides it is desirable to pick up a promising CCOP for geographic or demographic reasons. That information is not official, and final word from NCI may not come for several weeks.

So far, the best priority score obtained by **The Cancer Letter** is that of Grady Memorial Hospital in Atlanta, with 160. Melvin Moore is the principal investigator.

Minority CCOP applicants with scores of 220 or under which are not identified here are invited to phone **The Cancer Letter** with that information (202/543-7665).

Twenty three applications were reviewed. A few were disapproved because they did not meet key requirements of the program, which is designed to bring more minority patients into clinical trials.

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DCPC Plans To Develop Its Own Computer System, Reduce NIH Use

Acquisition of computer hardware and software which would permit NCI's Div. of Cancer Prevention & Control to save as much as $4.5 million over five years by using its own system rather than buying time on NIH central computers has received concept approval from the division's Board of Scientific Counselors.

The board unanimously approved the concept for a contract which would total an estimated $2.3 million for development and purchase of hardware and software. DCPC currently is spending nearly $2 million a year for timesharing services from NIH.

The edited concept statement follows:

Computer systems integration for cancer prevention and control. One five year contract, estimated total cost $2,283,000.

DCPC supports a wide range of scientific projects including SEER, the nationwide cancer registry effort; chemoprevention trials in Finland and China; community intervention trials for smoking cessation; and a human nutrition laboratory. All of these projects share a common element: they all utilize computers for data management and analysis, usually timesharing on the central NIH mainframes. It is not surprising that DCPC computer charges have gradually but continuously escalated.

Several different computer cost containment measures are being explored. On the software side, major programs are being rewritten in more efficient computer languages such as "C" that have the additional benefit of portability to different computing environments. Utilization patterns are being scrutinized. This concept primarily addresses hardware considerations: the acquisition of state of the art computer systems specifically configured for DCPC needs.

Recent developments in computer architecture have made it possible to support scientific computing projects more cost effectively than by the traditional, mainframe timesharing approach. RISC (reduced instruction set computer) systems were developed for computationally intensive chores such as high speed scientific work-stations performing elaborate graphics. Competition in RISC systems has become very active, and most major computer vendors now offer RISC machines in a range of sizes from single workstations to powerful super minicomputers. Because of the RISC design, these systems are very well matched to DCPC scientific computing needs.

Based on reviews of technical specifications for the major RISC computers and discussions with vendor technical representatives, a generic configuration for a network of RISC computers capable of supporting DCPC workloads has been devised. The proposed system has been configured to address the majority of DCPC scientific programs. The typical DCPC applications uses SAS or a custom DCPC package such as KISS to analyze a moderate size data set. One major cost is worth mentioning here: The RISC systems will not function without additional staff to implement and maintain them. Acquiring a systems integration contractor is proposed to support these computers. The costs for this support staff have been included in the project budget.

The total estimated cost for five years of $2.3 million compares to current timesharing charges of about $1.8 million annually or $9 million for five years. If all of the DCPC timesharing charges

could be eliminated, the project would be extremely cost effective. Two factors will mediate against the elimination of all timesharing charges: (1) The generic configuration includes software costs for the major packages (SAS, C, Fortran) used for DCPC programs. It does not include software licenses for all of the packages available on the central NIH mainframes, some of which are occasionally needed for DCPC applications. Work needing the less common packages will continue on the NIH mainframes. (2) Sufficient disk storage for the majority of DCPC projects is being allocated. However, a full tape library and operational support is not planned. Jobs requiring multiple tape accesses will also remain on the NIH central mainframes. A reasonable goal is to migrate at least half of the DCPC computing load. Accomplishing this would incur a five year cost of approximately $2.3 million vs. potential savings of up to $4.5 million. Since DCPC scientific computing work should continue to increase, the full savings may not be attained, but as a minimum, stabilization of costs is achievable.

Benefits of the project are not limited to financial. The RISC computers feature graphics user interfaces similar to those available and currently in use in DCPC on personal computers. These inter-faces are typically easier to learn and use than the traditional mainframe terminal approach supported by the central NIH computer facility. Users will benefit from a more consistent approach between the personal computers used for office automation, data base management, and simple computer, and the number crunching scientific applications on the RISC computers. In the long term, training loads will be reduced and more investigators will be encouraged to analyze their data directly rather than through a programmer.

The concept proposes acquiring a systems integration contractor to provide hardware, software, maintenance, and support for scientific computing applications within DCPC. The contractor will recommend the final configuration based on DCPC requirements. For budgetary purposes, the following generic configuration has been costed:

* Three RISC processors with sufficient memory (64 megabytes or more) to support at least 25 active users running computationally intensive jobs such as SAS.

* Adequate disk storage (6 gigabytes or more initially, more than 9 gigabytes over the contract life) for all DCPC data sets.

* Nine track tape drive for data interchange and a cartridge tape unit for system backup.

* Network interface for communication with DCPC PCs within the Executive Plaza complex.

* High speed telecommunications link for a heavy use, support contractor and eight dial up lines for remote ruse by other DCPC collaborators and contractors.

* Laser printers and graphics devices (e.g., screen camera, color hardcopy device).

* Operating system (including X/Windows interface), C and Fortran compilers, and SAS software for program development.

The contractor will configure, install, operate, and maintain the system. The contractor will integrate the RISC systems with the local area network being implemented in the Executive Plaza complex. The contractor will transfer applications (e.g. data sets and programs) from the NIH mainframes and assist users in running the applications on the new system. The contractor will provide training in and assist NCI staff with system use. To provide these services, a staff of four persons is required: one systems programmer, one project manager/computer analyst, and two junior programmers/ analysts.

Thomas Marciniak, chief of the Computer Systems Branch, is project officer, and Brenda Edwards, acting associate director for the Surveillance Program, is program director.

Board member Philip Cole had some advice based on his experience. "I suggest you not spend the money you think you are saving. By the time this is implemented, the cost may be more than you think. I would like to have all the money I was supposed to save on another computer." But Cole and the rest of the board supported the concept.

The board approved the concept of an interagency agreement with the National Center for Health Statistics to collect data assessing the impact of cancer control programs. The three year effort will cost an estimated $4.5 million.

New Agency To Evaluate PDQ, NCI Agrees To Pay One Third Of Cost

The new Agency for Health Care Policy & Research previously had offered to carry out an evaluation of the impact of NCI's PDQ on the practice of medicine, which will cost an estimated $750,000, with no cost to NCI. Before the project could be implemented and a contract awarded to carry it out, AHCPR determined that it could only come up with $500,000 of that and asked NCI for the rest.

Director Samuel Broder agreed to provide the $250,000 if the National Cancer Advisory Board agreed. The board did so, following a concept review of the proposal at last month's meeting of its Committee on Information and Cancer Control.

PDQ (Physician Data Query) is a clinical cancer treatment information resource developed by NCI to bridge the gap between cancer treatment research advances and clinical practice applications. A previous evaluation, completed in 1987 but not released until last year, found that awareness and use of PDQ within the medical community were too low to evaluate the impact of PDQ on physician behavior and patient outcome. Since then, use of PDQ has more than doubled, although a significant part of that increase has been by the NCI supported Cancer Information Service.

Excerpts from the concept statement presented to the committee follow:

Do physician treatment plans become more congruent with treatment options in PDQ after physicians are presented with treatment information from PDQ? This is the central question for NCI and AHCPR. All other questions to which NCI and AHCPR would like to know the answers, such as PDQ's impact on overall patient outcome, on identified subsets of patients and/or physicians and in special settings are to be secondary. Does the PDQ model work in typical American medicine? If it can be demonstrated that PDQ has an effect on the practice of medicine in this milieu, then ancillary or subsequent studies can address

whether PDQ has an effect under more difficult circumstances with multiple confounding variables.

The overall purpose of the study is to determine whether explicit standards and guidelines of treatment as provided in PDQ are an effective means to communicate treatment information. Success will be measured by modification in physician behavior, protocol delivered care, and patient outcome. Major assessment questions to be considered shall at a minimum include:

1. Does PDQ affect physician delivery of cancer care?

2. What is the effect of PDQ on the rate at which state of the art treatments are adopted?

Assessment of the implementation and impact of PDQ shall include examination of the following areas and their interactions:

A. Implementation of PDQ. The contractor shall work to overcome identified barriers to the adoption of PDQ by community physicians as part of the proposed plan and assessment. A number of barriers to the adoption of PDQ were identified in the final report on the evaluation of the PDQ system. The contractor shall identify a way or ways to provide PDQ information to physicians in community practice settings (office, clinic, hospital, etc.) at the point of patient care decision making.

B. Physician behavior. The contractor shall examine physicians' behavior when PDQ is fully implemented in different practice settings (office, clinic, hospital, etc.) at the point of patient care decision making. This can be thought of as a two part matrix involving physician and patient interactions. The ability of the physician to convey to the patient the recommendations in PDQ and have the patient accept them involves many factors including potential benefit and cost. The following questions should be addressed:

1. What is the specific impact on physicians' treatment decisions? What treatment approaches are adopted or rejected?

2. Does physician participation in or referral to clinical trials change when PDQ is phased into the practice setting?

3. Does the physician and/or support staff in the practice setting use PDQ? How is PDQ used in different practice settings to provide state of the art treatment information at the point of patient care decision making?

4. Are changes in the entry of patients onto standard or investigational treatment protocols limited to one or a few cancer diagnoses or do changes occur throughout the practice?

5. What unique features characterize physicians and practice settings that successfully incorporate use of PDQ as a decision making tool?

6. In addition to changes in treatment practice are there other changes in professional behavior after the introduction and use of PDQ?

7. Where else does the physician obtain treatment information?

8. Does PDQ effect differences or changes in patient referral, transfers, followup plans, and types of care for state of the art treatment, whether it be standard or investigational?

The following questions should be addressed regarding protocol delivered care:

1. Does the physician change practice consistent with changes incorporated into PDQ?

2. Does PDQ effect differences or changes in recording behavior and appropriateness of therapeutic monitoring and interventions?

3. Does PDQ effect differences or changes in provided services?

The majority of physicians felt in the earlier evaluation that PDQ would have a positive impact on the physician-patient relationship because it would enhance the patient's treatment options and would help the patient better understand his/her condition. The following questions should be addressed:

1. Will patient awareness of treatment information in PDQ, i.e. the patient information section, modify physicians' behavior and treatment practices?

2. Is there a measurable difference or change in the number of patients enrolled in or referred to clinical trials?

3. Does the patient in a PDQ influenced practice setting who is given the PDQ information statement about his/her cancer diagnosis better understand his/her condition and treatment options?

4. Are there measurable differences or changes in patient satis-faction in a PDQ influenced practice compared to non-PDQ influenced practice?

5. Does an awareness of PDQ by the patient create a perceived need for PDQ information?

6. How might PDQ be modified to be more useful for patients?

"PDQ is an experiment. If it is not the way to influence practice, we need to know that," said Susan Hubbard, director of NCI's International Cancer Information Center.

"I would like to know why information in PDQ is not being used," NCAB Chairman David Korn said. "There are two issues here. Are physicians using PDQ and interacting? Second, do they accept recommendations in PDQ? If not, why not?"

Norman Weissman, AHCPR staff, commented that his agency has been charged by Congress to identify guidelines for various aspects of medical practice, "to improve the system." He noted that in some states, physicians who follow guidelines reduce their malpractice exposure.

"That's what worries me," Korn said. "Pathologists [of which Korn is one] don't treat people. They just tell other people what they did wrong. But it seems to me that cancer therapy is not cut and dried. You can't assume that because a physician chooses not to use PDQ information, that is a bad decision."

When Weissman responded that the agency was only following Congress' direction, Korn snapped, "Congress doesn't know diddly about this."

"That's not the issue," committee Chairwoman Helene Brown said. "The issue is PDQ's usefulness."

Board member David Bragg wondered if NCI had designed the evaluation from the start, "is this the way we would do it? We thought we had an angel, which wanted to do a study. Now the angel's wallet is thin and we are asked for one third of the money. So in that case, is this what we want? I don't think so."

"The principal question is, is the information in PDQ good and does it change your practice?" Hubbard said. "If the answer is, 'I don't use computers, I need information presented some other way,' we need to try something else."

Board member Bernard Fisher said that "There is no question that medical practice has changed," but

added that there could be considerable doubt whether the change was due to PDQ.

"I have always been a supporter of PDQ, even in its darkest day," Korn said. "I am terribly concerned about guidelines, Papal bulls. I object to any study which presumes that physicians queried dutifully follow recommendations."

"The reason my agency was created was to do by scientific research rather than set guidelines," Weissman said. "PDQ has an approach to disseminate information. We asked around to find out who is doing information dissemination in the health field. It turns out that the Cancer Institute is the most advanced."

Brown restated what she said was the issue. "Is PDQ playing an important role in helping physicians make decisions?"

"We felt we couldn't dictate how the study is done," said Robert Esterhay of the International Cancer Information Center staff. "We would be accused of setting it up. We asked the questions, and let the proposer design the study."

Direct To Oncologists

Board member Erwin Bettinghaus noted that the project uses the term "physician in a broad sense. I doubt if you are aiming it at primary care physicians. Most of them refer patients after diagnosis to oncologists, with the exception of some rural physicians. This study needs to be directed to oncologists."

Esterhay noted that the project specifies that physicians in the survey have some familiarity with clinical trials."

"I'm in favor of going ahead with this. The price is right," Bragg said. "But if we were to design a study, would this be what we would do?"

"For the price, yes," Hubbard answered. "The central question, of the most importance to NCI, is, does the presence of guidelines have an impact on the practice of medicine.?"

"There is almost no body of literature that would allow you to come down with conclusions," Div. of Cancer Prevention & Control Director Peter Greenwald said. "How crucial is this to making a judgment about PDQ? I think very. If it comes out that there is no impact, then the question would arise whether to continue PDQ."

NCI spends about $2 million a year on PDQ. The government does recover some money from users through licensing to vendors and fees to the National Library of Medicine, but none is returned to the institute.

Applications Pour In For Construction Grants; Competition For Mouse Lab

There was no dearth of applications for the $3.2 million in extramural construction funds available this year from NIH, with about 57 institutions vying for that money.

There is also competition for the $10 million earmarked for a mouse production facility. Although that is intended to assist in construction of a facility to replace that destroyed by the fire at Jackson Laboratory, two other institutions--Goodwin Institute of Florida and Massachusetts Institute of Technology--are competing with Jackson for that money.

That information was based on letters of intent received by NIH, Kenneth Brow, chief of NCI's Research Facilities Branch, told the National Cancer Advisory Board Centers Committee recently. Applications will be reviewed in June and July, with summary statements scheduled to go out by Aug. 15.

The grants will have to be awarded during the current, 1990 fiscal year, prior to the next NCAB meeting, Oct. 1-2. This will require the NCAB secondary review by mail, a special meeting of the Centers Committee, or conference call.

Brow estimated that NCI will make three awards with its share of the construction funds. The only other institutes with construction authority are the National Heart, Lung, & Blood Institute and the National Eye Institute, each of which probably will make one award.

Congress designated $14 million for NIH extramural construction in the 1990 appropriations bill, and earmarked $10 million of that for the mouse facility. NCI received $2 million to apply to its backlog of reviewed but unfunded applications, and awards were made to the Univ. of Southern California ($1.2 million), and the Univ. of Wisconsin ($400,000). All other fundable applications were approved for amounts higher than the remaining $400,000, and the decision was made not to partially fund any of them (**The Cancer Letter**, March 23). The extra money was returned to NIH to be added to the $2.8 million originally intended as a competitive NIH wide pool. Applicants for cancer facilities were invited to compete for that money, and it appears that at least 16 did.

In a previous closed session, Centers Committee members led by Enrico Mihich argued for partial funding of the NCI grants and committing all of the $2 million, contending that cancer centers have used federal funds in the past with great success in leveraging it into additional money, frequently many times more than the grant. Their view did not prevail.

Institutions which submitted letters of intent for support of renovation or construction of cancer research facilities were:

Univ. of Alabama (Birmingham), UCLA, Univ. of California (San Diego), Univ. of Colorado, Goodwin Institute (in addition to a separate application for the mouse facility), Illinois Cancer Council, Harvard Medical School, Johns Hopkins Univ., Univ. of Michigan, McLaughlin Research Institute in Browning, MT, Univ. of North Carolina, Univ. of Medicine & Dentistry of New Jersey, Memorial Sloan-Kettering Cancer Center, New York Univ., Cancer Therapy/Research of San Antonio, and Fred Hutchinson Cancer Center.

Letters of intent for National Eye Institute grants were submitted by Doheny Eye Institute, Univ. of California (Berkeley), LSU Eye Center, Washington Univ. School of Medicine, State Univ. of New York (Stony Brook), Univ. of Rochester, and Oregon Health Science Univ.

Letters of intent for NHLBI grants were submitted by Gladstone Foundation Laboratories, Univ. of Iowa, Rockwater Offshore Center, Univ. of Minnesota, and Univ. of Pennsylvania.

Letters of intent which cut across two or all three of the institutes were submitted by Arizona State Univ., Children's Hospital of Oakland, City of Hope, National Jewish Center, Children's National Medical Center, Georgetown Univ. Medical Center, Florida Institute of Technology, Univ. of Florida College of Medicine, Yerkes/Emory Univ., Northwestern Univ., Rush Presby-terian-St. Luke's Medical Center, Purdue Univ., Univ. of Kansas, Boston Univ. School of Medicine, Harvard Medical School, Joslin Diabetes Center, MIT (in addition to the mouse facility application), McAuley Health Center, Michigan State Univ., Charlotte Memorial Hospital, North Carolina State Univ., Research Triangle Institute, Dartmouth Medical School, Primate Research Institute, Columbia Univ., Case Western Reserve, Ohio State Univ., Mercy Hospital, Univ. of Puerto Rico, Univ. of Tennessee, and Univ. of Texas.

NCI Lists Comprehensive Centers, Omits Georgetown/Howard, Adds Ariz.

When NCI and the National Cancer Advisory Board established the practice of "recognizing" or "designating" some cancer centers as "comprehensive cancer centers" in the 1970s, an effort which grew out of the National Cancer Act of 1971, those periodic "designations" or "recognitions" were made with great ballyhoo. Celebrations were organized, governors issued proclamations, and blizzards of press releases flowed from NCI, congressional offices, and the institutions.

Little thought was given then to what form an announcement might take when NCI would be forced to remove a center from the list of comprehensives. NCI executives did not relish the prospect of sending out a press release announcing that XYZ center no longer met the requirements for a comprehensive cancer center. That could be embarrassing to all concerned, especially to the person who had to explain it to congressmen and senators.

During the first life of comprehensive centers, only one faced being "defrocked," that located in Colorado. That center lost its NCI center core grant, which should have triggered the process leading to derecognition under the rules at that time. The center had two years to get the grant renewed; otherwise, the NCAB would review it for comprehensiveness and could, although this was not a requirement, withdraw recognition. The Colorado center saved everyone all that trouble by closing its doors. A new center has been established now at the Univ. of Colorado and it has received a core grant.

With adoption of new guidelines for comprehensiveness and the requirement for review of how well a center lives up to them at the time of core grant renewal, the likelihood that some centers would lose that status became real. In fact, it has now happened, although NCI is not admitting that withdrawal of recognition was under the new system.

At last week's annual meeting of the American Assn. for Cancer Research in Washington, an NCI news release was distributed which described the new guidelines and included a list of "NCI designated comprehensive cancer centers." Absent from this list was the Georgetown/Howard Comprehensive Cancer Center.

Georgetown Univ.'s Lombardi Cancer Research Center and Howard Univ.'s Cancer Research Center were recognized jointly as a comprehensive center in the mid-1970s. Georgetown failed to get its core grant renewed two years ago, decided not to reapply immediately, and then submitted a new application for the round which went to the NCAB last month.

Howard's grant also went to the NCAB last month. NCI will not identify those centers which will receive awards until the award process has been completed.

Does omission from the list of comprehensive centers mean that either or both centers did not compete successfully?

Margaret Holmes, chief of the Cancer Centers Branch, told **The Cancer Letter** that that was not the

case, and that the omission was made on the basis of the old guidelines.

Two other comprehensive centers were at risk this round--Ohio State and Roswell Park both were not funded on schedule last year but reapplied. Holmes said that their inclusion on the list did not necessarily mean that they competed successfully this time.

The Univ. of Arizona Cancer Center was included on the list. Apparently, that will be the new mode of announcement by NCI, since this was the first official listing of Arizona as comprehensive. Director Samuel Broder did reveal at a conference in Tucson last March that Arizona was the first center to be recognized as comprehensive under the new guidelines.

The NCI news release states that the number of comprehensive centers is 21, although Georgetown/ Howard was left off. Actually, the number remains at 20, since the NCI list showed Fox Chase and the Univ. of Pennsylvania as separate centers, but they were recognized jointly as a comprehensive center.

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.

NCI-CP-05651
Title: Laboratory rodent and rabbit facility for the Laboratory of Cellular Carcinogenesis and Tumor Promotion
Deadline: Approximately July 7

NCI has a requirement for a contractor to provide facilities and staff to house, care for and conduct experiments with laboratory rodents and rabbits as directed by protocols from NCI investigators. The numbers of animals for which facilities shall be provided will vary with current program needs, but facilities to house the following numbers of rodents are required: athymic mice, 1,000; intact mice, 3,700; transgenic mice, 300; rabbits, 50; hamsters, 200; rats, 150; guinea pigs, 20. Animals will be purchased by NCI, not the contractor.

This acquisition is to support the intramural research program of the Laboratory of Cellular Carcinogenesis and Tumor Promotion, located in Bethesda, MD, and respondents must be able to accomplish a frequent exchange of animals and fresh specimens and injectable cell suspensions with the LCCTP. This acquisition is a recompetition and one award is anticipated to cover a four year period. The proposed contract is a 100 percent small business set-aside, the size standard for which is 500 employees.
Contract Specialist: Chris Ptak
RCB Executive Plaza South Rm 620
301/496-8611

NCI-CO-03896
Title: Booklet printing
Deadline: Approximately July 9

Single award for a fixed price contract. Production area assumed 125-mile radius of zero milestone, Columbia, MD. Offerors outside area must furnish documentation of their ability to meet schedule. Inspection of source materials will be from June 25-26, 8 a.m.-5 p.m. local time at NIH Bldg 31 Rm 10A30, 9000 Rockville Pike, Bethesda, MD. For an appointment contact Erin Lange one week prior to source review. Booklet. 28 page book with separate wraparound cover. 350,000 copies. Four color process, PMS 100 yellow, PMS 319 aqua and PMS 148 peach. Solid inks, no builds allowed. Operations include printing, saddle wire stitch, trim, separations, packaging, shipping and f.o.b. destination to Columbia, MD. Contractor furnish paper. Quality attributes level II for printing and finishing. Bid request on firm's letterhead.
Contract Specialist: Erin Lange
RCB Executive Plaza South Rm 635
301/496-8628

Program Announcements

Epidemiologic studies of cancer and human retroviruses. NCI's Div. of Cancer Etiology invites grant applications for epidemiologic studies of the role of retroviruses, including HIVs, in the incidence and progression of malignancies.

NCI has a continuing interest in the study of malignancies associated with the human retroviruses, particularly HIVs. Some cancers of the lymphoreticular system (non-Hodgkin's lymphoma) and soft tissue (Kaposi's sarcoma) are significantly increased in incidence and display an aggressive pattern of development and progression in HIV infected individuals. Other tumor types, such as papillomavirus associated cancers, may also be emerging more frequently in association with HIV infection.

HIV-1 infection is a major health problem in some developing countries and the rate of disease progression and the major modes of HIV transmission appear to be different from those most prominent in the U.S. For example, as much as 80 percent of HIV infection in Africa is acquired by heterosexual transmission; in Asian countries, intravenous drug use, prostitution and receipt of blood products are major transmission modes. The route of HIV infection may be responsible for differences in clinical outcomes, as Kaposi's sarcoma is less common in individuals who have acquired infection through IV drug abuse or the administration of blood products compared to other routes of intection.

It remains to be determined whether the change from predominantly indolent, endemic KS to the more widespread occurrence of an aggressive, epidemic form of KS in Africa has resulted from HIV infections, and whether KS is disproportionately represented as an AIDS-associated illness in the KS endemic areas of central Africa compared to non endemic areas. While KS is very rare in children with AIDS in the U.S., 5 to 10 percent of African children with HIV infection have been reported to have KS. It is not known whether HIV has had an impact on the incidence of Burkitt's lymphoma in Africa, and whether HIV associated BL in Africa has the same frequency of specific chromosomal rearrangements as the HIV unassociated form, as is the case in the U.S. Comparing etiologic factors for KS, non-Hodgkin's lymphoma, BL and other tumors in different geographic areas could contribute to the understanding of retroviral carcinogenesis.

HIV-2 has some characteristics similar to HIV-1 and has been reported from African, South American and Caribbean countries but is rare elsewhere. Some cases of AIDS have been attributed to HIV-2 infection, but whether this virus is associated with

enhanced development of malignancies is unknown.

The proposed initiative seeks to encourage epidemiologic research projects on the incidence and etiology of retrovirus associated malignancies in North America and Europe, comparative epidemiologic studies of these malignancies in several geographic areas, or such studies in areas outside North America or Europe. The initiative will permit a wide range of investigations, including, but not limited to, the following:

--Investigations of KS in both the endemic and epidemic forms, and non-Hodgkins lymphoma, including Burkitt's lymphoma, in adults and/or children. Epidemiologic, genetic and multidisciplinary approaches may be used to elucidate the role of HIV and other viral and nonviral factors in carcinogenesis.

--Epidemiologic studies of the role of retroviruses, including the HIVs and the HTLVs, in the etiology of human malignancies. Historic collections of sera and other biologic materials maintained at various locations that can be well characterized epidemiologically can be utilized in conducting surveys of virus prevalence or in historical cohort studies of the association between viral infections, coinfections and malignancies.

--Studies monitoring retrovirus associated malignancies, for example, through population based registries; programs to enhance and utilize tumor registries in areas with high prevalence of retroviral infection; programs to collect tumor samples and other biologic materials from retrovirus infected and uninfected individuals who develop cancer, for utilization by collaborating laboratory based scientists with expertise in elucidating cancer etiology.

Inquiries concerning this announcement should be directed to Dr. G. Iris Obrams, Extramural Programs Branch, Epidemiology & Biostatistics Program, DCE, NCI, Executive Plaza North Suite 535, Bethesda, MD 20892, phone 301/496-9600.

Domestic animal models of retroviral assocated malignancies. The purpose of this program announcement is to inform the scientific community of NCI's continuing interest in supporting basic research on retroviral pathogenesis and neoplastic sequelae in domestic animal models of human cancer. These studies have the potential to provide valuable basic information on the mechanisms of cancer induction by viruses and to serve as models for the initial evaluation of intervention strategies prior to human clinical trials.

Mammalian retroviruses have been isolated from humans, monkeys, mice, cats, cows, goats, sheep, pigs and horses. In some virally infected animals, neoplastic and Kaposi's sarcoma-like lesions have been observed, supporting the hypothesis that retroviruses may be directly or indirectly involved in the development of malignancies and disease progression.

The overall purpose of the PA is to help stimulate research activity in these virus cancer models and overcome these limitations. Retroviruses appropriate for the PA include those of large domesticated livestock, such as cows, horses, sheep, goats and pigs; specifically excluded are retroviruses of cats, dogs, mice, primates and the avian species.

Specific research topics of interest to NCI include, but are not limited to 1) studies emphasizing the development and utilization of known retroviral domestic animal models for investigations of disease pathogenesis from the initial infection to the development of preneoplastic lesions and neoplastic sequelae, 2) studies emphasizing the use of domestic animals for investigations of virus-host interactions to define and understand viral pathogenic and immune function alterations leading to preneioplastic lesions and neoplastic sequelae, including the role of other RNA and DNA virus cofactors, 3) studies which emphasize the expression and regulation of viral or cellular genes in preneoplastic lesions and malignant tissues from retrovirus infected domestic animals, 4) studies to isolate and characterize new retroviruses from normal, preneoplastic lesions and neoplastic tissues of domestic animals and study the mechanisms of oncogenesis of these viruses. Where appropriate, collaborative arrangements to facilitate the achievement of research goals should be considered.

Inquiries concerning this program announcement should be directed to Dr. Kenneth Cremer, Program Director, AIDS Virus Studies, Biological Carcinogenesis Branch, DCE, NCI, Executive Plaza North Rm 540, Bethesda, MD 20892, phone 301/496-6085.

Obesity, endocrine and fat metabolism and cancer risk. NCI's Div. of Cancer Etiology invites regular research project grant applications for epidemiologic studies to define the relationship between obesity and cancer etiology.

The purpose of this PA is to encourage further studies to clarify associations recently found between body fat distribution and cancer risk, or risk factors, as well as to extend knowledge through the investigation of related or new hypotheses. A major goal is the definition of differences in adipose tissue metabolism and hormone metabolism from varied envrionmental exposures as they relate to site specific cancers.

Research topics of interest include but are not limited to:

--Development and validation of improved measurement techniques for cancer risk factors related to adiposity, caloric balance, steroid hormone and fat metabolism, and diet; assessment of interaction and its effect on specific cancer risks.

--The use of better measures of total adiposity and of the distribution of adipose tissue in evaluating risk of various cancer sites, such as breast, endometrium, prostate, colon, gallbladder, ovary, lung and kidney. This includes interest in definition of cancer risk associated with the deposition or metabolic activiety of adipose tissue in the visceral compartment, and clarification of any effect of height.

--The impact on site specific cancer risk of age, ethnic or race related variation in adiposity or in adipose tissue distribtuion, taking into consideration relevant confounding factors.

--Evaluation of the relationship between site specific cancer risk and risk of other diseases related to adipose tissue distribution, such as diabetes, hypertension, gallbladder disease and polycystic ovaries. This includes consideration of risk factors that may relate to cancer and to other diseases, such as serum lipids and variations in lipid metabolism.

--Evaluation of the etiologic validity of cancer risk estimates derived from case control studies of adiposity or adipose tissue distribtuion.

--Insight into whether environmental factors, which influence both cancer risk and steroid hormone metabolism, act directly as well as indirectly in affecting cancer risk. Environmental factors of interest include smoking, dietary variation, energy balance and intake of specific substances such as indoles, ethyl alcohol, saturated and unsaturated fatty acids.

--Studies of the impact of fluctuations in body fat over time on the mobilization of substances stored in body fat (such as pesticides) and the relationship of such changes to cancer etiology.

--Determination of the relationship to cancer risk of site specific variation in adipose tissue activity.

--Investigation into reasons for the crossover in obesity associated risk of breast cancer in pre and postmenopausal women.

Inquiries concerning this announcement should be directed to Dr. Genrose Copley, Extramural Programs Branch, Epidemiology & Biostatistics Program, DCE, NCI, Executive Plaza North Suite 535, Bethesda, MD 20892, phone 301/496-9600.