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ONS, ASCO, AACR Growth Surge Continues; Flex Political Muscles During DC Meetings

The three largest oncologic professional societies, meeting in tandem in the nation's capitol, found that their message and their impressive membership strength are commanding the respect of Congress and the Administration. Whether that can be translated into greater support for cancer research remains to be seen, but it is clear that all
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In Brief

Wittes To Return To NCI As Chief Of Medicine Branch; Owens Heads Cancer Research Coalition

ROBERT WITTES, former director of NCI's Cancer Therapy Evaluation Program, will leave his job as senior vice president for cancer research with Bristol-Myers Squibb and rejoin the Div. of Cancer Treatment in August as chief of the Medicine Branch. Wittes left NCI in November, 1988, after heading CTEP during most of the decade of the 80s. DCT Director Bruce Chabner said this week that the Medicine Branch, which had been combined with the Clinical Pharmacology Branch two years ago, would be split off, with Charles Myers resuming his role as chief of CPB; he had been heading the combined branches. When he left NCI, Wittes was also serving as editor in chief of the "Journal of NCI" and as acting deputy director of DCT. The **Cancer Letter** was unable to reach Wittes for comment by press time. . . . ALBERT OWENS, director of the Johns Hopkins Cancer Research Center, has succeeded John Ultmann as chairman of the National Coalition for Cancer Research. Ultmann will continue the work he started as cofounder of NCCR, carrying the message to Congress on behalf of the National Cancer Program, as chairman of the American Assn. for Cancer Research Public Affairs Committee. . . . NEW HONORARY members of AACR announced at last month's annual meeting are Gertrude Elion, Ernst Wynder, and Everett Koop. . . . MAX COOPER, Univ. of Alabama (Birmingham), and Jacques Miller, Walter and Eliza Hall Research Institute, Melbourne, received the first Sandoz Prize for Immunology at the annual meeting this week in New Orleans of the American Assn. of Immunologists. Each will receive \$50,000 for their "groundbreaking contributions to the understanding of T and B cells and how they interact in human responses," said Lester Salans, vice president of preclinical research for Sandoz Research Institute. . . . SALLIE SLATE, formerly account supervisor in health care for Burson-Marsteller, has been named director of international public relations for the Coordinating Council for Cancer Research.

"The Nurse Is
Key To All,"
Brown Tells ONS

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ONS, ASCO, AACR Continue Growth Surge, Flex Political Muscles

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three societies have established the organizational process required to enhance their clout with the government.

The Oncologic Nursing Society, the largest of the three by far with 16,601 members (exactly 1,600 more than a year ago), opened the mid-May gatherings with its 15th annual Congress. The nurses were greeted at their opening ceremony by a rousing speech from Sen. Edward Kennedy and by Marilyn Quayle, wife of the Vice President, who is leading a crusade for breast cancer research and early detection.

With the three meetings being held in Washington, the conventioners heard lobbyists and legislators lament about the difficulties of finding additional funds for cancer research in the era of the rising budget deficit and briefed the packed auditoriums on the tricks of the lobbying trade.

"The President's budget [for NCI] doesn't even take care of inflation," said Sen. Ernest Hollings (D-SC), addressing the American Assn. for Cancer Research.

However, Hollings said, finding additional funds for cancer research will not be easy at the time when the budget is strained by the rising deficit as well as the collapse of the savings and loan institutions while the President remains reluctant to raise taxes.

"What we need is a five percent value added tax," Hollings said.

"Nurses have a tremendous credibility on the Hill," said Marguerite Donoghue of Capitol Associates Inc., which represents the National Coalition for Cancer Research and AACR. "In fact, you are probably the only group that has a greater impact on cancer issues are cancer patients themselves."

A "Contact Congress" booth set up at the ONS

meeting provided the nurses with information to be incorporated in letters to congressmen. According to ONS officials, 1,200 letters were mailed to protest the 3.6 percent increase in the President's NCI budget at the time when the allotment for space exploration was being increased by 47 percent.

"I congratulate you on the excellent care you provide and I urge you to carry the fight for better health care to both Congress and the White House," Kennedy said in accepting the ONS public service award.

"A cause for which American people need your strong support is the ongoing struggle for universal health insurance," Kennedy said. "No American should be denied essential care because they cannot pay. But 37 million citizens have no health insurance at all, either public or private. Let the Senate and House, and the President, too, know that now is the time to move forward on the unfinished business of social security and medicare, and make access to decent health care a right for all the people of America."

The tips on dealing with legislators included suggestions to present no more than one issue, to cultivate relationships with staff members and, in meetings with members of Congress, to keep the conversations brief. "Assume that you will be meeting for 10 to 15 minutes," said Ellen Shillinglaw, director of government operations for ASCO.

Adding to ONS' clout is the fact that the society now has 135 chapters located in every state.

Dolores Esparza, who completed her year as ONS president at last month's meeting, used the \$5,000 President's Grant from SmithKline & French to establish "legislative roundtables," in which members of local chapters meet with their congressmen. One roundtable has already been held and six more are scheduled. Topics include federal support for cancer research, access to care, reimbursement for off label use of drugs, home chemotherapy, and related matters.

Barbara Britt, the new ONS president, plans to use her President's Grant on a project to study the impact of cancer on children, focusing on those who have a parent or sibling with cancer. Britt, a pediatric oncology nurse, said that this could be a joint project with the ONS president elect, Linda O'Conner, who is also a pediatric oncology nurse.

Helene Brown, who heads cancer control at UCLA Jonsson Comprehensive Cancer Center and has just completed a six year term on the National Cancer Advisory Board, fired up ONS members with a sanguine look at the future in her keynote address on cancer control in the 21st century.

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"It appears that in the coming 20 years biomedical research will push forward the boundaries and will have found that there are some 210 genes that cause cancer," Brown said. "They will have been mapped so that we know exactly where they are located on the chromosomes and they will have been sequenced so that we know precisely when in the life cycle they become oncogenes. We will have at hand the means to manipulate them back to normalcy and ONS members can begin to seek retraining for other occupations. . . The marriage of biotechnology and molecular genetics is very close to uncovering the secret of life. . . When the final chapters in the history of cancer are written, I believe that the turning point will have been when we were able to manipulate genes and their messages. . . If this can change the course of cancer, it will hold true for every disease that may be in any way genetically caused."

Brown predicted that by the year 2010, "at least 80 percent and perhaps as much as 90 percent of the disease will yield. This is based in part on the death of the tobacco industry, better therapies, greater opportunities for prevention and early detection, and the discovery of vaccines and other interventions that will turn off the process even after it has begun."

Brown noted that by the year 2010 there will be 40 million Americans over age 65, 27 million over 75, and a half million over age 100. "Since cancer is a disease predominantly of the older age groups, the incidence may stay high for a good while longer. . . If a universal health care system is not in place by 2000 I will be horrifyingly surprised. . .

"Hospital census will continue to decline through the coming 10 years and then it is expected to rise as the population ages. The shift to home care is evident but will be short lived. With fewer and fewer families as we know them and more of the alternative shared living there will need to be more homes for the retired, the ill, and the disabled.

"There will be medical complexes that are huge. Besides the usual facilities available now in single unit hospitals, there will be connected nursing homes, rehab and mental health centers, homes for the retired and disabled, and community health centers specializing in preventive, personal, and diagnostic medicine. . . In home diagnostic kits with monitoring devices will be part for the course and the doctor will

'face to face' with the patient via computerphone. By 2010, the doctor may well be the human biologist and a new kind of health advisor to patients, business, industry, etc., with the care of the patients in the hands of primary care oncology nurses in cancer and primary care nurses in other fields as well.

"The nurse is key to all. It is the nurse who will design these medical complexes because they best know what is good, what works and what does not work. They will use their knowledge base and skills more in the preventive health center because they convey confidence, they have the expertise and they will truly be the health change agents of the 21st century. With political action by ONS and others, we will have funded and accomplished the research that tells us how to prevent cancer or how to detect it earlier or how to treat it to the top of the state of the art. The nurse will be the full active partner of the physician as they create an advisor and delivery team.

"Nurses then will become architects, congresspersons, senators, physicians, attorneys, builders, and ethicists, to name a few choices, after their careers have been fulfilled in nursing."

"By 2010, the doctor may well be the human biologist and a new kind of health advisor, with care of patients in the hands of oncology nurses."

The American Society of Clinical Oncology reported an all time high membership of 8,300, with the addition of 806 new members during the year. This was also the year during which ASCO committed \$300,000 a year to establish and staff its Washington DC office, giving the

society year around full time representation in the capitol.

Departing ASCO President Robert Young cited the new presence in Washington and the society's determination to make its influence felt there in his presidential address. He also covered other aspects of the significant changes in the organization implemented as the result of the strategic planning undertaken two years ago.

The planning was preceded by a survey of members which found that most wanted a more responsive ASCO leadership, Young said. "ASCO needed to be a clearer voice for medical oncology specifically and also had to play its part in a collective voice for clinical oncology in general.

"Our society also recognized new needs and required expanded activities. ASCO members sought increased funding for clinical cancer research, increased funding for basic cancer research, increased dialogue with the NCI leadership, improved

reimbursement for cancer therapy, specialized educational conferences in addition to the annual meeting, increased monitoring of congressional and legislative issues, a clearing house for biomedical research and treatment information, and an increased emphasis on prevention and control programs."

Young said that the ASCO Board of Directors took action "which has changed the fundamental nature of the society and its administrative structure." ASCO committees are now required to be multidisciplinary in membership, and the Nominating Committee is required to propose multidisciplinary and nonacademic candidates for elective office.

(However, during the business meeting, past ASCO President Saul Rosenberg pointed out that the four newly elected members of the board, including President Harvey Golomb, were all medical oncologists. "We do have a history of electing nonmedical oncologists from time to time," Young responded. "But we have to do better." He suggested that in the future, Nominating Committee members consult the past three presidents on appropriateness of nominees).

"Two new committees have been established this year in direct response to the membership's interests," Young continued. "We established a Cancer Prevention and Control Committee under the leadership of Frank Meyskens. . . The second is Patient Advocacy. Under Nick Vogelzang's leadership, this committee has begun linking with other patient oriented groups such as the National Coalition for Cancer Survivorship, the Candlelighters, the National Alliance of Breast Cancer Organizations, and others. In addition, it has begun to focus attention on congressional legislation introduced to deal with the issues of workplace discrimination against cancer patients, insurance problems, and the serious problems facing cancer patients brought about by the shortened hospital stays which shift substantial and complex care back into the homes of recovering cancer patients. I believe this is a very important new direction for our society. We have an obligation to address the many problems which face our recovering cancer patients, not just the problems of third party reimbursement.

"While we have created new committees, we have also changed and expanded the responsibilities for others. Our Young Investigator Awards Committee, led by surgical oncologist Chuck Hoover, has increased the number of yearly awards to 11, and this year had 53 excellent applications.

"The Oncology Training Program Committee, led by Bob Mayer, has established a multidisciplinary committee and initiated a detailed ASCO survey of medical oncology training programs and their needs

and structure."

Young also noted expanded activities of the Education and Training Committee under Jim Armitage, including organization of the first ASCO Fall Education Conference; the Publication Committee, led by Clara Bloomfield, whose responsibilities include the "Journal of Clinical Oncology" which, Young said, "is now the premier oncology journal in the world--under George Canellos' editorial leadership, it continues to thrive and fulfill one of the central needs of this society's membership;" and the Public Relations Committee led by Bruce Cheson which "has begun to restructure the way this society publicizes its activities. . . We must not only address the scientific press but the public press and other public media as well. The public will not recognize our contributions nor understand our viewpoint unless we tell them. We are monumentally and dangerously naive if we think otherwise.

"The heart of ASCO's activities in the legislative and political arenas is centered in the work of the Clinical Practice Committee and the Public Issues Committees," Young continued. "We have carefully defined their separate responsibilities," which he listed as:

Clinical Practice Committee--Practice problems, reimbursement problems, coding, technology transfer, clinical investigation in private practice, and clearinghouse for regional reimbursement and other regional issues.

Public Issues Committee--Support for funding of clinical and basic research, research funding for NCI, reauthorization of the National Cancer Act, and spokesman for ASCO to Congress.

"An overwhelming consensus from the membership survey indicated that ASCO should speak more actively and forcefully in these areas," Young said. . . It is important to emphasize that (on reimbursement issues) there was only a modest (10 percent) difference between the views of the full time academicians and those in private practice. It is a mistake to think that reimbursement issues only affect those in private practice. Anyone who holds that view simply hasn't removed the stethoscope from his ears or looked up from his Western Blots during the last several years.

"Perhaps no other ASCO committee has been reorganized so completely and has worked so steadily and effectively this year as the Clinical Practice Committee under Joe Bailes. Reorganized by geographical regions which correspond to those of HCFA, Joe's committee has led the ASCO effort to establish appropriate CPT codes for oncology and to establish a preamble to the chemotherapy codes which

recognizes the professional component of medical oncology practice. . .

"Defining appropriate chemotherapy codes has not been an easy task and the battle is not yet over. Not only is there substantial resistance from HCFA and other third party payers, but our colleagues in the CPT coding committee of AMA have found it difficult to understand what is involved in the complexity of cancer care (*The Cancer Letter*, April 6). Joe and his committee have been tireless in many meetings with the coding committee and AMA staff. Joe and I formally presented the ASCO position to the coding committee, and I met with the immediate past president of AMA personally about the issue. Again, it is vital to recognize that this affects almost everyone in the society. It is not just a medical oncology issue, as it directly impacts on pediatric oncology where office based chemotherapy administration is rare."

Young then revealed a significant development with this problem.

"I am pleased to announce that AMA's CPT coding committee has agreed to revise the preamble to the chemotherapy codes to eliminate the exclusion of reimbursement in hospitals or home care settings. This is a major piece of progress and puts us in a much stronger position to negotiate appropriate reimbursement with HCFA.

"We have also written to the HCFA administrator, Dr. Gail Wilensky, explaining why the planning, management, and medical direction of chemotherapy administration do meet Medicare's standards for payment for physicians' services. HCFA has not formally responded, but just today we met with Dr. Wilensky and it appears they will likely modify their initial position. . . The difficulties in CPT coding will be of primary focus for this year and next. Nevertheless, they will be followed by even greater challenges when the relative value scale begins implementation in the fall of 1991. These coupled with the deliberations of the Physician Payment Review Commission will determine how reimbursement will be structured for the next decade. ASCO must be active and forceful in representing your views in this crucial area.

"The Public Issues Committee has been transformed in the past several years by Karen Antman into one of the most active and wide ranging of ASCO committees." These included establishing the Washington Office of Government Affairs and hiring

Ellen Shillinglaw as the full time director of governmental relations, with the law firm of Fox, Bennett and Turner providing legal assistance and office space; development of position papers for congressional visits and media distribution; an extensive congressional visit schedule; delivery of congressional testimony on a variety of issues, including reimbursement, cancer prevention, and antitobacco legislation; monitoring of the Lasagna Committee meetings; position statements on the proposed NIH conflict of interest guidelines and mammography screening.

"The government relations office is also a clearing house for questions, ideas, issues, and information for ASCO members," Young said. "I urge you to visit the office and get to know Ellen and our Washington based counsel."

Young concluded by noting that "ASCO is now structured to deal with the issues of the 90s."

Foremost among these is "the care and treatment of cancer patients. . . Every day, 1,350 Americans succumb to the disease which is our primary research and clinical focus. Progress in cancer has been characterized more by the steady improvement in outcome and a decrease in morbidity, than by the splashy breakthroughs so carved by the media and demanded by Congress. Nevertheless, we have learned more about cancer in the last 20 years than we did in the previous 100. Advances in molecular biology now let us probe

the inner workings of cancer cells in ways undreamed of 20 years ago.

"Faced with such opportunity, the American biomedical research environment which we originally entered might have responded with more resources, more commitment and more help in speeding cancer research. Present day reality is otherwise. This year, NCI's budget will not keep up with inflation. It will support fewer cancer centers or reduce support for all. Federal support for cancer facility construction slowed to a trickle and then stopped entirely. Less than 25 percent of the peer review approved grants in cancer research will be funded and the vital training programs for clinical investigators are fighting to stay level. Clinical cooperative groups could and should be expanded as should the highly successful Community Clinical Oncology Program. Increasingly, the shrinking NCI staff is unable to accomplish the tasks everyone wishes to complete. NCI has lost 20 percent of its full time positions over the past five years.

"ASCO is structured to deal with the issues of the 90s." Foremost among these is "the care and treatment of cancer patients."

"The money needed to revitalize this sputtering cancer research effort is well expressed in NCI's 1991 bypass budget which calls for \$2.4 billion, about \$750 million more than the President's budget. That is a few cents a pack on cigarettes or one B2 Stealth bomber. The magnitude of defense related costs staggers the mind.

"Our challenge is to make sure that our legislators examine our national priorities in terms of our national values. That is no small task but one well worth ASCO's attention.

American Assn. for Cancer Research President Harris Busch told his members that AACR had had positive interactions with Congress during the year, "the first time many of them had ever heard of AACR." He credited the Washington firm, Capitol Associates, and its staff headed by Terry Lierman and Marguerite Donoghue, for much of that progress.

Busch reported that AACR's membership had increased from 5,483 last year to 6,305, that the increase had averaged 15 percent a year since 1988, and that he expected the total to reach 7,709 by 1992.

The association's journal, "Cancer Research," hit all time highs in subscriptions, revenue, and number of manuscripts received and reviewed, Busch said. Carlo Croce is editor in chief. The new AACR journal, "Cell Growth and Differentiation," edited by George Vande Woude, has signed up 2,200 subscribers, including 45 percent of the association's membership, Busch said.

Busch's presidential address, "The Final Common Pathway of Cancer," reported discovery of a protein which may be present in all tumor cells and thus might be "a useful target for cancer chemotherapy."

The clinical final common pathway of cancer, Busch said, "is characterized by organ failure, cachexia, and death. Under the clinical layer of unfortunate biological events is the critical biological final common pathway, which includes the phenomena of growth without control, invasiveness, metastasis, and nucleolar pleomorphism. What dictates the constellation of these clinical and biological events which are brought about by processes that persist from mother to daughter cancer cells? Over 100 years ago, Virchow and Thiersch had concluded that cancer was a problem of cell genetics, which in modern terms represents

aberrations of the genes. . .

"One of the current critical questions is what controls the genes and how are these controls altered in cancer cells, particularly with respect to extracellular signals, protein kinases, and the mitogenic cascade. Attention is now focused on transacting factors which are mainly nuclear proteins involved in positive and negative regulation of gene function. . .

"In initial studies on distinctions between nuclear proteins of hepatomas and normal liver, two dimensional gel electrophoretic techniques demonstrated that the less differentiated the tumor, the greater the number of spot differences could be identified. Of the 950 individual proteins in the nucleus of hepatoma or normal liver cells, many had similar migration characteristics. To determine whether in this large group of proteins there were antigenic differences between tumor and nontumor

tissues, polyclonal antibodies to nuclei and nucleoli were developed in rabbits. These polyclonal antisera demonstrated several differences by immunofluorescence, Ouchterlony gels, and immunoelectrophoresis, particularly after the polyclonal antisera to the liver and tumor nucleoli were exhaustively absorbed to remove potential tumor or liver contaminants. Because more specific antibodies were required as detection probes, monoclonal antibodies were developed.

A key goal of these studies was to identify proteins that could account for the nucleolar pleomorphism in cancer cells.

"To block some determinants common to tumor and normal tissue nucleoli, tumor nucleoli were treated with polyclonal antisera to normal nucleoli. Immunization of mice with these complexes resulted in the development of monoclonal antibodies of which several identified G₁ phase antigens. We focused on a novel very early G₁ 120 kD nucleolar proliferation associated antigen. By indirect immunofluorescence, this antibody produced bright nucleolar staining in a variety of malignant tumors, including cancers of the breast, liver, gastro-intestinal tract, genitourinary tract, blood, lymph system, lung, and brain. Nucleolar immunofluorescence was not detected in most normal tissues including normal bone marrow and colon epithelium but was weakly detected in some proliferating nonmalignant tissues. . .

"The P120 antigen was not detected in 48 hour serum deprived HeLa cells but was readily detectable

AACR had positive interactions with Congress during the year, "the first time many of them had ever heard of AACR."

within 30 minutes following serum refeeding. The P120 antigen was not detected in retinoic acid treated HL-60 cells following morphological differentiation but was detected in rapidly growing undifferentiated HL-60 cells. These studies indicated that the P120 antigen is a proliferation associated antigen which plays a role in the G₁ phase of the cell cycle. Its tissue localization showed it was the most cancer related of the antigens we had found. Interestingly, it was found in beaded microfibrils within the nucleolar structure, which suggests it may play a role in nucleolar pleomorphism.

"... To determine if inhibition of the P120 protein would affect cell function, anti-P120 and control antibodies were microinjected into cells. At 10 to 18 hours following loading, the anti-P120 antibodies localized to the nucleoli of interphase cells and to the chromosomes of mitotic cells. The anti-P120 antibodies inhibited cell proliferation and DNA/RNA synthesis in a dose dependent manner (Freeman, J. and Bondada, V., unpublished data). At 24 to 48 hours after antibody loading, cells appeared more rounded and 25-60 percent of the cells became nonviable. Cells similarly loaded with antibody to nucleolar protein B23 did not show a significant inhibition of cell proliferation. This study suggests that the P120 protein may serve some regulatory function necessary for cell proliferation and/or cell viability; it may be involved in the pleo-morphism of nucleoli of cancer cells.

"To approach the possibility that the epitope to which the antibody was bound would be a useful target for cancer chemotherapy, it was necessary to define the amino acid sequence of the epitope region. The P120 cDNA was expressed in *E. coli* with a T7 promoter. Mutations and competition assays showed that residues 173-180 (EAAAGIQW) were an important part of the epitope (Valdes et al, in manuscript). A corresponding synthetic peptide completely blocked the binding of the anti-P120 MAb to both the *E. coli* expressed P120 and the isolated HeLa nucleolar P120 protein on western blots and ELISA assays. . .

"Studies like this offer a basis for a new type of synthetic chemistry, which links the tidal wave of developments in molecular biology and recombinant technology to drug design and drug development. This small epitope of the P120 protein may be a critical target for chemical attack because of its uniqueness, its availability in space, and the generality of its presence in human cancer. This approach calls for the rational design of new drugs based on the interaction between organic molecules and the chemical residues of this region.

"Specific therapeutic modalities can be developed if the interactions between reactive and binding groups

on drugs and binding elements on targets can be specifically defined. We hope that an attack on protein P120 will be chemotherapeutically useful, for this protein appears to be part of the final common pathway in many cancers. Other opportunities will clearly be forthcoming and hopefully the new science of pharmacotherapy based on rational design will bear a rich harvest in treatment of cancer."

Additional reports from the three meetings will appear in next week's issue of The Cancer Letter.

First "Annual" CCOP RFA Issued; Research Bases Must Compete

Annual competition for Community Clinical Oncology Program awards gets under way this summer with the first yearly RFA. NCI hopes to make five awards this year.

Competing for those five will be the four CCOPs which were funded as exceptions (above the payline) in last year's competition. All others received three, four, and five year awards. Also competing this time will be any of those who did not get funded in the previous round, along with any new applicants or those still active who were left unfunded from the first round.

CCOP research bases also are up for renewal this year and will have to compete for continued support. Their cooperative agreements expired along with those of the CCOPs last year but were extended administratively to lessen the review burden on NCI.

The decision last year by NCI to "institutionalize" the program, concurred in by the Div. of Cancer Prevention & Control Board of Scientific Counselors, called for staggered awards of three to five years to spread out the review workload. It also cuts administrative burdens of the stronger CCOPs who get the longer awards (generally, the top one third in priority scores).

The RFA announcement follows:

RFA CA-90-13

Title: Community Clinical Oncology Program

Letter of intent receipt date: June 15

Application receipt date: Aug. 24

The Div. of Cancer Prevention & Control invites applications from domestic institutions for cooperative agreements to the Community Clinical Oncology Program. New community and research base applications and currently funded programs are invited to respond to this RFA.

This reissuance of the CCOP RFA seeks to build on the strength and demonstrated success of the program over the past seven years by (1) continuing the program as a vehicle for supporting community participation in treatment and cancer control trials through research bases (clinical cooperative groups

and cancer centers supported by NCI, and public health departments); (2) expanding and strengthening the cancer control research effort; (3) utilizing the CCOP network for conducting NCI assisted cancer control research; and (4) evaluating on a continuing basis CCOP performance and its impact in the community.

Over 80 percent of patients with cancer are treated in the community. The CCOP was initiated in 1983 to bring the benefits of clinical research to cancer patients in their own communities by providing support for physicians to enter patients onto treatment research protocols. The CCOPs clearly were very effective in accruing patients to treatment clinical trials. The second RFA, issued in 1986, expanded the focus to include cancer control research.

The development of cancer control research in the CCOP network has been increasing steadily since funding began in 1987. Protocols are developed by the research bases and reviewed by DCPC's Cancer Control Protocol Review Committee. Protocols cover the full spectrum of cancer control research, including chemoprevention, marker studies, smoking cessation studies, screening and early detection, and pain control and other supportive care interventions aimed at reducing cancer incidence, morbidity, and mortality.

The CCOP initiative is designed to:

- * Bring the advantages of state of the art treatment and cancer control research to individuals in their own communities by having practicing physicians and their patient/subjects participate in NCI approved treatment and cancer control clinical trials.

- * Provide a basis for involving a wider segment of the community in cancer control research.

- * Increase the involvement of primary health care providers and other specialists with CCOP investigators in treatment and cancer control research.

- * Facilitate wider community participation, including minorities, women, and other underserved populations, in treatment and cancer control research approved by NCI.

- * Reduce cancer incidence, morbidity, and mortality by accelerating the transfer of newly developed cancer prevention, early detection, treatment, patient management, rehabilitation, and continuing care technology to widespread community application.

There will be two types of grantees: community programs and research bases. Community applicants may be a hospital, a clinic, a group of practicing physicians, a health maintenance organization, or a consortium of these. CCOPs will be required to enter patients onto NCI approved treatment and cancer control clinical trials through the research base(s) with which each CCOP is affiliated.

Research base applicants must be either an NCI funded clinical trials cooperative group or cancer center or a public health department. Research bases will be required to provide clinical research treatment and/or cancer control protocols, monitor the quality of protocol conduct, and follow CCOP accrual.

CCOP and research base awards will be made as cooperative agreements. It is anticipated that up to \$4.4 million in total costs per year for five years will be committed to specifically fund applications which are submitted in response to this RFA. Of the total, approximately \$3.9 million will be committed to research bases and approximately \$450,000 to CCOPs. It is anticipated that up to 17 research base awards and up to five CCOP awards will be made. Awards will be for three, four, or five years.

Letters of intent should be sent to and copies of the complete RFA obtained from Leslie Ford, MD, Community Oncology & Rehabilitation Branch, DCPC, NCI, Executive Plaza North Rm 300-D, NIH, Bethesda, MD 20892, phone 301/496-8541.

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-05632-21

Title: Support services for epidemiologic studies

Deadline: Approximately July 16

The Environmental Epidemiology Branch in the Epidemiology & Biostatistics Program in NCI's Div. of Cancer Etiology is seeking a contractor to provide support for 20 to 25 projects for studies of environmental and host factors in the etiology of human malignancy. This support contract is a recompetition of a currently on-going contract, which was awarded to Westat Inc. for a five year period. The current contract expires on Feb. 26, 1991. The research program is very broad in that it encompasses cross sectional, cohort, case-control, clinical and family-pedigree designs, evaluates air-borne and water-borne pollutants, diet, hormones, genetics and therapeutic drugs in relation to malignancies of many sites, and includes many interdisciplinary studies with a biochemical or clinical as well as epidemiologic component.

The contractor must be capable of providing support for a number of studies conducted simultaneously in widespread geographic regions of the U.S. and other countries. A critical capability is to be able to respond quickly to changes in priority and to supply support to urgent new efforts. While the scientific direction and overall supervision of all projects are the responsibility of the professional staff of the EEB, support services provided by the contractor would include the development of liaison with organizations and individuals, at local or international levels, whose cooperation is needed for the conduct of a study; assistance in the design and pilot testing for forms required to conduct field investigations (e.g. interview questionnaires, record-abstracting forms); the hiring, training and supervision of technical personnel (interviewers, nurses, record abstractors, other field staff); the collection of the required data, including biologic specimens; the shipment and handling of biologic specimens; the data reduction activities involved in field investigations (e.g. coding, keying, editing); and the management of data flow to ensure orderly delivery of data to NCI.

The contractor also will assist NCI in the provision of on-site field supervision and implementation of quality control mechanisms to ensure quality of the activities as well as maintenance of control of all aspects of each study by the appropriate EEB investigators. The support activities which may be required are 1) study initiation and liaison, 2) preparation of study materials and procedures, 3) data collection, 4) data preparation, 5) computer programming and data processing, 6) study monitoring, 7) family medical record room and database maintenance. Other services to be provided by the contractor will be discussed in detail in the forthcoming solicitation. Award is anticipated by Feb. 27, 1991.

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