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MSK, Fox Chase Volunteer To Limit Their Core Grants To Let Others Grow

NCI Director Samuel Broder said a few weeks ago that discussion of the issue of placing caps on cancer center core grants was something he was considering adding to his list of "things an NCI director should never

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In Brief

Owens New President Of AACI, Yates President Elect; UNC Gains Comprehensive Center Status

ALBERT OWENS, director of the Johns Hopkins Cancer Research Center, took office as president of the Assn. of American Cancer Institutes at the association's annual meeting last week in Rochester, MN. He replaced **Sydney Salmon**, who became chairman of the board. **Jerome Yates**, associate director for clinical affairs of Roswell Park Cancer Institute, was elected vice president and president elect. **Edwin Mirand** was reelected secretary treasurer. New board members are Laurence Baker, Paul Engstrom, Ronald Herberman, and Marion Morra. . . . **UNIV. OF NORTH CAROLINA** Cancer Center is the second to be recognized as a comprehensive cancer center under NCI's new system of conferring that status on centers. Joseph Pagano is director of the center. That brings to 21 the number of NCI designated comprehensive centers, and makes North Carolina the third state with more than one, with Duke just a few miles away. . . . **MICHAEL BOYD**, who gave up his position as director of NCI's Developmental Therapeutics Program earlier this year because he wanted to become more actively involved in new drug research, will be chief of a proposed new Laboratory for Drug Discovery Research & Development at Frederick Cancer Research Facility. His section chiefs will be John Cardellina, Natural Product Chemistry; and Louis Malspeis, Analytical Chemistry, Pharmacokinetics, & Metabolism. Boyd will be acting chief of the Cell Biology, Biochemistry, & Experimental Therapeutics Section. "That's a powerful team," DTP Acting Director Michael Grever said. **Correction:** Grever did not mean to imply that the pharmaceutical industry could not meet demand for taxol if it turns out to be effective for treating other tumors in addition to ovarian cancer (**The Cancer Letter**, June 15). Supply would be a major problem, since the natural product is not easily synthesized. . . . **ANOTHER NEW** branch is being organized by DTP, the Antiviral Evaluations Branch. It will be headed by John Bader, who has been special assistant for AIDS and antiviral evaluation. . . . **LEVAMISOLE**, trade name Ergamisol, has received FDA approval for adjuvant therapy of Dukes C colon cancer in combination with 5-FU. Janssen Pharmaceutica will market the drug.

MSK, Fox Chase Volunteer To Limit Their Core Grants, Let Others Grow

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do" (**The Cancer Letter**, May 18). It was not a remark made entirely in jest. NCI directors, including Broder, have found limits on core grants may be one of the many topics that can make their lives miserable.

The topic came up in Broder's absence last week, at a workshop for cancer centers sponsored by NCI prior to the annual meeting of the Assn. of American Cancer Institutes. A course of action was recommended which would replace the existing cap when centers apply for renewal of a flat 50 percent increase over the current budget with a "sliding scale" cap. The sliding scale would restrict the centers with larger grants and make available more money to those with smaller grants.

Similar proposals have been considered in the past, but opposition from centers with the larger grants invariably blocked them.

What could make Broder's life a little less miserable was the source of that recommendation this time: Vincent DeVita, physician in chief at Memorial Sloan-Kettering, which has the largest cancer center core grant. And concurring in the idea was Robert Young, president of Fox Chase Cancer Center, which has the second largest.

The disparity between those two and the third largest core grant is so wide that it is not likely anyone else would object. Suddenly, opposition to a cap which Broder may have perceived from the two large and powerful centers has dissipated.

NCI adopted the 50 percent limit on increase several years ago to slow the growth in core grant budgets. It was a compromise in which AACI concurred. Before that, the only limit was in peer review, with centers trying to demonstrate to the Cancer Center Support Grant Review Committee that their requests were appropriate and scientifically justifiable. The review committee had no instructions to limit budgets on the basis of availability of funds, fairness to other centers, or any other reason.

The 50 percent limit did slow the rate of overall increase but exacerbated differences in size--the big got bigger in bigger bites, the small may have gotten a little bigger, but sometimes it was hardly noticeable.

For instance, Memorial Sloan-Kettering's grant in the 1989 fiscal year was $8.2 million. A 50 percent increase would have lifted that to over $12 million. On the other end, Purdue Univ.'s grant was $392,000; the maximum increase would have raised that to a little less than $600,000.

A session at the workshop dealt with "Reducing Budget Disproportionality." Suggested options for "reaching parity among cancer centers with equivalent responsibilities" included development of cap policies administratively, cap structures based on some percentage of the Cancer Centers Program total budget, a cap based on the ratio of the core grant to total NCI support at the center, different ratios for different types of centers, recognition of critical, special activities by raising the ratio, reliance on peer review to reach parity.

DeVita pointed out that at one time, NCI policy was to exempt smaller centers from the 50 percent cap on increases. Brian Kimes, director of the Centers, Training & Resources Program in NCI's Div. of Cancer Biology, Diagnosis, & Centers, said that it still does, that exceptions to the cap go to the NCI Executive Committee "which listens to any reasonable request."

DeVita then suggested that a sliding scale should be considered, with those at the top held to no increase while those at the bottom would be permitted to request any amount, all of it of course subjected to peer review.

Workshop participants either couldn't believe what they had heard or they failed to grasp the significance of DeVita's suggestion. There were no immediate comments, and the discussion moved on to other topics.

A few minutes later, DeVita was asked if Memorial Sloan-Kettering was offering to limit itself to zero increases so that smaller centers could grow faster. He answered in the affirmative.

Joseph Simone, who chaired that session of the workshop, asked Young if Fox Chase would consider such a policy.

"Yes, we would agree to a cap on Memorial Sloan-Kettering," Young cracked.

He added, more seriously, that a complete freeze offering no prospect for growth could hurt morale of

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a center's staff, and suggested that the sliding scale start at five percent for the centers with the largest grants, scaling down to no limit for the smallest. "We would go along with something like that."

There it is: the centers with the two largest grants, which between them account for 16 percent of the total core grant budget, have volunteered to share the wealth.

"It makes sense," DeVita said later. "You have to give the other centers some room to grow. A sliding scale is a reasonable approach."

Centers with the smallest core grants are not necessarily the smallest centers. Some, such as M.D. Anderson and Roswell Park, derive much of their core support from their state governments. Others have varying reasons for not going after larger core grants from NCI.

The third largest core grant, in FY 1989, belonged to Fred Hutchinson Cancer Center, $4.1 million. That was followed by Dana-Farber, $3.6 million; Johns Hopkins, $3.2 million; Univ. of Alabama, $3.1 million; Albert Einstein and Duke Univ. $3 million each. All except Einstein are comprehensive centers, as are MSK and Fox Chase.

But comprehensive centers are at the bottom of the list, too. M.D. Anderson, one of the largest, if not the largest, in terms of total budget, patient flow, or research staff, had a core grant of $1.2 million. Newly recognized Arizona Cancer Center had $1.1 million. Three--Wayne State Univ./Michigan Cancer Foundation, Ohio State Univ., and Illinois Cancer Council, all had grants under $1 million.

Neither MSK nor Fox Chase has received the full 50 percent increase since that policy was established. "Peer review has had some impact in that regard," Kimes said. "The sliding scale is reasonable. I'm sure that money which has gone to Memorial Sloan-Kettering and Fox Chase has been well spent. This is a matter of making sure that every center has the opportunity to grow."

Kimes said he would recommend to Broder that if the sliding scale is adopted, it be done so as an NCI policy rather than being written into the core grant guidelines. "I don't think we should include things like a cap in guidelines." A change of guidelines must be cleared through NIH, published in the "Federal Register," and possibly entails other bureaucratic delays. "This could go out just as a policy statement of the NCI Executive Committee," Kimes said.

The various other suggestions for determining the size of a cap were not given much consideration by workshop participants, although they were not rejected.

Simone, who is chairman of the Cancer Center Support Grant Review Committee, spoke strongly against relying on peer review to control costs. "That would require macroeconomic judgments. It's too much to ask of peer review."

Panel Clear On Breast Conservation, Not On Adjuvant Therapy For Node -

The NIH consensus conference on treatment of early stage breast cancer came up with definitive recommen-dations on breast conservation and optimal techniques to achieve it. But the conference panel was able to make only general recommendations on adjuvant treatment of node negative breast cancer, suggesting that patients "should be made aware of the benefits and risks of adjuvant systemic therapy."

Following are the summarized conclusions and recommendations:

1. Breast conservation treatment is an appropriate method of primary therapy for the majority of women with stage 1 and 2 breast cancer, and is preferable because it provides survival equivalent to total mastectomy and axillary dissection while preserving the breast.

2. The recommended technique for breast conservation includes local excision of primary tumor with clear margins, level 1-2 axillary node dissection, and breast irradiation to 4,500-5,000 cGy with or without a boost.

3. The many unanswered questions in the adjuvant systemic treatment of node negative breast cancer make it imperative that all patients who are candidates for clinical trials be offered the opportunity to participate.

4. The majority of patients with node negative breast cancer are cured by breast conserving treatment or total mastectomy with axillary dissection.

5. The rate of local and distant relapse following local therapy for node negative breast cancer is decreased by both combination cytotoxic chemotherapy and by tamoxifen. The decision to use adjuvant treatment should follow a thorough discussion with the patient regarding the likely risk of relapse without adjuvant therapy, the expected reduction in risk with adjuvant therapy, toxicities of therapy, and its impact on quality of life.

6. While all node negative patients have some risk for recurrence, patients with tumors less than or equal to 1 centimeter have an excellent prognosis and do not require adjuvant systemic therapy outside of clinical trials.

The panel recommended as directions for future research:

--Refine existing prognostic factors by reassessing the predictive value of the T categories in the AJC-TNM staging system; standardizing nuclear grading patterns; exploring relationships between individual prognostic factors and resistance to systemic therapy; developing and utilizing new and existing tissue and clinical data banks for the study of prognostic factors.

--Develop risk factor profile systems with sufficient accuracy and reproducibility to allow identification of subgroups that may be treated with surgical excision without irradiation; do not require axillary node dissection; do not require systemic therapy.

--Improve systemic chemotherapy regimens through investigation of dose intensity, timing, and duration; introduction of new agents; evaluation of chemotherapy and hormonal therapy combinations; evaluation of preoperative chemotherapy.

--Gather further data concerning tamoxifen, including safety of prolonged use in premenopausal patients; optimal duration of therapy; efficacy in patients with steroid receptor negative tumors; comparison and combination with gonadotropin releasing hormone agonists.

--Assess quality of life parameters in future clinical trials.

--Determine optimal margins for local primary excision in the presence and absence of extensive intraductal cancer.

--Determine whether boost irradiation is required in patients with pathologically negative margins and whether boost irradiation produces a high probability of local control in patients with microscopic involvement of margins.

--Determine the optimal sequence and timing for radiation therapy and systemic adjuvant therapy.

DCE Board Ok's New RFA Programs To Provide $14 Million For Research

Two major new grants programs that together would provide $14 million over the next five years for epidemiology and basic research studies were given concept approval by NCI's Div. of Cancer Etiology Board of Scientific Counselors last week.

The board gave concept approval to a new RFA that would provide $10 million over five years for epidemiologic studies of cancer in minority populations in the U.S. DCE staff had originally proposed funding of $1.5 million a year, for a total of $7.5 million, but board members suggested increasing funding by another $500,000 per year.

The second RFA concept the board approved, titled "Molecular Analyses of Radiation-Induced Genetic Damage," would provide $4 million over four years for basic research.

The board also gave concept approval to recompetition of several support contracts and interagency agreements. The largest of these is published here; the rest of the concept statements will appear in the next issue of **The Cancer Letter.**

The texts of the RFA concept statements and board discussion follow:

Epidemiology of cancer in U.S. minority populations. This is a concept for a new RFA; proposed first year funding $2 million, total $10 million over five years.

The racial and ethnic diversity of the U.S. population offers a challenging opportunity for epidemiologic studies of cancer etiology. Cancer mortality and incidence rates, as reported by numerous population based registries, vary strikingly across population subgroups. For some tumors (e.g., stomach), several minority groups appear to have elevated rates, suggesting the need for analytic cross cultural epidemiologic studies to identify risk factors and mechanisms that the groups may have in common. In addition, elevated rates may be pronounced in a particular minority group (e.g., prostate cancer and multiple myeloma among blacks), while other population subgroups have relatively low rates, thus offering opportunities to identify both causative and protective factors.

The cultural and genetic heterogeneity of the population subgroups thus provide clues to lifestyle factors, other environmental exposures, and susceptibility states that may contribute to cancer risk. In addition, the migration of certain minority groups to the U.S., or within the U.S., provides a setting where epidemiologic research may help to disentangle the role of extrinsic and host factors in cancer etiology, and to clarify the role of diet and nutrition and other lifestyle determinants of cancer risk. It is important that the knowledge derived from special studies of minority groups advance understanding of cancer etiology and prevention for all people, and the degree to which this can be accomplished should be clearly identifiable.

The purpose of this RFA is to stimulate innovative, analytical site-specific studies of cancer etiology in minority populations of the U.S. The studies may involve cohort, case-control, or genetic designs. Emphasis should be placed on etiologic studies of the more common cancers affecting the U.S. population. Studies should make cost-efficient use of existing resources, such as population-based cancer registries or specimen repositories. Multidisciplinary collaboration with clinical and laboratory investigators is encouraged, and may be essential for the elucidation of certain environmental risk factors, host susceptibility, diagnosis of specific tumor types and precursor states, and mechanisms of carcinogenesis.

"When we put out the RFA, we will flesh it out," DCE Director Richard Adamson said when board members commented on the concept statement's brevity.

Board member Pelayo Correa said he thought the statement's original proposed first year funding of $1.5 million was "not sufficient."

"Should we increase it by another $500,000?"

Adamson asked. "There is a need for more study on etiology," Correa said.

"I think the objective is to engage laboratory based investigators with the methods we now have in epidemiology," board member David Schottenfeld said. "This is a very positive opportunity we have to be innovative."

The board granted concept approval after approving a motion to increase the funding by another $500,000 a year, to add the word "ethnic" to the title, and to have three members of the board appointed to look at the draft of the RFA. The board members appointed were Correa, Stephen Hecht and Alice Whittemore.

Molecular analysis of radiation-induced genetic damage. Proposed first year funding $950,000; total $4 million over four years.

Recent developments in the ability to detect and amplify mutations directly from the genomic DNA of somatic cells suggest that direct detection and analyses of mutations induced in vivo may be technically possible, bypassing the experimentally difficult and restrictive need for genetic selection of mutant clones prior to molecular level analyses. The ability for direct analysis of mutational damage in small populations of somatic cells would permit virtually any in vivo cell type to be a candidate for genetic analysis. It would also allow for the investigation of a greater number of genetic loci as possible DNA targets for mutagenesis than are now available because of the lack of a means for phenotypic selection. Finally, it would allow for detection and analysis of "silent" mutations that do not give rise to aberrant proteins or mutations that would otherwise be lethal for long term cell survival.

The scientific merit and feasibility of using the mutational specificity of ionizing radiation as a biologic marker was the subject of a workshop held in February, chaired by James Felton and sponsored by the Radiation Effects Branch. The attendees assessed current knowledge in molecular genetics and cytogenetics that might be applied to the detection of radiation induced mutations in populations of somatic cells exposed in vivo.

The workshop discussions revolved around three basic questions:

1. Are unique mutational spectra induced in human cells and other mammalian cells by exposure to ionizing radiation, in vitro and in vivo?

2. Are the technical means for analyses of mutations at the molecular level sufficiently sensitive to allow direct quantitative measurements of mutations induced in small populations of mammalian cells?

3. Can such mutation spectra be used as molecular markers for chronic human exposures to ionizing radiation against the background of other environmental mutagens?

The workshop concluded with a strong recommendation that the REB should develop an RFA to encourage research to characterize the distributions of mutations induced in mammalian somatic cells exposed to ionizing radiation as candidate molecular markers for human exposure. Areas of recommended study in the RFA should include efforts to:

--Determine whether ionizing radiation induces characteristic mutation spectra in mammalian cells that are different from the spontaneous mutation spectrum and from the mutation spectra for chemical mutagens and for ultraviolet radiation.

--Increase the absolute levels of sensitivity and accuracy of direct mutational analyses of mutations, deletions and chromosomal rearrangements induced in mammalian cells in vivo, with the ultimate objective of applying such experimental methods to humans.

--Determine the quantitative and qualitative distributions of mutational damage in vivo and in vitro as functions of both low and high LET radiations, and of dose and dose-rate.

After questioning whether the concept was meant to solicit basic science or clinical research, the board asked DCE staff to rewrite the concept statement "to reflect a more basic science approach." The motion to do so, made by board member Anna Barker, was approved unanimously.

Adamson said the draft of the RFA will be circulated to board members for their approval.

Support services for clinical epidemiological studies. Recompetition of a contract held by Westat Inc. Proposed first year award $399,840; total $1,723,361 over four years.

This concept is for recompetition of a support services contract which provides the core support for research in the Clinical Epidemiology Branch. The managerial and technical skills of contract staff are necessary to facilitate increasing numbers of studies on the epidemiology and genetics of human neoplasia. This recompetition would provide support for the five senior independent investigators and two junior physician-investigators in the branch.

The contract will provide support services for the clinical and field studies of cancer etiology and late effects of cancer treatment which will be undertaken by the CEB alone or in collaboration with others.

In addition, these support services will permit collection, processing and storage of appropriate biological specimens for laboratory studies of the biological mechanisms of cancer susceptibility.

The scientific direction and overall supervision for all projects are the responsibility of the professional staff of the CEB. The contractor has provided a broad range of support services from FY 86 tot he present and will do likewise during the renewal period. Support services provided by the contractor shall include the following: 1) preparation of data collection forms, such as questionnaires and abstracting forms, with accompanying manuals, 2) assistance in enrollment of appropriate patients for study, interviewing, medical records abstracting, data and technical editing, collection and drawing of family pedigrees, and requesting hospital records, pathology reports and death certificates, 3) collection, processing, transport and record keeping for biological specimens, and 4) aid in data management, e.g., data entry, proofing, editing, updating, records management, tabulations and statistical preparations.

To provide the support necessary for the proposed projects the level of effort for support personnel shall include: project manager, 0.8 person/years; study managers, 1.8; nurse, 1; research assistant, 1; and other support staff (including temporary staff for telephone interviewing, record abstracting, coders and data keyers), 3.0. Non-personnel costs include telephone charges, form printing, mailing, supplies and travel to sites of field work. The proposed budget allows for increases annually due to inflation.

Branch research projects in which the support services will be utilized in 1992-96 are: Studies of Cancer-Prone Patients, Mendelian Traits Predisposing to Neoplasia, Cancer Survivors

Follow-up, and Hepatitis B and Liver Cancer in World War II Veterans.

The concept was approved unanimously.

Certification=More Money For Nurses, ONS Finds; Role Study Completed

The impact of oncology nursing certification, initiated in 1986 by the Oncology Nursing Society through the Oncology Nursing Certification Corp. which the society established, is being felt.

ONS last year carried out a national survey of salary, staffing and professional practice patterns in oncology nursing. Questionnaires were mailed to the directors of nursing at 1,220 institutions in the U.S. and Puerto Rico, including comprehensive cancer centers and institutions with cancer programs approved by the American College of Surgeons Commission on Cancer. The overall institution response rate was 41.2 percent.

Average hourly salary rates reported were as follows:

Entry level staff nurses, $12.97 per hour; staff nurse with three years experience, $14.14 per hour; staff nurse with five years experience, $15.05 per hour; staff nurse with 10 years experience, $16.22 per hour; first line managers, $18.83 per hour; clinical nurse specialists, $18.87 per hour; and staff development instructors, $18.04 per hour.

The survey found that 30 percent of the institutions surveyed provide a salary increase or bonus to nurses who obtain certification in oncology nursing. In addition, 49 percent reimburse the nursing staff for taking oncology certification review courses and 51 percent reimburse nurses for the certification exam.

ONS and ONCC also completed and published a role delineation study, a "National Study of the Profession of Oncology Nursing." Mary Ropka was principal investigator of the study.

Oncology nurses were asked to judge each of a number of professional responsibilities in terms of importance to the job of oncology nurse and in terms of the frequency with which they are performed. Of the 56 professional responsibilities covered, 80.4 percent, or 45 tasks, were rated as being very important and 14.3 percent, eight tasks, were judge as extremely important. The remaining five tasks or 5.4 percent of the tasks were rated as moderately important.

"It can be concluded that since all of the 56 tasks which were included were rated as moderately important or higher, they represent activities that can be used in providing job related contexts for preparing questions for a certification examination for oncology nursing," the study report concluded.

PDQ Evaluation To Cost NCI More Than Reported; A View From Yakima

The evaluation of PDQ to be administered by the Agency for Health Care Policy & Research through a contract that agency will award probably will cost more than $2 million, not $750,000 as indicated in **The Cancer Letter's** report on the project (June 1).

The project received concept approval from the National Cancer Advisory Board at a funding level of $750,000 a year for three years, not one year. NCI had been asked by AHCPR to pick up one third of the cost, so NCI's commitment is $750,000.

Proposals for the contract were due this week, and the actual cost will be determined in negotiations between the successful contractor and the government.

David Wishart, radiation oncologist at Memorial Hospital in Yakima, WA, offered a view of the value of PDQ which may not be apparent to NCI, PDQ's critics, or the prospective evaluators. In a letter to **The Cancer Letter**, Wishart wrote:

"A feature of the usefulness of PDQ to physicians in community practice which was not addressed in the proposals that you catalogued in the June 1 issue of **The Cancer Letter** is of major importance to us in Yakima. That is, PDQ provides a touchstone for assess-ment of our current management approaches.

"There are four oncologists in our town of 50,000, with a watershed of about 200,000. We have good relationships with referral centers in the major cities, three hours away, but we are geographically isolated, and we collaborate with one another very closely. All four of us are literature freaks, and I think we have a good grip on what is current, and which direction management is taking. However, our anxiety to offer the best of care, and to steer patients in appropriate directions if they need to leave this region for specialized care means that we are always just a little uncertain about standards.

"Dr. [David] Korn's comments about guidelines are appropriate. A guideline is only as good as the committee that generates it, and every physician knows that consensus in one setting may not be identical with consensus in another setting, and that what gets written down is sometimes a product of accident to at least some degree. Therefore, individual application of the guidelines to specific situations is

always necessary in conscientious medical practice.

"In Yakima, we use PDQ frequently to check our knowledge against what passes for "standard." We usually find we are tuned in to current thinking, but occasionally we discover that we have harbored miscon-ceptions or haven't got a comprehensive view of what is going on in a specific management area. Sometimes we find the guidelines are apparently behind our own management awareness, and that is, in fact, reassuring. Thus, for the most part, PDQ is a useful source of reassurance, and not very often an influence toward a change in management styles or techniques.

"Finally, PDQ is really valuable for rare kinds of tumors. We had a young man with primitive neuroecto-dermal tumor (peripheral neuroepithelioma), who was being cared for partly in Seattle and partly here. The PDQ commentary and reference list was very helpful in giving us a perspective."

ACS Honors HHS Secretary Sullivan, Who Reaffirms Anti-Tobacco Efforts

HHS Secretary Louis Sullivan reaffirmed his commitment to a "smoke-free America by the year 2000" while receiving an American Cancer Society citation in Washington recently.

Sullivan was honored by ACS "for strongly confronting the issue of target marketing of cigarettes, thereby bringing his authority as Secretary of HHS into a leadership role for the public against the ravages of tobacco."

"As long as I am Secretary I am going to continue this kind of fight, because this is what we need to do to improve the health of our citizens," Sullivan said.

"I still have as my goal the attainment of a smoke free society by the year 2000," Sullivan said. "I am convinced that the major steps forward we can make in improving the health of our citizens are really steps in health promotion and disease prevention."

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

Sapporo Cancer Seminar--July 6, Sapporo, Japan. Contact Secretariat, Lab. of Pathology, Cancer Institute, Hokkiado Univ. School of Medicine, Kita-ku, Sapporo 060, Japan.

Surgical Advances in Cancer of Head & Neck--July 11, Mexico City, Mexico. Contact Dr. J. de la Garza, Instituto Nacional de Cancerologia, Ave. San Fernando No. 22, Tlalpan, 14000 Mexico D.F., Mexico.

Mammography & The Search for Breast Cancer--July 13-14, Rochester, NY, Radisson Hotel. Contact Dr. Wende Logan-Young, 1351 Mt. Hope Ave. Rm 121, Rochester, NY 14620-3992, phone 716/442-8432.

Cancer Management Course--July 13-14, Cincinnati, OH. Contact American College of Surgeons, Cancer Dept, 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

International Photodynamic Assn. Biennial Meeting--July 18-21, Buffalo, NY. Contact J. Felski, Roswell Park Memorial Institute, 666 Elm St., Buffalo, NY 14263-0001.

Challenging the Course of Cancer--July 20-22, Sept. 14-16 or Oct. 26-28, Leadville, CO. Contact Colorado Outward Bound School, Health Services Program, 945 Pennsylvania St., Denver, CO 80203, phone 303/831-6974.

Candlelighters Childhood Cancer Foundation 20th Anniversary Conference--July 22-25, Washington, Sheraton Washington Hotel. Contact CCCF, 1312 18th St. NW Suite 200, Washington, DC 20036, phone 1-800-366-2223.

Cancer Nursing for the '90s--July 24-25, Honolulu, Hawaii. Contact Karen Taoka, Queen's Cancer Institute, 1301 Punchbowl St. Honolulu, HI 96813.

Queen's Cancer Institute Symposium: Gastrointestinal Malignancies--July 24-26, Honolulu, Hawaii. Contact Karen Taoka, Queen's Cancer Institute, 1301 Punchbowl St. Honolulu, HI 96813.

Differentiation of Normal & Neoplastic Cells--July 29-Aug. 2, Vancouver, Canada. Contact Venue West Inc., 801-750 Jervis St., Vancouver, B.C. V6E A9, Canada.

Cancer Management Course--Aug. 10-11, Estes Park, CO. Contact Dr. Michael Peetz, American College of Surgeons Cancer Dept., 55 E. Erie St., Chicago, IL 60611, phone 312/664-4050.

Professional Development Invitational for Social Workers, Doctors, Nurses & Clinicians--Aug. 10-12, Denver, CO. Contact Colorado Outward Bound School, Health Services Program, 945 Pennsylvania St., Denver, CO 80203, phone 303/831-6974.

Cancer Nursing--Aug. 12-17, Amsterdam, The Netherlands. Contact International Society of Nurses in Cancer Care, Mulberry House, The Royal Marsden Hospital, Fulham Rd, London SW3 6JJ, UK.

International Assn. of Cancer Registries Annual Meeting--Aug. 13-15, Hamburg, W. Germany. Contact Hamburg Messe und Congress GmbH, Congress Organization, Jungiusstrasse 13, 2000 Hamburg 36, FRG.

UICC International Cancer Congress--Aug. 16-22, Hamburg, W. Germany. Contact International Cancer Congress, c/o Hamburg Messe und Congress GmbH, PO Box 30 24 80, D-2000 Hamburg 36, FRG.

International Consensus on Supportive Care in Oncology--Aug. 21-24, Brussels, Belgium. Contact ICSCO Secretariat, c/o Symedco, Two Research Way, Princeton Forrestal Center, Princeton, NJ 08540.

Negative Regulation of Hematopoiesis--Aug. 22-25, Providence, RI. Contact Dr. Athanasius Anagnostou, Memorial Hospital of Rhode Island, 111 Brewster St., Pawtucket, RI 02860, phone 401/722-6000.

Chemo-Immumoprevention of Cancer--Aug. 24-25, Vienna, Austria. Contact Vienna Academy of Postgraduate Medical Education & Research, Conference Secretary CCPC-90, Alser Strasse 4, A-1090 Vienna, Austria, phone 43-1-421383; or Dr. Wuan Hong, Univ. of Texas M.D. Anderson Cancer Center, phone 713/792-6363.

Marrow Transplantation: Nursing Symposium--Aug. 24-26, Seattle, WA. Contact Dr. Dean Buckner, International Society for Experimental Hematology, 1124 Columbia St., Seattle, WA 98104.

Marrow Transplantation: International Society for Experimental Hematology Annual Meeting--Aug. 26-30, Seattle, WA. Contact Dr. Dean Buckner, International Society for Experimental Hematology, 1124 Columbia St., Seattle, WA 98104.

FUTURE MEETINGS

Nicotine Dependence--Sept. 6-9, San Diego, CA. San Diego

Hilton. Contact Hermese Bryant, meeting manager, Meetings Unlimited, phone 708/848-6050.

Frontiers in Oncology: Implications for Social Workers in the 1990s--Sept. 13-14, Orlando, FL. Radisson Plaza Hotel. Contact Drew Straker, Arnold Palmer Hospital for Children & Women, phone 407/649-9111.

Society for Complex Carbohydrates Annual Meeting--Oct. 10-13, La Jolla, CA. Hyatt Regency. Contact Cass Jones, Professional Conference Management, 7916 Convoy Ct., San Diego, CA 92111, phone 619/565-9921.

Advances in Oncology: Applications in Patient Care--Oct. 11-13, Lexington, KY. Radisson Plaza Hotel. Contact Markey Cancer Center, phone 606/257-4500.

14th Cancer Symposium/10th Cancer Symposium for Nurses--Oct. 22-24, San Diego, CA. Sheraton Harbor Island Hotel. Contact Meeting Management, Cancer Symposium, 5665 Oberlin Dr. #110, San Diego, CA 92121.

Cancer Pain Mangement--Dec. 8, Minneapolis, MN. Contact E. Canaan, Office of Academic Affairs, 701 Park Ave., Minneapolis, MN 55415, phone 612/347-2075.

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-CN-05231-34
Title: Computing support for Biometry Branch, Div. of Cancer Prevention & Control
Deadline: Approximately Sept. 7

NCI's Div. of Cancer Prevention & Control is interested in soliciting proposals from small business organizations for a contract period of five years. The organization will be providing data processing support in three general areas which are as follows: 1) support for new studies and development of new systems, 2) support for completed studies, data analysis and modifications to existing systems, and 3) development of new software systems for statistical data analysis and implementation of new statistical methodology.

This procurement is a 100 percent small business set-aside. For the purpose of this procurement a small business is classified as small if its average annual receipts for its preceding three fiscal years do not exceed $7 million.

Contract Specialist: Elizabeth Abbott
RCB Executive Plaza South Rm 635
301/496-8603

RFP NCI-CM-17513-28
Title: Synthesis of congeners and prodrugs of anti-AIDS compounds
Deadline: Approximately Sept. 17

The Drug Synthesis & Chemistry Branch of NCI's Developmental Therapeutics Program is seeking contractors with expertise in chemical synthesis and drug design to synthesize a variety of compounds for evaluation as potential anti-AIDS agents. The assigned objectives of this project are to design and synthesize a) congeners of lead compounds having confirmed activity, to enhace activity or potency, b) prodrugs with structural modifications that may provide altered pharmacokinetics, altered drug transport, improved bio-availability through increased water solubility or increased chemical stability, c) other altered structures that possess elements of both congener and prodrug, and d) compoinds related to natural products, e.g., alkaloids, heterocycles, nucleosides, peptides, etc.

Each contractor should have available a fully operational facility, including all necessary equipment and instrumentation fo all aspects of the contract. The nature of this project requires that the following restruction be applied: "NCI signs legally binding agreements with certain suppliers (often pharmaceutical of chmeical companies) which state that all information on compoinds submitted by the supplier will be held confidential. The successful offeror will be expected to synthetically modify such commercially confidential (discreet) materials. Thus, pharmaceutical of chemical companies could obtain valuable data on new lead compounds. Therefore, in order to honor the confidentiality agreement with the original supplier, NCI believes that the compounds cannot be sent to potential competitors of the supplier, and thus pharmaceutical and chemical companies must be excluded from the competition." For purposes of this restriction, a pharmaceutical or chemical company is defined as an organization which sells drugs and chemicals to the general public for profit.

This is a recompetition of contracts currently held by the Univ. of Alabama, Georgia Tech Research Corp., Purdue Research Foundation and the Research Foundation of State Univ. of New York at Buffalo. It is anticipated that three cost reimbursement contracts will be awarded for a period of three years beginning on or about May 30, 1991.

Contracting Officer: Dorothy Coleman
RCB Executive Plaza South Rm 603
301/496-8620

NCI Contract Awards

Title: Booklet printing
Contractor: Printers II, Tuxedo, MD; $71,500.

Title: Booklet printing
Contractor: Bro's Lithographing Co., Chicago; $34,344.

Title: Phase 1 clinical pharmacokinetic studies of anticancer agents
Contractor: Board of Regents of the Univ. of Wisconsin system, $2,435,288.

Title: NCI/NICHD LAN hardware and software
Contractor: Management Systems Designers, Vienna, VA; $1,260,730.

Title: Phase 2/3 clinical trials of anticancer agents
Contractor: Memorial Hospital for Cancer and Allied Diseases, New York, NY; $2,640,720.

Title: Phase 1 and clinical pharmacokinetic studies of anticancer agents
Contractor: Univ. of Maryland at Baltimore; $2,647,454.

Title: Smoking, Tobacco & Cancer Branch support services
Contractor: ROW Sciences Inc., Rockville, MD; $2,471,044.

Title: Storage and distribution of chemicals and drugs used in preclinical evaluation and development
Contractor: ERC Bioservices Corp.