THE CANCER LETTER FAX

Vol. 22 No. 35
Sept. 13, 1996

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Price $265 Per Year US
$285 Per Year Elsewhere

Klausner Reaffirms NCI's "No. 1 Priority" Is Funding Investigator-Initiated Research

NCI's highest priority is to fund investigator-initiated research, Institute Director Richard Klausner said to the National Cancer Advisory Board this week.

To assure investigators of the predictability of funding, NCI plans to maintain the same funding rates established this year, Klausner said. NCI spent $1.022 billion to fund research project grants. The Institute's budget in fiscal 1996 was $2.25 billion.

"One year ago, we established that investigator-initiated research was the No. 1 priority of the National Cancer Institute," Klausner said at the

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In Brief

Move To NCI Director's Office Gives Greater Visibility To NCI Liaison Office

NCI's Liaison Office, established a year ago in the Office of Cancer Communications, has moved to the Office of the NCI Director.

The move provides greater visibility to the Institute's effort to work more closely with national advocacy and voluntary organizations, NCI officials said.

"We are just learning how best to involve and incorporate consumers and activists in the processes of the Institute," NCI Director Richard Klausner said to the Board of Scientific Advisors at its recent meeting. "The extent to which we have opened up the processes to consumer involvement has been working well, but we need to do much better."

Eleanor Nealon, former chief of the Reports and Inquiries Branch of the Office of Cancer Communications, was named director of the Liaison Office. She will report to NCI Deputy Director Alan Rabson.

"Putting the Liaison Office in the Office of the Director heightens the commitment of NCI to working with advocacy and professional groups," Nealon said to **The Cancer Letter**. "We will serve as a catalyst for bringing NCI and these groups together. These are important constituents that we view as full partners."

The Liaison Office formed a working group of NCI staff to identify priorities. The working group formed an advisory committee of representatives from cancer patient organizations.

Contact information for the NCI Liaison Office: Building 31 Room 10A16, 31 Center Drive, MSC 2580, Bethesda, MD 20892-2580, tel: 301/402-2421, fax: 301/435-2931.

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The Payline Is The Priority: NCI Grants Exceed $1 Billion

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NCAB meeting on Sept. 10. "That was, I believe, the right decision, and it's important that we start off looking toward the next year, reaffirming that decision, and reaffirming our commitment."

The update on grant awards was part of Klausner's overview of the initiatives he launched over the past year.

In FY96, NCI funded 626 R01 grants that fell within the 23rd percentile of grants ranked by study section score. The Institute also funded 49 R01 grants that were outside of this "payline."

In addition, NCI funded one-third of the program project (P01) grant applications received.

"We don't yet know what our budget will be, but we believe that even in the worst-case scenario of a continuing resolution at 1996 levels, we can achieve the goal of maintaining the payline," Klausner said. "It is the highest planning priority to maintain that payline."

Accelerated Executive Review

Earlier this year, NCI began a special review process for grant applications that miss the payline by a few percentage points—up to 10 percentage points for patient-oriented research and up to four percentage points for other research.

The Accelerated Executive Review was designed to shorten the waiting time as applicants revise and resubmit their grants in response to the criticisms of study sections.

Investigators were asked to write a short response to the criticisms for submission to the NCI Executive Committee.

Of the 51 AER submissions received, the Executive Committee approved 26, for a total of about $6 million, Klausner said.

"This is a mechanism we would like to keep," Klausner said. "We expect to allocate about $9 million to it in the coming fiscal year."

Exception Funding

In addition to the AER program, NCI set aside about $18 million, or 6 percent of the available research project grant funds, as a reserve for "exception funding" for grants that fell below the payline.

Funds were allocated on a case-by-case basis after review by the Executive Committee when grants were brought to its attention by NCI staff, Klausner said.

Of this reserve, $2.8 million was used as interim support for investigators whose grants were not funded.

"The majority were for P01 grants, where the complete loss of funding can be devastating," he said.

The remainder of the reserve funded 22 R01 grants and 10 P01 grants. Of the 22 R01s, 20 had not been eligible for the AER program because they had already been amended. However, most of these were within the AER payline of up to the 27th percentile, Klausner said.

Of the 10 P01s, seven were within 10 points of the 140 priority score that NCI had set for funding P01s.

In addition, NCI set aside $12 million for the extramural divisions to use as administrative supplements to grants. About half, or $5.6 million, supported the minority supplements program of the Division of Extramural Activities.

Grant supplements ranged from $2,000 up to $400,000. Any administrative supplement over $50,000 has to be approved by NCI Deputy Director Alan Rabson.

"This allows us to add small amounts of money to provide for a broad range of needs within the scope of the initial grant," Klausner said.

THE CANCER LETTER

Founded 1974
Member, Newsletter Publishers Assoc.

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World Wide Web URL: http://www.cancerletter.com

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Cancer Center Supplements

NCI also awarded supplements to Cancer Center Support Grants on high priority research topics.

Part of the funding, about $6 million, was provided through the NIH director's 1 percent transfer authority. Following are the initiatives and the funding results:

●Cancer genetics research projects and research infrastructure: 138 projects reviewed, 38, or 28 percent, funded for a total of $5 million.

●Cancer genetics counseling and education initiative: 38 projects reviewed, 19, or 50 percent, funded for a total of $1.58 million.

●AIDs malignancies collaborative groups: 173 projects reviewed, 52, or 30 percent, funded for a total of $5.2 million.

●AIDS malignancies clinical training programs: five funded for a total of $600,000.

Clinical Trials Cooperative Groups

With added funds from internal reprogramming and the budget increase, NCI issued grant supplements to the clinical trials cooperative groups.

●Enhancement or establishment of cooperative group tissue banking or biorepositories: 28 applications received, 19 funded for a total of $3 million.

●Correlative or translational studies of cancer associated with biologic factors: 77 applications received, 27 funded for a total of $3.5 million.

In his talk to the NCAB, Klausner provided the following statistics on the cooperative group program:

The Institute's cooperative group network includes 9,000 active affiliated investigators at 15,000 institutions.

In 1995, the groups accrued 27,000 patients to 530 trials, 400 of which are therapeutic trials. Fifteen percent of the trials are phase I, 50 percent are phase II and 35 percent are phase III.

In 1996, the group expect to open 75 phase I protocols, 143 phase II protocols and 48 phase III protocols.

This year, 11 Investigational New Drug applications were filed with FDA for group studies, and 15 additional INDs are expected to be filed by the end of the year, Klausner said.

Clinical Trials Information System

Over the past year, NCI began to study the infrastructure needs of the Cancer Therapy Evaluation Program, which oversees the clinical trials system. NCI staff, cooperative group leaders, and an outside consultant agreed that CTEP's computer system needed upgrading, Klausner said.

"[The clinical trials system] involves at its core the management of large amounts of information related to the initiation and conduct of clinical trials, the communication and analysis of results," Klausner said to the NCAB. "Much of this data continues to be using paper and pencil.

"There are databases, but they are different, disparate, in place in a variety of independent databases that may or may not communicate with each other," Klausner said. "The result has been inefficiencies of data collection, delays in accessing information and difficulties with respect to data analysis."

The goal of the CTEP "information systems initiative" is to establish a common desktop work environment for CTEP staff. This also would link databases.

NCI is working with FDA to incorporate international medical dictionary standards into the information system, Klausner said.

"We are beginning a process of revising the common toxicity criteria and are working with FDA and representatives from regulatory agencies from around the world to develop and implement an adverse effect reporting system aimed at meshing with and meeting international harmonization standards," he said.

Also, the information system also would establish consistent policies for electronic transmission of clinical data.

"Critical to all of these initiatives has been the involvement of the outside participants, members of the cancer centers and cooperative groups, in all aspects of the policy and technical development for the information reporting," Klausner said.

"The key principle about information systems design is that they are not what the computers or the computer techies can do, but they have to start with the needs of the scientific processes, and the perceived needs of the scientific community," he said.

In another initiative, NCI has contracted with the White House Office of Science and Technology Policy to conduct a feasibility study to determine whether the Department of Defense CHAMPUS medical databases could be used to determine costs and outcome analysis for patients on clinical trials.

Bypass Budget II

NCI has begun planning for the fiscal year 1999 Bypass Budget, the document that the director must submit to the White House each year outlining the funding needs of the National Cancer Program.

The Bypass Budget developed over the past year has improved NCI's communications with Congress and helped the Institute organize its long-term planning, Klausner said at the Aug. 7 meeting of the Board of Scientific Advisors.

Klausner's 70-page Bypass budget was about 530 pages shorter than the previous year's document. The document outlined five major "investment opportunities" for cancer research.

"We like this short approach," Klausner said to the BSA. "It is working for us."

What's more, the document will not need a complete re-write next year, Klausner said.

"If we were right with our deliberations with our advisors about these unusual investment opportunities, that we believe will have profound impact on all cancer and all individuals, then these don't go away after one year," Klausner said.

NCI will not need to revise the investment opportunities for two to three years, Klausner said. Next year's document will describe the progress toward achieving the goals outlined this year, he said.

Congressional News

Senate Subcommittee Okays $2.32 Billion Budget For NCI

The Senate Labor, HHS & Education Appropriations Subcommittee recommended a $2.326 billion budget for NCI, a $78.1 million increase over the current year's budget of $2.248 billion.

The appropriation level proposed by the subcommittee is $45.2 million above the President's budget proposal of $2.281 billion, but $59.6 million below the funding level of $2.386 billion proposed in the House bill.

The subcommittee bill is expected to come before the full appropriations committee later this week.

Under the Senate subcommittee bill, NIH would get $12.415 billion, a $487 million increase over the current year's budget of $11.928 billion. This proposed appropriation is $38 million above the President's budget proposal of $12.377 billion, but $333 million below the funding level of $12.747 billion recommended in the House bill.

The Senate subcommittee bill calls for spreading out the financing of the proposed NIH Clinical Center over three years. The House bill contained a similar provision. The Administration called for allocating $275 million, the estimated cost of the project, during the upcoming fiscal year.

Since Congress is planning to recess later this month for the elections, there may not be time to reach an agreement on the HHS appropriations, sources on Capitol Hill said. The fiscal year begins Oct. 1.

If no appropriations bill is passed, Congress would be likely to approve a "continuing resolution" that would fund federal agencies at the FY96 level. Both Republicans and Democrats have said they want to avoid a government shutdown.

In a related development, the House and Senate conferees later this week are expected to consider the Department of Defense bills. In their current form the DOD bills include provisions for $150 million for breast cancer research and $100 for prostate cancer research.

Managed Care

Outcomes And Cost Data Needed, Cancer Panel Says

Data on outcomes and cost are critically needed if cancer researchers are to convince health care providers and insurers of the value of supporting clinical trials, according to participants at a recent meeting of the President Cancer Panel.

Cancer researchers have relied on anecdotal data in the attempt to educate the public, patients and insurers of the impact of managed care on clinical trials, the Panel said in a statement following the July 30 meeting in Seattle, WA. "It is not enough to say that patients are not entering into protocols; reasons for non-participation must be monitored and supported by data," the Panel said.

The meeting, in which 10 physicians from the Northwest described the problems managed care has caused for clinical research, was the first in a series of four meetings the Panel plans to hold on the subject of managed care this fall.

The Panel is scheduled to meet Sept. 24 in San Antonio, TX; Oct. 25 in Providence, RI; and Nov. 22 in Raleigh, NC. Following the meetings, the Panel plans to draft a report on its findings.

Cost Containment Vs. Clinical Research

More than 58 million Americans are enrolled in managed care plans, Panel Chairman Harold Freeman said.

"The Panel is concerned that economic necessities favoring managed care and its emphasis on cost containment may be at the expense of access to quality medical care, and ultimately impede the ability of the research community to translate the results of its efforts to the public benefit," said Freeman, director of surgery at Harlem Hospital Center.

"The war against cancer cannot be won from the laboratory alone," Freeman said. "Clinical research on the prevention, diagnosis and treatment of cancer and the application of research findings to the public must continue to be supported. Access to investigative clinical trials is fundamentally linked to patient care. Cutting-edge therapies cannot be developed without the ability to test them in humans."

Meeting participants said managed care had impeded their ability to conduct research to varying degrees. However, several found that managed care had some positive effects, including the streamlining of study protocols.

The opportunities for gathering more and better patient data has the potential to expand under managed care, NCI Director Richard Klausner said.

"In addition to the challenges, there is a sense of the possibility of new opportunities for clinical research with the organization of the practice of medicine that managed care represents," NCI Director Richard Klausner said. "If we learn to create partnerships, if we learn to solve the financial problems to make sure our academic centers stay alive, the organization of medicine provides us with the opportunity to think about not just maintaining the ability to do population-based research but, in fact, expanding it."

Clinical trials need to be simplified and accessible, and include the ability to gather cost data, Klausner said. "For too long, we have lived in a situation where the vast majority of information about patients is lost," he said. "There are a lot of misperceptions and misinformation about clinical trials. We need to do a better job to make the system user-friendly and simple and bring it into the computer age."

Frederick Appelbaum, director of clinical research at Fred Hutchinson Cancer Research Center, presented data from his studies that attempt to quantify the difficulties posed by managed care.

In one randomized study of bone marrow transplantation for leukemia versus chemotherapy alone, 15 percent of patients randomized to BMT could not continue on the study because a third-party carrier refused to pay the patient care costs, Appelbaum said. There were no refusals for patients on the chemotherapy arm of the study.

Another, prospective, study for bone marrow transplantation for patients with AML offered IL-2 following the transplant if the cancer was in complete remission. Of the 39 patients accepted for IL-2, 15 were not treated because the insurer refused support, Appelbaum said.

The Hutchinson center also conducted a survey of patients who came to the center to be screened for BMT. Of the 68 patients for whom BMT was recommended, 12 were transplanted at other centers. In five of these cases, the insurer would not allow transplantation at Hutchinson. In another 12 patients, the insurer did not allow transplantation for their indications, which were either breast or ovarian cancer.

"We have pretty good evidence that anywhere from 10 to 25 percent of patients who would be eligible for a study are not allowed on to the study at the institution of their choice at least because of third party carrier issues," Appelbaum said. "Third party carriers are looking to manage cost. They do not want to be held at an economic disadvantage in a competitive marketplace.

"If we could even the playing field, we would be a lot better off," Appelbaum said.

One way to "even the playing field" would be to require insurers to cover the patient care costs of clinical trials, but researchers do not know how much those costs are, Appelbaum said.

Appelbaum and his colleagues attempted to quantify the patient care costs in a 1993 study that looked at clinical trials for all diseases in the state of Washington. The estimate was about $500 million, or about 3 percent of the total annual cost of health care in the state.

The estimated difference between costs on the treatment arm of trials versus the experimental arm was about $5,000 per case, or $86 million state-wide for the year—about .5 percent of the total health-care spending.

"In exchange for making patients available for these studies, we need to ensure third-party carriers

that the studies are well thought out, are reviewed, are informative, and are done in as cost-effective manner as possible," Appelbaum said. Insurers also would be more inclined to support research if there were a "louder political statement" of the importance of research, Appelbaum said.

Greater Support, Information Needed

Increased patient loads and rising competition for grants has made clinical research more difficult, other participants said.

Oliver Press, professor of medicine and biological structure at University of Washington Medical Center, said his patient load has doubled in the past five years and more patients have health insurance plans that do not cover the patient care costs of trials.

Scott Browning, a physician at Kaiser Permanente in San Diego, CA, said there was no company support for his effort to serve as principal investigator of an NCI-funded Community Clinical Oncology Program.

"It was clear that I had to conduct the trials on my own time, after hours," Browning said.

Paul Weiden, principal investigator of the Virginia Mason CCOP in Seattle, said drug companies offer generous physician compensation for their studies, enticing physicians away from NCI-sponsored CCOP studies. Weiden suggested that NCI provide more grant money for physicians and staff, and eliminate unnecessary tests and physician forms.

Improved information systems are necessary to make it easier for physicians to find appropriate clinical trials for their patients, said Laura Esserman, assistant professor of surgery at University of California, San Francisco. NCI should take the lead in building an information system, she said.

Eliminate Slow-Accruing Trials

Representatives of managed care organizations said told the Panel they would be willing to discuss coverage of patient care costs with the research community.

Kaiser Permanente, which has 6.6 members in the US, is willing "to embrace phase III trials, if cost considerations are incorporated," said Allen Bredt, assistant to the associate medical director of the company, based in Oakland, CA.

However, trials should address clinically important questions, Bredt said. NCI should eliminate trials that are expensive or duplicative, and those that are not accruing patients quickly, he said.

Research Regulation

NIH Fined For Mishandling Of Radioactive Materials

The staff of the Nuclear Regulatory Commission proposed to fine NIH for failure to secure radioactive materials used in research on the Bethesda campus, the commission said.

The $2,500 fine would penalize NIH for violations found by NRC inspection teams in July and October 1995.

The proposed enforcement action does not address the 1995 incident, when 27 NIH employees ingested phosphorus-32, NRC officials said. That incident is still under investigation by the commission, officials said.

A letter dated Aug. 23 gave NIH 30 days to pay the fine or submit a protest to NRC. "It is a significant regulatory concern that NRC inspectors repeatedly have been able to gain access to licensed materials at your facility without challenge, because it indicates that members of the public may do so as well," NRC Regional Administrator Hubert Miller wrote in a letter to NIH.

At this writing, NIH has not responded to the notification.

In documents submitted earlier, NIH officials pointed to their solid safety record and argued that the modular design of the NIH labs causes a hardship for compliance with the NRC regulations.

Funding Opportunities

AACR Elion Award, Research Fellowship Grants Available

The American Association for Cancer Research announces the availability of the fifth annual Gertrude Elion Cancer Research Award, as well as fellowships for young scientists.

The Elion award, provided through a grant from Glaxo Wellcome Oncology, is open to non-tenured cancer researchers in clinical, basic or translational research in the US and Canada. The award provides a one-year, $30,000 grant for meritorious research and travel to the AACR annual meeting.

The Research Fellowship in Clinical/ Translational Research, the Research Fellowship in Clinical Research, and the Research Fellowship in

Basic Research each provide one-year grants of $30,000 to young scientists who have been postdoctoral or clinical fellows for at least two but not more than five years.

Application deadline for the fellowships and the Elion award is Feb. 14.

Inquiries: American Association for Cancer Research, Public Ledger Building Suite 816, 150 South Independence Mall West, Philadelphia, PA 19106-3483, tel: 215/440-9300, fax: 215/440-9313, e-mail: aacr@aol.com.

Small Business Innovation Research Program RFP

Contract Proposal Receipt Date: Nov. 5

The Small Business Innovation Research (SBIR) program provides support for research and development of new or improved technologies and methodologies that have the potential to succeed as commercial products. The purpose of this notice is to (1) announce the issuance of the Solicitation of the Public Health Service for Small Business Innovation Research Contract Proposals (PHS 97-1) and (2) inform the public about the opportunities that the SBIR program offers to small business concerns as well as to scientists at research institutions, including colleges and universities.

Public Law 102-564 requires the PHS and and certain other federal agencies to reserve 2.5 percent of their extramural research or R&D budgets for an SBIR program. The PHS SBIR set-aside requirement for FY 1997 is estimated to be $230-$240 million.

The offeror organization must be a small business concern, and the primary employment of the principal investigator must be with the small business concern at the time of award and during the conduct of the proposed project. In accord with the intent of the SBIR program to increase private sector commercialization of innovations derived from federal R&D, scientists at research institutions can play an important role in an SBIR project by serving as consultants and/or subcontractors to the small business concern. Normally, up to one-third of the Phase I budget may be spent on consultant and/or subcontractual costs, and up to one-half of the Phase II budget may be spent on such costs. In this manner, a small business concern with limited expertise and/or research facilities may benefit from teaming with a scientist(s) at a research institution; for the scientist(s) at a research institution, this team effort provides support for R&D not otherwise obtained.

The SBIR program consists of the following three phases:

Phase I: The objective of this phase is to determine the scientific and technical merit and feasibility and potential for commercialization of the proposed research or R&D efforts and the quality of performance of the small business concern, before consideration of further Federal support in Phase II.

Phase II: The objective of this phase is to continue the research or R&D efforts initiated in Phase I. Funding shall be based on the results of Phase I and the scientific and technical merit and commercial potential of the Phase II proposal. Only Phase I contractors are eligible to apply for Phase II funding, and Phase II proposals may be submitted upon the request of the Contracting Officer only.

Phase III: The objective of this phase, where appropriate, is for the small business concern to pursue, with non-SBIR funds, the commercialization of the results of the research or R&D funded in Phases I and II.

The amount and period of support for SBIR awards are as follows:

Phase I: Normally, awards may not exceed $100,000 for direct costs, indirect costs, and negotiated fixed fee for a period normally not to exceed six months.

Phase II: Normally, awards may not exceed $750,000 for direct costs, indirect costs, and negotiated fixed fee for a period normally not to exceed two years, that is, generally, a two-year Phase II project may not cost more than $750,000 for that project. Only one Phase II award may be made for any SBIR project.

Fast-Track Pilot Initiative (Applicable only to proposals submitted to NIH): Fast-Track is a parallel review option available to those small business concerns (offeror organizations) whose proposals satisfy additional criteria which enhance the probability of the project's commercial success. Proposals that do not meet these criteria may be redirected for review through the standard review procedures described in the PHS SBIR Contract Solicitation under section VIII, Method of Selection and Evaluation Criteria.

Inquiries: PHS SBIR/STTR Solicitation Office, 13687 Baltimore Ave., Laurel, MD 20707-5096, tel: 301/206-9385, fax: 301/206-9722, email: a2y@cu.nih.gov

NCI Program Project Grant Application Information

NCI isued the following statement in the NIH Guide to Grants and Contracts clarifying information on P01 grants:

There are three receipt deadlines for all NCI Program Project (P01) applications. Regardless of whether the application is new, a competing renewal, amended, or a request for a supplement, the only receipt dates are: February 1, June 1, and October 1.

Incoming applications are assigned to the review round that follows the date that they are received by the Division of Research Grants. For example, a grant

application received in March would be assigned to the June 1 review cycle.

Also note that effective June 1, 1996, NIH Program Staff are required to notify the Division of Research Grants Receipt and Referral Office of any new application requesting $500,000 (direct costs) or more in any one year, before the application is received. In order to do this, Program Staff must be notified in advance of the intent to submit such an application. Since the vast majority of NCI P01s exceed $500,000 per year, PIs must inform the NCI Referral Officer of their intent to submit a new P01 application.

The mailing address, telephone number and E- mail address are as follows: Referral Officer, Division of Extramural Activities, NCI, 6130 Executive Boulevard, Room 636A - MSC 7405, Bethesda, MD 20892-7405, tel: 301/496-3428, fax: 301/402-0275, email: friedbet@dea.nci.nih.gov

The Office of the Director, NIH, issued a notice in June 1996 that beginning with the October 1, 1996 receipt date the NIH no longer accepts applications amended more than twice. This policy applies to all applications, including new and competing continuation program projects. Applicants approaching this limit are strongly advised to consider alternative funding mechanisms (e.g., concurrent submission of individual R01s) at the time of submission of any A2 (second amended) P01 application. Copies of the NCI P01 Guidelines can be obtained from the NCI Referral Office (address shown above). The Guidelines may also be accessed via the NCI Home Page at: http://www.nci.nih.gov/extra/deaweb/dea.htm

Questions related to NCI P01 review may be directed to: David Irwin, Division of Extramural Activities, 6130 Executive Boulevard, Room 635E - MSC 7405, Bethesda, MD 20892-7405, tel: 301/402-0371, fax: 301/496-6497, email: irwind@dea.nci.nih.gov

RFP Available

RFP N01-BC-71006-21

Title: **Resource For Collection And Evaluation Of Human Tissue And Cells From Donors With Epidemiology Profiles**

Deadline: Approximately Oct. 15

The Laboratory of Human Carcinogenesis, NCI Division of Basic Sciences, is recompeting a four-year tissue-collection contract. Proposals are being solicited from qualified firms to provide the necessary resources for the collection of viable surgical, biopsy and autopsy specimens from a variety of human tissues and cells (lung, bronchus, colon, liver, pancreas) and other biological specimens (pleural effusions, blood and urine) from donors with epidemiological profiles prepared in specifically designed patient questionnaires which include the relevant medical records. The incumbent contractor is University of Maryland at Baltimore (Contract N01-BC-33010), which is scheduled to expire March 30, 1997.

The LHC subjects the tissues and cells to in vitro adaptability and carcinogenesis, biochemical characterizations and assays of chemical and oncogene-induced alterations of macromolecules, innovative methods for determining populations at risk for certain carcinogens by biochemical epidemiology survey. Relevant studies are extenuated by the application of xenotransplantation techniques for definitive assay of chemically stimulated tumorigenesis. Offerors must demonstrate, in their technical proposal, their ability to facilitate delivery of the nonfrozen viable tissues to the NCI in Bethesda, MD, within two hours of collection as a mandatory qualification criteria of this solicitation. Failure to demonstrate this element at the time of original submission will result in the offeror's elimination from further consideration. This contract will be awarded as a multiple-year, cost-reimbursement, level-of-effort (term) type contract with a required level-of-effort for all four years of 50,284 person hours (an estimated 12,571 hours per year) and incremental funding will be used.

Inquiries: Barbara Shadrick, Research Contracts Branch, NCI, 6120 Executive Blvd, Room 620-MSC 7224, Bethesda, MD 20892-7224, tel: 301/496-8611, e-mail: shadricb@rcb.nci.nih.gov.

What Did Cancer Letter Write In 1995? Index Now Available

Subscribers to **The Cancer Letter** should have received one copy of the Index to articles published in **The Cancer Letter**, Vol. 21, for the calendar year 1995, including the monthly supplement **Cancer Economics**.

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Also available in limited quantities are indices for previous years: 1993-94 (covering both years), 1992, 1991, and a 20-year history of the National Cancer Program, including an index to **The Cancer Letter** for 1974-1990. Please call for prices.

Contact: The Cancer Letter, tel: 202/362-1809, fax: 202/362-1681. Mailing address for pre-paid orders: PO Box 9905, Washington, DC 20016.