

JRS 2/16/88

THE

CANCER LETTER

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

Vol. 14 No. 7

Feb. 12, 1988

©Copyright 1988 The Cancer Letter Inc.
Subscription: \$175 year North America,
\$190 year elsewhere

NCAB Votes To Bring Organ Systems Coordinating Center Into NCI, Disperse Entire Grants Portfolio

The Organ Systems Coordinating Center cooperative agreement will not be recompeted, ending 15 years of external management of "fill the gap" organ site research supported by NCI. That decision was made last week by the
(Continued to page 2)

In Brief

NCI To Work More Closely With Biotherapeutics, DeVita Says; Apportionment May Be Abolished

ARE NCI and Biotherapeutics burying the hatchet? Vincent DeVita told the National Cancer Advisory Board that he and Div. of Cancer Treatment Director Bruce Chabner are going to visit Biotherapeutics' headquarters in Franklin, TN, "to discuss what we can do better cooperatively." DeVita has objected in principle to Biotherapeutics' policy of charging patients for experimental therapy. But he said last week, "Once a treatment has been proven, we are all on the same side, except for FDA. When you sell something that works, I have no problem with it. When you sell something that you don't know whether it works, that's something else"

THE DESPISED "apportionment" process which drastically limits NCI's flexibility in managing its money may soon be abolished, DeVita said last week. NCI, NIH and the congressional appropriations committees have all objected; the Office of Management & Budget may finally be listening

"I'M DISAPPOINTED people out there aren't offering this therapy (LAK/IL-2) to patients with metastatic melanoma and kidney cancer," DeVita told the NCAB. He feels the responses seen so far in treating those diseases, along with lack of any other effective therapy, demand that the new treatment be made available to those patients. Board member Victor Braren cautioned that LAK/IL-2 has worked against renal cell carcinoma, not all forms of kidney cancer, and suggested that NCI statements encouraging use of that treatment say that it is for renal cell carcinoma. "Your point is semantically correct," DeVita said. "But people are dying of what they've been told is kidney cancer. Many of them won't know that it could help them if we just say renal cell carcinoma." He agreed he would add the qualifier when referring to kidney cancer. . . .

HAL BROXMEYER, professor of medicine, microbiology and immunology at the Indiana Univ. School of Medicine, has been named scientific director of the Walther Oncology Center at the university.

New Cancer Survival,
Incidence, Mortality
Statistics Cause For
Optimism, Concern

. . . Page 6

RFPs Available

. . . Page 8

EODW
New note
Pur

NCAB Backs NCI's Position On OSP Coordinating Center, Grants Portfolio

(Continued from page 1)

National Cancer Advisory Board when it voted to accept the NCI proposal to bring the coordinating center into the Institute, as proposed by Director Vincent DeVita and his Executive Committee.

The one sided decision, by an 11-3 vote, represented a complete about face by the NCAB which for the last eight years had defended the concept of extramural management of the Organ Systems Program against DeVita's efforts to bring it more under NCI control.

Supporters of the program were shocked, for several reasons:

--The compromise worked out between DeVita and the NCAB six years ago, in which the headquarters functions of all the working groups were consolidated into the one OSCC, and review of grants generated by working group initiatives was brought back to NIH and NCI study sections, had been working well. DeVita has frequently said as much. Research concepts coming out of the groups made it through review by the divisional boards of scientific counselors with remarkable success, and the resulting grant applications more than held their own in NIH and NCI competition.

--When DeVita revealed last year that NCI was considering asking the NCAB to agree to "internalizing" the OSCC, he insisted that it didn't really make much difference to him and that he had no strong feelings one way or another about it.

--The hearing on the five issues related to the program, conducted by the NCAB's Committee on Organ Systems Programs last Dec. 3, produced a day long litany of support for an external center. NCI staff offered the only argument to the contrary, and that was lukewarm.

--DeVita had said at first that the primary reason for bringing OSCC into NCI was that it would save \$1 million. That was an exaggeration, which he later admitted. The OSCC grant was for somewhat in excess of \$800,000, and most of that supported the working groups, travel to their meetings and workshops, and costs of printing and distributing newsletters and program information, all costs which will continue wherever the program is headquartered. DeVita scaled down his estimate of the savings last week to \$300,000, which probably is still high.

With overwhelming support from the outside for an external coordinating center, and apparently modest support from within NCI to the contrary, why did the NCAB vote so overwhelmingly to make the change?

For one thing, NCI came up with a different reason for its position. With the coordinating center a part of the Institute, the working groups could be made into NCI chartered committees. "As chartered committees," an NCI position paper said, "the working groups would be permitted to see unfunded applications and could identify those which merit special staff attention such as consulting with the applicant about revisions in order to compete more successfully."

Also, "The establishment of new and the lapsing of existing organ systems working groups at the time of the regular expiration of their charters would be with the approval of the NCAB"

That last point dealt with one of the five issues presented to the NCAB--develop criteria for determining when to start new a new organ systems program and when to terminate existing ones. Neither the NCAB nor its Organ Systems Committee dealt with that issue.

Fisher, Durant The Keys

The sunrise-sunset factor was a nonissue in the fate of the coordinating center. The NCAB could start or end the programs at any time, whether the OSCC was external or internal. But the ability of chartered committees to have a close look at unfunded grants could be considered important, since their most important role is identification of research gaps and translating that information into funded research projects.

The two most important reasons why the NCAB changed its historic position are named Bernard Fisher and John Durant. Fisher is chairman of the Board's Organ Systems Committee and Durant is a member of it. Both let it be known at the start of the committee's consideration of the issue last week that they favored bringing the OSCC into NCI. Throw in the support of NCAB Chairman David Korn, and the fate of the coordinating center was sealed.

Only Victor Braren, Ed Calhoun and Geza Jako supported the status quo. They were veterans of the fight six years ago, but it was the final meeting for all three, and the Board members who had helped lead the fight then are no longer around--the late Tim Lee

Carter and former members William Powers and Rose Kushner.

Fisher and Durant indicated their decision had been heavily influenced by a new proposal drafted by NCI staff for overseeing the Organ Systems Program within the Institute. That plan had been drawn up to improve management and coordination of all organ systems related grants. It was presented to the NCAB as one of the arguments for dispersing the program's grants among the four program divisions; they have been managed by the Organ Systems Section in the Div. of Cancer Prevention & Control.

Although dispersal of the grants portfolio had been seen by some as the death knell for the program, NCI's proposal for the internal management organization ended all opposition. Braren, Calhoun and Jako dropped their objections. Fisher said he viewed it as a management decision. Durant said it was not up to the NCAB "to micromanage the Institute." James Karr, director of the OSCC, agreed. Braren acknowledged that a consensus existed, provided the NCAB continued to follow it closely.

Here's how NCI described the organizational setup:

Grants will be distributed among the NCI divisions based on the science as are the majority of NCI organ related grants (those not derived from OSP RFAs and program announcements). "To correct current communication problems, NCI will implement an internal process to assure adequate internal communication and communication with the working groups. This process will include the following:

"A. To assure a direct line of communication with each working group, each NCI program division will name an Organ Systems Coordinator who attends all full working group meetings. In addition, all working group subcommittee meetings and workshops will be attended by NCI program staff, based on science area, who then prepare the final version of any resulting concepts for RFAs/PAs/RFPs.

"B. NCI will create an internal Organ Systems Program Committee composed of the division Organ Systems Coordinators and chaired by the staff person responsible for the headquarters. This committee will meet regularly at NCI so that each coordinator is aware of all scientific activity in relation to each organ system.

"C. The Organ Systems Program Committee

will prepare an annual report on the status of research for each organ system to serve as an information source and planning tool for the working groups. This report will not be limited to research supported in response to Organ Systems Program initiatives. These reports will also be presented to all NCI boards of scientific counselors and to the National Cancer advisory Board.

"D. In contrast to the system implemented with the change to the current program, concepts in the future will be approved by the NCI Executive Committee, as are other concepts, and submitted to the relevant board of scientific counselors with no unnecessary delay.

"E. Resulting grants or contracts will be managed in the division whose BSC approved the concept."

Kimes Report Eliminated Opposition

Brian Kimes, who heads the Div. of Cancer Biology & Diagnosis Extramural Program, wrote a summary of the NCI position on the grants portfolio, which was distributed to NCAB members prior to the meeting. That, and the proposed internal organization, eliminated any opposition that might have remained.

"There are a number of general conclusions and recommendations to consider," Kimes wrote. "Fifteen years ago and more, the Organ Site Program with its working cadres and the Breast Cancer Task Force were organized because NCI had no way of effectively implementing the multidisciplinary objectives of organ systems research. Today, nearly all research is highly multidisciplinary as the distance between basic biology and clinical application shrinks and the entire structure and management of NCI has changed to promote effective integration of both administrative and scientific activities within the Institute.

"The implementation of weekly Executive Committee meetings and Institute retreats to evaluate and integrate NCI objectives and priorities are major examples of how different NCI is today compared to 15 years ago. In addition, the Office of Director seminars offer the opportunity for presentation of issues that cut across disciplinary and programmatic lines. A separate Organ Systems Program and the maintenance of separate organ systems portfolios are organizationally and operationally inefficient within the current context of NCI. We now employ better ways of translating basic scientific information into the clinic than

we did at the inception of the OSP.

"The related issues of visibility, identity and advocacy can be separated from the need for an Organ Systems Program with its own project portfolio. The former are provided by the working groups and either an external OSCC or an internal office responsible for supporting and coordinating their activities. Problems of individual investigators in getting information or assistance should be addressed for all researchers, not just those funded through the OSP.

"The need for an effective organ systems advisory structure to NCI can also be separated from the need for a standing OSP with a separate project portfolio. There is no doubt that the working groups include important clinical and basic research scientists who are in fact the same individuals used for advice by the program divisions. By linking these working groups to an OSP rather than to the NCI program divisions, our scientific advisory resources are being utilized inefficiently. The objectives of organ systems research should be realized by integrating it with all other NCI activities.

All NCI Directly Involved

"By connecting the divisional programs directly to the working groups rather than indirectly through the OSP, organ systems' research perspectives, objectives and priorities will be imparted more effectively to the entire NCI. If our ultimate goal is to make more meaningful and substantial progress in understanding and curing the solid tumors, then this will be better accomplished by directly involving all of NCI rather than maintaining a small, separate OSP grant program.

"At the December hearing, the NCAB committee asked whether we could maintain the OSP and the current system with more staff. Increased staff would not make the system more efficient or remove the barriers of a separated grant program. Under the realities of personnel ceilings, we must seek ways to use our current staff resources and scientific advisory resources as efficiently as possible. We shouldn't maintain a system that requires complex coordination when it is unnecessary, we shouldn't plan and conduct meetings that do not ensure the participation of key Institute staff, and we shouldn't hold two or three meetings when one will suffice.

"In conclusion, the reasons for maintaining the portfolios in OSP are more per-

ceived than real compared to the real advantages of incorporating these portfolios into the divisional programs supporting the bulk of NCI organ related research and linking the divisional program staff more directly to the working groups. Both scientific advisory resources and the resident scientific expertise of the program divisions would be used more effectively and efficiently and in a much broader capacity. The goals and objectives of organ systems research would be realized on a wider scale throughout all of NCI in all areas of research and training."

Fisher commented, in the debate at his committee meeting, that the internal organ systems proposal "relates to more than the portfolio issue." With it, the working groups "might play the same important role they have been playing, or possibly be even more visible. They would be closer to the whole. If they become chartered committees, they might have more stability. I find it difficult to see why we should have an external coordinating center. If NCI is serious about maintaining a full Organ Systems Program, with viability and visibility, an external coordinating center is a redundancy."

Jako argued that the external center brings the program "closer to its constituents. It is away from the government bureaucracy. It has worked well, at least for the last two to three years."

"The external center has worked well," Braren said. "If something is not broke, why try to fix it?"

"That's one managerial approach," Fisher countered. "Another is that if it ain't broke, that's the time to fix it. One can always improve on what one has."

Braren argued that one major change is enough, and that the best way to analyze whether the new system for handling the portfolio is working well would be to continue with the external coordinating center for two or three more years.

"My view is that leaving it external could be a potentially divisive force," Fisher said. "It would keep alive the issue. It would be like having your first wife continue to live in your house after you remarry."

At the full Board meeting, Durant said he was convinced there would be more safety and visibility in the program if the working groups are chartered committees. Referring to a review of the Div. of Cancer Etiology's Biological Carcinogenesis Program held the

previous day in a closed meeting, he said that program and the way the AIDS program has been coordinated among intramural and extramural scientists had convinced him of the advantages of close communication among inhouse and outside investigators. "That's not to say that the OSCC has not been adequate. I just feel that the entire program will be better served if we move it in."

Board member Elizabeth Strong said the strength of the OSP is in the working groups. "If we can achieve a higher level of communication and visibility by bringing it in, and not lose contact with the outside community, that would seem to be the thing to do."

"Location should not be a big issue," Board member Nancy Brinker said. "We should be interested in running a lean organization, and this will do that."

"What is wrong with getting practicing physicians and scientists working together?" Calhoon asked. "It seems a bit selfish to get everything under one umbrella."

"Turmoil over the OSP and its location has haunted us ever since I've been on the Board," Helene Brown said.

Richard Bloch, one of the departing members, said that "a vote any other way (than for NCI's proposal) is a lack of confidence in the management of the Cancer Institute."

"That's not my reason for opposing it," Braren said.

Voting for the motion not to recompetete the OSCC cooperative agreement were Bloch, Roswell Boutwell, Brinker, Brown, Durant, Gertrude Elion, Fisher, Phillip Frost, Irene Pollin, Strong and Louis Sullivan. Enrico Mihich, associate director of Roswell Park Memorial Institute where the OSCC is headquartered, did not vote and made a point of noting that he also did not abstain. Barbara Shook and Howard Temin were not present when the vote was taken.

There could be some fallout from this that NCI may not expect and certainly would not want.

External management of first the Organ Site Program and then the revised Organ Systems Program has been a "safety valve" which defused to some extent the contention that NCI staff is too heavily involved in management of the cancer program. The program was founded originally with external headquarters on the theory that at least some part of the National Cancer Program should be

managed outside of Bethesda, by nongovernment scientists.

DeVita feels that NCI has been far more open to outside input than almost any other government agency of this era. Under his direction, no extramural research is initiated by NCI without approval of nongovernment scientists. Their advice, and that of the NCAB, is solicited on nearly all major issues although that is not a requirement in law or NIH policy.

Nevertheless, his earlier effort either to kill or drastically modify the Organ Site Program, and his now successful effort to bring the OSCC into NCI and to disperse the grants portfolio, have been viewed as another example of a bureaucratic power grab, to consolidate his power over all facets of NCI.

Flexibility Limited

A few possible consequences of the "internalization" of the OSP working groups and converting them to chartered committees should be pointed out.

As chartered committees, they will be subject to department and HHS regulations. Those now prohibit a member of one chartered committee from serving at the same time on others. That could prevent the program from getting the best or most appropriate scientists on the working groups at any particular time, although they probably could be brought in as consultants or workshop participants. There could be delays in getting approval of appointments, and rules regarding representation of minorities and women, and geographic considerations, could limit flexibility.

The issue of whether elimination of an outside center will save money may never be answered. It is difficult to see how it could be done. At least one full time staff person will have to fill the role now handled by Karr, whose salary is paid by New York State.

Most of the routine functions now performed by Karr's staff probably will be done at NCI by contract with private firms. Whether those costs will be in the range they are now remains to be seen.

Overhead costs at NCI are rarely if ever attributed to individual programs, so a fair comparison with the external OSCC might never be available.

In any event, cost was not a significant factor in the decision to make the change.

"Control has been the key issue in all of the organ systems debates," a furious Karr told *The Cancer Letter* after the meeting. He

charged that NCI had ignored the Dec. 3 hearing, when most of the presentations were heavily in favor of continuing the external center. "If it had not been for **The Cancer Letter**, the public and the full NCAB would never have known what came out of the meeting. The transcript and minutes of the hearing have never been made available."

NCI sent NCAB members copies of the new internal plan for the program, Kimes' report including details backing up the points made in the summary above, and the rationale for moving the center inhouse, were included. No summary of the Dec. 3 opposition presentations was made, nor was there any attempt to present that side of the issue. Jako, who had objected prior to last week's meeting to those omissions, wrote up his own summary and presented it to NCAB members at last week's meeting.

"The value of an external coordinating center did not appear to be a controversial issue," Jako wrote. "In fact, when Dr. Fisher asked whether anyone could give a reason for not continuing to have the external coordinating center, there was no response."

Worth Continuing

Jako said the conclusions that could be reached from the hearing were:

"The organ systems approach is worth continuing. The progressive improvement of the Organ Systems Program over the past three years was well documented.

"The recommendation to recompute the RFA for the external coordinating center can be made independently of the grant portfolio matter. In the interest of maintaining the vitality of the OSCC, the support for its continuation as an external headquarters was unanimous.

"Support for cancer control was stated by NCI, OSCC and the working groups representatives and this issue will be emphasized in future Organ Systems Program activities.

"The grant portfolio issue condenses to the need for better communications, coordination and flow of information within NCI on organ systems solid tumor research."

The issue "came down to a matter of control, power and politics," Karr said. "Science and medicine did not seem to enter into the logic or decision making process. For years, NCI has wanted to slam the door on the external input provided through the Organ Systems Program, but they didn't have the votes on the NCAB. It was simply a matter of time until the composition of the Board was

changed, with organ systems supporters rotating off.

"There is a tremendous and growing constituency that has supported the reorganized Organ Systems Program," Karr continued. "The record attests to that. I continue to believe strongly in the organ systems approach, and I am hopeful that the transition will be smooth and orderly, but these decisions will not improve morale on the outside. The chairs and many others put a tremendous amount of time and effort into trying to ensure that people understand the ramifications of the Dec. 3 hearing and the issues discussed. They were ignored."

The present cooperative agreement for the coordinating center had been extended through July 31, 1989. NCI reaffirmed this week that that commitment will be honored, while transition to the internal coordinating center is carried out.

Lung Cancer Mortality Drops In Males, Youths; Breast Cancer Incidence Up

The annual cancer statistics review was released by NCI last week, with trends in incidence, mortality and survival offering reasons both for optimism and concern.

Cancer mortality rates among Americans under the age of 55 have been decreasing during the time period covered by the report, 1950-85, for all age groups up to age 85 when lung cancer, a largely preventable disease, is excluded. According to the 1980 census, 79 percent of the U.S. population was under age 55. Decreases for 1973-85 are also observed for all sites combined both including and excluding lung cancer. The mortality rates for each of the four major race-sex groups, white males and females and black males and females, have shown decreases between 1973-85 for each age group up to and including 45-54.

During the most recent time period, 1973-85, the mortality rates for all sites combined in the age group 45-54 decreased by 6.0 and 8.1 percent among white and black males, respectively, while mortality rates decreased by 6.1 and 15.2 percent among white and black females, respectively. The largest decreases in mortality rates for all sites combined have been in the under age 15 group with a 34 percent decrease among both white and black males, and a 33 percent decrease among both white and black females.

The incidence of lung cancer, the leading cause of cancer deaths, decreased among both

white and black males in 1985. Among white males, lung cancer incidence decreased from the 1984 figure of 84.0 cases per 100,000 males to a rate of 80.5 in 1985. The figure is the lowest since 1977 when the rate was 80.0. The rate among black males declined from 135.5 in 1984 to 124.7 in 1985, the lowest rate since 1981 for black males. There appears to be a leveling off of the rate of lung cancer mortality in males.

The trend for lung cancer morbidity in females has been increasing when assessed as an overall age adjusted rate, although the trend among young women (under 45) has been decreasing. An additional significant potential change is that, in the overall rate, there has been only a 1.1 percent increase in mortality between 1983-84 and 1984-85, the lowest in many years, and the overall incidence rate has been essentially level since 1983.

Lung cancer mortality rates have also shown decreases among younger Americans between 1973-85. Decreases have been observed for males under the age of 55, 9.6 percent for whites and 14.7 percent for blacks. Lung cancer mortality rates for white and black women under the age of 45 have also been decreasing during this 13 year period.

Breast Cancer Mortality Level

Breast cancer incidence for all cases except in situ carcinomas has increased by about 1 percent per year between 1973-85. The detailed graphs for incidence show a large spike in incidence in 1974 which probably indicates earlier disease detection because of publicity concerning cases of breast cancer among a number of prominent Americans. The recent increase in incidence in 1984 and 1985 and the dramatic increase in in situ carcinomas of the breast diagnosed since 1983 may be due in part to increased screening activities both for women over 50 and those under 50. It is unlikely that these increases are due to changes in disease coding or terminology.

Breast cancer mortality has remained essentially level among white females and increased about 1 percent per year among black females during the 13 year period, 1973-85. Analysis by age group shows that women under 50 experienced a distinct decline in mortality up through 1983; but in 1984, there was an increase in mortality followed by another small increase in 1985. The pattern for women over 50 has been essentially one of no change through 1979, after

which each succeeding year shows a small increase. The reasons for these changes are not clear. For example, the decrease in mortality resulting from improvements in survival afforded by treatment might be offset by increases in incidence. However, the lack of a large decline in mortality is strong evidence that little effective screening is taking place because clinical trials have shown that early detection through mammography and physical examination with appropriate followup can reduce the mortality rate from this disease by over 30 percent.

Some of the other major findings include:

*Colon and rectal cancer mortality continues to decline in the face of increasing incidence, and figures on survival show that 5 year survival is increasing. The incidence of colorectal cancer has increased about 19 percent since 1950; however, the mortality has decreased 20 percent. The changes in mortality and survival are consistent with both better management and earlier detection. In particular, the use of radiation therapy in rectal cancer may play a significant role.

*The cancer site with the largest increase in the number of deaths is lung cancer, amounting to an increase of 90,898 deaths in 1985 above that expected from the 1950 rates. Without lung cancer, the total cancer deaths in 1985 would have been below that expected from the 1950 rates by about 44,500.

*The decrease in testicular cancer mortality for 1950-85 is all the greater when the increase in incidence is taken into account. The decrease in mortality is directly attributable to improved treatment and is clearly evident in the change in 1 year survival figures which jumped from about 90 percent to about 95 percent between 1975-78, amounting to a decrease in first year mortality by about half. Testicular cancer is now one of the most curable cancers occurring among men with a five year relative survival rate in excess of 90 percent.

*Prostate cancer was diagnosed in an estimated 96,000 U.S. males in 1987, and was responsible for some 27,000 deaths. The trend in new cases per year had been rising steadily but now shows signs of stabilising. In contrast, over the past 35 years, the mortality rate has increased only slightly. The reasons for the increase in incidence are believed by some to be largely (but not exclusively) due to increased detection of

disease which would otherwise go undiagnosed, but which may have caused the patient symptoms. Yet, the data show that there has been an increase in the disease at all stages of detection. Of particular significance is the increase in survival for disease detected in the distant stage, increasing from about 20 percent in 1950 to about 30 percent in 1980.

*The decline in Hodgkin's disease mortality (61 percent over 1950-85) compared with an increase of 24 percent in incidence over the same period is consistent with the improvements in treatment that emerged from research over the past 15-20 years.

*There has been a marked increase in the constellation of cancer diseases known as non-Hodgkin's lymphoma (123 percent between 1950 and 1985 with 26,500 new cases in 1985), and an increase in mortality (100 percent) which lags behind the increase in incidence. A definitive reason for these two increases is not known. Mortality rates have also increased but not as much as incidence. Very large increases in survival occurred between 1960 and 1976.

*Over the past 36 years the incidence and mortality rates for cancer of the cervix have fallen more than 70 percent, and this cancer has become one of the most preventable and curable cancers when detected in an early stage. The 5 year relative survival rate for all stages combined was 67 percent for cases diagnosed during 1979-84 while the survival rate for cases with localized disease was almost 90 percent.

*Cigarette smoking is most likely the primary cause of the 70 percent increase in cancer of the larynx; however, this increase has been more than offset by the 12 percent decline in mortality which is the result of improved treatment.

*Stomach cancer is the ninth leading cause of cancer mortality accounting for an estimated 24,600 cases and 14,200 deaths in 1987. Both the incidence and mortality rates have been falling, although the rate of decrease in both rates has declined in recent years. Survival from stomach cancer is about 16 percent; however, survival from local stage disease is about 57 percent, an increase from about 42 percent in 1950-54. Improvements in

diet and advances in diagnostics are the most likely factors causing the changes.

*Cancer among children under age 15 account for 6,000 new cases of cancer a year or less than 1 percent of all cancers. However, childhood cancers present the largest life lost with an average of 65 years per child dying from cancer. From 1950-85, the incidence increased 32 percent while mortality decreased by 56 percent. The dramatic decrease is due to major treatment advances.

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 Blair building room number shown, National Cancer Institute, NIH, Bethesda MD 20892. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring MD, but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-61016-57

Title: Support services for epidemiologic studies to address emergent cancer issues (master agreements)

Deadline: Approximately March 26

The Epidemiology & Biostatistics Program of NCI's Div. of Cancer Etiology is seeking experienced firms to provide support services on emergent cancer issues as the need arises.

The required services will be defined by master agreement orders issued during the four year period of performance. This is a reissuance of a master agreement announcement which is being reissued with the intention of seeking new sources and enlarging the current pool of master agreement holders. Contractors selected for award of MAOs shall provide managerial data collection, and data processing support for epidemiological studies to be designed and executed alone or in collaboration with other research organizations. Specific tasks may include: study planning and liaison activities; data collection forms design; development of data collection manuals, data abstracting and coding; identification, locating and interviewing of study subjects; exposure assessment; quality control activities; and the submission of computerized data and associated reports and deliverables.

The master agreement pool currently consists of nine MA holders under an existing four year MA which expires March 30, 1991. Existing MA holders are not required to respond to this announcement.

Master agreements will be awarded to all firms whose technical proposal is considered acceptable. Multiple MAO/RFPs will be issued each year. An MA holder is free to respond to any particular RFP without having any effect on its MA.

Contract Specialist: Trina Porter

RCB Blair Bldg Rm 114
301/427-8888

The Cancer Letter — Editor Jerry D. Boyd

Associate Editor Patricia Williams

Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter. All rights reserved. None of the content of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of the publisher. Violators risk criminal penalties and \$50,000 damages.