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Clinical Societies, Patient Groups Need New Alliance, Glick Proposes To ASCO

PHILADELPHIA—Clinical societies and patient groups need to form an alliance that would represent clinical oncology in public policy debates, John Glick, president of the American Society of Clinical Oncology, said at the group's annual meeting.

"The rapidity of change in health care delivery, cost containment, and managed care all threaten the practice of oncology," Glick said May 20, in his final address as ASCO president. "I strongly believe that there

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In Brief

Middle East Cancer Consortium Formed; Armitage, Mayer Elected To ASCO Positions

FIVE MIDDLE EAST COUNTRIES agreed to form a consortium for cancer control activities. Ministers of health of Cyprus, Egypt, Israel, Jordan and the Palestinian Authority signed an agreement May 20 in Geneva to create the Middle East Cancer Consortium. HHS Secretary **Donna Shalala** and NCI Director **Richard Klausner** attended the ceremony. The consortium will help the member nations develop cancer registries, cancer information and dissemination programs, and training programs in cancer research, education, and patient care. In 1994, NCI helped create the Middle East Cancer Society, a nongovernmental scientific organization. Last November, Klausner and the Israel Minister of Health, **Ephraim Sneh**, met with representatives from several countries, which resulted in the formation of the consortium. The consortium will be funded by contributions from member countries. NIH will contribute initial financial support. Klausner will serve on the consortium's Board of Governors as the US representative. . . . **JAMES ARMITAGE,** University of Nebraska Medical Center, succeeded **John Glick** as president of the American Society of Clinical Oncology at the society's annual meeting in Philadelphia May 18-21. **Robert Mayer**, Dana-Farber Cancer Institute, was elected president-elect of the society. Other new members of the Board of Directors are: **Douglas Blayney**, Wilshire Oncology Group; **Nancy Davidson**, Johns Hopkins Oncology Center; **Larry Norton**, Memorial Sloan-Kettering Cancer Center; and **Philip Pizzo**, Children's Hospital, Boston [after July 1]. . . . **GEORGE CANELLOS**, of Dana-Farber Cancer Institute, was appointed to a second five-year term as editor of ASCO's Journal of Clinical Oncology. . . . **BRIAN MARKISON**, vice president, marketing and advanced medical services, Bristol-Myers Squibb Oncology/Immunology, was named general manager, Bristol-Myers Squibb Netherlands.

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ASCO President Proposes Clinical Oncology Federation

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is a need for a new coalition whose goals would be to keep oncologists in control of the practice of oncology, protect the rights of cancer patients to easily access quality cancer care, and to support cancer research and education."

Glick, director of the University of Pennsylvania Cancer Center, proposed to name the new group the American Federation of Clinical Oncology Societies.

Glick's proposal coincided with the society's decision to withdraw from the National Coalition for Cancer Research, a Washington-based group formed 10 years ago to consolidate the political agendas of cancer organizations.

ASCO and another organization, the National Coalition for Cancer Survivorship, have withdrawn from NCCR. Both groups cited unresolved differences over governance of NCCR as their reasons for leaving the coalition [further details in next week's issue of **The Cancer Letter**].

In his remarks, Glick characterized ASCO as an organization undergoing rapid growth and facing major changes. The society's annual meeting attracted nearly 14,000 participants this year, making it the largest in the group's 32-year history. The society has 10,700 members, about 1,000 more than last year.

Over the past year, Glick said, ASCO has:

—Endorsed a new set of long-range goals as well as priorities for the next three years.

—Implemented the recommendations of a 1993 strategic plan, which called for ASCO to hire an executive vice president and establish headquarters in the Washington area.

—Expanded scientific and educational programs.

—Developed ASCO Online to make ASCO information available over the Internet.

—Broadened the active membership category and created an associate membership category for residents and trainees.

—Improved ASCO's relationships with other oncology societies and patient advocacy groups.

The excerpted text of Glick's address follows:

It is a time of transition, growth and maturity for ASCO. We must be prepared to realistically assess our strengths and meet new challenges in a time of unprecedented scientific and educational opportunities. Revolutionary new knowledge from laboratory research has raised public expectations for the prevention and cure of cancer to a higher level than before. At the same time, we are confronted by major changes and challenges in our everyday practice of medicine and in the conduct of both laboratory and patient-oriented research. The practice of oncology and the delivery of high quality cancer care are threatened by major changes in health care delivery and financing, as well as by frequent changes in public policy.

Today I want to discuss with you ASCO as a society in transition; a society that is proactively engaged in helping its members and the public meet the challenges and the opportunities offered in cancer research and in the practice of oncology as we approach the year 2000.

I believe ASCO's credo should be, "Do what's right for and in the best interest of people with cancer." If we can remember to do what's right for our patients and their families, and make that the guiding principle that motivates our actions and policies, then we will do what's right for our profession.

At last summer's retreat of the ASCO Board of Directors, the Board endorsed a new set of goals for the society: ASCO is a scientific and educational society responsible for the delivery of programs to and on behalf of our membership and to the larger audience who attend our annual meeting; ASCO is a society whose advocacy programs are directed to the education of outside groups about the needs of its membership and of people with cancer, ranging from NIH, Congress, the insurance industry, and patient advocacy organizations. ASCO is an organization that represents the needs of the academic oncology community across multispeciality lines.

ASCO's initiatives are aimed at advancing

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knowledge through laboratory, clinical and patient-oriented research; and our efforts are directed to improving the clinical practice of oncology whether that be in the community or academic setting; and ASCO is dedicated to the training of future generations of cancer researchers and specialists.

Some have argued that ASCO spends too much of its time and energy on practice and reimbursement issues of interest only to community oncologists, while others argue that ASCO has lost sight of the needs of the academic community. Neither is true. The goals represent a continuum of our mission across all components of ASCO's membership. The oncologist in practice in the community must understand molecular genetics, while academic oncologists will not survive if they fail to understand reimbursement issues and the influence of managed care.

The most tangible evidence of transition is the full implementation of the 1993 strategic plan which called for ASCO to recruit a full-time Executive Vice President and to establish and staff an office near Washington, DC. During the past year, we have moved from association management by the Bostrom Corp. to a full-time ASCO staff and headquarters in Alexandria, VA. The goal is to provide enhanced programs and services to our members, and we are very fortunate to have Dr. John Durant [former senior vice president for health affairs at the University of Alabama at Birmingham] as our first Executive Vice President. John has recruited a talented director of finance and administration, Ron Beller, who brings a wealth of experience to his ASCO responsibilities. There are four major departments: Stacey Beckhardt continues her role as director of public policy. Michele Kaminsky is director of science and educational programs. Dr. Mark Somerfield is director of a new department of health services research; and we have recently recruited Saundra White as director of membership services.

Now that ASCO has defined our mission and goals and established the organizational structure to implement policies, we needed to identify our important priorities for the next one to three years, develop key recommendations and successfully implement these changes. ASCO decided to focus on those priority areas that we can either control or directly influence rather than devote time to areas clearly outside the Society's control. One of the key ASCO priorities was to develop a partnership with the NCI and its new director, Rick Klausner, to achieve a common agenda. I am sure all of you will agree with me that Rick Klausner is the single best thing to happen to the National Cancer Institute and its research programs for a long time.

Working closely with NCI, ASCO has accomplished more of its research agenda in the past nine months than it did in the past five years. ASCO identified increasing the funding for patient-oriented research and improving the training of clinical investigators as major priorities. We have increased the emphasis on translational research in our scientific and education programs, while continuing our leadership role in reporting the results of major phase II and III clinical trials. We have significantly expanded ASCO's public policy initiatives on issues relevant to our mission and goals, and have promoted active relationships with other oncology organizations.

In order to improve the health and well-being of people with cancer, we established a partnership with patient advocacy organizations to achieve common goals. We have expanded our health services research program and have a mandate from the membership and the board to develop more evidence-based clinical practice guidelines. We continue to work very hard to promote insurance coverage for patients on clinical trials and for off-label uses of FDA-approved drugs. We are in the process of developing referral guidelines to facilitate patient access to cancer specialists and other appropriately trained health care professionals. And we have identified the need to improve communications with our members as a major priority and, at this meeting, we will launch ASCO Online with our home page on the Internet.

The board and the Program Committee understand the need to attract and retain both the academic members of our society and practitioners by increasing the scope and relevance of our scientific programs. The Program Committee was reorganized to expand its membership, broaden the areas of expertise, add more basic scientists, and international members. This year we saw an increased number of abstracts submitted and 48% were accepted for presentation.

Recognizing the importance of improved communication with our members in this age of electronic informatics, the Education Committee proposed the concept of ASCO Online. We are in the midst of launching phase I of this project and have secured industry support for the first phase of development. We will shortly have the 1996 scientific abstracts and education book Online. Members will have access to ASCO public policies and will be able to electronically link to JCO.

We broadened our active membership category to make it much easier for non-physician oncology specialists, scientists and leaders of important national organizations to join ASCO. We have streamlined the application process for international candidates as they are an increasingly important part of our society, and we established a new associate member category to make our society more attractive to trainees.... With this change in our rules, we are encouraging trainees to actively submit their research for presentation at ASCO. Associate members may serve and vote on ASCO committees.

More than six years ago, the Board approved reciprocal membership in ASCO for members of other American clinical oncology societies. This year, we wrote to the presidents of these organizations and they enthusiastically endorsed expedited reciprocal membership in ASCO for members of their societies. One of the major purposes of this initiative is to broaden the multispecialty representation in ASCO as we embark on a time of enhanced public policy initiatives requiring oncology to speak with one voice.

One of the major priorities to come out of ASCO's strategic planning retreat last summer was an initiative to promote ASCO's relationships with other organizations. Some of you may be aware that ASCO's interactions with the American Association for Cancer Research in recent years have not been harmonious. Several years ago, it was AACR that unilaterally decided to separate their annual meeting from that of ASCO. This year, the ASCO leadership met with its AACR counterparts. After a candid exchange of views, we recognized that it was in the best interest of both societies to work together.

For logistical, scheduling and financial reasons, it will not be possible to reunite the ASCO and AACR annual meetings, but we have agreed to jointly sponsor interim educational and scientific conferences.

Prior to this year, ASCO has had little formal interaction with the American Cancer Society. After John Durant recently served on a blue ribbon panel regarding the future structure and function of ACS, ASCO decided to work closer with the American Cancer Society on a range of issues, most notably the development of guidelines for referral and access of cancer patients from primary care specialists to oncologists.

ASCO can clearly do only so much by itself to achieve many of our important public policy initiatives. We recognize that people with cancer also share many of our goals, hopes, and aspirations. Thus, we made it a priority this year to initiate dialogues with the leaders of the national patient advocacy organizations. One-on-one meetings were held, as well as joint meetings with the Cancer Leadership Council, which represents the leading patient advocacy organizations in this country. Recently, ASCO has been invited to participate in future deliberations of this council.

We have appointed patient representatives to all key ASCO committees including the Program and Education committees, appointed patient representatives to all our expert panels that are developing practice guidelines, as well as involving patients as voting members on our public policy subcommittees that develop ASCO position papers.

In broadening ASCO's membership categories, we have invited leaders of national patient advocacy organizations to join ASCO and they have responded enthusiastically. We have broadened the educational programming at our annual meeting to include topics of importance to people with cancer, including educational symposia on patient-physician communication, ethics, and spirituality.

After working closely with the patient advocates during this year, I have concluded that they represent a critically important grass roots and national effort that can only help ASCO achieve our mission of improving the health and well-being of people with cancer.

NCI Funding For Patient-Oriented Research

One of the most successful ASCO initiatives this year has been to lobby successfully for a significant increase in funding from NCI for patient-oriented research.

Much of the research classified as clinical by NIH has largely been basic laboratory research carried out on human tissues. ASCO has long argued that NIH direct additional monies to funding a subset of clinical research referred to as patient-oriented research, that is, research which involves direct interaction with a patient.

We are defining patient-oriented research as hypothesis-driven research that employs measurements in whole patients or normal human subjects in conjunction with laboratory measurements as appropriate on a broad range of subjects important to patients.

In our attempts to increase funding for patient-oriented research, an important ASCO position paper was written in mid-1995 by a team led by Larry Shulman and Allen Lichter. This paper documented limited NCI funding of investigator initiated patient-oriented research grants. In fact, if funding for the intramural clinical program at NCI, cooperative groups and specific contracts are not included, investigator-initiated R01 funding for patient-oriented research accounted for only 1% of the NCI budget in fiscal year 1994.

In this JCO paper, ASCO recommended a concerted effort by both the NCI and NIH to direct increased funding of patient-oriented research, to improve training of clinical investigators, and to establish a separate study section to review clinically oriented grants. While a patient-oriented study section is vital, some clinically related and translational grants will be best reviewed by existing study sections. However, these existing review panels must have adequate representation by clinical scientists with expertise in translational research, and NIH must also broaden the criteria by which study section members are selected.

The leadership of ASCO met with the new NCI director in August, and presented him and the NCI Executive Committee with a pre-print of our position paper on increased funding for patient-oriented research. While ASCO cannot claim all the credit for the very positive NCI response, we clearly played a major role in the initiatives recently announced by Dr. Klausner.

We also recognize that the clinical investigator is presently on the endangered species list. It has become increasingly difficult for junior faculty engaged in patient-oriented research to obtain peer-reviewed funding, and many of them do not have grant writing or methodologic skills to successfully compete for an NIH grant. Moreover, junior faculty are under heavy pressure from department chairs to generate their own salary and do not have protected time for their research efforts. When we recruit a promising laboratory investigator, we commonly give them 75-80% protected time, and provide a laboratory technician and supplies for three years until they obtain funding. This is almost never the case for a new clinical investigator.

Therefore, ASCO recognizes that our academic institutions and senior clinicians must take a leading role in improving training for these individuals. ASCO recommends improved training of clinical investigators by having appropriate role models and mentors, as well as formalized course work in clinical trials design. We also recommend guidance in developing clinical grants, and the grants writing seminar held at this ASCO meeting is another example of our commitment to young investigators. And, most assuredly, we advocate a significant increase in NIH training grants.

Although the clinical researcher is still on the endangered species list, we have made progress in our goal of improving training for clinical investigators. Earlier this year, the NCI announced increased funding for training grants and K08 awards. ASCO's scholarship grant program for Young Investigator and Career Development Awards is now in its 13th year and has awarded more than $8 million since the initiation of this program. Working with AACR, ASCO has developed a joint course on Methods in Clinical Cancer Research that will introduce clinical fellows and junior faculty in any oncology specialty to the full spectrum of challenges in patient-oriented research.

Our goal is to develop a cadre of well-trained, experienced researchers whose expertise in clinical trials design will speed the introduction of new agents for cancer therapy and prevention into everyday medical practice. We received a three-year grant from NCI and unrestricted educational grants from industry to fund this workshop, which will be held this summer.

In a recent membership survey, development of evidence-based clinical practice guidelines was also identified as a high priority by ASCO members. During the past year, we made a major commitment to expand our health services research, led by the new chairman of this committee, Tom Smith from the Medical College of Virginia. We made the commitment to develop up to four guidelines per year by multidisciplinary expert panels with patient representatives, and we streamlined the process of topic and guideline approval.

We adopted criteria for the selection of topics and these included that the disease or technology was common; economic burden was high; the health condition was associated with high morbidity and/or mortality; and there were significant variations in clinical practice. To develop a guideline, there has to be evidence available regarding the efficacy of relevant interventions, and this distinguishes ASCO's program from guidelines based primarily on consensus.

The Health Services Research Committee published outcomes to use for evidence-based practice guidelines. ASCO outcomes are patient-based and include improved disease-free and overall survival, decreased toxicity, improved quality of life, and improved cost effectiveness. ASCO's guidelines are not based on tumor responses in terms of complete or partial remissions except as that translates into better or longer life. ASCO's guidelines will not advocate chemotherapy simply for the purpose of maintaining hope.

Guidelines that have been completed during the past year include an update on colony stimulating factors to include peripheral blood stem cell and allogeneic transplantation, and the use of growth factors in AML. This update is part of the ASCO process to update each guideline on an annual basis with a full evaluation of a published guideline every three years. At its Board meeting [on May 17], we approved guidelines on the use of Tumor Markers for Breast and Colon Cancer. We also decided to develop guidelines on common medical conditions, most notably the management of metastatic and locally unresectable non-small cell lung cancer.

An expert panel has been formed on the followup of patients with breast and colon cancer after local regional treatment with or without adjuvant therapy, and the work of this panel should also be completed this year. We have chosen the topic of management of metastatic prostate cancer, and approved an expert panel on the use of anti-emetics.

The Handwriting On The Wall: Practice Issues

Holly Smith from the University of California recently said that we must be conscious to avoid mural dyslexia, or the inability to read the handwriting on the wall. As I now turn to a subject that is of critical importance, let us remember Holly Smith's admonition. We all know that there are multiple forces at work which threaten the current practice of oncology as we know it today as well as the rights of our patients. These forces range from cost containment, managed care, hospital networks, for-profit conglomerates, the acquisition of oncology practices, lack of coverage for clinical trials, and decreased funding for graduate medical education. Consequently, oncologists in the US are in a constant state of anxiety about their future and the practice of our specialty.

ASCO has traditionally dealt with practice issues through its Clinical Practice Committee chaired by Joe Bailes who works tirelessly on behalf of the society. The ASCO state and regional affiliate program continues to grow with 42 state societies now officially approved. This year, John Durant, Joe Bailes, and I visited 12 cites throughout the US updating members on important changes within ASCO and seeking their input about local and national issues related to the practice of oncology. One of the most important byproducts of these 12 regional visits was a clear appreciation that there is no schism between practicing oncologists and the national leadership of ASCO. We learned a great deal about the local problems and needs of oncologists.

The Clinical Practice Committee continues to represent the practicing oncologist both in the community and in academic institutions. ASCO continues its active work in improving coding, and coverage policies and new CPT codes for transplant procedures were adopted this year. ASCO was instrumental in convincing HCFA to approve Medicare coverage for oral anti-emetic drugs when used in association with approved oral antineoplastic agents. ASCO was also instrumental in overturning the HCFA coverage policy for hydration, and we educated the HCFA panel evaluating practice expenses relating to the Medicare physician fee schedules.

In order to ensure that efforts to contain health care costs do not lower the quality of chemotherapy delivery, the Clinical Practice Committee is developing a manual on "Criteria for Facilities and Personnel for the Administration of Systemic Anti-Neoplastic Therapy." A new initiative of the state/affiliate program will be a manual on "Practical Tips for the Practicing Oncologist," and we continue our reimbursement hotline for members of the state societies.

ASCO is working in close alliance with patients in advocating reform of discriminatory insurance policies. We have been very active during the recent congressional debates on health care reform, advocating limits on pre-existing condition clauses; portability of policies from group-to-group and group-to-individual; adequate risk pools to keep insurance affordable; advocating no discrimination based on genetic susceptibility, and increasing lifetime caps on insurance coverage.

The cancer community has turned to insurance reform as a vehicle to prohibit use of experimental exclusion clauses as a means of denying coverage of patient care on approved clinical trials, and we are working at both the state and national level to achieve this extremely important goal.

ASCO has long advocated FDA reform that would accelerate approval of cancer drugs, and real progress has been made toward achieving this objective over the past year. Michael Friedman, a well-known medical oncologist and ASCO member, became deputy commissioner of the FDA last October. Through his efforts and that of the FDA leadership, the White House recently announced four anti-cancer initiatives intended to improve and expedite approval of cancer-related products.

ASCO and others in the cancer community strongly believe that further concerted action is necessary to push for legislative solutions to long-standing problems. We believe that FDA reform should include lifting of restrictions on the dissemination of peer-reviewed literature and other reliable medical information about new uses of approved products. New or so-called "off label" uses are particularly important in cancer treatment, with over 50 percent of anti-cancer therapies involving uses not found on the FDA-approved label. In ASCO's opinion, quality peer reviewed literature should also form the basis for expedited review and approval of supplemental indications for new uses of approved products. However, off-label provisions are being opposed by the FDA and the Clinton Administration.

For a number of years, ASCO has urged the FDA to make these reasonable reforms and is now turning to Congress to take these steps legislatively. In this regard, we have the strong support of the patient advocacy community and are working closely with them to achieve this legislative reform.

Need For A New Coalition

While ASCO has been successful in achieving many of its public policy and legislative initiatives, we cannot do this by ourselves. The rapidity of change in health care delivery, cost containment, and managed care all threaten the practice of oncology. I strongly believe that there is a need for a new coalition whose goals would be: 1) to keep oncologists in control of the practice of oncology; 2) from a provider's perspective, protect the rights of cancer patients to easily access quality cancer care; and 3) to support cancer research and education.

The first task of this new coalition would be to define quality cancer care. The cancer community from specialists to consumers must speak with one voice about the need to ensure access to quality cancer screening, diagnosis, and treatment. Cancer patients must have timely referral to oncologic specialists when cancer is diagnosed or tests are inconclusive. I strongly believe that oncologic specialists should serve as the principal care-giver or disease manager during active phases of cancer treatment. This tenant must be a key component of a cancer patient's Bill of Rights which would be the first task of this new coalition.

Cancer patients must have access to oncologists for cancer-related followup care. Our patients are demanding this in the face of a mandate from many managed care companies that once active treatment is completed, the patient should be followed only by their primary car physician. If oncologists are deprived of seeing their

cured patients in follow-up, our profession will become much less rewarding.

For years, ASCO has strongly advocated that patients must have access to and coverage for treatment on approved clinical trials. We also recognize that costs should be controlled consistent with good medical practice, and we should rely on evidence-based guidelines to assist in the development of cost-effective diagnostic and treatment plans.

Managed care organizations should develop consumer-friendly report cards from which the quality of care provided by the plan can be objectively evaluated. ASCO has formed an Ad Hoc Task Force on Report Card Quality Measures to identify oncology-specific endpoints that can be used to compare plans.

The new coalition must be vigorous in advocating continued support for medical research and education. Congress approved a 5.7 percent increase in NIH funding in 1996. Retaining this level of support will require active advocacy by the scientific community. I strongly believe that health care insurers should contribute to the costs of maintaining the biomedical research and educational infrastructure. I would once again raise the politically unpopular idea of a 'superfund' to supplement federal support for research and medical education, and that this fund should be raised from a tax on all health care insurers, including both indemnity and managed care plans.

Third party payors should be required to cover patient care costs associated with clinical trials.... ASCO endorses the NCI-Dept. of Defense initiative [that will cover patient care costs of CHAMPUS beneficiaries on phase II or III trials]. ASCO strongly urges that this coverage be expanded to include other high-quality clinical trials, most notably phase I studies. All cancer treatment studies are developed and offered to patients with therapeutic intent. It may be important for us to abandon the jargon of phase I, phase II, and phase III studies.

ASCO will continue to advocate the view that the development of new cancer treatments represent a continuum from initial clinical trials through definitive randomized trials to post-marketing experience. We must convince or require all third-party payers, including HCFA, managed care organizations and indemnity plans to provide coverage of patient care costs on all approved clinical trials.

If Medicare can be brought to the realization that coverage of patient care costs on clinical trials is both cost-effective and a good investment, then I am confident that the rest of the insurance industry will follow their example.

Simplify Clinical Trials

Our goal of covering patient care costs on clinical trials comes with a major responsibility: how can clinical trials in general and the clinical trials program of the NCI in particular be improved? We clearly need faster and more efficient development and activation of trials. We must simplify our large-scale phase III trials, which should be directed toward resolving major therapeutic questions that can change the practice of medicine. Eligibility criteria need to be liberalized to allow most patients with the disease under study to enter a clinical trial. Data collection requirements should be simplified and limited in scope to decrease the cost of our trials, and we should eliminate all but essential tests necessary to achieve major endpoints.

Our current IRB procedures are cumbersome and labor intensive, and our consent forms are impossible for patients to comprehend. We must simplify IRB procedures and informed consent forms and we must do this immediately.

There is great need for an enhanced informatics network to draw investigators together on a national basis, and this should involve NCI, cooperative groups, CCOPs, universities and cancer centers. Electronic data collection must replace paper forms.

If we are to answer important scientific questions in an accelerated time frame demanded by our patients, we need to see a significant increase in the number of patients entered on to clinical trials. We must enhance our public relations efforts to convince people with cancer that it is in their best interest to enter into a clinical trial.

FDA Approves Two Drugs: RPR's Taxotere, Lilly's Gemzar

FDA last week approved two drugs for the treatment of metastatic cancer, Taxotere (docetaxel) and Gemzar (gemcitabine HCl).

The approvals came May 15 and 16, a few days before the American Society of Clinical Oncology annual meeting in Philadelphia.

Taxotere, by Rhone-Poulenc Rorer Inc. of Collegeville, PA, is indicated for the treatment of locally advanced or metastatic breast cancer that has progressed or relapsed during anthracycline-based therapy.

Gemzar, by Eli Lilly and Co., of Indianapolis, IN, is indicated for the treatment of locally advanced or metastatic pancreatic cancer.

The FDA Oncologic Drugs Advisory Committee recommended both drugs for approval last year. The drugs were not included in FDA's traditional year-end rush to act on pending applications (**The Cancer Letter**, Jan. 5).

In another action prior to the ASCO meeting, FDA sent a letter to Bristol-Myers Squibb Co. on May 17 notifying the company that its New Drug Application for Etopophos (etoposide phosphate) is approved. The company's promotional material and package insert must be approved before final clearance for marketing.

Etopophos is indicated for the first-line treatment of small-cell lung cancer, as well as treatment refractory testicular tumors, in combination with other approved chemotherapy agents.

RPR Submits Japanese Data On 60 mg/m^2

Although Rhone-Poulenc sought approval for Taxotere at a dose of 100 mg/m^2, FDA granted approval for doses of 60 to 100 mg/m^2 administered intravenously over one hour every three weeks.

The approval for the lower dose was the result of discussion at the ODAC meeting, company officials said. ODAC Chairman Paul Bunn noted that Japanese studies suggested that Taxotere at a dose of 60 mg/m^2 produced similar responses, but lower toxicity than the higher dose (**The Cancer Letter**, Oct. 20, 1995).

In the US and European studies submitted to FDA for the drug's approval, the response rate for the 100 mg/m^2 dose was 47 percent overall, the company said.

Rhone-Poulenc submitted the Japanese data to FDA, company spokesman Bob Pearson said. "FDA talked with us about having the 60 to 100 mg/m^2 dose because it gives doctors flexibility in tailoring treatment to patients," Pearson said.

Data from the Japanese studies are included in the package insert:

"The safety and efficacy of Taxotere have been evaluated in three phase II Japanese studies in 174 patients (3 patients had elevated LFTs) who had received prior chemotherapy for locally advanced or metastatic breast carcinoma; 26 patients had progression of disease as best response to prior anthracycline treatment. In the 26 patients who had progression of disease as best response to prior anthracycline treatment the [overall response rate] was 34.6 percent (95% CI: 17.2-55.7) and the [complete response] was 3.8 percent. The median duration of response was four months."

According to FDA, adverse effects of Taxotere were lessened at the lower dose. "Trials using a lower dose showed that the drug shrank tumors in 35 percent of patients for four months with fewer adverse effects than those associated with the higher dose," FDA said in a statement dated May 15.

"Taxotere, like many cancer drugs, is associated with serious side effects including a decrease in white blood cell counts, fluid retention, allergic reactions, and hair loss," FDA said. "While the higher dose of the drug is also associated with more severe cases of fluid retention and skin toxicity, these effects were negligible at the lower dose."

The agency said Taxotere was granted accelerated approval, a regulatory mechanism that bases early approval on clinical improvements such as tumor shrinkage rather than survival time. FDA may withdraw the approval if post-marketing studies fail to verify clinical benefits.

Gemzar: Improved Median Survival

FDA cleared Gemzar for marketing after evaluating results of two clinical studies which demonstrated improved median survival in patients with advanced and metastatic pancreatic cancer, according to Eli Lilly and Co.

In a phase III study involving 126 patients randomized to either Gemzar or 5-FU, the Gemzar patients had a 5.7 month median survival as compared with 4.2 months for 5-FU patients.

The company developed a new endpoint, clinical benefit response, to assess the effect of Gemzar on measured disease-related symptoms. Clinical benefit response is a measure of symptomatic improvement based on level of pain, consumption of pain medication, ability to perform daily activities and weight change. Patients were considered to be clinical benefit responders if they had improvement in at least one measurement without deterioration in any of the others; this improvement must have reached an established level for at least four consecutive weeks.

The phase III trial demonstrated that 24 percent of previously untreated patients who received Gemzar experienced a clinical benefit response, compared with five percent of patients treated with 5-FU.

A phase II trial, conducted among 63 patients who had previously been treated with 5-FU, showed a median survival time of 3.9 months. Of these patients, 31 percent survived for six months, and four percent survived for one year. Clinical benefit response was observed in 27 percent of patients.

Common adverse events included nausea and vomiting, fever, edema or fluid retention, rash, and flu-like symptoms. About 10 percent of all patients participating in Gemzar trials discontinued therapy due to side effects, the company said.