THE CANCER LETTER

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Breast Cancer Incidence Reduced 45% In Tamoxifen Arm Of BCPT; Trial Unblinded

Six years after it began, the Breast Cancer Prevention Trial has demonstrated a 45 percent reduction in breast cancer incidence among women at high risk of the disease who took tamoxifen, NCI and the National Surgical Adjuvant Breast and Bowel Project said this week.

The dramatic, statistically significant result in the primary endpoint of the study caused the trial's independent data monitoring committee on March 24 to recommend notifying the 13,388 participants of the findings, about 14 months earlier than had been expected, NCI and

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In Brief:

Cavanee Succeeds Coffey As AACR President; Von Hoff Is President-Elect; Awards Presented

WEBSTER CAVANEE became president of the American Association for Cancer Research at the AACR annual meeting last week in New Orleans, succeeding **Donald Coffey**. Cavanee is director of the San Diego branch of the Ludwig Institute for Cancer Research, and head of the Laboratory of Tumor Biology, professor in the department of medicine, and member of the Center for Molecular Genetics at the University of California, San Diego. **Daniel Von Hoff** became AACR president-elect. Von Hoff is director of the Institute for Drug Development at the Cancer Therapy and Research Center in San Antonio. **Karen Antman**, director of the Herbert Irving Comprehensive Cancer Center; **Carl Barrett**, scientific director of the division of intramural research at the National Institute for Environmental Health Sciences; **Tom Curran**, chairman of the department of developmental neurobiology at St. Jude Children's Research Hospital; and **Jean Wang**, professor of medicine at the University of California, San Diego, and associate director of basic research at the UCSD Cancer Center, were elected to the AACR board of directors. . . . **DAVID FISHER** received the Gertrude B. Elion Cancer Research Award, sponsored by AACR. Fisher is assistant professor at Children's Hospital/Dana-Farber Cancer Institute and Harvard Medical School. The $30,000 award is presented annually to a nontenured scientist in basic or clinical research in cancer causation, prevention, or treatment. . . . **ARNOLD LEVINE** received the AACR 1998 Clowes Award in honor of his discovery of the p53 gene and experiments on the gene's mechanisms and functions. Levine is the Harry C. Weiss Professor in

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Breast Cancer Prevention Possible, NSABP Study Shows

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NSABP officials said.

Letters are being sent to participants so that those who had been taking the placebo could consider starting tamoxifen or enrolling in a proposed study testing tamoxifen against a new drug, NCI and NSABP said.

"This is the first time in history that we have evidence that breast cancer can not only be treated, but also prevented," Bernard Fisher, scientific director and founding member of the NSABP said at an April 6 press conference.

While some studies have indicated that alcohol use and lack of regular exercise increase the risk of breast cancer, there is no evidence from prospective, randomized clinical trials that lifestyle changes reduce the chance of developing breast cancer, NCI Director Richard Klausner said.

"The results of this study are remarkable," Klausner said. "It is not often that we get to present results of the magnitude of a 45 percent reduction, certainly not in this disease.

"For women whose risk of developing breast cancer fall within the range of the study, tamoxifen can provide a first opportunity to reduce that risk, much as cholesterol-lowering medications can reduce the risk of heart attacks," Klausner said.

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"But there is much we don't know about how long the protection will last, details about how long the drug should be taken, and what may happen in the future," he said. "It is important that we provide tools that will help women and their physicians attempt to calculate their risks in order to make informed decisions."

Adverse effects of taking tamoxifen included a higher incidence of developing endometrial cancer and blood clots; however, the side effects were not greater than the study had originally anticipated, and affected only women over age 50, officials said.

Because taking the drug is not risk-free, a woman's decision to begin tamoxifen therapy should be an individual decision based on discussion with a physician, Klausner said.

"We know from several studies that women often overestimate their risk of developing breast cancer," Klausner said. "The first thing is to sit down with a physician and evaluate what that risk is and attempt to understand it. Then, women will have to consider their risk of developing unwanted effects of tamoxifen."

The study took place at 300 centers in the U.S. and Canada.

In the trial, women assigned to take 20 milligrams of tamoxifen daily developed 85 cases of invasive breast cancer compared to 154 cases in the women assigned the placebo. The result was "highly statistically significant," said Joseph Costantino, associate director of the NSABP Biostatistical Center.

Also in the group taking tamoxifen, there were 31 cases of non-invasive cancer, a secondary endpoint, compared to 59 cases in the placebo group, a statistically significant reduction of 47 percent.

The reductions in invasive and non-invasive breast cancer were statistically significant within each age group, Costantino said. About 40 percent of the participants were ages 35 to 49, 30 percent were ages 50 to 59, and 30 percent were age 60 or older. In spite of efforts to enroll minorities, African American, Asian American, Hispanic, and other groups made up only about 3 percent of the participants, NCI said in a statement.

Eight participants died of breast cancer, three in the tamoxifen group and five in the placebo group.

Adverse events included 33 cases of endometrial cancer in the tamoxifen group versus 14 cases in the placebo group; 17 cases of pulmonary embolism in the tamoxifen group versus 6 cases in

the placebo group; and 30 cases of deep vein thrombosis in the tamoxifen group versus 19 cases in the placebo group.

All cases of endometrial cancer were stage I and occurred in women over 50 who had not had a hysterectomy. The cancers were treated by hysterectomy, Costantino said.

Women in the tamoxifen group had fewer bone fractures of the hip, wrist, and spine (47 cases in the tamoxifen group versus 71 cases in the placebo group).

The BCPT also examined whether taking tamoxifen decreases the incidence of heart disease. There was no difference between the tamoxifen and placebo group in four types of cardiovascular endpoints, including heart attacks.

The National Heart, Lung, and Blood Institute, which had promised $8 million to the BCPT for heart studies, decided three years ago to cease its funding for the trial.

NHLBI said that the trial's enrollment of women over 55 was too low to have the statistical power to determine the cardiovascular effect of tamoxifen within a reasonable number of years. Since younger women have few cardiovascular events, the trial would likely end before the heart disease endpoints were reached, NHLBI said (**The Cancer Letter**, Oct. 27, 1995).

Whether tamoxifen benefited women in the study who carry the BRCA1 and BRCA2 gene mutations that predispose for breast cancer is not yet known, but the investigators expect to have that information in the next six to 12 months, Klausner said.

FDA has received data from NSABP to consider a new drug indication for tamoxifen, Klausner said. In a statement, FDA said it would review the trial data within six months.

"Zeneca is prepared to work closely and quickly with NCI, NSABP and FDA to determine the appropriate next steps," said Gerard Kennealey, vice president of medical affairs for Zeneca Pharmaceuticals, of Wilmington, DE, which markets tamoxifen under the trade name Nolvadex.

Women 60 and older were eligible for the trial based on age alone. At age 60, about 17 of every 1,000 women are expected to develop breast cancer within five years, NCI said.

Women between the ages of 35 and 59 who demonstrated an increased risk of breast cancer equivalent to or greater than that of an average 60-year-old woman were also eligible. Their risk was determined by a calculation based on a model developed by NCI scientist Mitchell Gail that includes the following factors:

—Number of first-degree relatives diagnosed with breast cancer;

—A woman's age at birth of her first child;

—Number of breast biopsies, and the presence of atypical hyperplasia;

—A woman's age at her first menstrual period;

—Whether a woman had lobular carcinoma in situ.

A Big Finish For Controversial Study

"This is a big deal," NIH Director Harold Varmus said at the press conference. "We don't often get the chance to announce such results.

"This is a credit to the efforts of federal agencies desirous to fight disease, it's a credit to the NSABP which carries out the mandate with federal dollars to improve the nation's health, and it's a great credit above all to those patients who engaged as our partners in research," Varmus said. "Without them, such trials would not be possible."

The BCPT was controversial from its inception in 1992. Some public health advocates said testing tamoxifen in a healthy population would be too risky. However, in the first two years, 8,000 women enrolled in the study.

Ironically, the resulting rapid expansion of NSABP as it attempted to enroll thousands of women onto the BCPT may have partially contributed to a stunning public crisis that threatened the NCI clinical trials system.

The crisis erupted in March 1994 when The Chicago Tribune reported that in the previous year, a Canadian contributor to several NSABP treatment trials was found to have committed scientific misconduct by falsifying eligibility criteria for some patients. NSABP was criticized, both by NCI, Congress, and some health advocates, for not promptly publishing a reanalysis of the studies, even though the falsifications did not affect the results of the studies.

Some clinical trialists speculated that the cooperative group may have delayed publishing a reanalysis because of the pressure to begin the BCPT (**The Cancer Letter**, April 1, 1994).

The situation worsened when an NCI team sent to NSABP headquarters in Pittsburgh discovered that the cooperative group had delayed conducting audits

of its member hospitals and failed to report promptly to NCI one irregularity in data for one patient enrolled on the BCPT.

NCI ordered the cooperative group to halt enrollment in all of its trials and demanded that Fisher step down as the cooperative group chairman and principal investigator. Fisher had served as NSABP chairman for 27 years.

Questions also arose about the reporting of endometrial cancer for women taking tamoxifen. Informed consent forms were rewritten and later participants in the BCPT had to undergo endometrial biopsies.

NCI allowed NSABP to resume enrollment in the BCPT and other trials in November 1994, but the nine-month hiatus was harmful to the study's momentum, sources said. It took three years for the trial to enroll the 5,000 additional participants to complete accrual. However, because women who enrolled had higher risk profiles for developing breast cancer than the study had originally anticipated, about 3,000 fewer participants were required. The study closed to new participants in September 1997.

None of the falsifications by the Canadian researcher, Roger Poisson, of St. Luc Hospital in Montreal, affected the outcome of NSABP studies, reanalyses by NCI and NSABP found. The HHS Office of Research Integrity said Fisher and other NSABP officials had not committed scientific misconduct.

NSABP Chairman Norman Wolmark thanked the BCPT participants for their "courage, commitment, and perseverance" in continuing with the trial. "This is their trial and the credit should go to them," he said.

Members of the trial's participant advisory board "have been the source of lucid perspective and input to us, and during some very difficult and trying times throughout the course of this trial, they have been our greatest inspiration and we are grateful to them," Wolmark said.

Wolmark also thanked NCI officials for their "unyielding support and commitment" to the trial, which has cost the Institute about $50 million. "Trials of this magnitude require a considerable government commitment relative to prevention," he said.

Fisher: "Debate, Confusion" With Every Advance

"This is an extremely emotional experience for me, probably the most emotional of my entire career," Fisher said at the April 6 press conference. "This is the 40th anniversary of the NSABP, and it is also the 40th anniversary of my beginning my career in laboratory and clinical research related to breast cancer."

Anticipating the scientific discussion and public debate likely to ensue over the BCPT results, Fisher said controversy is not new to the cooperative group. "When we changed from radical mastectomy to lumpectomy, when we began systemic therapy, there was always, with every new accomplishment, debate and confusion which required resolution," he said.

"There will be innumerable arguments over this information," Fisher said. "Who should get the drug? Who should not? How long should it be given? What is the relationship of genetics to the findings? What are the characteristics of patients who get tumors and those who do not? And at least 50 other questions you could tick off without any trouble.

"These questions, and what happens when we start to answer these questions, in no way challenges the results [of the BCPT], because these arguments arising relative to the questions will not alter the fact that evidence has been obtained that the clinical expression of women at high risk for breast cancer can be altered," Fisher said. "They also indicate that there is much more work that needs to be done."

What's Next: Tamoxifen Vs. Raloxifene

NSABP plans to offer postmenopausal BCPT participants who were taking the placebo the opportunity to participate in a proposed randomized trial to test tamoxifen against raloxifene hydrochloride (Evista, by Eli Lilly & Co. of Indianapolis, IN).

FDA approved raloxifene last December for the prevention of osteoporosis. The drug is the first of a new class of drugs called selective estrogen receptor modulators to be approved by FDA.

NSABP said raloxifene may have similar breast cancer prevention properties as tamoxifen, but might be associated with fewer adverse effects.

Eli Lilly said it has begun a clinical trial called Raloxifene Use for the Heart (RUTH) to determine the drug's ability to reduce the incidence of coronary death and nonfatal myocardial infarction in postmenopausal women at risk for cardiovascular events.

In osteoporosis trials, raloxifene decreased serum cholesterol and other blood-clotting factors, but did not increase fatty acids, the company said in

a March 24 statement. The most commonly reported side effect of raloxifene was hot flashes, though discontinuation rate due to hot flashes was about 2 percent in both the raloxifene and the placebo groups. The incidence of blood clots was "rare but serious," the company said. The drug did not increase the risk of breast or endometrial cancer, the company said.

New NCI Clinical Trials Website

NCI this week opened a new website offering access to clinical trials information, including information about the BCPT, at http://cancertrials.nci.nih.gov.

The page will serve as a new front door for NCI clinical trials information, officials said. The page includes educational information on clinical trials and how to find specific trials, as well as links to other information, including the NCI Physician Data Query database of current clinical trials and treatment, screening, diagnostic, and supportive care recommendations.

Information on NSABP trials is available on the World Wide Web at http://www.nsabp.pitt.edu.

Countdown To The March, Sept. 26:
Cancer Centers To Plan Events In Conjunction With The March

Cancer centers are likely to assume a key role in planning national events for the march against cancer scheduled for Sept. 26.

It appears that ideas for march events and strategies for promoting them in the media will be developed by the NCI Designated Cancer Centers Public Affairs Network in collaboration with the Association of American Cancer Institutes.

The Public Affairs Network represents press officers at cancer centers, and AACI represents cancer center directors. Strategies—as well lists of activities—would then be forwarded to the organizers of The March: Coming Together to Conquer Cancer. March-related activities would then be posted on the march web site.

In a related development, organizers of the march announced the event at a Washington press conference April 2.

The audio recording of the press conference that included statements by Olympic figure skater Scott Hamilton and Olympic cyclist Lance Armstrong is posted on the site www.themarch.org. Also, the web site offers information on the day's events and offers assistance with travel arrangements. The offices of the march can be reached at 800-THE-MARCH.

The march, which will include a candlelight vigil by the reflecting pool in front of the Lincoln monument the evening of Sept. 25, and other events on the Mall the following day, is intended to generate political support for expanding cancer research, assuring access to treatment, and defining and improving quality of cancer care.

Another goal is to build a database and a list of donors to create a national constituency interested in cancer issues.

Though the Washington events are expected to be the focal point of the march, the success of the event will depend on how well the message will be delivered in similar events around the country, organizers of the march say.

These events—which will include marches on state capitals, "town hall" meetings for survivors, hikes, races, and announcements at half-time shows during college athletic events—will be designed to deliver the message of the march in a variety of ways.

"The march is both a local and national story," said Ellen Stovall, executive director of the National Coalition for Cancer Survivorship and president of the march. "Cancer center directors and public affairs officers are in touch with the grassroots constituencies of the march and have the relationships with the media to make this local story gather critical mass and go national."

A strategy for conducting events—as well as a large, detailed list of events for the march—are expected to emerge following the annual meeting of the American Society for Clinical Oncology and the congress of the Oncology Nursing Society next month.

Last week, at the annual meeting of the American Association for Cancer Research in New Orleans, AACR and AACI formed an informal joint committee on the March.

"Time is short, and our priority should be to create a forum for sharing ideas on the kind of events that cancer centers and local groups can sponsor," said Suzanne Mahler, AACI executive director. "This is not a competition, so sharing ideas should be encouraged."

AACR Executive Director Margaret Foti said the cancer researchers are committed to the march. "We are very enthusiastic about this coordinated effort between AACR and AACI and the Public Affairs Network," Foti said to **The Cancer Letter**.

"It is very important to the success of the march. The march is an important event and we all want to make it a success, particularly now with the funding situation so uncertain. We are going to work hard in AACR to put all we can into this."

Many members of the committee as well as Stovall and Mahler are expected to meet again May 17, during the ASCO annual meeting. Information about the time and location of the meeting will be available from PAN, AACI, and ASCO.

The Public Affairs Network web site will allow cancer center press officers to develop ideas and media strategies. Discussions will be held in a closed portion of the site, and events would be submitted to the march and posted on its web site.

The ASCO annual meeting will offer the organizers of the march the opportunity to generate publicity for the event, said Kristin Ludwig, the society's director of communications.

"We expect about 150 reporters at our meeting, and we will provide a venue for generating publicity for the march," Ludwig said. This will include a press conference by Stovall, and a march exhibit in the Los Angeles convention center.

Another key organization, the Oncology Nursing Society is encouraging its 200 local chapters to stage march events and participate in events organized by other groups.

Marie Bagay, ONS director of leadership and membership, said the society plans to follow up with local chapters once a month and inform the march organization about activities that are being planned.

Anna Barker, a scientist and organizer of the march, said the cancer centers, together with AACR, bring together a valuable set of assets that could assure the success of the march.

"We have two power houses here," said Barker at a breakfast meeting where AACR and AACI leadership discussed plans for the march. "We have the cancer centers and we have AACR. Amongst us we have the cancer survivors. We have the families. We have PR networks. We have it all."

Barker said the plans for the march should include leadership from the AACR Associate Member Council, a group of politicized young scientists.

"They have 9,000 ideas, they are eager to participate," said Barker, a member of the march board of directors, and a member of the board of directors of the research task force for the march. Barker is president and CEO of BIO-NOVA Inc., a Portland, OR, firm that specializes in translational research.

One of the events planned to precede the march will be the signing of a "Declaration of Independence from Cancer," a document written by former AACR President Donald Coffey.

Contacts for The March Events:

The March director of community operations Donna Doneski: 301-650-9130; ddoneski @themarch.org.

AACI executive director Mahler: 734-764-8492; gustavma@umich.edu.

Public Affairs Newtork founder and former chairman Eric Rosenthal: 215-728-2700; et_rosenthal@fccc.edu.

AACR public information coordinator Jennie Anne Horst-Martz: 215-440-9300; horst@aacr.org.

ASCO communications director Kristin Ludwig: 703-299-1010; ludwigk@asco.org.

ONS director of leadership and membership Marie Bagay: 412-921-7373; marie@ons.org.

Intercultural Cancer Council manager TJ Dunlap: 713-798-4617; tjdunlap@compuserve.com

In Congress:

Senate Budget Resolution Includes $15 Billion For NIH

Congress has enough money in the $1.7 trillion budget to appropriate a large increase for NIH in fiscal 1999, Sen. Arlen Specter (R-PA) said last week at hearing of the Senate Appropriations Subcommittee on Labor, HHS, and Education.

"If we set our priorities right, it should be no problem to increase your funding tremendously," Specter, chairman of the Subcommittee, said to NIH officials at an April 1 hearing.

The Senate budget resolution (Sen. Con. Res. 86), passed April 2 by a vote of 57-41, would provide $15.1 billion for NIH in fiscal 1999. This would amount to an 11 percent increase over the current NIH budget of $13.6 billion. The resolution would increase NIH funding to $15.5 billion over the next five years.

The resolution provides $300 million over President Clinton's fiscal 1999 budget proposal for NIH. The President proposed $14.8 billion for NIH, an increase of $1.15 billion over the current year. The Administration proposal also recommends increasing the NIH budget by 50 percent over the

next five years.

The Senate resolution includes an amendment introduced by Sen. Connie Mack (R-FL) that would double NIH funding over the next five years. The Mack amendment provides an increase of up to $2 billion for NIH in fiscal 1999. At a minimum, NIH appropriations should match the recommendations included in the Senate budget resolution, the amendment said.

Under the Administration's budget proposal, the increase for NIH would depend on passage of comprehensive tobacco legislation during the current Congressional session.

Under the Senate resolution, all money derived from a tobacco legislation would be put into a reserve fund set aside for the Medicare program.

Receipts from tobacco legislation would be placed in the Medicare Hospital Insurance Trust Fund, and Federal proceeds from a tobacco settlement would be used "for saving Medicare until legislation is enacted to make Medicare actuarially sound."

Several public health organizations have protested using the tobacco reserve fund for Medicare, including the Ad Hoc Group for Medical Research Funding, and Effective National Action to Control Tobacco, a coalition of 45 public health organizations including the American Cancer Society, the Oncology Nursing Society, and Campaign for Tobacco-Free Kids.

"Funding for tobacco-related public health programs should be the first priority for any funds raised through tobacco legislation," ENACT said in a letter to Sen. Robert Torricelli (D-NJ). "We believe that the budget resolution should be changed to allow the tobacco reserve fund to be used for programs that will reduce the use of tobacco and its harmful effects."

If Congress is truly committed to increasing funding for NIH, it should do so independent of a tobacco settlement, said Dave Kohn, spokesman for Rep. John Porter (R-IL), chairman of the House Appropriations Subcommittee on Labor, HHS, and Education.

"If we consider biomedical research to be an important priority, we ought to pursue an increase in the budget resolution and do the hard work to provide that increase without assuming revenues that have not materialized," Kohn said to **The Cancer Letter**.

The Senate Commerce Committee recently approved comprehensive tobacco legislation that could generate up to $516 billion over the next 25 years.

The bill, proposed by Sen. John McCain (R-AZ), would raise the price of cigarettes by $1.10 per pack over the next five years, limit the tobacco industry's civil liability to $65 billion per year, and impose penalties of up to $3.5 billion per year if the industry does not meet targets to reduce youth smoking by 60 percent over the next 10 years.

Under a nonbinding amendment to the McCain bill, funds generated through tobacco legislation would be used to fund cancer research, smoking cessation programs, and child-care.

Klausner: Funding More Grants

The Administration's fiscal 1999 budget proposal provides $2.776 billion for NCI, an increase of 9 percent over the current budget of $2.547 billion.

The NCI Bypass Budget for 1999, submitted to the President last year, requests $3.191 billion for the Institute.

At the April 1 hearing of the Senate Appropriations Subcommittee, NCI Director Richard Klausner said that in addition to a major expansion and redesign of the clinical trials program, the $3.191 billion requested in the Bypass Budget would allow the Institute to fund about 34 percent of grant proposals.

The President's proposed budget would allow only 28 percent of grants to be funded, Klausner said.

"Our view is that, ultimately, we would like all of the good ideas to be funded," Klausner said. "There is this tension of wanting to make sure that all of the excellent grants are funded and wanting to maintain a robust and competitive peer-review system.

"Moving up to that 33-34 percent will maintain the value of the responsiveness of the peer-review system and assure that more excellent grants are funded," Klausner said.

In testimony to the subcommittee, Klausner said the President's proposed budget would allow NCI to support new initiatives to translate basic science discoveries into clinical practice.

NIH Priorities

"My colleagues and I are enthusiastic about the prospects for building vigorously on the handsome increases the NIH has received over the past few years, when budgetary prospects were more

problematic," NIH Director Harold Varmus said in his testimony. "We are heartened by this year's request, in part, because it embodies optimistic views about the nation's future."

Varmus said the 8.4 percent increase proposed by the President would be used to:

—Increase the number of research grants to 30,000 awards. The size of new and competing awards would increase by almost 10 percent.

—Expand efforts to develop new instruments.

—Fund innovative research training programs that emphasize trans-disciplinary work and increase graduate and post-doctoral stipends by 25 percent.

—Initiate new categories of awards for clinical investigators.

—Increase support for clinical research centers.

—Augment clinical trials by developing accessible databases, enhancing patient recruitment, initiating trials of alternative and complementary medicines, and improving clinical trial designs.

Specter: Raise Priority Of Alternative Medicine

Alternative medicine is not receiving the priority it should at NIH, given the public interest and the expanded NIH budget, Specter said to the institute directors.

Specter asked why Wayne Jonas, director of the NIH Office of Alternative Medicine, was not included in the hearing, which the directors of all of the institutes attended.

"I would ask you to make a high priority of reporting to this subcommittee what is going on in alternative medicine, and to give us a projection as to what more can be done, because it is not inappropriate to respond to public interest and public concerns," Specter said.

Specter said previous reports by NIH on the status of alternative medicine research have been inadequate. He called for a "complete report" on U.S. federal efforts and international research.

The Administration's budget proposal requests $20 million for the NIH Office of Alternative Medicine.

In Brief:

AACR Presents Awards

(Continued from page 1)

the Life Sciences in the Department of Molecular Biology at Princeton University. . . . **LEE NADLER** received the AACR Richard and Hinda Rosenthal Foundation Award. Nadler, chairman of the Department of Adult Oncology at the Dana-Farber Cancer Institute, chief of the Division of Medical Oncology at Brigham and Women's Hospital, and professor of medicine at Harvard Medical School, was honored for contributions to the fields of lymphoma biology and therapy and tumor immunology. . . . **MICHAEL DEAN**, chief of the Human Genetics Section at the NCI Laboratory of Genomic Diversity, received the Cornelius P. Rhoads Memorial Award for research on the MET oncogene, participation in the cloning of the VHL gene, mapping of the CCR5 gene, and contributions to cloning the nevoid basal cell carcinoma gene. . . . **BRUCE CHABNER** received the Bruce F. Cain Memorial Award in recognition of his work on the basic and clinical pharmacology of anticancer agents. Chabner is professor of medicine at Harvard Medical School, director of the Clinical Cancer Center, chief of the Division of Medical Hematology and Oncology, and chief medical officer of Dana-Farber/ Partners Cancer Care in Boston. . . . **ERNST WYNDER** received the American Cancer Society Award, presented by AACR in recognition of his research identifying the first links between cigarette smoking and lung cancer. Wynder is president and medical director of the American Health Foundation and a clinical professor of community and preventive medicine at the New York Medical College in Valhalla, NY. . . . **BERNARD FISHER**, director of research in the Division of Human Oncology at the Allegheny University of the Health Sciences, distinguished service professor at the University of Pittsburgh, and scientific director of the National Surgical Adjuvant Breast and Bowel Project, received the Joseph H. Burchenal AACR Clinical Research Award. . . . **ANTHONY PAWSON** received the AACR Pezcoller International Award in recognition of his discovery of SH2 domains, and the demonstration of their role in mediating protein-protein interactions. Pawson is senior scientist and head of the Program in Molecular Biology and Cancer at the Samuel Lunenfeld Research Institute, Apotex Chair in Oncology at Mount Sinai Hospital, professor at the University of Toronto, and Terry Fox Cancer Research Scientist at the NCI of Canada. . . .

CORRECTION: An article in the March 27 issue of **The Cancer Letter** incorrectly listed the email address for Barbara Redding, contact person for the NCI Cancer Prevention Fellowship Program. The correct address is br24v@nih.gov.