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Trials Show No Advantage For ABMT In Breast Cancer; Should Insurers Pay?

The American Society of Clinical Oncology April 15 released preliminary results of five phase III clinical trials of high-dose chemotherapy and bone marrow transplantation as treatment for advanced or metastatic breast cancer.

Four of the studies will be discussed at the plenary session at the society's annual meeting in Atlanta May 17, and a fifth study will be presented in a poster session.

The results showed no survival advantage for the procedure in patients

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In Brief:

"Sense Of Urgency" In Research Is Theme Of New AACR President Daniel Von Hoff

PHILADELPHIA—**DANIEL VON HOFF** became president of the American Association for Cancer Research at the association's annual meeting earlier this week. Von Hoff, director of the Institute for Drug Development of the Cancer Therapy and Research Center, San Antonio, succeeds **Webster Cavenee**, director of the Ludwig Institute for Cancer Research, San Diego, and professor of medicine at University of California, San Diego. Von Hoff said the theme of his presidency is "translation to the millenium—a sense of urgency." . . . **TOM CURRAN**, chairman of developmental neurobiology, St. Jude Children's Research Hospital, and professor of anatomy and neurobiology, University of Tennessee College of Medicine, Memphis, became president-elect. Five AACR members were elected to the Board of Directors. They were **Anna Barker**, president and CEO, Bio-Nova Inc., Portland, OR, who will serve out Curran's term; **Mina Bissell**, senior staff scientist and laboratory associate director, biosciences, Lawrence Berkeley Laboratory; **Michael Kastan**, chairman of hematology-oncology, St. Jude Children's Research Hospital; **Edison Liu**, director, NCI Division of Clinical Sciences; and **Frank Rauscher III**, professor and chairman, Molecular Genetics Program, Wistar Institute. . . . **YUE XIONG**, assistant professor, Lineberger Cancer Center, Chapel Hill, received the Gertrude B. Elion Award from AACR for his proposal for work on the cell cycle and CDK inhibitors. The award is given annually to a non-tenured scientist at the level of assistant professor engaged in meritorious basic or clinical research in cancer causation, prevention, or treatment. . . . **CAREER DEVELOPMENT** awards were presented to **Renata Pasqualini**, of the Burnham Institute,

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Tough Competition For HDC: Better "Conventional" Chemo

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with metastatic breast cancer who participated in a randomized, controlled trial by the Eastern Cooperative Oncology Group, the investigators said at an ASCO press conference announcing the findings. A smaller study conducted in France also failed to produce a statistically significant survival advantage in metastatic disease.

Similarly, in two trials, no advantage was demonstrated for the controversial, toxic treatment in the adjuvant setting. Trials by the Cancer and Leukemia Group B and the Scandinavian Breast Cancer Study Group did not produce statistically significant differences in survival for patients treated with high-dose chemotherapy.

A third trial, conducted in South Africa, did demonstrate increased survival rates and lower relapse rates for women on the high-dose chemotherapy.

According to NCI Director Richard Klausner, these results do not bode well for the procedure. "The hypothesis going into these trials, our hope, was that the more aggressive approach would prove clearly superior to standard therapy," Klausner said in a statement. "But based upon these studies, high-dose therapy has not been shown to be superior to lower-dose treatment. These studies do suggest it is at least equivalent in terms of overall survival, but the added toxicity and costs of high-dose treatment require that it be superior if it is to become a standard of care."

The trials slated for presentation at the ASCO have a common limitation: Since the trials do not use taxanes in the control arm, they do not reflect recent advances in breast cancer treatment. "If we believe in high-dose therapy, we have to compare high-dose therapy against conventional chemotherapy with taxanes," said Jean-Pierre Lotz, of Hopital Tenon in Paris, principal investigator of the French study.

Taxane compounds, Taxol and Taxotere, have improved the outcomes in standard therapy for breast cancer. Results reported at the ASCO annual meeting last year from a large intergroup study led by CALGB involving about 3,000 patients with breast cancer demonstrated a 25 percent reduction in risk of recurrence or death by the addition of Taxol to the standard chemotherapy regimen Adriamycin and cyclophosphamide.

However, because they cause neurotoxicity, taxanes are more likely to be used on the control arm than on the high-dose arm in future ABMT studies, experts said. "Many oncologists are now accepting that Adriamycin and cyclophosphomide followed by Taxol in adjuvant setting might need to be the control arm," said Richard Schilsky, CALGB chairman. "We are going to have to reconcile with the taxanes in designing future studies."

Over the past decade, physicians, patients, attorneys, jurors and state legislators have been acting as though the trials had been concluded, and ABMT represented the patients' best chance of beating breast cancer. Ten states mandate some form of insurance reimbursement for the procedure, as does the Federal Employees Health Benefits Program. Medicaid, too, pays for ABMT in some states.

The cost of ABMT has been reduced over the past 10 years from about $140,000 in 1990 to about $60,000, said William Peters, president and director of the Karmanos Cancer Institute in Detroit and principal investigator of the CALGB study. In contrast, conventional chemotherapy costs about $25,000 to $28,000, he said. Standard therapy is increasing in cost with the addition of Taxol and Taxotere, growth factors, and new antiemetics, he said.

About 1,400 American women underwent the treatment in the two clinical trials conducted by ECOG and CALGB. Altogether, about 12,000 women received the treatment, predominantly off-protocol or

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in "trials" not designed to produce meaningful answers.

"These five trials took nine years to yield these preliminary data because it took so long to enroll the required number of patients," Klausner said. "Greater participation by physicians and patients in clinical trials would speed answers, not only to crucial questions concerning high-dose chemotherapy with transplants, but other cancer treatments as well."

Now that the partial results are in, can the procedure remain widely available outside clinical trials? Should insurers continue to reimburse the ABMT procedures for breast cancer? How much of an additional effort should scientists invest in refining the answers?

First, let us consider the data from the ASCO abstracts:

Metastatic Breast Cancer

—Phase III Randomized Trial of High-Dose Chemotherapy and Stem Cell Support Shows No Difference in Overall Survival or Severe Toxicity Compared to Maintenance Chemotherapy with Cyclophosphomide, Methotrexate and 5-Fluorouracil (CMF) For Women with Metastatic Breast Cancer who are Responding to Conventional Induction Chemotherapy: The Philadelphia Intergroup Study (PBT-01). Edward Stadtmauer, ECOG, University of Pennsylvania.

The Philadelphia Bone Marrow Transplant Group began the trial in December 1990 to compare overall survival, time to treatment failure, and toxicity in women with metastatic breast cancer. ECOG assumed coordination of the trial in 1995. Between 1990 and 1997, 553 women were enrolled and received induction chemotherapy of four to six cycles of either Cytoxan, Adriamycin, and Fluorouracil or Cytoxan, Methotrexate, and Fluorouracil.

Of the women who had either complete or partial response to induction therapy, 199 women were randomized to either high-dose chemotherapy and stem cell support or maintenance therapy. Of the 199 patients randomized, 184 were eligible for the analysis, (101 patients assigned to the high-dose chemotherapy/ stem cell transplant regimen and 83 assigned to the maintenance chemotherapy.) The median follow-up time is 37 months.

"The results showed no difference in overall survival, regardless of complete or partial response to induction chemotherapy," the abstract said. The three-year survival, calculated from the date of randomization, was 32 percent for patients on the stem cell transplant arm (42 percent complete responses and 27 percent partial responses) and 38 percent for patients on the maintenance chemotherapy (49 percent complete responses and 36 percent partial responses).

No significant difference was seen between the two treatments for time to progression of disease (9.6 months for stem cell transplant and 9 months for maintenance chemotherapy). No significant differences were seen in life-threatening toxicities. One patient died during the stem cell transplant; no patient died of toxicity on the maintenance arm.

Though peer review of the trials is far from concluded, ECOG investigators say their data make a compelling case against the use of ABMT in metastatic disease.

"Our trial does not suggest in metastatic disease that even with longer waiting [for further data], that there's going to be a substantial benefit to high-dose therapy," Edward Stadtmauer, the study's principal investigator, said in a telephone press conference April 15. "We are doing a number of subset analyses, but it is very unlikely that the results will change over time.

"I believe our study shows an equivalence of the two treatment approaches," Stadtmauer said.

—High-Dose Chemotherapy with Hematopoietic Stem Cells Transplantation for Metastatic Breast Cancer: Results of the French Protocol Pegase 04. Jean-Pierre Lotz, et al, Hopital Tenon, Paris, France.

The study, begun in 1992, randomized 61 women with metastatic breast cancer to either high-dose chemotherapy and stem cell transplant, or standard doses of chemotherapy. The chemotherapy used in the high-dose arm was cyclophosphamide, mitoxantrone and Melphalan (CMA). Patients on the standard dose arm received conventional anthracycline-based chemotherapy.

After five years of follow-up, there was no statistically significant difference in progression-free survival or overall survival. The overall survival rate was 18.5 percent in the standard-dose arm, and 29.8 percent in the high-dose arm. The cancer relapse rate at three years was 79.3 percent in the standard-dose arm, and 50.8 percent in the high-dose arm. At five years, the relapse rates were nearly identical: 90.8 percent and 90.7 percent.

"This delay in relapse for patients on high-dose chemotherapy could potentially offer a better quality

of life with a longer 'off-therapy' period," the abstract said. "No cardiac events were observed in the high-dose arm, and there were no therapy-related deaths or unusual toxicities."

High-Risk Primary Breast Cancer

—A Prospective, Randomized Comparison of Two Doses of Combination Alkylating Agents as Consolidation After CAF in High-Risk Primary Breast Cancer Involving Ten or More Axillary Lymph Nodes: Preliminary Results of CALGB 9082/SWOG 9114/ NCIC MA-13. William Peters, CALGB, et al.

The study randomized 783 women with primary breast cancer spread to 10 or more lymph nodes under the arm to either high-dose chemotherapy (cyclophosphamide, cisplatin and BCNU) with bone marrow and peripheral blood stem cell support, or intermediate-dose chemotherapy using the same drugs at doses that could be safely administered without the transplant. All patients were initially treated with four cycles of cyclophosphamide, Adriamycin and 5-fluorouracil (CAF) prior to the high- or intermediate-dose chemotherapy. All patients were to receive radiation therapy to the chest area, and tamoxifen was prescribed for women whose tumors were hormone-receptor positive or unknown.

"The early results of this randomized, multi-center trial indicate that, at the present time, a patient receiving the high-dose therapy has about a 68 percent chance of being alive without breast cancer at three years, compared with a 64 percent chance for a patient receiving the intermediate-dose therapy," the abstract said. This was not statistically significant.

The investigators reported 29 treatment-related deaths (7.4 percent) due to the high-dose therapy, but no treatment-related deaths among patients on the intermediate-dose therapy.

"Although fewer breast cancer relapses have occurred in the high-dose arm, at this time there is insufficient evidence to conclude that there is any difference in survival between the two treatments," the abstract said. CALGB plans another analysis of the data in May 2001.

Peters said patients on both arms of the trial are living about 20 percent longer than had originally been anticipated.

"There are many reasons contributing to that, including better patient selection, the additional chemotherapy, radiation therapy and hormonal therapy," Peters said. "That is good news for patients, but what it means is there is a longer period required to show a difference between the two arms.

"Unfortunately, the only way we can decide whether treatments are different is to have sufficient failures," he said. "At this point, patients are doing so well, that will take another three years before we have adequate information to conclude about differences. It is too early to draw conclusions."

CALGB Chairman Schilsky said it would be premature to discard the whole strategy of dose-intensive therapy on the basis of the study.

"It is perfectly conceivable to me that high-dose chemotherapy may not be effective in women with a high tumor burden, but it could be in women with lower tumor burden," Schilsky said to **The Cancer Letter**. "In the adjuvant setting, its too early to draw conclusions."

The CALGB study shows fewer relapses on the high-dose therapy arm, but there are more treatment related deaths, Schilsky said. "There are about the same number of treatment-related deaths as there are relapses," he said. "The primary endpoint is event-free survival, which accounts for both, so the curves are overlapping."

Since the deaths occur in the first few several months of treatment on the high dose chemotherapy arm, it is possible that with continued follow-up, the curves will separate and a benefit might emerge, Schilsky said. "We are reluctant at this point to say the study is clearly a negative study," he said.

The ECOG study, by contrast, appears to be negative, Schilsky said. "In the metastatic setting, I thought I heard Dr. Stadtmauer say [in the press conference] that ECOG seems prepared to conclude that high-dose chemotherapy is not effective," he said.

—Randomised, Controlled Trial of High Dose Chemotherapy (HD-CNVp) vs. Standard Dose (CAF) Chemotherapy for High Risk, Surgically Treated, Primary Breast Cancer. Werner Bezwoda, University of Witwatersrand Medical School, Johannesburg, South Africa.

This study of 154 women with high-risk breast cancer involving 10 or more lymph nodes shows increased survival rates and lower relapse rates among women who received high-dose chemotherapy and stem cell support, compared to women receiving standard dose chemotherapy.

The high-dose arm received cyclophosphamide, mitoxantrone, and VP16 and the standard-dose arm received cyclophosphamide, Adriamycin or epiadriamycin, and 5-fluorouracil.

After more than five years of follow-up, 25 percent (19/75) of patients on the high-dose regimen had relapsed, compared with 66 percent (52/79) on the standard dose arm. Mortality was 17 percent (8/75) in the high-dose arm, compared with 35 percent (28/79) in the standard dose arm.

"The chemotherapy agents used in this trial were different from those in the other trials and the particular approach employed by the South Africans may be responsible for the positive results," NCI Director Klausner said.

Principal investigator Werner Bezwoda said that even though he reported a positive result, he felt high-dose chemotherapy and bone marrow transplant should only be offered in the context of clinical trials.

"We have in the past analyzing all the data found that patients with 10 or more nodes did extremely poorly in terms of disease-free survival," Bezwoda said in the press conference. "In the study that we reported now, there was a change of therapy in the so-called conventional dose treatment, and those patients actually did better than in the previous 10 years. I'm not excluding the fact that changes in conventional dose treatment might also improve, and therefore, I think it will be important to continue to do randomized trials to refine both the conventional dose treatment and the high-dose treatments."

—Results from a Randomized Adjuvant Breast Cancer Study with High Dose Chemotherapy with CTCb Supported By Autologous Bone Marrow Stem Cells Versus Dose Escalated and Tailored FEC Therapy. Scandinavian Breast Cancer Study Group, Jonas Bergh, University Hospital, Sweden.

A nine-year randomized Scandinavian study of 525 women with high-risk breast cancer indicates that there is no overall benefit to high-dose chemotherapy with bone marrow or stem cell support versus those who received more conventional doses tailored according to blood counts.

Women in this study were randomized to receive either a customized standard dose regimen—nine cycles of "tailored" 5-FU, Epirubicin and Cytoxan (FEC) with G-CSF support—or three cycles of FEC followed by high-dose chemotherapy (Cytoxan, Thiotepa and Carboplatin) with stem cell support.

After a median 20 months of follow-up, 50 relapses and 40 deaths occurred with "tailored" FEC therapy compared with 78 relapses and 40 deaths in the high-dose arm. There were eight deaths in the "tailored" FEC arm due to secondary acute myeloid leukemia/myelodysplastic syndrome while two deaths attributed to therapy occurred in the high-dose arm.

Principal investigator Jonas Bergh said selection bias could account for the better than expected outcomes for women in several of the studies. "In clinical trials, the patients are more carefully screened, and just by that, they have a better prognosis," he said. Because a greater proportion of available patients in Scandinavia go on trials rather than seeking treatment outside of studies, the Scandinavian study may be more representative of the breast cancer population, he said.

Komen, ACS: ABMT Payment Off-Protocol

With preliminary data in public domain, physicians, patients and insurers appear to agree that clinical trials are a good thing. However, a closer look shows deep disagreements over reimbursement of ABMT and future directions for investigation of the value of the procedure.

In a conference call with patient advocacy groups, CALGB principal investigator Peters urged the advocates to keep the pressure on insurers to reimburse the procedure in the context of clinical trials.

"It is incumbent upon us in the medical community to push as hard as we can to gain further information in clinical research studies, and that requires the collaboration and cooperation of the insurers," Peters said in a conference call April 15. "You cannot do clinical care without coverage. The alternative to participation in a clinical research study is not no therapy. It is outdated, ineffective, standard therapy. Which is why we've tried to do these studies in the first place. We were interested in trying to improve patient benefit. If insurers aren't interested in doing that, I think the advocates ought to get on their back."

Nancy Brinker, founding chairman of the Susan G. Komen Breast Cancer Organization, the group that hosted the call, agreed.

"I think it's going to be very important at this juncture not to fall back or be laid back about this issue," Brinker said. "With the new approaches coming downstream, it's going to be more important for us to insist that a long look is taken. This is a battle that's going to be fought, starting with this issue. So it's really important that advocates pay attention to this, and work very hard to make sure that this does not make a difference in insurance coverage."

Earlier that day, at a telephone press conference, Komen President and CEO Susan Braun said access to the procedure should not be limited to

clinical trials. "We strongly support the fact that as many women as possible should be in the context of the clinical trial," Braun said. "However, clinical trials are not available everywhere."

The American Cancer Society joined Komen in applauding clinical trials while at the same time urging that the procedure remain available off-protocol.

"Until such time as the studies are conclusive, physicians and patients should not be impeded by limitations of health plan reimbursement and be free to determine on an individual basis what course of treatment is medically necessary and appropriate," ACS said in a statement.

ASCO President Allen Lichter said it would not be practical to expect that ABMT would become available exclusively in clinical trials.

"In the past we had the overwhelming number of women transplanted outside studies, and a very small percentage of women treated on study," Lichter said. "We hope that the ratio would flip over, and the majority of patients would have this done inside trials.

"We hope that the equation would shift," Lichter said.

Peters: Answers Aren't Close

"Cancer therapies evolve over time, and no single study, or even group of studies is enough to resolve the issue," CALGB investigator Peters said to the advocates in a Komen conference call.

"If you go back in the history of the development of standard adjuvant therapy for the treatment of breast cancer, you will recognize that it was not until the overview analysis by [Richard] Peto and his colleagues at Oxford, that 144 different randomized trials and 77,000 women around the world that we were able to conclude with confidence that we had the most important treatment for women with breast cancer," Peters said.

Though insurers are not saying they would stop reimbursement for off-protocol ABMT procedures, they have made it clear that they are keeping an eye on the data and the issues involved.

"There is an important lesson to be learned: political, judicial, or media activism is not a substitute for scientific evidence," Karen Ignagni, president and CEO of the American Association of Health Plans, said in a statement. "By rushing to mandate coverage of this treatment before its efficacy has been clearly proven, lawmakers may have unintentionally delayed research findings and subjected women to unknown risk."

In Minnesota, a state where coverage of ABMT is required by law, Blue Cross and Blue Shield of Minnesota said legislators may have harmed patients by enacting a law before obtaining scientific evidence.

"While the results of the studies are preliminary, there is clearly no evidence to indicate that ABMT is the promising treatment that breast cancer patients had been led to believe," the health plan said in a statement. "The findings reinforce the importance of understanding the facts before we create laws mandating coverage. In Minnesota, a law was passed before we knew all the facts—a law we now understand has not been beneficial to our members and purchasers."

The results of the studies could lead to suits against physicians who oversell transplants and health plans that pay for them, said attorney and patient advocate Grace Powers Monaco.

Monaco, co-founder of the Candlelighters Childhood Cancer Foundation, is the director of the Bethesda, MD, based Medical Care Ombudsman Program, which has arranged expert reviews of hundreds of cases where patients and insurers disputed reimbursement for bone marrow transplantation for breast cancer.

"Plans have a fiduciary obligation to their members," Monaco said to **The Cancer Letter**. "Continuing off-trial coverage—and coverage of scientifically inadequate trials—could invite lawsuits from those who feel that their family member's life was shortened through treatment implicitly endorsed through coverage, even though it falls outside the plan's criteria for coverage.

"Providers who promoted this intervention as if it was ready for prime time are also potential targets," Monaco said.

A Dilemma For Advocacy Groups

In addition to establishing new strategies and new targets for litigation, the results of the clinical trials pose a profound dilemma for advocacy groups. "The advocacy community has to make some choices," Monaco said. "Should we disregard these compelling data and promote the use of this medical intervention off-trial? Or should we advocate for actions that will get high quality trials enrolled and answers quickly provided?

"I think it's the latter," Monaco said.

Patient activists Ellen Stovall and Fran Visco also choose Door No. 2. "The issue is not reimbursement for ABMT," said Stovall, executive

director of the National Coalition of Cancer Survivorship and a member of the National Cancer Advisory Board. "The issue is reimbursement for patient care costs in clinical trials."

Some of the same insurers who deny payment for patients enrolled in legitimate clinical trials turn around and pay for ABMT outside clinical trials, Stovall said to **The Cancer Letter.** "It's sad that patients are not being reimbursed for the routine costs of patient care in clinical trials, while this highly toxic but politically popular procedure is being routinely reimbursed off-protocol."

Visco, president of the National Breast Cancer Coalition and a member of the President's Cancer Panel, said the controversy is about the role of evidence-based medicine in the U.S. healthcare system.

"You can't say that clinical research is important in one breath, and then say in the next that these very large-scale, long-term, multi-institution, randomized clinical trials are not going to answer the question," Visco said to **The Cancer Letter**. "Then what is going to answer the question? Should we just have everybody doing whatever they want, without any regard for scientific evidence?

"You can't say that you want to have evidence-based medicine and quality health care and control spiraling healthcare costs on one hand, and then, on the other hand, say that even though treatment has not been proven effective—and there are data in fact showing that it isn't—that someone should pay for it anyway," Visco said.

"The community can't have it all ways," she said. "If we want to move forward, we need to make some difficult decisions."

Similarly, scientists should avoid focusing narrowly on the role of ABMT in the treatment of breast cancer, Visco said.

"When we are designing the next clinical trial, we have to make that decision in a broader context," she said. "The question isn't what should the next bone marrow transplant trial be? The question is what, given all that we know about breast cancer, are the most compelling hypotheses that will get us closer to a cure?

"How can we change the paradigm?"

• • •

Summaries of the five studies are available on the ASCO Web site at http://www.asco.org. Additional information is available from NCI at http://cancertrials.nci.nih.gov.

NCI Programs:

Pediatric Brain Tumor Grants Awarded To Nine Institutions

NCI has awarded funds to nine academic medical centers to establish a Pediatric Brain Tumor Consortium to conduct pilot studies and early clinical trials of promising treatments for children with brain malignancies.

NCI will provide $2 million a year for five years to fund the consortium.

"A wide range of clinical research opportunities exist in childhood brain tumors," NCI Director Richard Klausner said in a statement. The consortium "will be able to take advantage of these opportunities and, by rapidly identifying and evaluating novel treatments, expedite progress toward our ultimate goal, which is improved outcomes for children with brain malignancies."

The nine principal investigators and their institutions are: Mark Kieran, Dana-Farber Cancer Institute, Boston; Henry Friedman, Duke University Medical Center, Durham, NC; Marc Horowitz, Baylor College of Medicine, Houston; Larry Kun, St. Jude Children's Research Hospital, Memphis, TN; Peter Phillips, The Children's Hospital of Philadelphia; Ian Pollack, Children's Hospital Pittsburgh; Michael Prados, University of California, San Francisco; Russell Geyer, Children's Hospital and Regional Medical Center, Seattle; and Roger Packer, Children's National Medical Center, Washington, DC.

St. Jude Children's Research Hospital will host the consortium's Operations and Biostatistics Center. James Boyett will head the center.

Peter Phillips, of The Children's Hospital of Philadelphia will serve as chairman of the consortium's steering committee.

Dana-Farber joined with Children's Hospital, Boston, and Massachusetts General Hospital to apply for the consortium grant. "The new consortium will enhance our ability to share ideas and new approaches to pediatric brain tumor treatment with colleagues across the country," said Kieran, clinical director of pediatric medical neuro-oncology in Dana-Farber's Jimmy Fund Clinic. Kieran and Nancy Tarbell, head of pediatric radiation oncology at Mass General, serve as co-investigators of the Harvard-affiliated center.

The consortium is expected to enroll 80 to 100 patients a year in three to four clinical trials, with the first trials opening in September, NCI said.

NCI Meeting For Investigators

An information session for investigators planning to submit applications in response to RFA CA-99-001 will be held April 22, 10 a.m.-4:30 p.m. in NIH Building 31, Room 6C-10, 9000 Rockville Pike, Bethesda, MD.

Additional information may be found on the Tobacco Control Research Branch web site at: http://dccps.nci.nih.gov/tcrb/scrfa.html. The RFA solicits R01 applications on tobacco control interventions relevant to state and community tobacco control programs. The text of the RFA can be found at http://www.nih.gov/grants/guide/rfa-files/RFA-CA-99-001.html.

Contact by April 19: Bob Vollinger, Division of Cancer Control and Population Sciences, NCI, phone 301-496-0273, fax 301-496-8675, email: bv26n@nih.gov

RFP Available

RFP N02-CP-01000-21: Molecular Epidemiology Assay Support

Proposals Due: Approximately May 19

The Epidemiology and Biostatistics Program, NCI Division of Cancer Epidemiology and Genetics, and the Laboratory of Human Carcinogenesis, NCI Division of Basic Sciences are soliciting proposals for support services for Molecular Epidemiology Assay Support projects. This is for recompeting a contract performed by Microbiological Associates Inc. RFP is available at http://rcb.nci.nih.gov/ncics/rfps_published.asp

Inquiries: Barbara A. Shadrick, Contracting Officer, ESS RCAB NCI, 6120 Executive Blvd. MSC 7224, Executive Plaza South Room 620, Rockville, MD 20892-7224, phone 301-435-3787, fax 301-480-0241, e-mail bs92y@nih.gov

In Brief:

AACR Board Honors Barker With Naming Of Fellowship

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and **Fang Liu**, of Rutgers University. Pasqualini received the AACR-Susan B. Komen Foundation Career Development Award. Liu received the AACR-National Foundation for Cancer Research Career Development Award. . . . **ANNA BARKER**, an AACR member since 1978 and chairman of the Public Education Committee since 1983, was honored by the Board of Directors with the renaming of a fellowship to the AACR-Anna D. Barker Research Fellowship in Basic Research. In accepting the honor, Barker encouraged other AACR members to become politically active, and to work on communicating with the public and with cancer survivors. "I would like to live long enough to see everyone play the same role in AACR as I have played," Barker said. . . . **AACR** also presented: six fellowship awards; 20 faculty scholarships in cancer research from historically black colleges and universities; eight undergraduate and two graduate Science Education Awards; 129 young investigator travel awards; 44 minority scholars travel awards; 60 awards to associate members for AACR-AFLAC Scholars in Cancer Research; 26 AACR-ITO EN Young Investigator Awards for Asian investigators; and 20 AACR-Glaxo Wellcome Oncology Scholar Awards. . . . **JAMES WATSON**, president of Cold Spring Harbor Laboratory, was named an honorary member of AACR. Watson has been a member of the association since 1962. . . . **CYNTHIA BYER** was named director of communications for AACR, a newly created position. Byer has 20 years experience in health care communications. She established the communications office of Georgetown University Hospital in Washington, DC, and headed communications for the American Association of Blood Banks. Most recently, she was director of communications for the March of Dimes. Byer will start the new job in mid-May. . . **ADAM BLISTEIN**, an AACR staff member since 1983 and director of administration since 1995, plans to leave the association to take the position of executive director of the American Philological Association (http://www.apaclassics.org), effective July 1. The APA calls itself the "principal learned society for classical studies in North America." Its membership is composed primarily of university and college teachers of classical studies. "The Search Committee was particularly impressed by Dr. Blistein's work with AACR in its move to a professionalized staff, and in its growth in membership, meetings, and other programs over the last few years," the APA said in a statement. Blistein's Ph.D. from Yale is in classical languages and literature. His dissertation was entitled, "The Nature and Significance of the Protagonists in the Fifth-Century Comedies of Aristophanes.". . . **MARY ANNE MENNITE**, associate director of publications for AACR, is leaving after 21 years to pursue new career opportunities. . . . **ATTENDANCE** figure for the annual meeting was 11,000, AACR officials said. There were about 5,000 abstracts and 385 commercial exhibits. . . . **VIDEO FILES** of selected sessions of the meeting are available on the AACR website at http://www.aacr.org. . . . **NEXT YEAR'S** AACR annual meeting is scheduled to be held April 1-5, in San Francisco. Abstract deadline is Nov. 1. **Peter Jones** is the program committee chairman.

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