THE CANCER LETTER INTERACTIVE

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Spending Bill Could Give 15% Raise To NIH; Gimmicks Complicate Picture, Veto Looms

First, the good news: the conference appropriations bill passed by the House and Senate includes a second 15 percent increase for NIH in two years.

The proposed increase would give NIH $17.913 billion, a $2.3 billion boost over fiscal 1999.

Now, the bad news:

1. The conference bill calls for cutting spending by 0.97 percent, a cut that would shrink the proposed FY2000 increase to a little over $2.1 billion. The institutes would also have to absorb a portion of a $121 million

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In Brief:

DeVita, Seffrin Head Committee Advising Feinstein On National Cancer Act Revision

VINCENT DEVITA, Yale Cancer Center director, has been selected by **Sen. Diane Feinstein** (D-CA) as co-chairman of an advisory committee that will make recommendations to revise and modernize the National Cancer Act of 1971. DeVita will work with co-chairman **John Seffrin**, chief executive officer of the American Cancer Society, and advisory committee members, as well as members of the cancer community, to get broad-based recommendations for new cancer legislation. The advisory committee plans to work with the National Dialogue on Cancer, a forum of leaders from public, private and nonprofit sectors, spearheaded by former President **George Bush**. . . . **GARY KREPS** has been appointed by NCI as chief of its new Health Communication and Informatics Research Branch in the Division of Cancer Control and Population Sciences. Kreps was dean and professor in the School of Communication at Hofstra University. . . . **RALPH STEINMAN** received the Robert Koch Prize for his pioneering work in the discovery of dendritic cells. Steinman is head of the Laboratory for Cellular Physiology and Immunology at Rockefeller University. At the same award ceremony at Bonn University, **BARRY BLOOM** received the Robert Koch Medal for the first-ever description of how a cytokine plays a key role in the tuberculin reaction, which then led to his discovery of the cellular basis for delayed-type allergic reactions. Bloom is Dean of the Harvard School of Public Health. . . . **UNIVERSITY OF ALABAMA AT BIRMINGHAM** received $1 million to endow a chair for its Comprehensive Cancer Center from **Martha Ann May Klaus** of

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Bill Includes 1% Cut, Delay Of $7.5 Billion In Funding

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cut in the HHS administrative appropriations.

2. About $7.5 billion in NIH funds would be disbursed no earlier than Sept. 29, 2000, the last business day of the fiscal year. That accounting gimmick allowed the appropriators to get around the budgetary caps and tap into funds that would ordinarily be spent in fiscal 2001.

3. The President is expected to veto the bill. His reasons are expected to include opposition to the across the board cut, delayed obligations in NIH funds, and a disagreement over the bill's education provisions.

Under the spending bill, NCI would receive $3.332 billion, which could be reduced by $32.3 million if the 0.97 percent cut is ultimately applied.

After the bill cleared the Senate in a 49-to-48 vote, Clinton issued a statement characterizing the measure as "deeply flawed."

"This bill is a catalog of missed opportunities, misguided priorities, and mindless cuts," Clinton said. "I will not let it become law."

Flaws notwithstanding, in its current form, the bill gives NIH the largest increase in its history, and, according to Capitol Hill insiders, the increase could well remain after the bill's offending features go away.

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

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-362-1681
PO Box 9905, Washington DC 20016
E-mail: kirsten@cancerletter.com or paul@cancerletter.com

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724

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Moderate Republicans who in recent years financed an unprecedented expansion for NIH have been measured in their response to the off-the-top cut and the delayed obligations. Capitol Hill sources said advocacy groups have been cautioned against opposing the delayed obligations scheme since an excessive reaction could ultimately jeopardize the 15 percent increase.

After the Labor, HHS bill cleared the Senate, Sen. Connie Mack (R-FL) issued a celebratory press release. "Passage of a $2.3 billion increase for NIH—which is the largest increase in NIH history—is a significant step in our goal to double the funding to NIH over the next five years," Mack said. "If we can keep going in this direction, I believe we will see cures for cancer, Parkinson's disease, Alzheimer's, sickle-cell anemia, and many other diseases."

Dave Kohn, a spokesman for Rep. John Porter (R-IL), said the bill's delayed obligations provision would be unlikely to have a significant impact on research. However, Kohn said advocacy groups should be concerned about the prospect that some of the delayed $7.5 billion would count against the FY2001 appropriation. "People who are concerned about research should contact their Congressmen and Senators and ask them to ensure that the amount of money spent on NIH in 2001 does not diminish the money available that year."

The imminence of a veto is no surprise to the leadership of the House and Senate appropriations committees. The Labor, HHS spending bills are hardly the kind of documents that would inspire the pride of authorship. Working under unrealistic budgetary caps, the bill involves an unprecedented amount of budgetary gimmickry. Inviting the White House veto is part of the strategy aimed at delineating the gimmicks acceptable to the White House from gimmicks that would have to be negotiated away.

Delayed obligation of 40 percent of the NIH and NCI budgets stands out as a likely candidate for being eliminated from the bill, Capitol Hill sources said.

Should it remain, the provision would affect all funding mechanisms, but would have the greatest impact on continuing and new grants, sources said. Extramural research would be particularly vulnerable, because NIH intramural spending consists largely of salaries, which cannot be easily deferred. Though NIH has not worked out a survival strategy, sources said that the institutes would be able to use standard procedures for evaluating grants, and even issue checks that would be mailed out on Sept. 29, 2000.

NIH Director Harold Varmus said the current bill would hamper research, particularly new grants.

"The NIH is grateful for the proposed $2.3 billion increase to expand our understanding of disease and improve the health and quality of life for all Americans," Varmus said in a statement. "We are concerned, however, about the potential adverse effects of delaying obligations proposed for NIH.

"Delaying such a significant portion of the NIH budget will create an administrative challenge for the agency," Varmus said. "But more importantly, we are concerned that some new grant awards will be delayed for up to several months. The proposed delay will slow the progress of new research and our ability to support young new researchers just starting their careers. We hope that Congress will make every effort to limit the amount of deferred obligations by NIH."

The payout schema has a precedent. In fiscal 1992, $200 million in NCI money had to be paid out on Sept. 30. However, the current appropriation involves a greater portion of the funds and, presumably, requires a more complicated fiscal juggling act on the part of NIH.

Advocacy:

Groups Urge More Research On Pollutants And Cancer

The Breast Cancer Fund, the Susan G. Komen Foundation and the National Organization of Women last week began a campaign to seek funds to research potential links between breast cancer and the environmental exposures to pollutants.

"If cancer is a crime, among the suspects are toxicants in our environment," the representatives of 60 organizations wrote in an Oct. 27 letter to President Bill Clinton and the major presidential candidates. "There are 75,000 chemicals in commerce today. We know a little about the toxic nature of less than 3,000 of them… We have a right to know what toxic chemicals are in our bodies and the impact these agents may have on our health."

Debates over the environmental causation hypothesis have been a part of cancer politics for three decades. While proponents of this hypothesis often point to "hot spots" like Long Island and the San Francisco Bay area, skeptics counter that research into potential links involves investigations of uncertain targets, requires research with small cohorts, and therefore does not represent the best possible use of cancer research funds.

One of the more surprising elements in the current debate is the appearance of Komen, a group usually aligned with mainstream positions in science, on the environmental causation end of the oncopolitical spectrum.

Diana Balma, senior counsel to Komen, said the decision to sign the letter was motivated by repeated inquiries from the group's constituents.

"We've been asked, why are we now engaging in the environmental cause, and I will tell you that every time our constituency asked us what is the correlation between the environment and breast cancer, we don't have those answers," Balma said at a Capitol Hill press conference Oct. 27. "We are asked in the field, at our 98 affiliate races. We field questions on our hotline and help line. We are asked on our three award-winning web sites, and we can't answer that question at this point. We feel that we have been charged with helping these women find the answers that they so desperately want to know and deserve to know."

Though establishing conclusive links between environmental exposures and disease is a daunting scientific problem, the letter to Clinton and the presidential contenders makes specific demands:

The government should create a "national registry and inventory" of chemicals. This should be done through expansion of research at the Environmental Health Laboratory at Centers for Disease Control and Prevention, which monitors the levels of chemicals in the blood, the letter said. This 'biomonitoring' research should be expanded to include a wider range of chemicals, as well as testing of breast milk, which often contains high levels of carcinogenic and hormone disrupting chemicals," the letter said. Also, the letter asked for full funding of a program of the Environmental Protection Agency to screen and test hormonally active agents. To oversee these initiatives, the letter asks for the creation of a cross-agency committee that would include consumer representation.

Going beyond the text of the letter, Martin, executive director of Breast Cancer Fund, said the government must invest in "long-term prospective studies" to define suspected culprits.

"We completely concur with scientists who are creating the emerging knowledge about the question of contaminants on this disease and we also concur that research funding for this kind of work is insufficient," Martin said at a press conference on

Capitol Hill. "Women have the right to know the chemicals that we are carrying around in our breasts. Are our breasts becoming reservoirs for toxics? Is this why we are experience more breast cancer in our breasts than any other organs of our bodies?"

"Turn The Microscope Around"

It is traditional for proponents of the environmental causation to assert that the U.S. is "losing the war on cancer" because of the emphasis on treatment, as opposed to "prevention." In her remarks, Martin stayed faithful to that tradition.

"Thirty years and $35 billion into our war on all cancer, we still have no idea what causes the vast majority of breast cancer," Breast Cancer Fund's Martin said at the press conference. "The groups that have joined to speak with you today are joining together to raise their voices to say prevention is our best protection."

This assertion was followed by an attack on mainstream science: "Science has remained very focused on genes and molecules. And we are saying, you must turn the microscope around."

Rep. Nancy Pelosi (D-CA), said Congress has the responsibility to mandate "hot spot" studies similar to politically mandated studies of breast cancer incidence on Long Island and in the San Francisco Bay area, her district. "Scientists believe that all the answers are in the lab," Pelosi said at the press conference. "However, we want to be able to say that there is some empirical information—there is some coincidence—there is some reason for us to suspect that certain women in certain areas are affected disproportionately, and we want to know, is this a coincidence or is this something beyond that? And that takes money and a decision on the part of the government to go forward on that other track—other than the lab."

How will the answers emerge? Is anyone suggesting prospective trials of up to 75,000 chemicals separately, in combinations, or in their interaction with specific genes?

"No one said it would be easy," said Julia Brody, executive director of Silent Spring Institute, a partnership of scientists and citizens studying the links between the environment and women's health. "And while I salute the Komen Foundation, the recent tamoxifen trial cost $50 million. You can see that we are going to need a very substantial funding base to go forward with the large number of chemicals out there."

Brody's institute is monitoring the levels of 86 chemicals in 2,500 women on Cape Cod. "Yes, scientists would prefer to do it one at a time," Brody said. "But if we are going to do it one at a time, we are not going to get there by the time our granddaughters are grown up. So we believe it's very important to choose a broad range of chemicals for which there is a sound hypothesis and go through screening, find out which ones are most common in the environment, and begin to narrow them down."

Devra Lee Davis, an epidemiologist with the Washington-based World Resources Institute and a long-time proponent of the environmental causation hypothesis, said now is not the time to answer methodological questions.

"The bottom line here is that when this country makes a commitment, whether it is to put man on the Moon or to figure out how to get smoking out of our schools, we can do it," Davis said. "What this coalition is calling for is a national commitment. And that's the answer. We can't answer the methodological questions, which are very complex and challenging. But we know that we have to begin to ask them."

NCI Programs:

Institute To Plan Large Trial For Lung Cancer Screening

NCI officials said they will develop plans for a definitive study of a promising, but largely unproven method of lung cancer detection that is increasingly being marketed by hospitals and physicians.

The new technique, helical low-dose computed tomography scanning, also know as spiral CT scanning, can find smaller lung tumors than can be found with conventional chest x-rays. At a workshop sponsored by NCI last week and at a recent NCI advisory group meeting, experts expressed optimism about the technique and suggested that the Institute move forward on plans for a large randomized trial.

"We are quite a distance from launching such a trial, but the preliminary information suggests this could be promising, but also have potential harms," said Barnett Kramer, deputy director of the NCI Division of Cancer Prevention. "We've learned from previous experience in lung cancer screening trials where preliminary information did not bear out a benefit that we should be careful in dealing with lung cancer screening technologies."

Routine screening for lung cancer using conventional chest x-ray currently is discouraged

because randomized trials in the 1970s found that screened individuals did not live any longer than those in the control group, and screening resulted in complications and even deaths due to biopsy and treatment.

According to a study published earlier this year in The Lancet, researchers at Cornell Medical Center and McGill University found that spiral CT scanning detected malignant tumors while they were still in stage I.

The study of 1,000 asymptomatic smokers or former smokers age 60 or older subjected participants to spiral CT scanning as well as conventional x-ray. The new method detected lung nodules in 233 (23 percent) of the participants, while x-ray detected nodules in 68 (7 percent). Twenty-seven of the 233 CT positives were diagnosed as malignancies, compared to seven of the 68 chest x-ray positives. Of the 27 malignancies, 23 were diagnosed as stage I, while four were at later stages. Following surgery, none of the stage I patients had radiation or chemotherapy and have no further sign of disease. The four patients with later-stage disease have died, the study said.

At a meeting of the National Cancer Advisory Board in September, board members encouraged NCI to move ahead cautiously with plans for definitive studies.

"What I took from the NCAB meeting was a consensus that we shouldn't declare victory short of a randomized trial with mortality endpoints," Kramer said. "Also, because of the potential loss of a window of opportunity, we ought to be thinking about a trial sooner rather than later."

Christine Berg, acting chief of the NCI lung and upper aerodigestive cancer research group, said spiral CT scanning is available in 47 percent of all diagnostic imaging units in the U.S. Thus, like several cancer screening procedures, the scans could become widely used despite the lack of evidence of its ability to improve survival. The average cost of a spiral CT scan is $500, and is not covered by insurance plans, Berg said.

Berg said her group will develop a concept for a trial or trials for presentation to the NCI Board of Scientific Counselors. "The sentiment at the workshop was for a large trial," Berg said. "I think it would be reasonable to consider smaller steps first to assess spiral CT, to make sure we know the characteristics and get diagnostic algorithms worked out. But those issues remain to be determined."

Berg said she could not predict when a concept would be finalized. "These things always take longer than you expect," she said.

Science Policy:

All's Well In Patient Access To Clinical Trials, GAO Finds; NIH Says Report Is Flawed

In a report released earlier this week, the General Accounting Office said its investigators found no evidence of widespread limitations on patient access to clinical trials.

"Most health insurers we interviewed said they allow for coverage of trials in some circumstances, most cancer centers we interviewed reported no shortage of patients for trials, and NIH did not document significant trial enrollment problems," the report said.

The GAO conclusion that all is well is debated by NIH officials. Describing the report as methodologically flawed, NIH officials said GAO concentrated on gathering information on trials that continue to receive funding, excluding researchers who lost support because of failure to enroll patients in trials.

Failure to survey patients and assess barriers to physician participation also hampered the accuracy of the GAO conclusions, Lana Skirboll, NIH Director of Science Policy, wrote to GAO. "The report does not address the key question of whether patients receive adequate and timely information about clinical trials," Skirboll wrote in a letter dated Sept. 13.

Some plans monitor referrals to trials as part of evaluation of physicians' efficiency and provide financial incentives to increase the number of patients seen, Skirboll wrote. "Absent this data, there was no way of evaluating the impact of the health plan policies on physician referral to clinical trials," she wrote.

The GAO report, titled "NIH Clinical Trials; Various Factors Affect Patient Participation," was based on interviews with officials of 26 health plans and officials of 11 NCI-designated cancer centers. The document is available on the agency's web site, http://www.gao.gov/

In other highlights of the report:

—Insurers could be covering more clinical trials-related expended than they realize. "On the one hand, having to seek approval through a plan's review and appeals process and negotiating payment for standard

care in a trial may dissuade some patients and physicians from pursuing clinical trial opportunities," the report said. "On the other hand, because of the perceived obstacles associated with obtaining insurance coverage, some patients and physicians may submit claims without identifying the services as trial-related."

—Data do not support the claim that enrollment in clinical trials is declining. "Patient enrollment in the NIH-sponsored clinical trials for which we could obtain data appeared to be meeting the goals of those trials," the report said. "NIH does not have quantitative data that indicate that patient enrollment has slowed or that trials have been delayed or prematurely closed because of patient enrollment problems."

—Dealing with health insurers imposes a burden on cancer centers. "Paperwork requirements can be labor-intensive and time-consuming when staff physicians and nurses must document the necessity of enrolling each patient and negotiate the specific services and amounts to be paid as standard care," the report said.

—Many barriers are not related to reimbursement policies. "Community physicians may be unaware that clinical trial opportunities exist or lack the time and resources to evaluate candidates for trials," the report said. "Some patients may be unable to participate because of a trial's eligibility criteria or constraints on the patients' time and resources. For many other patients, uncertainty about the benefits and risks of experimental treatments can make clinical trials unattractive."

"This is a very difficult area to quantify," said Robert Comis, president of the Coalition of National Cancer Cooperative Groups and chairman of Eastern Cooperative Oncology Group.

Considering the difficulty of getting the payer's approval to put a patient on a clinical trial, physicians often have to give up on the idea. "It becomes easier not to worry about clinical trials than to put a patient on a clinical trial," Comis said to **The Cancer Letter**.

The coalition has been working with private insurers to convince them to pay for patient care in clinical trials. Two payers—Aetna/US Health Care and United Health Care Group—recently agreed to remove these obstacles to enrollment in trials.

"We are making much more progress on the private side than on the public side," Comis said. "[Health Care Financing Administration] is the most threatening and recalcitrant of the third party payers right now. We have one arm of the government—NCI—saying that increased enrollment in clinical trials is desirable, and we have the other arm that is becoming an increasingly feared obstacle."

The GAO report did not gauge the impact of HCFA's reimbursement policies on enrollment.

NIH Curriculum Series For K-12

NIH introduced a curriculum supplement series for grades kindergarten through 12 at the National Convention of the National Association of Biology Teachers last week in Ft. Worth, TX. NIH will distribute the series free to teachers.

The curricula will contain new information about medical discoveries being made at the NIH and their effects on public health. The first three supplements are designed for use in senior high school classrooms. Each comes with an interactive CD-ROM.

"Cell Biology and Cancer" (Collaborating institute: NCI); "Emerging and Re-Emerging Infectious Diseases" (Collaborating institute: National Institute of Allergy and Infectious Diseases); and "Human Genetic Variation" (Collaborating institute: National Human Genome Research Institute).

Three NIH scientists (Dinah Singer of NCI, Karyl Sue Barron of NIAID, and Alan Guttmacher of NHGRI) discussed recent discoveries related to the supplement topics at the conference.

The new curricula are among the first educational resources aligned with the National Science Education Standards released by the National Academy of Sciences in 1995. Three additional supplements with accompanying CD-ROMs or Web-based activities are planned per year.

Further information is available at http://science-education.nih.gov/supplements.

Funding Opportunities:

Program Announcements

PA: Flexible System to Advance Innovative Research for Cancer Drug Discovery By Small Businesses

Recent advances in all branches of medical sciences provide new insights into the underlying mechanisms in malignancy and suggest new targets and approaches for therapy. For example, key growth regulatory pathways are being delineated, genes mutated in cancer cells have been identified, array technology for expression of thousands of genes as well as computer-assisted evaluation of data are available, new technologies in chemistry allow facile synthesis of millions of new chemicals, and high resolution structures of important target proteins are becoming

available.

Application or translation of these discoveries into clinical benefit is a lengthy and costly process. Following initial discovery, efficacy testing and optimization, lead compounds must undergo a series of rigorous evaluations culminating with the clinical trial. The initiative will expedite cancer therapeutic development by small businesses by providing a flexible system for research support at all stages of drug and vaccine development including initial clinical trials.

The initiative will provide a flexible system regarding award time and costs within the Small Business Innovative Research and Small Business Technology Transfer programs to support the extensive and costly research for development of cancer drugs and vaccines from basic discovery to proof of principle in clinical trials.

Inquiries: George Johnson, Division of Cancer Treatment and Diagnosis, NCI, phone: 301 496-8783; email: johnsong@exchange.nih.gov

PAR-99-167: Specialized Program of Research Excellence in Human Cancer. Additional receipt dates for Prostate Cancer SPORE Applications

Letter of Receipt Dates: Feb. 1 and June 1, 2000, as well as on the previously announced date of Oct. 1, 2000. All other aspects of this PAR remain the same.

NCI gives a notice of inclusion of additional receipt dates for prostate cancer SPORE applications submitted in response to PAR-99-167, Specialized Program of Research Excellence in Human Cancer. This PAR appeared in the Sept. 23 issue of the NIH Guide for Grants and Contracts and can be accessed at the following URL: http://grants.nih.gov/grants/guide/pa-files/PAR-99-167.html

Inquiries: Jorge Gomez, Organ Systems Branch, Office of Centers, Training, and Resources, Office of Deputy Director for Extramural Science, NCI, Executive Plaza North, Suite 512, 6130 Executive Blvd., MSC 7386, Rockville, MD 20852-7386 (for express/courier Service)Bethesda, MD 20892-7399 (for U.S. Postal Service), phone: 301 496-8528; email: jg1w@nih.gov

PA-00-001: Aging Women and Breast Cancer

Participating Institutes of NIH invite research applications to focus on the problems of older women with breast cancer. The purpose of this broad-based program announcement is to expand the knowledge base on breast cancer in older women through studies in the fields of biology, clinical medicine, epidemiology, and the behavioral and social sciences.

Women 65 years and older have the highest cancer incidence and mortality rates. Of the 175,000 new breast cancer cases estimated for 1999, over 82,000 will be in women 65 years or older (American Cancer Society, 1999). Women in their mid-seventies and older are generally those most severely affected by breast cancer and are already quite likely to have preexisting chronic conditions.

The population-based epidemiologic evidence demonstrates the disproportionate number of older women afflicted with breast cancer. Yet there is insufficient information on biological mechanisms affecting the onset and progression of cancer in older women, recommended treatment, response of older women to cancer risks and symptoms, individual and family coping with breast cancer, and survival outcome (including quality of life). The problems of breast cancer and its association with advanced age have not been adequately addressed. Breast cancer prevention, early detection, and management in older women may be complicated by the presence of other diseases, age-associated problems, and risk factors. No comprehensive guidelines for prevention, diagnosis, pretreatment evaluation, or treatment have been formulated which take into account the multiple health problems and recurrent medical, economic, and social needs of women age 65 and older who survive breast cancer or are newly diagnosed with the disease. Although older women are less likely to engage in cancer prevention practices such as mammography screening, little research has promoted the development of strategies to improve either patient or physician behavior to encourage communication about cancer prevention. Sufficient data on the treatment of elderly women with breast cancer are not available from clinical trials.

The mechanisms of support will be the individual research project grant (R01), exploratory/developmental grant (R21), and the Small grant (R03).

Inquiries: For NCI—Robert Hawkins, Grants Administration Branch, NCI, Executive Plaza South, Room 243, Bethesda, MD 20892, phone: 301 496-7800 Ext. 213; fax: 301 496-8601; email: HawkinsR@gab.nci.nih.gov

CRFA Offers Fellowship Awards In Lung Cancer Prevention

Application Deadline: Feb. 1

The Cancer Research Foundation of America and the International Association for the Study of Lung Cancer announce the establishment of a fellowship program in lung cancer prevention. Three Lung Cancer Prevention Fellowships will be awarded at the next meeting of the IASLC, in Tokyo, Japan on Sept. 9-13, 2000. The two-year fellowships will be renewable for a third year. Funding for the fellowships is provided by unrestricted educational grants from Bristol-Myers Squibb Oncology and CRFA.

To be considered, the proposal of the applicant must address either primary or secondary prevention of lung cancer. The following will not be reviewed: basic science projects which have no impact on human lung cancer prevention; studies related to treatment or therapy; applications that do not include a layman's summary; applications received after the deadline. Pre-clinical research is acceptable, but it must be prevention oriented and clearly identifiable as translational. Fellowship support

should be requested by a principal investigator who applies on behalf of a designated candidate.

The second year of the fellowship is contingent upon receipt of a satisfactory progress report at the end of the first year. To ensure adequate exposure in the discipline of cancer prevention, CRFA and IASLC require fellows take one course per year in an area in which the candidate has not received prior training: biostatistics/research methods; epidemiology; health promotion; public health; or behavioral science. The name of this course, its location and a timeline for its completion must be included in the fellowship application.

Inquiries: For applications—IASLC, Executive Office, c/o Heine Hansen, The Finsen Center – 5072, National University Hospital, Blegdamsvej 9, DK-2100, Copenhagen, Denmark, phone: 45 3545 4090; fax: 45 3535 6906; e-mail: Fellowship@iaslc.org; website: http://www.iaslc.org

In Brief:

AACE Elects New Officers, Foley Receives Edwards Award

(Continued from page 1)

Vicksburg, MS. **Albert LoBuglio**, center director said the Martha Ann and David May Endowed Chair for Cancer Research will enable UAB to recruit nationally or internationally for an individual with clinical trials expertise in breast and prostate cancer. . . . **NEW OFFICERS** were elected and awards were presented at the 33rd meeting of the **American Association for Cancer Education** in Cleveland, OH. The new officers are: **Charles Kupchella**, president; **Richard Gallagher**, president-elect; **Robert Kuske,** vice president; **Phyllis Rideout,** treasurer; and **Virginia Krawiec**, secretary. **John Foley** received the Margaret Hay Edwards Award—the highest association honor— for his contributions to cancer education; **Douglas Weed** received the annual Samuel E. Harvey Lecture award; and **Robert Adams** was recognized, "for his achievements in support of cancer education and the development of new leaders and innovative programs." Adams retired last April from the NCI Cancer Training Branch as Program Director of the R25/Cancer Education Grant Program. In 2000, the AACE and the European Association for Cancer Education will jointly sponsor a meeting on Nov. 2-5 in Washington, DC. Abstract forms and information are available from the AACE homepage http://rpci.med.buffalo.edu/ or contact Virginia Krawiec—phone 404 329-7612; fax 404 321-4669; e-mail gkrawiec@cancer.org . . . . **JOEL NELSON** has been recruited as professor and chairman of a newly established department of urology at the University of Pittsburgh School of Medicine, as part of an initiative against prostate cancer. Nelson, former director of urologic oncology at Johns Hopkins Bayview Medical Center, will co-direct the UP Cancer Institute Comprehensive Prostate and Urologic Cancer Center. . . . **ARTHUR LEVINSON**, Genentech CEO, received the 1999 Corporate Leadership Award from the National Breast Cancer Coalition Oct. 28. The award recognized the successful partnership between Genentech and NBCC around the clinical trial for Herceptin, a treatment for metastatic breast cancer. . . .**COLD SPRING HARBOR LABORATORY** celebrated its 109-year history of science education at the inaugural convocation of the **Watson School of Biological Sciences.** The school is named for James Watson, who along with Francis Crick and Maurice Wilkins was awarded the 1962 Nobel Prize for the discovery of the double-helix structure of DNA. Watson was director of CSHL (1968-94) and currently serves as president. The curriculum of the CSHL Watson School is designed for a small and select group of candidates and structured to grant the Ph.D. degree after four years of intensive study, rather than the traditional five to seven years. The six students in the 1999 graduate class were chosen from an international pool of 130. At the inaugural ceremony, three scientists were awarded the Honorary Degree of Doctor of Science in recognition of their long associations with educational activities at CSHL. The three awardees are: **David Baltimore**, president of the California Institute of Technology; **Seymour Benzer**, James Griffin Bell Professor of Neuroscience at CIT; and **Gerald Fink**, director of the Whitehead Institute for Biomedical Research and American Cancer Society Professor of Genetics at the Massachusetts Institute of Technology. . . . **DAVID STUMP** has been appointed senior vice president of drug development and a member of the Operating Committee at Human Genome Sciences Inc. of Rockville, MD. Stump was vice president of clinical research for Genentech Inc. . . . **BENJAMIN LICHTIGER** was appointed chairman of the Department of Laboratory Medicine at M.D. Anderson Cancer Center, where he had been departmental chairman ad interim since 1998. Lichtiger directs the Section of Transfusion Medicine and the Blood Band at M.D. Anderson—one of the largest transfusion services in the nation, according to M.D. Anderson officials.

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