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South African Investigator Bezwoda Admits Falsifying Data In High-Dose Chemo Study

A South African investigator has admitted that he falsified data in a study of high dose chemotherapy and autologous stem cell transplant for the treatment of breast cancer. The study was presented in a plenary session at the annual meeting of the American Society of Clinical Oncology in Atlanta last May.

Following admission of scientific misconduct, Werner Bezwoda, a researcher whose studies contributed to a wide acceptance of the experimental breast cancer treatment, resigned as chairman of hematology and oncology at the University of Witwatersrand in Johannesburg.

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In Brief:

Three Win Medals Of Science For Biology; Social Worker, Survivor, Wins Professorship

NATIONAL MEDAL OF SCIENCE, the highest national science honor, administered by the National Science Foundation, will be presented by **President Clinton** at a formal White House ceremony March 14. The awardees in biological sciences are **David Baltimore**, professor of biology and president, California Institute of Technology, for discoveries in virology, molecular biology and immunology, for excellence in building scientific institutions, and in fostering communication between scientists and the general public; **Jared Diamond**, professor of physiology, UCLA School of Medicine, for applying Darwinian revolutionary approaches to the fields of physiology, ecology, conservation biology and human history, and for science communication; **Lynn Margulis**, distinguished university professor, Department of Geosciences, University of Massachusetts, for contributions to the understanding of the structure and evolution of living cells, and science teaching and communication. The awardees in chemistry are **Stuart Rice**, Frank P. Hixon, distinguished service professor, James Franck Institute, University of Chicago, for changing the nature of modern physical chemistry through research, teaching, and writing; **John Ross**, professor of chemistry, Stanford University, for physical chemistry, especially in molecular studies, statistical mechanics, nonlinear kinetics, and chemical science; and **Susan Solomon**, senior scientist, Aeronomy Laboratory, National Oceanic and Atmospheric Administration, for insights into the cause of the Antarctic ozone hole. . . . **HESTER HILL SCHNIPPER**, chief, Oncology Social Work, Beth Israel Deaconess Medical Center in Boston, has been appointed Hatcher Survivorship

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Control Group Received CNV, Not CAF, Bezwoda Admits

(Continued from page 1)

According to a statement by the university last week, other faculty have been assigned to oversee research Bezwoda was supervising. The university asked ASCO to withdraw the abstract of Bezwoda's study.

"This study is discredited and must not be used as a basis for further trials," Peter Cleaton-Jones, chairman of the university's Committee for Research on Human Subjects, wrote in a letter dated Feb. 3 to ASCO President Joseph Bailes.

"The control arm was not what it was purported to be," Cleaton-Jones wrote.

The fraud was discovered by four U.S. cancer clinical trials experts who visited Bezwoda last month to audit the results of his study, said Jeffrey Abrams, senior investigator in the NCI Cancer Therapy Evaluation Program.

The audit was arranged and financed by U.S. Oncology, a Houston-based physician practice management company that was considering collaborating with NCI and the clinical trials cooperative groups to conduct a confirmatory trial of Bezwoda's high-dose chemotherapy/stem cell transplant regimen, said ASCO President Bailes, who is also the executive vice president of the company.

"Prudence really dictated an audit, regardless of the findings," Bailes said to **The Cancer Letter**.

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"This was the only positive trial of the four presented at the ASCO plenary session."

The audit was proposed to NCI by U.S. Oncology investigators at a meeting Dec. 15, Abrams said. Institute officials approved of the audit, but were not involved in it, he said. Bailes said he was not directly involved in discussions of the audit.

"The auditors found major protocol violations that would have made some patients ineligible, and weren't allowed to see charts of patients on the control arm of the study," Abrams said to **The Cancer Letter**. "Those two findings made the entire study suspect. I also was told that the hospital's institutional review board did not approve the protocol."

The auditors are writing a paper on the findings for submission to a major scientific journal, sources said. The audit was led by Roy Beveridge, of Inova Fairfax Hospital, in Fairfax, VA, and Ray Weiss, of Rockville, MD.

The University of Witwatersrand officials that they are conducting an inquiry into the breast cancer study, and plan to audit all of Bezwoda's research.

"Foolish Desire" For Acceptance

Bezwoda's study was the only one of the four randomized trials presented at ASCO's prestigious plenary session that showed a statistically significant result in favor of HDC plus transplant over standard treatment.

In his presentation, Bezwoda said the study enrolled 154 women with high-risk primary breast cancer with 10 or more positive lymph nodes. Patients were randomized to either a standard regimen of cyclophosphamide, Adriamycin, and 5-FU (CAF), or the experimental treatment of cyclophosphamide, mitoxantrone, and VP16 with stem cell transplant (CNVp), Bezwoda said (**The Cancer Letter**, May 28, 1999; and Proceedings of ASCO 1999, Abstract #4).

In reality, Bezwoda said in a statement Jan. 30, the control group received a regimen of CNV.

"This was done out a foolish desire to make the presentation more acceptable to an audience who I believed would have regarded CAF as a more familiar and more standard control arm," Bezwoda said.

An earlier Bezwoda trial, published in the Journal of Clinical Oncology in 1995 (J Clin Oncol 13: 2483-2489), compared high-dose CNV with either autologous bone marrow or stem cell rescue to conventional-dose CNV as first-line treatment for metastatic breast cancer.

The results of that study played a major role in encouraging physicians, insurers, and, ultimately, women with breast cancer, to seek the transplant procedure.

In 1996, the Blue Cross and Blue Shield Association's Technology Evaluation Center said the Bezwoda study and a study at Duke University (Peters et al., Proceedings of ASCO 14:347, 1995) led to its recommendation that the insurance plans pay for the procedure as first-line therapy for women with metastatic breast cancer or as first treatment for metastatic disease that has recurred after a complete remission (**The Cancer Letter**, March 8, 1996).

Craig Henderson, senior medical advisor, ALZA Corp., of Mountain View, CA, was chairman of the panel that made the recommendation.

"Bezwoda's trial was a randomized, controlled trial by an investigator who had published extensively, and I accepted those two studies as less than ideal, but as evidence that we were moving in the right direction," Henderson said to **The Cancer Letter** last week. "Now to find that Bezwoda's study was falsified, obviously is very painful. I went out on a limb."

Henderson said he has previously visited Bezwoda in South Africa. "I had no reason to suspect that his papers were misleading or incorrect," Henderson said. "This comes as a shock."

Bezwoda's concern that U.S. oncologists would criticize his use of CNV as the control regimen was justified.

At last year's ASCO plenary session, Robert Livingston, professor of medicine and section chief, Division of Oncology, at the University of Washington, said Bezwoda's 1995 results represented a "new paradigm" for HDC that ought to be confirmed.

"Unfortunately, the standard regimen was not really a standard regimen," Livingston said at the session.

ASCO Review "Based On Trust"

Earlier this week, Livingston said Bezwoda's admission cast suspicion on the investigator's entire body of work in HDC for breast cancer.

"Like everyone else, I'm waiting for details on what actually happened in South Africa," Livingston said. "Now that we know there was falsification of data in the high-risk adjuvant trial, there will be doubts about the earlier study as well."

Proper statistical analysis was prominently missing in the 1995 paper and the 1999 abstract. Neither included p-values. However, unless there were prior suspicions about an investigator's work, the lack of statistical analysis would not necessarily prevent the presentation of an abstract, sources said.

"ASCO's peer review process for abstracts is consistent with the highest standards and is similar to review for journal publications," Bailes said. "I don't think anything fell down in the process. It is based on trust. We have to rely on the scientific integrity of individuals."

Bailes said he could not recall any instance of an entire clinical trial being discredited on the basis of scientific fraud.

"This is a very rare occurrence," Bailes said. "This is very disturbing."

"A Major Disservice" To Clinical Trials

The revelation about Bezwoda's study is particularly painful to investigators since it comes during the controversy over the death of a patient in a gene therapy clinical trial at the University of Pennsylvania (**The Cancer Letter**, Feb. 4). Even though the gene therapy trial was not for the treatment of cancer, the two developments may make patient recruitment difficult this year.

"It's not something to make everyone proud," said NCI's Abrams. "We are concerned about the one large intergroup trial we are supporting, SWOG 9623, comparing transplant to the Memorial Sloan-Kettering regimen for breast cancer for women with four or more nodes involved. It offers women at high risk with two modern, aggressive approaches." Scott Bearman, of the University of Colorado, is the principal investigator of the study.

The trial has accrued 523 patients and has a goal of 1,000, Abrams said. "Ever since the ASCO meeting, the accrual has been decreasing," he said. "Now more physicians and patients may be unwilling to consider participation, and we may never get a clear answer.

"[Bezwoda] could have done a major disservice to this trial and to clinical trials in general," Abrams said.

"This whole field has gone back and forth like a pendulum," Abrams said. "We couldn't get trials done in early 1990's because centers were springing up to offer transplantation outside of clinical trials, and we couldn't get trials done. We don't have enough clinical data to know whether it works or not.

"Physicians and patients ran to this too quickly

and too many transplants were done outside of trials," Abrams said. "Now the pendulum has swung in the other direction."

No Clear Direction For HDC In Breast Cancer

Bezwoda's admission of fraud is a major setback for investigators pursing the HDC approach for breast cancer, cancer trialists said this week.

"We are at a crossroads about what to do with high-dose chemotherapy in breast cancer," said Richard Schilsky, chairman of the Cancer and Leukemia Group B. "Most people would like to see more trials done, but it is not clear what direction to go in."

The time might be right to move on to explore other treatments for metastatic breast cancer, some investigators and patient advocates said.

"This was the last target of the BMT clinical trials advocates," said Robert Comis, chairman of the Eastern Cooperative Oncology Group. "We have to step back from that now and figure out how we can do new things."

Fran Visco, president of the National Breast Cancer Coalition, agreed. "I think it is time that the cancer community accepts that we now have the answer and that we need to move beyond the infrastructure created about ABMT's," she said in a Feb. 4 statement. "It is time to look at something better."

However, others said it's still too early to completely discredit transplantation.

"The fact that one investigator has falsified data has no bearing on the scientific merit of the question being investigated: whether high dose chemotherapy works in women with breast cancer," Livingston said. "That question still deserves an answer, and the 'negative' trials reported at ASCO are not definitive.

"The results were either reported too early to draw conclusions (William Peters' trial) or did not have a standard central arm (the Scandinavian trial), or dealt with a patient population where the expectation of benefit was already low (partial responders in the Philadelphia trial)."

Bailes agreed that the other trials require more time for analysis. "If a woman and her physician decide on transplantation, it should only be done in the context of a clinical trial," Bailes said. "It should be a carefully controlled trial, whether it is based at a single institution or federally-funded clinical trial at multiple institutions."

Comis said Bezwoda's admission should not reflect negatively on investigators outside the U.S. Many of the NCI cooperative groups conduct research with non-U.S. institutions. "This doesn't speak to the state of cancer clinical research in South Africa," he said. "ECOG has an exceptional site in Pretoria that has had consistent, impeccable records at every audit we've performed."

Text of Bezwoda's Statement

Bezwoda signed the following statement dated Jan. 30:

"I, W.R. Bezwoda, hereby acknowledge that I have committed a serious breach of scientific honesty and integrity in a presentation made at the American Society for [sic] Clinical Oncology meeting in May 1999.

"The abstract and presentation purported to describe the results of a clinical trial comparing CAF (control) to high dose CNVp (experimental) chemotherapy for the treatment of high risk breast cancer.

"The patients presented as having received CAF had in fact received a different chemotherapy regimen: namely CNV.

"This was done out a foolish desire to make the presentation more acceptable to an audience who I believed would have regarded CAF as a more familiar and more standard control arm. This misrepresentation was not for financial gain. No person or agency provided any inducement.

"I acknowledge my error and take sole responsibility.

"I apologize to the scientific community.

"I can only hope that this action will not bring the SA scientific community or the institutions or colleagues I have worked with into undeserved disrepute.

"I also hope that this action will not hamper the efforts of other investigators who continue to try to establish the value of high dose chemotherapy for the devastating disease that is breast cancer."

* * *

For further information, visit the following websites:

For ASCO, http://www.asco.org. For NCI, http://www.cancer.org or for clinical trials information, http://www.cancernet.nci.nih.gov. For the University of Witswatersrand, http://www.wits.ac.za. For the NBCC, http://www.natlbcc.org. For links to NCI-funded cooperative groups, http://ctep.info.nih.gov/relsites.htm.

The White House:

Fewer New Grants Funded Under President's Proposal

President Clinton's proposed $1 billion increase for NIH would require a decrease in new grant awards in fiscal year 2001, primarily due to the agency's increase in funding commitments over the past two years, according to budget documents the White House released earlier this week.

Under the proposed $18.8 billion budget for NIH, the Institutes would support the highest total number of grants in its history, 31,524 research project grants, compared to 31,287 this year.

However, the increase would fund 7,641 new grants, 1,309 fewer than the 8,950 new grants projected this year and 891 fewer than the 8,532 new grants NIH funded last year.

NCI would receive an appropriation of $3.505 billion, a 5.9 percent increase, under the White House proposal.

NIH plans to "restrain the growth of award and award size so as to control the growth of the commitment base and to avoid impeding our ability to undertake new initiatives," the Institutes said in a statement. NIH proposes to hold cost increases for existing grants at 2 percent over the current year. The Biomedical Research and Development Price Index is currently 3.6 percent.

"Based on the absolutely outstanding increases that we had in 1999 and 2000, we have built up a very large commitment base, and with this President's budget we will try to emphasize as best we can new and competing research grants within the limits," NIH Acting Director Ruth Kirschstein said at a Feb. 7 news conference.

"But many of the new technologies require large investments requiring funding mechanisms that are not always exactly the same as the traditional investigator initiated research grants," Kirschstein said.

The Presdident's budget proposal includes $43.3 million for the first phase of a new neuroscience center to be built on the NIH campus, and a commitment for $26 million for the center in FY2002.

Under the proposal, the Centers for Disease Control and Prevention would receive $3.5 billion, a $195 million, or 6 percent, increase. The Food and Drug Administration would receive $1.39 billion, a $163 million, or 13 percent, increase.

NIH budget tables are available at http://www4.od.nih.gov/ofm/budget/fy2001Pressbriefing.htm.

Breast And Cervical Cancer Treatment

The Administration proposal includes funding to extend Medicaid coverage of low-income women screened through the Centers for Disease Control Breast and Cervical Cancer Early Detection Program.

Although the cost of the program is uncertain, the Administration estimated that the program would need $220 million over five years to care for women who have no medical insurance but do not currently qualify for Medicaid.

The problem of the working poor women diagnosed through the CDC program first surfaced on Capitol Hill three years ago, as part of the legislative agenda of the National Breast Cancer Coalition.

While support for the legislation, called the Breast and Cervical Cancer Treatment Act, has been increasing over the years, this is the first time the measure has been included in the Administration's budget proposal.

White House support could prove to be what's needed to overcome apparent resistance from CDC.

At a Capitol Hill hearing last summer, the agency used admittedly sketchy data to state that 92 percent of women diagnosed with breast and cervical cancer initiated treatment. At the same hearing, the Susan G. Komen Foundation expressed "concern" about the bill (**The Cancer Letter**, July 23, 1999).

"This is a huge victory for women living with breast cancer and all women," said NBCC President Fran Visco. "With this announcement and the strong support of Congress and the Administration, I am confident we can move this bill quickly through the process and make this life-saving treatment available to women as soon as possible."

Letter to the Editor:

Boy Has Little Chance At Cure Without Proven Treatments

Re: "Republican Contenders Slam FDA Decision In Care Of Boy With Treatable Brain Tumor," **The Cancer Letter**, Feb. 4.

The central issue is whether parents should be allowed to enact decisions that jeopardize the welfare of their child. When parents make a mistake, despite their best intention, that will lead to needless suffering

or a preventable death, should society not protect the child? Our national history has many examples of parents' actions or lack of action based on religious or philosophical beliefs that have led to preventable deaths in their children. From centuries of experience, our society has determined that our government has a right to protect these children until they are mature enough to decide for themselves.

The child in question, a four-year-old, has a medical condition in which the *society-versus-parents* issue is clear. Current outcome data indicate that this child has a 70-95% chance of being cured with standard therapy, including surgery, chemotherapy and radiation (J Clin Oncol 17:2127-36, July 1999), and virtually no chance at cure, certainly less than 20%, if any two of these treatments are not provided. If the parents decide against both radiation and chemotherapy, they will risk a very high likelihood that their son will not survive beyond early childhood.

This dramatic improvement in survival has occurred at the cost of side effects, both during and after treatment, that are often severe. On the other hand, most children treated with surgery and chemotherapy have little to no permanent adverse neurologic sequelae as a result of the treatment. For example, we have published the long-term results of children with brain tumors in the same location as the child in question but all of whom were younger (less than 3 years of age) (J Clin Oncol 17:3476-86, November 1999). Among those reported are 20 children treated with surgery and chemotherapy. At an average of six to seven years after treatment, the academic and IQ scores are the same as in normal children, despite being treated as such a young age.

We know that radiation doses required to cure children with brain tumors are neurotoxic, particularly in children less than 3 years of age. In our study (ibid.) and in the most recent report (J Clin Oncol 17:3720-8, December 1999), this well known fact is further documented. In older children, however, the neurologic sequelae are clearly less and the older the child the less it is. With lower doses of radiation that we can now safely use *because* of the anti-tumor effectiveness of chemotherapy (J Clin Oncol 17:2127-36, July 1999), we expect that the neurologic morbidity will be significantly less than in the past. Early results support this prediction (Int J Radiat Oncol 34:889-904, 1996).

I read a letter posted on a public website about this child that Rep. Dan Burton, chairman of the House Committee on Government Reform, wrote to the FDA Commissioner. I disagree with the statement in that letter that the parents have "determined, based on published scientific journal articles, that giving their four-year-old son chemotherapy or radiation would cause him irreparable harm and most probably cause him to be deaf, brain damaged, or to have leukemia."

The peer-reviewed medical literature that I have reviewed for the past 30 years, my own experience in treating children with brain tumors and that of my colleagues in the Children's Cancer Group throughout North America, indicate to me that standard brain tumor chemotherapy in a four-year-old is not likely to make the child deaf, brain damaged, or have leukemia. These unfortunate sequelae can occur, but are not likely. The child may sustain decreased hearing from one of the drugs used in some patients with brain tumors, but deafness *per se* is infrequent. Chemotherapy-induced brain damage or leukemia is even less common. Brain radiation before age four frequently causes some brain damage, but becoming deaf or developing leukemia is not probable.

What is probable without chemotherapy and radiation is premature death, and the longer these treatment modalities are delayed, the more likely the cancer will be fatal.

Archie Bleyer

University of Texas M. D. Anderson Cancer Center, Houston; Chairman, Children's Cancer Group

Funding Opportunities:

NCI Program Announcement

PA-00-047: Quick-Trials for Novel Cancer Therapies

Letter of Intent Receipt Date: One month prior to application receipt date

Application Receipt Dates: April 9, Aug. 9, Dec. 9 through Aug. 9, 2002

The Quick-Trial program was published as a pilot program in prostate cancer. The PA, sponsored by NCI and the National Center for Complementary and Alternative Medicine expands the initiative to all cancer sites and provides investigators with rapid access to support for pilot, phase I, and phase II cancer clinical trials testing new agents and patient monitoring and laboratory studies to ensure the timely development of new therapeutic approaches. Quick-Trial will provide a new approach designed to simplify the grant application process and provide a rapid turnaround from application to funding. Features include a modular grant application and award process, inclusion of the clinical protocol within the grant application, and accelerated peer review with

the goal of issuing new awards within five months of application receipt. Investigators may apply for a maximum of two years of funding support using the exploratory/ developmental R21 grant mechanism for up to $250,000 direct costs per year.

Inquiries: Diane Bronzert or Roy Wu, Program Directors, Cancer Therapy Evaluation Program, Division of Cancer Treatment and Diagnosis, NCI, Executive Plaza North, Room 734, Bethesda, MD 20892, phone 301- 496-8866; fax 301-480-4663; e-mail: db85g@nih.gov or rw51j@nih.gov

NCI RFP Available

RFP N01-CN-85092-41: Master Agreements

Receipt Date: April 1, annually

The NCI Division of Cancer Prevention, Chemoprevention Branch, will award Master Agreement contracts for the study entitled, "Evaluation of Chemopreventive Agents by In Vivo Screening Assays." Pursuant to the Statement of Work the contractor shall conduct in vivo screening studies in small rodents using gavage and other routes of administration to administer the designated chemopreventive agents in animal models using any carcinogenic mechanism, such as the administration of carcinogens, promoters, hormones, irradiation, cells or other carcinogenic agents. Agents to be tested are potentially hazardous. The animal model systems also involve the use of carcinogens. Laboratory practices shall be employed which will keep any element of risk to personnel at an absolute minimum. Where indicated, tissue and compound handling must be performed in Class I laminar flow agents.

It shall be required that the animal facilities be maintained in accordance with the NIH Guide for the Care and Use of Laboratory Animals, the Animal Welfare Act as administered by the USDA, and the U.S. Government Principals for Utilization and Care of Vertebrate Animals Used for Testing Research and Training. The contractor shall have all the equipment necessary to accomplish the studies including but not limited to animal racks and caging, hazardous chemical storage cabinets and refrigerators, pathology equipment such as microscopes and microtomes and miscellaneous laboratory equipment. The laboratory shall have or have access to appropriate terminal and computer facilities and equipment for data collection and storage.

Since Master Agreements are un-funded, the obligation of funds shall be accomplished solely through the award of contracts. This research will be performed under cost reimbursement and/or fixed price contracts. It is estimated that four (4) to five (5) contracts will be awarded per year. Any MA awarded as a result of this solicitation will be in effect from the effective date to February 28, 2003.

Inquiries: Susan Hoffman, Contracting Officer, NCI, RCAB PCPSS, 6120 Executive Blvd., Executive Plaza South Suite 635, Rockville, MD 20852, phone 301-435-3799; fax 301-402-8579; e-mail sh191h@nih.gov.

NIH Notice: Nanoscience and Nanotechnology Grant Applications: The NIH Bioengineering Consortium (http://grants.nih.gov/grants/becon/becon.htm) encourages applications for research in nanoscience and nanotechnology as related to 1) development of new research tools for elucidating biological principles essential for design and implementation of nanostructured materials in biomedicine and 2) transfer of nanotechnology advances in other fields of science and engineering to develop new ways to prevent, detect, diagnose, and treat disease.

Inquiries: Jeffery Schloss, Division of Extramural Research, National Human Genome Research Institute, Bldg. 31 Room B2B07 MSC 2033; Bethesda, MD 20892-2033, phone 301-435-5538; fax 301-480-2770; e-mail: jeff_schloss@nih.gov.

DFCI Puts The Cancer Letter On Its Intranet For Employees

Dana-Farber Cancer Institute has contracted with The Cancer Letter Inc. to provide Dana-Farber employees access to **The Cancer Letter Interactive** on the cancer center's new intranet site, "DFCIonline."

The site license agreement will enable all DFCI employees to read **The Cancer Letter Interactive** online or print out copies. **The Cancer Letter Interactive** is published on Fridays, 46 times a year, and includes the same content as **The Cancer Letter** paper edition.

DFCI has about 1,950 employees, 559 of whom are MDs and PhDs.

DFCI is the first cancer center to provide **The Cancer Letter Interactive** to all employees, said Editor and Publisher Kirsten Boyd Goldberg. "Top officials of cancer centers have been among our most long-term subscribers," Goldberg said. "This agreement with DFCI is an exciting opportunity to broaden our readership to all cancer center staff interested following the fast-moving developments in national cancer policy and research funding, patient advocacy, cancer care, and the pharmaceutical industry."

Existing subscribers to **The Cancer Letter** at DFCI have the option of continuing to receive their personal subscriptions.

The Cancer Letter is in its 26th year of publication. The Interactive version was begun in 1998.

In Brief:

Foti Receives Del Duca Award; Wake Forest To Hire 60 Faculty

(Continued from page 1)

Professor. The award is sponsored by the Susan G. Komen Breast Cancer Foundation and carries a $20,000 one-year honorarium. Schnipper, a breast cancer survivor, oncology social worker and author, said she plans to use the support to write about survivorship issues. . . . **MARGARET FOTI**, chief executive officer of the American Association for Cancer Research, was awarded the Cino del Duca Oncology Award at the Hall of Battles, Versailles Palace, on Feb. 4, in conjunction with the 10th International Congress on Anticancer Therapy in Paris. Foti was honored for her "outstanding work in raising public consciousness in the support of cancer research, treatment, and prevention." The award is presented annually to individuals who have made exceptional contributions to oncology. Foti joined AACR as an editorial assistant in 1965. . . . **WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE** will hire more than 60 new faculty members in five research areas as part of a $67 million research initiative. New faculty will conduct research in genomics, cancer, pulmonary diseases, diabetes and complimentary medicine. Wake Forest has established a Center for Human Genomics to support research in heart disease, cancer, diabetes, pulmonary diseases, drug abuse, alcohol abuse, women's health and aging. . . . **G&P CHARITABLE FOUNDATION FOR CANCER RESEARCH** has funded $1.4 million in research grants to eight young medical researchers in the U.S. The Medical Research Awards are given for conventional and integrative research into the prevention and treatment of cancers of the blood. G&P appointed the following individuals to its expanded medical advisory board: **Stephen Nimer**, **Sidney Winawer**, **Cheryl Willman**, **Jerome Groopman**, **Rainer Storb**, **Ronald Levy**, **Curt Civin**, and **Janet Rowley**. . . . **M. D. ANDERSON** Cancer Center received a $2 million grant to establish a Telehealth Center, expected to open this fall. The grant, by the SBC Foundation, parent company and philanthropic arm of Southwestern Bell, will enable the center to use dedicated information technologies to support telemedicine and distance learning activities for health professionals and the public. . . . **DAVID GERSHENSON**, a 20-year M. D. Anderson Cancer Center faculty member, was appointed chairman of its Department of Gynecologic Oncology. He serves as principal investigator of the M.D.Anderson Gynecologic Oncology Group, as co-principal investigator, with **Robert Bast**, of the NCI $10 million Specialized Program of Research Excellence grant in ovarian cancer and as principal investigator of a four-year $ 1.2 million grant from the Department of Defense to study the chemoprevention of ovarian cancer. Gershenson will continue to direct the M.D. Anderson Blanton-Davis Ovarian Cancer Research Program, which he helped establish in 1996. . . . **UNIVERSITY OF PITTSBURGH** Medical Center and University of Pittsburgh Cancer Institute were awarded a $800,000 grant from the Commonwealth of Pennsylvania to fund a prostate cancer awareness initiative. The Comprehensive Prostate Cancer Awareness Program will have three components: public education, professional education, and a component that designs informational tools and methods to help at-risk men deal with diagnosis and treatment. . . . **SIDNEY KIMMEL CANCER CENTER** of San Diego received funding from the Sidney Kimmel Foundation to buy land to expand the center to a four-building, 200,000 square foot campus over the next 10 years, center director **Ivor Royston** said. . . . **PEGGY McCARTHY,** founder of the Alliance for Lung Cancer, resigned as volunteer executive director. McCarthy will remain active as a member of the ALCASE board of directors. **Betty Lane** and **Nadine Jelsing,** were named co-interim executive directors. . . . **NATIONAL ACADEMY OF SCIENCES** has selected individuals who will be honored May 1 for their outstanding contributions to science. **K. Barry Sharpless**, W.M. Keck Professor of Chemistry, Scripps Research Institute, will receive the award in chemical sciences. The award in molecular biology goes to **Patrick Brown**, associate investigator, Howard Hughes Medical Institute, and associate professor, Department of Biochemistry, Stanford University School of Medicine. **Charles Stevens**, investigator, Howard Hughes Medical Institute, and professor, Salk Institute for Biological Studies, will receive the award for scientific reviewing. The two recipients of the Troland award for research in experimental psychology are **Elizabeth Gould**, assistant professor, Department of Psychology, Princeton University, and **Earl Miller**, associate professor, Department of Brain and Cognitive sciences, Massachusetts Institute of Technology.

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