THE CANCER LETTER INTERACTIVE

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The Meeting Worth Lobbying For: A "PRG" For Disease-Specific Review; NCI Plans Six

The must-have meeting in cancer patient advocacy is not necessarily a tête-à-tête with NCI Director Richard Klausner.

A meeting with Klausner is only the second step toward a more important goal. (The first step is a meeting with Deputy Director Alan Rabson, but more on that later.)

The prize coveted by many patient advocates, the meeting that's worth lobbying for, the meeting that could get a disease on the map is:

A Progress Review Group.

(Continued to page 2)

In Brief:

Dana-Farber Picks Rosenthal To Direct New Center For Integrated Therapies

DAVID ROSENTHAL, past president of the American Cancer Society and director and CEO of Harvard University Health Services, was appointed medical director of Dana-Farber Cancer Institute's new Leonard P. Zakim Center for Integrated Therapies. Rosenthal said the Zakim's Center's mission and focus is in close alignment with his role as chairman of the Alternative and Complementary Methods of Cancer Management Advisory Committee for ACS. The Center was named for Dana-Farber supporter and former executive director of the New England region Anti-Defamation League, Lenny Zakim, who died last December of multiple myeloma. The center is expected to open in the fall. Rosenthal is a professor of Medicine at Harvard Medical School and a senior physician at Brigham and Women's Hospital, Dana-Farber, and Beth Israel Deaconess Medical Center. . . . **AMERICAN SOCIETY FOR BLOOD AND MARROW TRANSPLANTATION** presented awards to the following individuals: **George Santos**, expert in blood and marrow transplantation, founder in 1968 of the Johns Hopkins Bone Marrow Program and engineer of clinical strategies that are now standard-of-care in the field, received the Lifetime Achievement Award; **Susan Stewart**, Blood and Marrow Transplant Newsletter founder and director of the Blood and Marrow Transplantation Network, received the ASBMT Public Service Award; **Robert Good**, professor of pediatrics and Distinguished Research Professor at University of South Florida College of Medicine and physician-in-chief at All Children's Hospital in St.

(Continued to page 8)

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NCI Starts A New PRG Every Three Months, Klausner Says

(Continued from page 1)

A PRG is not just a meeting, it's a series of meetings of experts and advocates who review NCI's research portfolio in specific cancers and develop recommendations for making progress against the disease.

Advocacy groups see the PRG as a highly visible way to press for more attention and funding for "their" cancer. Some groups have lobbied Congress to persuade NCI to start PRGs. Members of Congress have written letters to Klausner requesting specific PRGs.

"The PRG planning process has become institutionalized to the point where Congress asks us to do PRGs," Klausner said to the NCI Board of Scientific Advisors at its meeting this week.

All this attention for a souped-up version of an advisory committee?

NCI makes funding decisions based on PRG reports, implementing most of the recommendations, Klausner said. Investigators can respond to PRG reports with research proposals, much as they would respond to a program announcement indicating NCI's funding interests.

Congressional interest in PRGs could be the ultimate measure of success for a process that began as a way to guard against earmarking of NCI appropriations for disease-specific research. At a time when Congress considered setting aside chunks of the budget for breast and prostate cancer in response to pressure from cancer patient advocates, NCI responded by demonstrating that it had what Institute officials said were painstakingly developed, consensus-based, scientifically valid plans for research in the two diseases (**The Cancer Letter**, Feb. 26, 1999).

The Progress Review Groups began as a logical extension of Klausner's preferred method of strategizing for the cancer program:

Invite 20 to 30 prominent scientists, clinicians, and patient advocates in the field, put them in a conference room for several days and ask them to figure out what needs to be done. The cost is minimal, the buy-in potential is great, and the advice may not be too bad either.

The first PRG reports, in breast and prostate cancer, were completed in 1998. Last May, the Colorectal Cancer Progress Review Group submitted its report to NCI.

The PRG reports are online at http://planning.cancer.gov.

Six PRGs Planned Or Underway

Judging from NCI's schedule for new PRGs over the next year, advocates have been busy. NCI has begun three new PRGs since last November—one group combining leukemia, lymphoma and myeloma, and groups in brain tumors and pancreatic cancer. These PRGS have held their first few meetings and are expected to send their recommendations to the Institute later this year or early next year.

Three more PRGs are scheduled to begin over the next nine months, in lung cancer, gynecologic cancers, and kidney and bladder cancer.

"We start one every three months now," Klausner said to the BSA at its June 22 meeting.

To further "institutionalize" the PRG process, Klausner said the Institute plans to develop ways to link the PRG process to the NCI Bypass Budget, which describes scientific opportunities.

"We are working on ideas or plans for how we turn this from the production of a [PRG] report to an ongoing process of reporting and monitoring of what we've done, as well as continuing discussion with the PRG to figure out how things changed," Klausner said to the BSA. "We need to develop some ideas so this doesn't feel like a one-time [report]."

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Founded Dec. 21, 1973, by Jerry D. Boyd

Cherie Nichols, head of the NCI Office of Science Planning and Assessment, leads this effort.

As for the meeting with Rabson: It's mandatory, sources said.

Rabson, a 45-year veteran of NCI, meets regularly with advocacy organizations to discuss their concerns. These discussions have often led to the formation of PRGs. Toward the end of these meetings, Klausner makes an appearance.

PRG Chairmen Appointed

The chairmen of the Lymphoma-Leukemia-Myeloma group are Riccardo Dalla-Favera, College of Physicians and Surgeons, Columbia University; Bart Barlogie, director of the Arkansas Cancer Research Center; and Clara Bloomfield, director of the Comprehensive Cancer Center and deputy director, at James Cancer Hospital and Research Institute at Ohio State.

Co-chairmen of the Brain Tumor PRG are David Louis, of Dana-Farber Cancer Institute, and Jerome Posner, of Memorial Sloan-Kettering Cancer Center.

Co-chairmen of the Pancreatic Cancer PRG are Scott Kern, of Johns Hopkins Univeristy School of Medicine, and Margaret Tempero, of University of California, San Francisco.

Science Policy:

New Office For Protection Of Research Subjects Formed

The Department of Health and Human Services has established a new office to lead efforts for protecting human subjects in biomedical and behavioral research.

The Office for Human Research Protections, in the office of the Assistant Secretary for Health, replaces the Office for Protection from Research Risks, which was part of NIH and had authority over NIH-funded research.

Edward Greg Koski will serve as the first director of the OHRP, the department said earlier this month. Koski is director of human research affairs at Partners HealthCare System Inc., of Boston, and associate professor of anesthesia at Harvard Medical School. At Partners HealthCare, Koski oversees patient protection for research conducted at a consortium of institutions including Massachusetts General Hospital, Brigham and Women's Hospital, and their joint venture with the Dana Farber Cancer Institute, as well as several Partners-affiliated community hospitals and physician practices.

"Dr. Koski is a national leader in today's renewed efforts to assure that patients taking part in research are better protected and fully informed," HHS Assistant Secretary for Health and Surgeon General David Satcher said. "The new office will have increased resources and broader responsibility, and we will look to it for leadership in articulating our goals for protecting individuals who volunteer to participate in research."

The new office will provide leadership for all 17 federal agencies that carry out research involving human subjects under a regulation known as the Common Rule.

HHS also plans to charter a new National Human Research Protections Advisory Committee, to provide broad-based counsel on patient protection and research needs. A Federal Register notice will solicit nominations for the new 12-member committee, which was a recommendation made last year by the Advisory Committee to the Director of NIH.

The new OHRP will focus entirely on protection for human subjects, while treatment for animal subjects will be overseen separately by a new Office of Laboratory Animal Welfare at NIH. The OPRR had been responsible for both human and animal subjects.

Taking over from OPRR, the new OHRP will monitor programs for the protections of human subjects at more than 4,000 HHS-funded universities, hospitals and other medical and behavioral research institutions in the U.S. and abroad. These programs must meet the requirements of HHS regulations for the protection of human research subjects and comply with the assurances that the institutions must have approved by HHS as a prerequisite for funding.

The OHRP will also work with NIH and the Food and Drug Administration to carry out new patient protection initiatives. These include:

—New efforts to educate and train clinical investigators and members and staff of the Institutional Review Boards

—New guidance and procedures on informed consent for patients and volunteers in research

—Improved monitoring by researchers, sponsors and FDA to ensure safety

—Clarification of existing policies on potential conflicts of interest affecting researchers, and development of updated policies.

NIH last week released two new guidelines and a set of issues for investigators and IRBs to consider on financial conflict of interest and research objectivity. One of the new guidelines requires that clinical researchers seeking NIH funding certify that they have taken special training in the ethical conduct of clinical research, and the other requires researchers applying for grants to conduct phase I and phase II clinical trials to send their clinical trials monitoring plans to NIH. Each of the documents is available on the NIH website at http://grants.nih.gov/grants/oer.htm.

Under the new OHRP structure, FDA retains its enforcement authority to ensure that researchers carrying out FDA-authorized drug and medical device clinical trials are complying with HHS patient protection and consent requirements. The new organizational structure will enable more effective coordination of HHS-wide policies and actions, Satcher said.

"With strong leadership and coherent policy guidance for all HHS agencies, researchers will get a single set of messages, they will understand their responsibilities better, and they will understand they are being held more closely accountable," he said.

HHS Secretary Donna Shalala said she will seek new authority for FDA to levy civil monetary penalties of up to $250,000 per clinical investigator and up to $1 million per research institution in the event of violations of patient protection agreements. No financial penalties are currently available to FDA for such violations, although the agency can issue warning letters and take action to halt research until problems are rectified.

In another development, the HHS Inspector General released three reports on June 12 on protections for human subjects in clinical research.

Two of the reports address the recruitment of subjects in industry-sponsored clinical trials. The reports conclude that pressure for investigators to recruit subjects can lead to problems with informed consent, patient confidentiality, and eligibility for enrollment. Oversight of recruitment methods is limited, the reports say.

The third report examines FDA's oversight of clinical investigators. The study found that this system does not provide day-to-day oversight of clinical trials and is not intended to do so. Rather, it provides a retrospective review, after trials are completed.

The reports are available at http://www.hhs.gov/oig/oei/whatsnew.html.

Cancer Research:
Marijuana Ingredient Promotes Tumor Growth, Study Finds

Researchers report in the July issue of the Journal of Immunology that tetrahydrocannabinol (THC), the major psychoactive component of marijuana, can promote tumor growth by impairing the body's anti-tumor immunity system.

While previous research has shown that THC can lower resistance to both bacterial and viral infections, this is the first time that its possible tumor-promoting activity has been reported.

A team of researchers at the Jonsson Comprehensive Cancer Center at University of California, Los Angeles, found in experiments in mice that THC limits immune response by increasing the availability of two forms (IL-10 and TGF-ß) of cytokine, a potent, tumor-specific, immunity suppresser.

The authors also suggest that smoking marijuana may be more of a cancer risk than smoking tobacco. The tar portion of marijuana smoke, compared to that of tobacco, contains higher concentrations of carcinogenic hydrocarbons, including benzapyrene, a key factor in promoting human lung cancer. Marijuana smoke deposits four times as much tar in the respiratory tract as does a comparable amount of tobacco, thus increasing exposure to carcinogens.

"What we already know about marijuana smoke, coupled with our new finding that THC may encourage tumor growth, suggests that regular use of marijuana may increase the risk of respiratory tract cancer and further studies will be needed to evaluate this possibility," said Steven Dubinett, head of the research team that conducted the study.

The UCLA researchers examined the effects of THC on the immune response to lung cancer in mice. Over a two-week period, the animals were injected four times per week with either THC or a saline solution. Fourteen days after the injections were started, murine Lewis lung cancer and line 1 alveolar cell cancer cells were implanted in the mice. The mice continued to receive THC or saline injections after the tumor cells were implanted, and tumor growth was assessed three times each week. To test the hypothesis that THC impairs tumor-specific immune system response, a group of mice with compromised immune systems was also studied.

The researchers found that in the mice with normal immune systems there was significant

enhancement of tumor growth, but THC had no effect on tumor growth in the immunodeficient mice. The study also showed that when lymphocytes from the THC-treated mice were injected into untreated mice, the immune deficit was transferred and tumor growth was accelerated in the normal controls.

The study also demonstrated that when anti-IL-10 and anti-TGF-ß were administered, there was no acceleration of tumor growth in THC-treated mice. These results suggest that enhanced tumor growth is prompted by THC's ability to stimulate production of IL-10 and TGF-ß, which inhibits anti-tumor immune response.

The research was funded by the National Institute on Drug Abuse.

Letter to the Editor:

Cvitkovic Responds To Story On March ODAC Meeting

I found myself quoted both out of context and in partially inaccurate form in your interesting March 24 issue regarding the oxaliplatin and CPT-11 discussion at the FDA Oncologic Drugs Advisory Committee. Having been implicated as a clinical research expert, investigator, and a consultant for both these agents, and committed to their combination from the preclinical to the clinical development stages, I feel entitled to a brief comment.

Regarding the quotes, I feel that portraying me as "shouting" when I was talking to Dr. Steven Hirschfeld, the FDA reviewer, in the presence of Professor Misset and a third party is inappropriate. Moreover, Dr. Richard Schilsky made public my private remarks to him, and thus deflected the fact that the ODAC has no will or power to bypass the FDA's liturgical and rhetorical stranglehold. The ironic meaning of my remarks to him has been thus lost, as my deep disappointment on the ODAC's hearing result regarding oxaliplatin, a remarkably effective anticancer agent in this indication.

A careful "by the book" U.S. development of CPT-11 resulted in its approval recommendation on the same day in previously untreated advanced CRC patients (combined with 5FU/LV), strengthened in a major way by the European studies.

I congratulate the U.S. and European investigators and licensees of this agent, and I'm very happy for the U.S. patients who will benefit from its efficacy.

Oxaliplatin, on the other hand, has suffered from its sequential multiple sponsors/licensees, its long-time geographical confinement, and its historically "upside down" development sequence.

The first impressive data on its efficacy were obtained over 10 years ago with a chronomodulated combination of oxaliplatin with 5FU/LV, followed by the same association within the 48 hours hybrid bolus/infusional 5FU/LV regimen developed by A. de Gramont et al. The early experience was thus limited to a few French institutions. Single agent activity/safety data and the pharmacologic and preclinical data on its pharmacodynamic synergy with 5FU, necessary for scientific and regulatory purposes were obtained post facto.

The two first line multicentric phase III trials conducted with third party verified PFS as the main time related endpoint were done on a European accrual platform, with 5FU/LV delivered by a five-day chronomodulated infusion or as the LV5FU2 de Gramont regimen. They were acceptable for a decentralized European NDA approval in the same indication that was refused at the ODAC hearing, which followed the French registration in previously treated CRC patients two years afore. This agent has proven active and safe with a variety of other 5FU/LV regimens. European and South American prescribers have had several years advantage in its use, with thousands of CRC patients having the longest time related progression / available parameters to date both in first line and in 5FU pretreated patients. The prevalence of crossover oxaliplatin use (and to some extent CPT-11) in the second and third line treatment of patients in the control arms resulted in overall survivals in excess of 15 months in both arms of both studies (the best ever reported in multicentre large CRC trials), pointing to the undiluted efficacy of the oxaliplatin- 5FU/LV combination in both pretreated and untreated CRC patients. All this was part of material submitted to ODAC and available for review.

The PFS main endpoint in European phase III trials of both oxaliplatin and CPT-11 was a clinically relevant ethical imperative, since oxaliplatin and CPT-11 were already available in some countries where the trials were conducted, both agents being proven active in the 5FU pretreated patients. The limitation to access of active second line treatment in first line controlled trials, or the imposition of sub-optimal (but obviously valid from a regulatory agency point of view) control treatment arms has serious ethical implications. I dwell on this because absence of

equipoise is a major problem in controlled trials. Dr. Starzl has addressed this regulatory driven problem a few years ago (The Lancet, Vol. 346, pp 1346-50, 1995), albeit outside oncology, where examples of nonsensical pivotal controlled trials with an exclusive regulatory aim also abound.

The oxaliplatin ODAC hearing outcome is due to a series of circumstances where everybody shares some responsibility. The lack of effective transduction to the FDA regulators and ODAC members of the historical and clinical context of its development is a key element of the ODAC fiasco.

Contacts between the sponsor and the FDA were done over the years without the participation of the European investigators and opinion leaders familiar with its use, while an enormous amount of intellectual and regulatory energy was spent in discussions trying to define the best associated 5FU/LV regimen (an insolvable, byzantine, and non-relevant issue), with the FDA defending the obsolete, now acknowledged toxic and sub-optimal Mayo Clinic regimen, being the up to now official U.S. prescription and regulatory reference in CRC treatment.

The oxaliplatin saga is a dramatic evidence of the cultural, functional, and structural difference between regulatory standards for anticancer agent approval between Europe and the U.S. The need for European data in European NDAs is nowhere near the implicit "only U.S. (or North American) data for U.S. NDA approvals" the FDA requires.

I point out both the remarks of Dr. Richard Simon of NCI during the ODAC meeting, casting doubts on the trial randomization process validity and transparency, and Dr. Kathy Albain's comment/question regarding European standards of informed consent. Although well intentioned, they reveal the problems in credibility of non-U.S. clinical research, even when in compliance with GCP standards.

After a brilliant career as an oncologist specializing in early development and Gastrointestinal Oncology, Dr. Richard Pazdur recently joined the FDA as director of the Oncology Drug Products Division. He is, nevertheless, to be excluded from policy and decision making whenever drugs or companies he has had an interest as an investigator/consultant come forward in the NDA process. Everybody that has an academic or investigator's career in the past years has worked with and/or for the industry, because that is where nowadays the progress comes from. Depriving the NDA process from somebody that understands the present context of oncological clinical issues and needs for the sake of political correctness will not help U.S. cancer patients gain access to the many upcoming therapeutic possibilities and, sadly, will make Dr. Pazdur operational only when his experience becomes obsolete.

Your article shows that the focus of the ODAC and post-ODAC discussion has already shifted to what is to be an adequate/current/valid first line prescription standard, and confusing it with the issue of adequacy of a regulatory valid control arm. The possibility of having two mechanistically different effective therapeutic possibilities in the first line treatment of advanced CRC patients does not even come to mind in the different authoritative opinions expressed in it.

The CPT 11-5FU/LV combination appears now as the first line treatment reference for U.S. oncologists and eventually the regulatory control standard in first line treatment of advanced CRC patients, which eliminates de facto the chance of a first line registration for oxaliplatin for North American patients. This makes unlikely in the near future the close to 20 months median survival and frequent post metastasectomy long term survivors we take now as European therapeutic benchmark. This is self-evident, if survival is still the only primary endpoint possible in first line controlled trials. Moreover, I would like to add that the oxaliplatin/CPT-11 combination is, to my experience, one of the most active and exciting prescription possibilities for colorectal cancer patients.

My personal opinions are often (but not necessarily) politically incorrect, and seldom affected by oncopolitical considerations or consulting status. I have always considered consultantship as something I do for the cancer patient and the anticancer agent, eventually paid by the licensee or sponsor. This letter is another example of my professional tenets, and is of my sole responsibility.

Esteban Cvitkovic
Le Kremlin-Bicêtre, France

Funding Opportunities:

CFL Two-Year Fellowship Applications Available

Application Deadline: October 2, 2000
Fellowship Start Date: July 1, 2001

The Cure For Lymphoma Foundation seeks

candidates for its 2001-02 Two-Year Fellowship program. The intent of the CFL Fellowship is to encourage careers in lymphoma translational and clinical research. Research may be laboratory or clinic based, but the results and conclusions must be relevant to the treatment of lymphoma.

The Two-Year Fellowships provide salary support in the amount of $45,000 the first year and $50,000 the second year (including fringe benefits but excluding indirect costs) and $5,000 each year for the research project. Candidates must be fellows or junior faculty at or below the level of assistant professor, at an institution in the U.S., at the start of the award period and hold a M.D. or Ph.D. or equivalent degree. There are no restrictions for applicants as to age, race, sex, creed or national origin.

Inquiries: Fran Morris, Director of Medical & Scientific Outreach; Cure For Lymphoma Foundation; 215 Lexington Avenue, New York, NY 10016; Tel: 212-213-9595 or 1-800-CFL-6848; fax: 212-213-1987; email: fmorris@cfl.org; website: http://www.cfl.org

Program Announcements

PA-00-106: Basic and Translational Research in Emotion: Small Grants

Under the PA, which will use the NIH R03 small grant award mechanism, National Institute of Mental Health, National Institute on Aging, National Institute on Alcohol Abuse and Alcoholism, NCI, National Institute of Child Health and Human Development, and the National Institute on Drug Abuse invite research grant applications to expand basic research on the processes and mechanisms involved in the experience and expression of emotion.

Inquiries: For NCI—Sara Stone, Grants Administration Branch, NCI, 6120 Executive Blvd, Rm 243, MSC 7150, Bethesda, MD 20892-7150, phone 301-496-7249; fax 301-496-8601; e-mail stones@gab.nci.nih.gov

PA-00-105: Basic and Translational Research in Emotion R01

National Institute of Mental Health, National Institute on Aging, National Institute on Alcohol Abuse and Alcoholism, NCI, National Institute of Child Health and Human Development, National Institute on Drug Abuse, and the National Institute of Neurological Disorders and Stroke invite research grant applications to expand basic research on the processes and mechanisms involved in the experience and expression of emotion. The PA will use the NIH R01 research project grant mechanism.

Inquiries: For NCI—Wendy Nelson, Basic Biobehavioral Research Branch, Behavioral Research Program, NCI, 6130 Executive Blvd., MSC 7326, Executive Plaza North, Rm 211, Bethesda, MD 20892-7326, phone 301-435-4590; fax 301-435-7547; e-mail wn14x@nih.gov

RFAs Available

RFA OH-01-001: Endocrine Disruptors: Epidemiologic Approaches

Letter of Intent Receipt Date: Aug. 11, 2000

Application Receipt Date: Sept. 22, 2000

National Institute for Occupational Safety and Health, Center for Disease Control and Prevention, National Center for Environmental Research, EPA, NCI, National Institute of Environmental Health Sciences and NIH invite applications for research on the relationship between exposure to endocrine disruptors and adverse health effects in humans, particularly reproductive and developmental, with a focus on epidemiologic approaches. The mechanism of support will be the NIH investigator-initiated research project grant R01 or the Environmental Protection Agency's Office of Research and Development STAR (Science to Achieve Results)program.

Inquiries: For NCI—Kumiko Iwamoto, Division of Cancer Control and Population Sciences, NCI, 6130 Executive Blvd, Executive Plaza North, Rm 539, Bethesda, MD 20892-7395, phone 301-435-4911; fax 301-402-4279; e-mail ki6n@nih.gov

Notice CA-00-019: Addendum—Planning Grant for Minority Institution/Cancer Center Collaboration RFA-CA-01-003 and Cooperative Planning Grant for Comprehensive Minority Institution/Cancer Center Partnership RFA-CA-01-008

This addendum is to inform potential applicants of the following deletion from the original RFAs. Under ALLOWABLE COSTS, on page 2 of the original RFA CA-01-003 and on page 3 of the original RFA CA-01-008, the following sentence should be deleted: "In this case, the maximum allowable costs for such equipment items can not exceed $10,000 for research purposes without prior approval by the NCI." All other provisions remain unchanged. The complete RFAs can be found at: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-01-003.html and http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-01-008.html.

Inquiries: Sanya Springfield, chief, CMBB, OCTR, ODDES, NCI, 6116 Executive Blvd., Suite 7008, Bethesda, MD 20892-8347, phone 301-496-7344; fax 301-402-4551; e-mail springfs@mail.nih.gov

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For further information and advertising rates, contact Publisher Kirsten Boyd Goldberg, phone 202-362-1809 x11, or email kirsten@cancerletter.com.

In Brief:

Weinstein Receives Award; LRFA Honors Vincent DeVita

(Continued from page 1)

Petersburg, received the E. Donnall Thomas Lecture; **Nelson Chao**, Duke University Medical Center and **Janice Brown**, Stanford University Medical Center, were presented with the Annual Meeting Best Abstract Awards. . . . **I. BERNARD WEINSTEIN** received the Anthony Dipple Carcinogenesis Award for his research contributions to the field. Weinstein, the Frode Jensen Professor of Medicine, Genetics and Development, and Public Health at Columbia University College of Physicians and Surgeons, is known for his work with the molecular mechanisms of action of environmental carcinogens during the multistage process of carcinogenesis as well as his more recent work on the abnormalities in signal transduction and cell cycle control in cancer cells. The award, sponsored by Oxford University Press, was presented June 1 at the biennial meetings of the European Association for Cancer Research and comes with a medal and an invitation to lecture on his work. . . . **VINCENT DEVITA**, director of the Yale Cancer Center, received the Saul Rosenberg Research Award from the Lymphoma Research Foundation of America for his contributions to the treatment of Hodgkin's lymphoma and other lymphomas. The award, named in honor of Stanford Professor Emeritus of Medicine and Radiation Oncology, comes with a $50,000 prize for a lymphoma research project. . . . **CITY OF HOPE CANCER CENTER** in Duarte, CA, received two grants from the Louis and Harold Price Foundation for cancer programs. The first, a $100,000 award, will provide transportation for medical appointments as well as visits between pediatric patients and their families. The second, a four-year $350,000 award, will fund microarray equipment including a cancer cell subtyping system. The Price Foundation supports community-based programs and individuals dealing with poverty. . . . **MARGARET SPITZ**, chairman of the Department of Epidemiology at the University of Texas M.D. Anderson Cancer Center, was presented the Distinguished Achievement Award by the American Society of Preventive Oncology. Spitz, an award winning molecular epidemiologist who has served on NIH Study sections, is known for her research in genetic susceptibility to cancer development. . . . **ELIZABETH TRAVIS**, professor of experimental radiation oncology and Mattie Allen Fair Professor in Cancer Research at M.D. Anderson Cancer Center, received the annual 2000 BPW Award from the Business Professional Women of Texas for her research in radiation and drug induced damage on normal tissue. Travis and her team are working on the identification of genes that regulate radiation and drug-induced fibrosis in the lung and colon.

A Full Page In

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