THE CANCER LETTER INTERACTIVE

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Vol. 27 No. 1
Jan. 5, 2001

Finally, An FY01 Appropriation For NIH; NCI's Share $3.757 Billion, A 13.5% Raise

The appropriations bill passed by Congress and signed by President Clinton last month gives NCI $3.757 billion for the fiscal year 2001, $446.3 million above last year's budget, about a 13.5 percent increase.

The spending bill, passed after a succession of 21 continuing resolutions, is $36.3 million below the level proposed in the House, and $46.8 million below the Senate bill.

However, the appropriation for the Institute is $252.2 million above the President's budget proposal.

The conference bill represents the second Congressional effort to

(Continued to page 2)

In Brief:

AACR 2001 Honorary Awards Announced; Nora Janjan Is ASTRO President-Elect

AMERICAN ASSOCIATION for Cancer Research announced the winners of its 2001 Honorary Awards. The AACR-Pezcoller Foundation International Award for Cancer Research: **Elizabeth Blackburn**, for her contributions to the discovery of telomerase and its role in maintaining the telomere, an essential feature of all chromosomes. AACR-G. H. A. Clowes Memorial Award: **Stephen Elledge**, for his contributions to many aspects of biology, particularly the cell cycle, cellular responses to DNA damage, regulation of the stability of signaling proteins, and the control of protein abundance. AACR-Richard & Hinda Rosenthal Foundation Award: **Brian Druker**, for his outstanding contributions to molecular-targeted therapy resulting in improved treatment of cancer patients. Most recently, he identified and tested the compound STI571 which acts as a specific inhibitor of the Abl tyrosine kinase. AACR-American Cancer Society Award for Research Excellence in Cancer Epidemiology and Prevention: **I. Bernard Weinstein**, for his pioneering role in elucidating the molecular mechanisms by which environmental agents act to enhance the specific stages of multi-stage carcinogenesis. AACR-Joseph H. Burchenal Clinical Cancer Research Award: **Rainer Storb**, for his work in transplantation biology, which has defined and improved treatment and has increased the long-term survival of cancer patients. AACR-Bruce F. Cain Memorial Award: **Alan Sartorelli**, for his pioneering work in cancer pharmacology and drug development research, particularly his work on antimetabolites. AACR-Cornelius P. Rhoads Memorial Award: **Scott Lowe**, for his groundbreaking contributions to understanding of the role of p53 in tumor suppression and the processes

(Continued to page 8)

Click Here for Photocopying Guidelines

NIH Gets 14.2% Increase, $20 Billion Budget, For FY01

(Continued from page 1)

reconcile the House and Senate proposals. An earlier version of a conference bill, which was never sent to the White House because of disagreements unrelated to biomedical research, gave NCI about $37 million more than the final version of the bill that passed Congress Dec. 15.

The final bill gives NIH $20.313 billion, a $2.523 billion increase over last year, about a 14.2 percent increase. This is $200 million below the House and Senate bills and the earlier conference bill. However, the increase is $1.5 billion above the President's budget proposal. Clinton signed the bill on Dec. 26.

Cancer-related highlights of the legislation follow:

Cancer in Minorities: The final legislation contains two initiatives aimed at studying cancer in minorities and the underserved. At NIH, the bill calls for formation of the National Center for Minority Health and Health Disparities.

Under the Medicare program, the conference report mandates a "demonstration project" aimed at improving "clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns" among minority populations.

Goals of the study include eliminating "disparities in the rate of preventive cancer screening measures, such as pap smears and prostate cancer screenings, among target individuals. HHS would evaluate "best practices" that reduce disparities, launch nine projects in minority populations, and submit a report to Congress within three years.

The bill provides $130.2 million to the new NIH center. The center is being created at a time when NCI is creating its own center on cancer in minorities.

In the past, much of the NCI budget for this work was financed through transfers from NIH. Now, NIH is likely to devote these funds to its own programs.

The report language on the new NIH center follows:

"While the overall health of the nation has improved over the last two decades, there continues to be striking disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asian-Pacific Islanders.

"Moreover, the largest numbers of medically underserved are white individuals, and many of them have the same health and access problems as do members of minority groups. Overcoming such persistent and perplexing health disparities, and promoting health for all Americans, ranks as one of our Nation's foremost challenges.

"These disparities are believed to be the result of the complex interaction among socioeconomic and biological factors, the environment, and specific behaviors, as well as other factors. While some of the causes of inequitable health outcomes may be beyond the scope of biomedical research, the conferees recognize that NIH has made research into health disparities a high priority, and has already taken steps to expand the role of research into why some minority groups have disproportionately high rates of disease.

"Congress recently passed and the President has signed the Minority Health and Health Disparities Research and Education Act of 2000. The Act established the National Center on Minority Health and Health Disparities, which will enable NIH to move ahead more rapidly toward its goal of elucidating the factors that contribute to these disparities.

"The center will conduct and support research through grants to support programs targeting diseases and conditions that disproportionately affect minority groups and other populations with health disparities.

"The center will build on the work of the Office for Research on Minority Health and the success of the Minority Health Initiative, currently located in the NIH Office of the Director.

THE CANCER LETTER

Member, Newsletter and Electronic Publishers Association

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: 202-318-4030
PO Box 9905, Washington DC 20016
E-mail: news@cancerletter.com

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724
E-mail: info@cancerletter.com

Subscription $295 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc. Founded Dec. 21, 1973, by Jerry D. Boyd

"This will complement the ongoing research of the NIH research institutes and centers also aimed at reducing health disparities. To emphasize the visibility of this new center and the importance of its research mission, the conferees have included bill language providing $130.2 million for the center."

Breast Cancer and the Environment: The conference report includes a mandate for the National Institute of Environmental Health Sciences to develop methodology for studying the potential impact of the environment on breast cancer.

The language that ended up in the report was developed by the National Breast Cancer Coalition.

"The causes of breast cancer are largely unknown. There is little agreement in the scientific community on how the environment impacts breast cancer.

"While studies have been conducted on the links between environmental factors like diet, pesticides, and electromagnetic fields, no conclusive evidence exists. The conferees encourage NIEHS to enhance research efforts to study the links between the environment and breast cancer through all available mechanisms, as appropriate, including establishing centers of excellence."

The report also refers to the Department of Defense breast cancer program:

"The conferees direct that, using funds appropriated in the Department of Defense Appropriations Act, 2001 for medical research programs, the Assistant Secretary of Defense (Health Affairs) conduct a study on whether environmental factors, such as air pollutants and electromagnetic radiation, contribute to a higher than usual rate of incidence of breast cancer in large populations."

Human Tissue and Organs: "The conferees continue to be interested in matching the increased needs of researchers who rely upon human tissue and organs to study human diseases and to search for cures. The conferees are aware of a recent review by a panel of experts that found that there is a rapidly expanding and unmet demand for the use of human tissue samples for research purposes. The conferees encourage the Director of NIH to work with the relevant Institutes to consider expanding support in this area and request that the Director be prepared to report on its plan to meet the demand for human tissue at the fiscal year 2002 appropriations hearing."

Genealogical databases: The conference report language for NCI encourages the Institute "to take appropriate steps to take full advantage of scientific opportunities that may be available from using genealogical databases to understand, diagnose, treat and prevent cancer and other diseases."

Other cancer related mandates for NIH include:

—The report mandates a study of the structure of NIH.

"The conferees concur with the language in the Senate report regarding a study of the structure of NIH and expect to receive a report and recommendations one year from the date of confirmation of the new NIH Director," the report states.

—The report urges NIH to prepare a plan to ensure optimal compensation when drugs developed by the government are commercialized.

"The conferees have been made aware of the public interest in securing an appropriate return on the NIH investment in basic research," the report states.

"The conferees are also aware of the mounting concern over the cost to patients of therapeutic drugs. By July 2001, based on a list of such therapeutic drugs which are FDA approved, have reached $500 million per year in sales in the U.S." No deadline is set for completion of the plan.

—NIH should launch an interdisciplinary committee to study the lymphatic system. "The conferees encourage NIH to consider establishing a trans-NIH coordinating committee to focus on the lymphatic system, with particular emphasis on lymphedema and related lymphatic disorders," the report states.

—The conference agreement includes a provision to name the NIH National Neuroscience Research Center the John Edward Porter Neuroscience Research Center. The center honors Rep. Porter (R-IL), chairman of the Labor, HHS and Education appropriations subcommittee, who retired at the end of the Congressional session.

The report also urges the NIH Director to designate the plaza in front of the James Shannon building on the NIH campus as the Paul G. Rogers Plaza, in honor of the Democratic House member from Florida, who served as chairman of the House health appropriations subcommittee. Rogers retired from Congress in 1979.

—The conference report also includes a provision to allow Ruth Kirschstein, NIH Acting Director, to remain in that position until a new director is confirmed by the Senate. The House and Senate bills contained

no similar provision.

CDC Mandates: The report praised Centers for Disease Control and Prevention for its plans to convene a meeting to develop a national prostate cancer public health agenda.

"The conferees urge the agency to continue its work with voluntary public and professional organizations to develop and implement a national educational and outreach campaign with special attention to minority and underserved populations," the document said. "CDC should be prepared to report on its prostate cancer programs at the fiscal year 2002 appropriations hearing."

The report urged CDC "to give full and fair consideration to a proposal to develop a diversified screening demonstration project with the Dean and Betty Gallo Prostate Cancer Center at the Cancer Center of New Jersey, and the Men's Health Network designed to determine effective methods for encouraging men in the underserved population to participate in colorectal screening and screening for other high risk diseases."

The final bill gave CDC $173.9 million for its breast and cervical cancer screening program. The House recommended $160.9 million, and the Senate $167 million.

The report urged CDC "to give full and fair consideration to proposals from Access Community Health Network in Chicago for delivering breast and cervical cancer screening and follow-up services to minority women." Also, the conference bill funds the evaluation of breast cancer incidence in DuPage County, IL, and the San Francisco Bay area.

Drug Approval:

ODAC Recommends Femara, Campath For FDA Approval

The FDA Oncologic Drugs Advisory Committee unanimously recommended approval for Femara (letrozole tablets), sponsored by Novartis Oncology, as first-line hormonal treatment for advanced breast cancer in postmenopausal women.

At the meeting Dec. 13-14, ODAC also recommended accelerated approval for Campath (alemtuzumab), a humanized monoclonal antibody, for patients with chronic lymphocytic leukemia who have been treated with alkylating agents and have failed fludarabine therapy. The agent is sponsored by a joint venture of Millennium Pharmaceuticals Inc. and ILEX Products Inc.

In another action, the committee unanimously voted against approval of Maxamine (histamine dihydrochloride) as an adjuvant to interleukin-2 for advanced metastatic melanoma with liver metastases. The agent is sponsored by Maxim Pharmaceuticals of San Diego.

The case of Femara is important because the Novartis-sponsored trials used median time to progression as the primary endpoint. When it comes to cytotoxic drugs for first-line treatment of advanced metastatic breast cancer, FDA requires proof of a survival advantage. Are the standards different for hormonal treatments?

The Femara application forced the agency to juxtapose its standards for hormonal agents with the standards for cytotoxic drugs.

"At the June 1999 meeting, the committee indicated that for approval of new cytotoxic drugs for initial treatment of advanced metastatic breast cancer, a favorable effect on survival in randomized controlled trials is required," the FDA summary for ODAC said.

"The committee indicated that a favorable effect on time to tumor progression is not adequate for approval. An impressive improvement in TTP may be adequate for accelerated approval. A modest improvement in TTP, even if statistically significant, would not be adequate for accelerated approval. A better response rate is not adequate for approval.

"The rationale is that cytotoxic drugs have been shown to increase survival. TTP and tumor response rates are not shown to be surrogates for survival. Also, cytotoxic drugs usually have significant toxicity. Usually, only a minority of patients have a tumor response, and most of these are partial responses. TTP effects are usually modest. In the absence of a favorable effect on survival, it is not clear that a better TTP or tumor response rate is sufficient to overcome the drug toxicity.

"In contrast, FDA has accepted a favorable effect on tumor response or TTP in randomized, controlled trials as adequate for approval of hormonal drugs for initial treatment of advanced metastatic breast cancer. Updated survival data are required at the time of approval, but demonstration of statistical superiority, or non-inferiority of survival is not required.

"If survival is tending strongly against the new hormonal drug, a decision on approval will be delayed until more mature survival data are available. Mature survival data are not usually available when Marketing Applications for hormonal drugs are initially submitted

to FDA.

"The rationale is that hormonal drugs have modest toxicity relative to cytotoxic drugs. A favorable effect on tumor response rate or TTP comes at a lesser cost in toxicity than with cytotoxic drugs. In addition, hormonal drugs have not been shown to increase survival in this setting. Non-inferiority of survival in this setting is considered a safety endpoint and is not an indication of efficacy.

"If a new hormonal drug is shown to increase survival, FDA will probably require new hormonal drugs to demonstrate a favorable effect on survival to gain marketing approval."

Preliminary data from the company indicate that in terms of survival, Femara is not inferior to tamoxifen, Novartis officials said.

"It does not worry me that we don't have survival data, or even if it should come out that there is no survival benefit," said ODAC member Kathy Albain, professor of medicine at Loyola University Medical Center.

Albain said that the question of the optimal duration of therapy for aromatase inhibitors remains to be determined. "The safety profile here is reassuring for shorter duration therapy, but what would happen to lipid, what would happen to bone density, in the scenario of a longer duration in the adjuvant setting is not known," she said.

The question of viability of TTP as a criterion for approval remains valid, Albain said. "Will we need to see an [equivalent] survival benefit for all new hormonal agents, or new biologics?" she said. "I am just a little tweaked at the FDA that we need to continue to have some open discussion of TTP as a realistic and viable primary endpoint, as this trial has shown."

Femara, an aromatase inhibitor, is a once-a-day oral treatment approved for advanced breast cancer in postmenopausal women with disease progression following antiestrogen therapy. The drug was approved for this indication in 1997.

The application to move the drug to first-line was based on a randomized, controlled, double-blind, multinational trial that enrolled 916 postmenopausal women with hormone-receptor-positive disease or unknown hormone receptor status. Trial participants, who had locally advanced or advanced metastatic disease, were randomized to Femara or tamoxifen.

The company's study demonstrated that Femara delays progression of advanced breast cancer for 9.4 months, as compared to 6 months for tamoxifen. Results also indicated significant differences between Femara and tamoxifen with respect to overall tumor response rates (30 percent vs. 20 percent), clinical benefit (49 percent vs. 38 percent) and time to treatment failure (9.1 months vs. 5.7 months).

Femara and tamoxifen were equally well tolerated, the company said.

Supporting the pivotal trial was a phase III randomized controlled trial of 324 postmenopausal women with large localized or locally advanced breast cancer tumors who were given Femara or tamoxifen as pre-operative treatment to reduce tumor size before surgery. Clinical responses after four months of preoperative therapy were significantly better for Femara than for tamoxifen (55 percent versus 36 percent).

"The availability of letrozole as a first-line option could lead us to seriously consider changing the treatment paradigm for advanced breast cancer in postmenopausal women," Matthew Ellis, clinical director of the breast cancer program at Duke University Medical Center, said in a Novartis press release. "It is the first therapy to consistently challenge tamoxifen in multiple endpoints, including response rates, time to progression and clinical benefit."

"Femara's superiority to tamoxifen based on these studies means these women may soon have a more effective treatment," said David Parkinson, vice president, clinical research, at Novartis Oncology.

ODAC member George Sledge noted that the data from the pivotal trial raises questions about standards of care in the countries where the patients were accrued. In the Novartis study, the majority of patients were accrued outside the US, and some had an unknown estrogen receptor status.

"I really don't think in the year 2000 we should be approving drugs that don't test ER status in a significant percentage of the population," said Sledge, professor of medicine and pathology at Indiana University School of Medicine. "I understand why one does a trial on a worldwide basis in places where ER may not be available, why it's convenient not to do that, but the clinical reality in the US is that virtually everyone has had ER tested, and that's the clinically relevant population for drugs that are being introduced in the US."

ODAC voted unanimously to recommend approval.

Approval Recommended for Campath for CLL

ODAC voted 14-1 to recommend accelerated

approval of Campath (alemtuzumab) for chronic lymphocytic leukemia for patients who have been treated with alkylating agents and have failed fludarabine therapy.

Accelerated approval requires further studies aimed at determining the therapy's clinical benefit.

Casting the single vote against approval, biostatistician Richard Simon cited inconclusiveness of phase II data, and his reservations about the accelerated approval mechanism.

"It was difficult to interpret the single-arm trial to determine whether the treatment was beneficial and whether it was safe," Simon, head, Molecular Statistics and Bioinformatics Section, NCI Division of Cancer Treatment and Diagnosis, said to **The Cancer Letter**.

"It was unclear whether the responses to treatment represented either patient benefit or prolongation of survival. It was also difficult to distinguish toxicity of therapy from effects of the disease," Simon said.

"I also had reservations about the accelerated approval process. Accelerated approval diminishes the chances of a randomized trial being done for that indication, and I object to approval when a randomized trial has not even begun accruing patients. Although it is difficult to do randomized trials for indications where no approved treatment exists, sponsors should consider using randomized control groups where the treatment or supportive care is 'physicians choice' for each patient," Simon said.

Campath works by targeting the CD52 antigen, which is prevalent on cancerous B lymphocytes, to clear the blood and bone marrow of cancer cells, the company said.

The committee recommendation is based on a pivotal phase II trial involving 93 patients, as well as two earlier supporting trials involving 32 patients and 24 patients. Seventy percent or more of the patients participating in the trials had advanced disease (Rai stage III/IV).

All of the study participants in the pivotal trial had received previous therapy with alklylators and were refractory to fludarabine therapy. In the pivotal trial, an objective response rate of 33 percent (31 of 93 patients) was observed with a median duration of response of about seven months, the company said. Improvement of disease-related symptoms and improvement in hematological parameters were noted in most responders who had symptoms or hematological compromise at initiation of Campath therapy.

Adverse events associated with Campath therapy include infusion-related events, infections and hematological toxicity. Common infusion-related toxicities included fever, rigors, nausea, vomiting, rash and hypotension.

Most of these events were mild (NCI Common Toxicity Criteria Grade 1/2) and were controlled with premedication and appeared to decrease in occurrence over the duration of therapy.

Infections of any severity were reported in about 50 percent of the study population. Half of these infections were serious in nature. Opportunistic infections were reported in about one-fourth of the study population. Hematological toxicities reported in the study included anemia, neutropenia and thrombocytopenia. Serious hematological toxicity (Grade 3/4) noted in the study or shortly after completion of study drug therapy resolved within two months after discontinuation of therapy.

If approved in the U.S., the agent will be marketed by Berlex Laboratories Inc. of Richmond, Calif., the U.S. affiliate of Schering AG, Germany.

Thumbs-Down for Histamine Dihydrochloride

The committee voted unanimously against approval of Maxamine (histamine dihydrochloride) for adjunct use in the treatment of adult patients with advanced metastatic melanoma that has metastasized to the liver.

ODAC concurred with the agency reviewers' analysis that randomization in the company's pivotal trial was not stratified based on prognostic factors.

Though 305 patients were enrolled in the two-arm trial that compared IL-2 with histamine/IL-2, the company sought approval based on efficacy results in a subset of 129 patients with liver metastases.

The company presented no data from supporting trials.

According to FDA, the company data were not adjusted for prognostic factors. "There were many imbalances in known prognostic factors and other patient characteristics between the two treatment arms in the subgroup of patients with liver metastases, perhaps because there was no stratified randomization," the agency said. "These included performance status, albumin, disease-free interval, and number of metastatic sites. These imbalances consistently favored the histamine/IL-2 arm."

When the data were adjusted, the result lost statistical significance, showing no survival benefit.

"The statistically strong effect seen in the

unadjusted analysis appears to be in part the result of baseline imbalances," the agency said.

Though the committee voted down the drug, Larry Stambaugh, Maxim chairman and CEO, attempted to put a positive spin on the poor outcome.

"While today's outcome is disappointing, the Maxamine phase III study remains the only randomized, multi-center, well-controlled trial conducted to date that has demonstrated a significant survival benefit in this patient population," Stambaugh said in a statement.

"These data, and the data from our other clinical trials, leave us confident in the value of Maxamine as an adjunct to immunotherapy. Our take-home message from the meeting was that the phase III trial demonstrated a survival benefit, but was not adequate as a single study to support approval. We will now work with the FDA to develop a strategy to support the approvability of this drug in this patient population."

Richard Pazdur, director of the FDA Division of Oncology Drug Products said relying on a single trial is a risky policy for a sponsor.

"We see an increasing trend of sponsors leveraging their drugs' success on the basis of a single trial," Pazdur said to **The Cancer Letter**. "This can be very risky.

"Although a single, multi-center, randomized trial can be considered substantial evidence leading to approval, this trial should be conducted flawlessly, be internally consistent, and statistically persuasive," Pazdur said.

"Everyone wins by duplicating results," he said. "Most importantly, patients and prescribing physicians are assured that findings are not simply due to chance, but represent true therapeutic gains."

Funding Opportunities:

NCI RFA Available

RFA-CA-01-018: Exposure Assessment Methods for Cancer Research

Letter of Intent Receipt Date: Feb. 19, 2001

Application Receipt Date: April 19, 2001

The Division of Cancer Control and Population Sciences of NCI and the Division of Extramural Training and Research of the National Institute of Environmental Health Sciences invite exploratory/developmental grant applications to develop, improve, and/or validate environmental exposure assessment methods applicable in epidemiologic research on cancer. Of special interest will be methods and markers useful in studies of environmental epidemiology focusing on tumor initiation and exogenous environmental factors, other than infectious agents. Consideration of bio-behavioral and psychosocial measurements as secondary or confounding factors associated with environmental exposures and cancer risk may be included.

Inquiries: Kumi Iwamoto, Division of Cancer Control and Population Sciences, NCI, 6130 Executive Blvd, Suite 5104, MSC, Bethesda, MD 20892-7324, phone 301-435-4911; fax 301-402-4279; e-mail iwamotok@mail.nih.gov

NIH Program Announcements

PAR-01-040: AHRQ Small Research Grant Program

Receipt Dates: March 24; July 24; Nov. 24

Agency for Healthcare Research and Quality announces a program of small research grants to support new investigators or researchers new to health care services issues and encourage preliminary, exploratory, or innovative research in new or previously unexamined areas. The PA is available on the AHRQ Web site (http://www.ahrq.gov).

Inquiries: Kelly Morgan, Primary Care Research, phone 301-594-1782; e-mail kmorgan@ahrq.gov

PA-01-035: Pathogenesis and Treatment of Lymphedema

National Heart, Lung, and Blood Institute, National Institute of Child Health and Human Development, National Institute of Arthritis and Musculoskeletal and Skin Diseases, and NCI invite research project grant applications for primary and secondary lymphedema.

Inquiries: Colette Freeman, NCI, Division of Cancer Biology, Executive Plaza North, Rm 5000, Bethesda, MD 20892-7950, phone 301-496-7028; fax 301-402-1037; e-mail freeman@mail.nih.gov

PAR-01-034: NCRR Shared Instrumentation Grant

Application Receipt Date: March 23, 2001

The National Center for Research Resources is continuing its competitive shared instrumentation grant program for groups of NIH-supported investigators to obtain commercially-available, technologically sophisticated equipment costing at least $100,000 in both basic and clinical research.

Inquiries: Marjorie Tingle, Shared Instrumentation Grant Program, National Center for Research Resources, 6705 Rockledge Dr, Rm 6148, MSC 7965, Bethesda, MD, 20892-7965, phone 301-435-0772; fax 301-480-3659, e-mail SIG@ncrr.nih.gov

In Brief:

ASTRO Names Officers; Lane Returns To Rice Univ.

(Continued from page 1)

of multi-step carcinogenesis, cellular senescence, and tumor cell drug resistance. AACR-DeWitt S. Goodman Lecture: **Diane Birt**, for her novel work in the areas of nutrition and chemoprevention. . . . **AMERICAN SOCIETY** for Therapeutic Radiology and Oncology named its officers for 2000-2001: chairman, **David Hussey**; president, **David Larson**; president-elect, **Nora Janjan**; treasurer, **K. Kian Ang**; and secretary, **John Bedwinek**. Hussey is on the faculty of the Radiation Oncology Department at the University of Texas at San Antonio. Larson is a professor in the Departments of Radiation Oncology and Neurological Surgery, University of California, San Francisco. Janjan and Ang are professors of radiation oncology at M.D. Anderson Cancer Center. Bedwinek is a partner with Missouri Cancer Care. . . . **NEAL LANE**, President Clinton's science and technology advisor and director of the White House Office of Science and Technology Policy since 1998, will return to Rice University this month. He was head of the National Science Foundation from 1993-98. . . . **NINE CANCER ORGANIZATIONS** recognized 100 breast cancer researchers at the San Antonio Breast Cancer Symposium on Dec. 6. Ten researchers received the "Celebrating Survival: A Century of Advancements in Early Breast Cancer Award" for published phase III clinical studies that demonstrated a five-year survival benefit for breast cancer patients. The recipients were **Michael Baum, Gianni Bonadonna, Monica Castiglione-Gertsch, Bernard Fisher, Gabriel Hortobagyi, Mark Levine, Edward Mansour, Roar Nissen-Meyer, Lars Rutqvist,** and **William Wood**. Hortobagyi, of M.D. Anderson Cancer Center, received special honors for publishing more than 268 clinical studies in peer-reviewed journals. The awards were supported by Cancer Care, Cancereducation.com, Living Beyond Breast Cancer, MAMM, the Coalition of National Cancer Cooperative Groups, The Oncologist, Pharmacia Oncology, Vital Options TeleSupport Cancer Network and Y-ME National Breast Cancer Organization. . . . **MESOTHELIOMA APPLIED** Research Foundation awarded its first two research grants, of $100,000 each, to **Joseph Testa**, Fox Chase Cancer Center in Philadelphia, and **Hedy Kindler**, M.D., University of Chicago. **Harvey Pass**, chairman of MARF's Science Advisory Board, both of the research projects represent cutting-edge, translational efforts toward eradicating mesothelioma as a life-ending disease. Details and application requirements for MARF's next round of grants, to be awarded in mid-2001, will be posted at http://www.marf.org. . . . **HHS SECRETARY'S** Advisory Committee on Minority Health was appointed by **Donna Shalala**. The committee, created by the Health Professions Education Partnerships Act of 1998, will meet four times a year to advise the Secretary on ways to improve the health of racial and ethnic minority populations, and on the development of goals and program activities within the department. **Louis Stokes**, the former congressman from Ohio, and a former chairman of the Congressional Black Caucus, was named chairman of the committee. Members are: **Isamu Abraham**, Department of Public Health, Saipan, Commonwealth of the Northern Mariana Islands; **Salvador Balcorta**, Centro de Salud Familiar La Fe, Inc., El Paso; **Henry Chung**, Chinatown Health Clinic, New York City; **Estevan Flores**, Latino/a Research and Policy Center, Denver; **Theodore Mala**, Office of Village Initiatives, Southcentral Foundation, Anchorage; **Clyde Oden**, Watts Health Foundation, Inglewood, Calif.; **Joan Reede**, Harvard Medical School, Boston; **Yvette Roubideaux**, Association of American Indian Physicians, Tucson; **Delight Satter**, UCLA Center for Health Policy Research, Los Angeles; **Ho Tran**, Illinois Department of Public Health, Chicago; and **Antonia Villarruel**, University of Michigan School of Nursing, Ann Arbor. . . . **NATIONAL HUMAN RESEARCH** Protections Advisory Committee was appointed by HHS last month. **Mary Faith Marshall**, director of bioethics at University of Kansas Medical Center, was named chairman of the committee. Members are: **Mark Barnes**, Proskauer Rose LLP, New York City; **Sanford Chodosh**, Public Responsibility in Medicine and Research, Wayland, Mass.; **Elliot Dorff**, University of Judaism, Los Angeles; **Jennie Joe**, University of Arizona-Tucson; **Robert Levine**, Yale University School of Medicine; **Abbey Meyers**, National Organization for Rare Disorders, New Fairfield, Conn.; **Mary Pelias**, Louisiana State University Health Sciences Center, New Orleans; **Robert Rich**, Emory University School of Medicine, Atlanta; **Adil Shamoo**, University of Maryland School of Medicine-Baltimore; **Judith Siegel**, Hoffmann-La Roche Inc., Caldwell, N.J.; and **Denyse Thornley-Brown**, University of Alabama at Birmingham.

NATIONAL PROFESSIONAL ORGANIZATION SEEKS DIRECTOR OF ADMINISTRATION

Reporting to executive officer, develops, implements and manages administrative operational procedures related to organization-wide communications, membership, compliance, and meeting logistics. Facilitates budget development, implementation and monitoring. Supports federal and private grant applications. Supervises QA, Administrative Services, Communications, Study Development Office, and Information Systems.

Requirements: BA/BS Business or related area with a minimum of 10 years experience in healthcare administration, budgeting and grant preparation, or MS Business or Health Administration with 3-5 years related experience. Computer literate: Microsoft Office with Excel and Access.

About the Organization:

The National Childhood Cancer Foundation is a not for profit, public benefit charitable organization dedicated to eliminate cancer as the disease that causes more deaths during childhood than any other. This is accomplished by raising funds from public and private sources for support of research on childhood cancers and by education and advocacy to benefit children with cancer and their families.

We offer a competitive salary and benefits package.

The Foundation is located in Arcadia, CA., in the beautiful foothills just outside of Pasadena.
Visit our Web Site at http://www.NCCF.org.

Contact Information:

E-mail to HR@NCCF.org
Fax resume to (626) 447-6359
Mail: 440 E. Huntington Dr.
P.O. Box 60012
Arcadia, CA 91066-6012

Assistant Director
NEWS BUREAU

UPMC (University of Pittsburgh Medical Center) **HEALTH SYSTEM**

For

University of Pittsburgh Cancer Institute

The University of Pittsburgh Cancer Institute (UPCI) is one of the top NCI-supported comprehensive cancer centers in the country. This position offers an exciting opportunity for an enthusiastic person who has an interest in overseeing comprehensive media relations for this premier institution. Established in 1985, UPCI has an excellent international reputation for its clinical and basic research programs. The active recruitment of some of the country's leading oncologists and the construction of a new integrated facility, ensures UPCI's future growth in both size and reputation.

The individual selected for this position must have a minimum of eight years experience working with print media or in an academic medical setting. Experience in cancer communications is strongly preferred. An undergraduate degree is required and a graduate degree is preferred. Education should reflect training in English, journalism or communications along with significant course work in one of the biological sciences. A successful candidate must have the ability to translate scientific/medical information for a lay person's understanding and proven news judgment. Excellent benefits are offered and salary is commensurate with experience.

Applicants will be considered immediately and until the position is filled. Send a cover letter, resume and writing samples to: Jane Duffield, Director, News Bureau, UPMC Health System, Medical Arts Building, Suite 201, 3708 Fifth Avenue, Pittsburgh, PA 15213-2582. Applications also will be taken through e-mail, duffielddj@msx.upmc.edu or by fax: 412-624-3184.

Copying Policy for The Cancer Letter Interactive

The software that comes with your issue allows you to make a printout, intended for your own personal use. Because we cannot control what you do with the printout, we would like to remind you that routine cover-to-cover photocopying of The Cancer Letter Interactive is theft of intellectual property and is a crime under U.S. and international law.

Here are guidelines we advise our subscribers to follow regarding photocopying or distribution of the copyrighted material in The Cancer Letter Inc. publications in compliance with the U.S. Copyright Act:

What you can do:

--Route the printout of the newsletter to anyone in your office.

--Copy, on an occasional basis, a single story or article and send it to colleagues.

--Consider purchasing multiple subscriptions. Contact us for information on multiple subscription discounts.

What you can't do without prior permission:

--Make copies of an entire issue of the newsletter. The law forbids cover-to-cover photocopying.

--Routinely copy and distribute portions of the newsletter.

--Republish or repackage the contents of the newsletter.

We can provide reprints for nominal fees. If you have any questions or comments regarding photocopying, please contact Publisher Kirsten Boyd Goldberg, phone: 202-362-1809, email: kirsten@cancerletter.com

We welcome the opportunity to speak to you regarding your information needs.

Click Here for
Photocopying Guidelines