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Deaths On Saltz Regimen Prompt Groups To Suspend Accrual On Colon Cancer Trials

Two clinical trials cooperative groups have suspended accrual of patients to trials involving the state-of-the-art treatment for metastatic colon cancer, a combination regimen of Camptosar, 5-fluorouracil, and leucovorin.

Acting on data from two separate trials involving the "Saltz regimen," the data and safety monitoring committees of the North Central Cancer Treatment Group and Cancer and Leukemia Group B put a hold on accrual to the trials.

In both trials, the death rate on the Saltz regimen was elevated. However, the differences between the death rates among patients on the

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In Brief:

Norton Succeeds Einhorn As ASCO President, Colorado's Paul Bunn Is President-Elect

LARRY NORTON will succeed **Lawrence Einhorn** as president of the American Society of Clinical Oncology at the society's annual meeting May 14 in San Francisco. Norton is head of the Solid Tumor Division at Sloan-Kettering Cancer Center, director of the MSKCC Specialized Program of Research Excellence in Breast Cancer, chair of the Breast Committee of the NCI Cancer and Leukemia Group B and medical director of the MSKCC Evelyn H. Lauder Breast Center and Iris Cantor Diagnostic Center. He was appointed by former President Clinton to the National Cancer Advisory Board and is president of the board of directors of the National Alliance of Breast Cancer Organizations. Einhorn, now the ASCO immediate past president, is professor of medicine at Indiana University. **Paul Bunn Jr.** was elected to succeed Norton as president in 2002. Bunn is the Grohne/Stapp Chair in Cancer Research and director of the University of Colorado Cancer Center. A member of ASCO since 1977, Bunn was the board reviewer for the ASCO guidelines for the treatment of advanced lung cancer and helped to develop a formal tobacco policy for ASCO that was published in the Journal of Clinical Oncology. Six board members also were elected: **Robert Comis**, professor of medicine and director, MCP Hahnemann University Clinical Trials Research Center and group chair of the Eastern Cooperative Oncology Group in Philadelphia; **Ian Tannock**, Daniel E. Burgsagel Professor of Medical Oncology at Princess Margaret Hospital and University of Toronto; **Andrew Turrisi III,** professor and chairman, Department of Radiation Oncology at the Medical University of South Carolina; **Denis Hammond**, private practitioner, New Hampshire

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Groups Suspend Accrual To Two Colon Cancer Trials

(Continued from page 1)

Saltz regimen and other treatments were not statistically significant. Still, investigators said they decided to disclose the findings.

"I think we have a responsibility to point out that these toxicities are occurring," said Richard Schilsky, chairman of CALGB. "But we don't want people to come away with the impression that the Saltz regimen is a death sentence, when in fact it could be life-saving."

The regimen, which includes Camptosar (irinotecan hydrochloride, also known as CPT-11), demonstrated a survival advantage over the previous standard of 5-FU/LV and was endorsed by the FDA Oncologic Drugs Advisory Committee as the new standard in the treatment of metastatic colorectal cancer (**The Cancer Letter**, March 24, 2000).

After reviewing mortality data, two separate data and safety monitoring boards suspended accrual of patients to the North Central Cancer Treatment Group trial N9741, a metastatic disease trial, and, a few days later, to the CALGB-led intergroup trial C89803, a trial that evaluates the new regimen in adjuvant therapy.

The regimen is named after Leonard Saltz, an oncologist at Memorial Sloan-Kettering Cancer Center. Another FDA-approved regimen, known as the Douillard regimen, requires a central line for continuous infusion of 5-FU, and is therefore regarded as less convenient by American physicians.

The two regimens have not been compared side-by-side.

Back to the 5-FUture?

According to data presented last year to FDA, median survival of metastatic colon cancer patients receiving the Saltz regimen was 14.8 months, compared to 12.6 months for the Mayo Clinic regimen of 5-FU/LV, and 12 months for CPT-11 as a single agent.

Though thin, the survival advantage was statistically significant (p=0.042). Now, the same colon cancer experts who applauded the change of the standard of care in front-line treatment of colon cancer are urging caution in the interpretation of the new mortality data.

"My hope is that these findings are not going to derail the treatment of colon cancer or integration of new drugs into the treatment of colon cancer, but that it will tell us that we need to make a mid-course correction and go on," said Richard Goldberg, chairman of the NCCTG gastrointestinal cancer program and protocol chairman for one of the suspended trials.

The cooperative groups and the drug's sponsor, Pharmacia, are announcing the toxicities to clinical investigators, community oncologists, and the public. The text of the letter from Pharmacia appears on later in this issue.

Earlier this week, NCCTG and CALGB officials described the toxicities in a letter submitted to the New England Journal of Medicine. The toxicity data were scheduled to be presented at the annual meeting of the American Society for Clinical Oncology in San Francisco.

Hunkering down in anticipation of the impact of the disclosure, clinical trialists acknowledge feeling edgy about the prospect of hasty abandonment of the FDA-approved Saltz regimen and setting the clock back to the time when 5-FU/LV represented the best that could be done for patients with colon cancer.

Whatever the outcome, the Saltz regimen is widely used outside clinical trials, and all physicians should be informed about the side effects, said Richard Pazdur, director of the FDA Division of Oncology Drug Products.

"Physicians should know that these trials were put on hold, and they should be cognizant of toxicity,

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

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

Editorial: 202-362-1809 Fax: 202-318-4030
PO Box 9905, Washington DC 20016
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and efforts to use supportive measures for patients receiving this therapy," said Pazdur, an expert in colorectal cancer.

According to Pharmacia, about 15,000 colorectal cancer patients in the U.S. have been treated with CPT-11-containing regimen since approval a year ago.

Two Trials; Two Toxicity Profiles

Ultimately, physicians may find methods for preventing or managing toxicity associated with the Saltz regimen. Also, the risk of death could be judged acceptable once overall survival data become available, clinical trialists say.

On both suspended studies, nearly all deaths occurred within 60 days after initiation of treatment. On the CALGB adjuvant study, the majority of deaths occurred within 60 days of initiation of treatment, but the causes of death on the Saltz arm were varied.

The signs of elevated treatment-related mortality in the Saltz regimen first emerged in the NCCTG trial N9741 two weeks ago, Goldberg said. The trial compares the Saltz regimen to oxaliplatin plus 5-FU/LV and oxaliplatin plus CPT-11.

"We have a rapid reporting system, and we have been watching the meter," Goldberg said. "Any time someone is hospitalized, has a grade 4 or 5 side effect, we get a fax and an email."

As of three weeks ago, seven deaths had been reported on the Saltz arm. "The confidence interval for the death rate still included a 1 percent treatment associated mortality, which was the death rate reported in the four largest previous advanced colon cancer studies," Goldberg said.

"As soon as we hit the red line, and the confidence interval for the observed death rate excluded 1 percent, that was when we alerted the data and safety monitoring committee," he said.

Within four days of the regularly scheduled meeting of the data and safety monitoring board, the cooperative group learned about two additional deaths. Looking over the data on April 24, the board decided to suspend accrual long enough for scientific leadership to consider strategies for managing toxicity.

The death rate in the trial is 4.8 percent on the Saltz arm, and 1.8 percent on the other arms.

All but one death on the Saltz regimen arm in the NCCTG metastatic disease study occurred during the first six weeks of therapy, sources said. Also in that trial, 12 of the 14 deaths on the Saltz regimen began with dehydration, followed by neutropenia, sepsis, and shock.

After learning about the NCCTG decision to stop accrual, on April 26, CALGB convened a special meeting of its data and safety monitoring board. The group's trial C89803 is comparing 5-FU/LV alone to the Saltz regimen in patients with resected stage III colon cancer.

The CALGB committee had been monitoring an apparent excess of thrombotic events on the Saltz arm, and had seen the safety data at a special meeting last March, Schilsky said.

"When the data from NCCTG became known to our data and safety monitoring board—that they were seeing an imbalance of death rates—then we went back and looked at all our data again, and became concerned that we, too, had an imbalance in death rates." Schilsky said. "At that point, the committee recommended that accrual to our study be suspended."

The death rate in the CALGB trial was 2.2 percent on the Saltz arm, and 0.8 percent on 5-FU/LV. Three patients died of pulmonary emboli, three of sepsis and three of aspiration. Myocardial infarction, dehydration/neutropenia, a cerebrovascular event, and bowel ischemia claimed one patient each. In one case, the cause of death was unknown.

"We are not exactly sure why we are seeing all these clots, and [NCCTG] is not," Schilsky said.

One possible explanation is that patients in the adjuvant study are treated immediately in the post-operative period, Schilsky said. "Some of them may have been immobilized during recovery from surgery, which could predispose them to forming blood clots," he said.

After learning about the hold on the two trials, Pharmacia conducted an analysis of mortality in the pivotal study that supported the approval of the Saltz regimen. According to the company, mortality rate within 60 days of the start of treatment was the same—7 percent—for the Saltz regimen and for 5-FU/LV.

"Recognizing the implicit limitations of any post-marketing surveillance system, no new patterns of toxicity have emerged" since approval of the Saltz regimen, the company said in its letter to physicians.

The CALGB trial has just met its accrual target of 1,260 patients. The NCCTG trial has accrued 841 patients, about 300 patients short of its goal.

Managing Toxicity

All of the toxicities seen in these studies had been observed in previous studies of the Saltz regimen.

"The fact that there is an increase in early deaths does not meant that as the study proceeds that overall

the survival might not be better for people who get the Saltz regimen as part of adjuvant therapy," Schilsky said. "We will not know this for several years, until all the patients have completed their treatment and we have had enough events to evaluate the disease-free and overall survival."

Ultimately, clinical trialists will have to determine which patients are at risk for severe toxicity and find a way to screen them out. "I think this points out that there is a narrow therapeutic window, and for some patients it's narrower than in others, so you have to be cautious about it," Goldberg said.

At this stage, the two groups are considering different approaches to managing toxicity. The approach considered by CALGB involves close monitoring of patients.

"The message we are trying to send is that people have to be cautious in using this regimen," Schilsky said. "Patients have to be monitored closely, and patients who develop severe toxicity need to have their chemotherapy doses modified."

The dose for patients showing signs of toxicity would be dropped lower than suggested in the Saltz regimen, Schilsky said.

An approach considered by NCCTG involves dropping the starting dose of both CPT-11 and 5-FU/LV for all patients, and escalate it for patients who appear to be able to tolerate the therapy, Goldberg said.

"The data we are seeing suggests that there is a small percentage of the population that's particularly sensitive to the side effects of the combination of CPT-11and 5-FU/LV," Goldberg said. "One way to manage that is to reduce the starting dose, watch people like a hawk, and intervene to support them vigorously at the first sign of side effects."

The group is considering reducing the starting dose from 125 mg/m^2 to 100 mg/m^2 for CPT-11 and from 500 mg/m^2 to 400 mg/m^2 for 5-FU.

"It may be that the bar was set a little bit too high," Goldberg said.

According to the Camptosar package insert, 67 percent of patients treated in the Saltz regimen pivotal trial had adverse reactions that led to dose reduction. However, dose variations of the regimen have not been compared in randomized trials.

Changing the initial dose for all patients could amount to introduction of a new regimen, warns FDA oncology division director Pazdur. "The survival benefit of the approved regimen may not be retained if reductions in starting doses are made," he said.

Pharmacia Letter Announces Suspension Of Two Trials

Following is the text of a letter sent by Pharmacia to announce the suspension of the two trials of the CPT-11-containing regimen. The letter, dated April 10, was signed by Langdon Miller, vice president in charge of oncology operations in the US, and Ivan Horak, clinical vice president, oncology.

Dear Doctor,

The purpose of this letter is to inform you that enrollment in two NCI-sponsored cooperative group trials has been suspended because of preliminary safety information about the number and pattern of deaths on the weekly Camptosar plus bolus 5-fluorouracil and leucovorin arms of these studies.

NCCTG Study Evaluating First-Line Therapy for Metastatic Colorectal Cancer (Study N9741)

The North Central Cancer Treatment Group has temporarily suspended enrollment to their ongoing 3-arm first-line colorectal cancer trial (N9741) following a routine safety evaluation.

The External Data Monitoring Committee noted in April 2001 that the preliminary estimate of the mortality rate from any cause within 60 days of treatment initiation was 4.8 percent (14/289) on the Camptosar+bolus 5-FU/LV arm compared to 1.8 percent on each of the other two study arms.

Although the control arm mortality rate was not statistically significantly different from the other two arms of this study, the EDMC recommended temporary suspension of enrollment because the absolute number of deaths was higher.

CALGB Study Evaluating Adjuvant Colorectal Cancer Therapy (Study C89803)

The Cancer and Leukemia Group B announced the suspension of new patient accrual to study C89803 (Weekly Camptosar plus bolus 5-FU/LV versus weekly bolus 5-FU/LV for adjuvant colorectal cancer, an investigational use of Camptosar on April 27.

As a result of the NCCTG recommendation to temporarily suspend accrual to N9741, the CALGB Data Safety Monitoring Board reviewed the safety data from C89803 and found a higher than anticipated incidence of serious adverse events related to sepsis, diarrhea and thromboses.

The preliminary estimate of the mortality rate from any cause within 60 days of treatment initiation

on the Camptosar +bolus 5-FU/LV arm was 2.2 percent (14/635), compared to 0.8 percent (5/628) in the 5-FU/LV arm. There were no statistically significant differences in mortality rates between treatment arms.

On the basis of these developments, Pharmacia has conducted an additional analysis of mortality in the pivotal study which supported the registration of the weekly Camptosar plus bolus 5-FU/LV regimen. The mortality rate from any cause within 60 days of treatment initiation on the Camptosar +bolus 5-FU/LV arm was 7 percent (15/225), compared to 7 percent (16/219) in the 5-FU/LV arm. The mortality rate from any cause within 30 days of receiving drug during any cycle on the Camptosar +bolus 5-FU/LV arm was 9 percent (21/225) compared to 7 percent (15/219) in the 5-FU/LV arm. There were no statistically significant differences in mortality rates between treatment arms.

Since approval of the first-line indication in April 2000, an estimated 15,000 patients have been treated in the U.S., primarily with the weekly regimen. Recognizing the implicit limitations of any post-marketing surveillance system, no new patterns of toxicity have emerged.

Physicians should be aware that Camptosar can induce severe myelosuppression and both early and late forms of diarrhea that may be life threatening. Rare cases of ileus, complicated colitis, or renal impairment have been observed.

Camptosar is emetogenic, and premedication with anti-emetics is recommended. Patients should be instructed to inform their physician and nurses of any signs or symptoms of toxicity at their earliest manifestation so that appropriate supportive care and/or dose modifications can be promptly initiated. It is important to employ careful management of patients in accordance with the supportive care guidelines contained in the package insert for Camptosar.

In April 2000, Camptosar was approved as a component of first-line therapy in combination with 5-FU/LV for patients with metastatic colorectal cancer. Two treatment regimens were approved: 1) Weekly Camptosar plus bolus 5-FU/LV and 2) Camptosar plus infusional 5-FU/LV every 2 weeks. Each of these regimens prospectively demonstrated a significant survival benefit over 5-FU/LV. Any modification of the recommended regimens does not assure retention of efficacy or safer delivery.

Pharmacia is committed to the safety and well being of all patients receiving Camptosar as part of any standard or investigational treatment regimen, and thus felt it was important to inform you of these events. We will continue working with the cooperative groups, NCI, and FDA to fully evaluate the preliminary data reported by the NCCTG and the CALGB.

If you have any questions, please contact your local Pharmacia representative or the Pharmacia Medical and Drug Information 24-hour hotline at 800-253-8600, extension 38244, or via the Pharmacia Oncology Web site http://www.pharmaciaoncology.com.

Health Care Policy:

Medicare Expands Coverage For Lymphedema Pumps

HHS Secretary Tommy Thompson said Medicare will expedite coverage of pneumatic compression pumps to make it easier for Medicare beneficiaries with lymphedema to take advantage of the technology.

Thompson announced the expanded Medicare coverage on May 3 while working at the Baltimore offices of the Health Care Financing Administration. He moved his office to Baltimore for a week to give HHS and HCFA staff an opportunity to work together.

Medicare's new coverage policy eliminates language that made compression pumps the treatment "of last resort" for beneficiaries with lymphedema, an accumulation of lymphatic fluid causing abnormal swelling of the arms, legs, breast, neck or head that often develops when lymph nodes are removed during surgery. Breast cancer surgery is the most common cause of the condition in the U.S.

"It's important to make effective technologies available to Medicare beneficiaries when it helps them the most," Thompson said. "This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily."

Under the new coverage policy, Medicare will cover the pump if a beneficiary first undergoes an initial therapy of conservative care, which includes elevation, exercise and the use of a compression garment, for at least four weeks without results. The new policy eliminates the need for a Medicare beneficiary to purchase a more expensive, custom-made garment before being eligible to receive a pump.

"HCFA's new coverage process is helping Medicare make the right decisions, based on scientific

evidence, on when the program should cover new items, services and procedures," said Jeffrey Kang, director of HCFA's Office of Clinical Standards and Quality. "By getting this device, which is proven effective, to beneficiaries sooner, we are improving the health care available to the senior citizens and disabled Americans who rely on Medicare."

Further information on the coverage decision is available at http://www.hcfa.gov/coverage/8b3-z.htm.

NIH News:

Newest NIH Institute, NIBIB, Gets An Acting Director

NIH Acting Director Ruth Kirschstein appointed Donna Dean as acting director of the National Institute of Biomedical Imaging and Bioengineering, the newest NIH Institute.

NIBIB was formed by statute and was signed into law last December. HHS Secretary Tommy Thompson approved the establishment of NIBIB on April 20.

"Dr. Dean has extraordinary scientific and administrative skills, and I appreciate her willingness to lead NIBIB while we conduct a national recruitment effort to find its first permanent director," Kirschstein said. Thompson will appoint the permanent director.

The mission of NIBIB is to support the fundamental research that applies the principles of engineering and imaging science to biological processes, disorders and diseases. The Institute will facilitate the transfer of this basic research to medical application.

"As part of the NIBIB mission, the new Institute will coordinate the research of the NIH Institutes and Centers and will foster the exchange of information with other federal agencies," Kirschstein said. "While dedicating an Institute to medical technologies rather than to diseases, organ systems, or populations may seem novel for the NIH, it is truly a reflection of what science is today—and where science will be taking us tomorrow."

The creation of an agenda for research and research training will be the primary activity for NIBIB. In fiscal 1999, NIH's Institutes and Centers awarded about $447 million for bioimaging research and about $697 million for bioengineering research. The President's budget request for FY 2002 includes $40.2 million for NIBIB.

"I expect that the majority of the activity in other Institutes will continue while NIBIB will support important basic and crosscutting research in the bioengineering and imaging sciences," Kirschstein said.

Dean has served in the Office of the NIH Director as a senior scientific advisor for the past three years, and played a lead role in implementing the legislative establishment of NIBIB. She served as NIH liaison to the Congressionally-mandated Commission on the Advancement of Women, Minorities, and Persons with Disabilities in Science, Engineering, and Technology over the past two years. Dean received an A.B. degree in chemistry from Berea College in 1969, and a Ph.D. in biochemistry from Duke University in 1974. After postdoctoral work in cell and developmental biology at Princeton University, she joined the NIH intramural research program as a research chemist in biochemical endocrinology.

* * *

The National Institute of Environmental Health Sciences has funded five research centers to develop and breed mice with key genetic variations similar to those of humans.

The centers will provide the mice for NIH scientists and to other research programs. The centers named by NIEHS and their principal investigators are:

—Albert Einstein College of Medicine of Yeshiva University, Raju Kucherlapati.

—University of Washington, Seattle, Warren Lapiges.

—University of Cincinnati, Ohio, Peter Stambrook.

—University of Texas Health Science Center at San Antonio, Jan Vijg.

—University of Texas MD Anderson Cancer Center, Smithville, David Johnson.

NIEHS said it will spend up to $5 million a year in grants in each of the next five years to establish the five new centers—or about $1 million per center per year— under cooperative agreements. The centers will sequence mouse genes and compare them to human genes and their sequences, produce mice with mutations or missing genes ("knock-out" mice) and maintain breeding colonies to supply test rodents or breeding stock to other scientists.

Jose Velazquez, NIEHS program director for the mouse centers, said that the animals and the data will be made available to scientists.

The NIEHS mouse centers will support and supplement a $21 million NIH-wide effort to map the genes of the mouse via a Mouse Genome Sequencing Network.

Funding Opportunities:

RFA Available

RFA-NS-02-005: Research on Research Integrity

Letter of Intent Receipt Date: Oct. 15, 2001

Application Receipt Date: Nov. 19, 2001

The Office of Research Integrity, the National Institute of Neurological Disorders and Stroke and the National Institute of Nursing Research invite applications to support research on research integrity. Integrity in this context is understood as adherence to rules, regulations, guidelines, and commonly accepted professional codes or norms. Proposals are encouraged that will provide generalizable empirical knowledge about the ways in which researchers and research institutions meet or fail to meet their professional responsibilities in the conduct, evaluation, and reporting of research. The RFA will use the NIH individual research project grant R01 award mechanism. The RFA is available at http://grants.nih.gov/grants/guide/rfa-files/RFA-NS-02-005.html.

Inquiries: Karin Helmers, Office of Extramural Programs, National Institute of Nursing Research, Bldg., 45, Rm Number 3AN12, MSC 6300, Bethesda, MD 20892-6300, phone 301-594-2177; fax 301-480-8260; e-mail Karin helmers@nih.gov

Program Announcements

PA-01-087: Exploratory/Developmental R21 Research Grants

The Division of Extramural Research at the National Institute of Dental and Craniofacial Research invites applications for one-time grants to support innovative, high risk/high impact research requiring preliminary testing or development; exploration of the use of approaches and concepts new to a particular substantive area; research and development of new technologies, techniques or methods; or initial research and development of data upon which significant future research may be built.

The DES provides support for: (a) basic and clinical research on the processes that affect normal and abnormal development of craniofacial structures; (b) basic studies on the ecological, molecular, biological and physiological factors contributing to microbial virulence, colonization and transmission; (c) genetic determinants of host susceptibility to infection; (d) oral manifestations of HIV infection and AIDS; (e) basic and applied research related to head and neck cancers; (f) basic and clinical studies on neurobiology, pathogenesis, diagnosis, treatment or prevention of pain; (g) autoimmunity; (g) biomimetics, tissue engineering, instrumentation development and refinement (i.e., saliva based diagnostic technologies), and development of methods to improve biomaterials for the repair of orofacial structures; and (h) clinical, behavioral and health promotion studies related to craniofacial, oral and dental health. The objective of the exploratory/developmental grant R21 mechanism is to encourage applications

Applicants for the R21 award may request direct costs of up to $100,000 per year for up to two years. The R21 cannot be renewed; if sufficient data are generated during the term of the award, investigators could then apply for further funding through regular research grant, e.g., the research project grant R01 mechanism. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-01-087.html.

Inquiries: Rochelle Small, Craniofacial Anomalies and Injuries Branch, National Institute of Dental and Craniofacial Research, Division of Extramural Research , Natcher Bldg., Rm 4AN-24K, Bethesda, MD 20892, phone 301-594-9898; fax 301-480-8318; e-mail rochelle.small@nih.gov.

PA-01-091: Flexible System to Advance Innovative Research for Cancer Drug Discovery by Small Business

Letter of Intent Receipt Dates: June 6, 2001, March 6, 2002, Oct. 8, 2002

Application Receipt Dates: July 12, 2001, April 10, 2002, Nov. 12, 2002

Projects submitted in response to the PA should be focused on discovery and development of a specific agent or class of agents. Applications devoted to topics relating more generally to drug discovery such as technology and model development without direct relevance to development of a specific agent are not appropriate.

Flexibility within the PA allows for projects to be presented at all stages of the drug discovery and development process. Projects will be evaluated on Overall innovation, strength of the drug discovery approach, and probability of clinical success, with less emphasis on the nature of the specific stage proposed in the application. This aspect is especially important if applications are focused on later stages of the drug discovery and evaluation process that may be more routine and often considered less innovative as stand-alone projects.

Support for this PA is through the SBIR and STTR mechanisms which are set-aside programs. Applications can be submitted for support as Phase I STTR R41 or phase I SBIR R43 grants; phase II STTR R42 or phase II SBIR R44 grants; or the SBIR/STTR Fast-Track option. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-01-091.html.

Inquiries: George Johnson, Division of Cancer Treatment and Diagnosis, NCI, Executive Plaza North, Rm 8152, MSC 7456, 6130 Executive Blvd., Bethesda, MD 20892-7456; phone 301- 496-8783; fax 301-402-5200; e-mail johnsong@exchange.nih.gov

Other Funding Notices

Notice of Limited Competition for Competing Supplemental Applications to Disseminate Promising Cancer Control Interventions Tested in Effective Research Projects: NCI Division of Cancer Control and Population Sciences announces a limited competition for research projects supported by R01, P01, P50, U01 and U19 grant mechanisms. The purpose of these supplements is to fund the dissemination of promising interventions where statistical significance and potential public health/clinical significance of intervention effects strongly suggest the merits of dissemination to the broader population from which the intervention sample was drawn. The supplement may also support cost-effectiveness evaluations of interventions, qualitative and quantitative research needed to adapt intervention products for use after formal research evaluation has ended and dissemination of intervention products. The notice is available at http://grants.nih.gov/grants/guide/notice-files/NOT-CA-01-10.html.

Inquiries: Jon Kerner, assistant deputy director for research dissemination and diffusion, Division of Cancer Control and Populations Sciences, 6130 Executive Blvd., Executive Plaza North, Rm 6144, Rockville, MD 20852.

NCI Contract Award

Title: Encoding Surgical Pathology Data into Standard Nomenclature within XML. Contractor: Computer Science Innovations, Inc. Melbourne, FL. Amount: $836, 784.

In Brief:

Vermont Cancer Center's NCI Core Grant Renewed

(Continued from page 1)

Oncology Hematology PA; **Sandra Swain**, acting chair, NCI Medicine Branch; **Everett Vokes,** director, Section of Hematology/Oncology and the John E. Ultmann Professor of Medicine and Radiation Oncology at the University of Chicago. . . . **VERMONT CANCER CENTER** at the University of Vermont, in Burlington, has been awarded a five-year renewal of its core grant by NCI. The VCC has been an NCI cancer center for 22 years and a comprehensive center for nearly 10. The grant will support infrastructure and developmental funding to enhance and expand the VCC programmatic efforts in cancer prevention and control, cell signaling and growth control, genome stability and expression, and clinical research. "It's a fine endorsement of our research programs and permission to go full steam ahead in the coming years," said **David Yandell**, VCC director. . . . **BARNETT KRAMER** has been appointed associate director for disease prevention at NIH, effective May 6. In his new position, Kramer will serve as director of the Office of Disease Prevention with responsibility for advising the NIH Director on disease prevention research and coordinating prevention research across the institutes and centers of NIH. He will continue as director of the NIH Office of Medical Applications of Research and editor-in-chief of the Journal of the National Cancer Institute. Kramer served as deputy director of the NCI Division of Cancer Prevention from 1996 until 2000. . . . **SUSAN G. KOMEN** Breast Cancer Foundation received a $50,000 grant from Kaiser Permanente to support initial phases of the Young Women's Initiative. The award will fund a nationwide needs assessment of healthy women and breast cancer survivors ages 20 to 39. Results will be used for strategic planning for educational programs emphasizing awareness and early detection among young women. "We must educate young women about breast cancer so they can develop positive breast health practices early and be empowered to take charge of their health," said **Susan Braun**, president and CEO of the Komen Foundation. "This national grant from Kaiser Permanente Cares for Communities program is invaluable because it will support a comprehensive needs assessment, the first step toward achieving that goal.". . . **PAUL CARBONE** has received the University of Wisconsin Medical Alumni Association Clinical Science Emeritus teaching award. Carbone was director of the UW Comprehensive Cancer Center. . . . **OHIO STATE UNIVERSITY** Comprehensive Cancer Center is conducting a three-year, $375,000 study to evaluate health risks of consuming beef from cattle implanted with zeranol, a nonsteriodal estrogenic growth promoter. Funded by the Department of Defense Breast Cancer Research Program, the in vivo mouse study follows an earlier in vitro study which found that the serum and meat of beef cattle implanted with zeranol can alter the expression of estrogen-regulated genes in cultured normal and cancerous human breast cells in the cell line, MCF-7. Study results could identify zeranol as a synthetic dietary contaminant with estrogenic activity that stimulates breast cancer growth. "We have no proof, an we are thoroughly neutral on the matter," said **Young Lin**, professor of Veterinary Biosciences, member of the Comprehensive Cancer Center Hormones and Cancer Program and principal investigator of the study.

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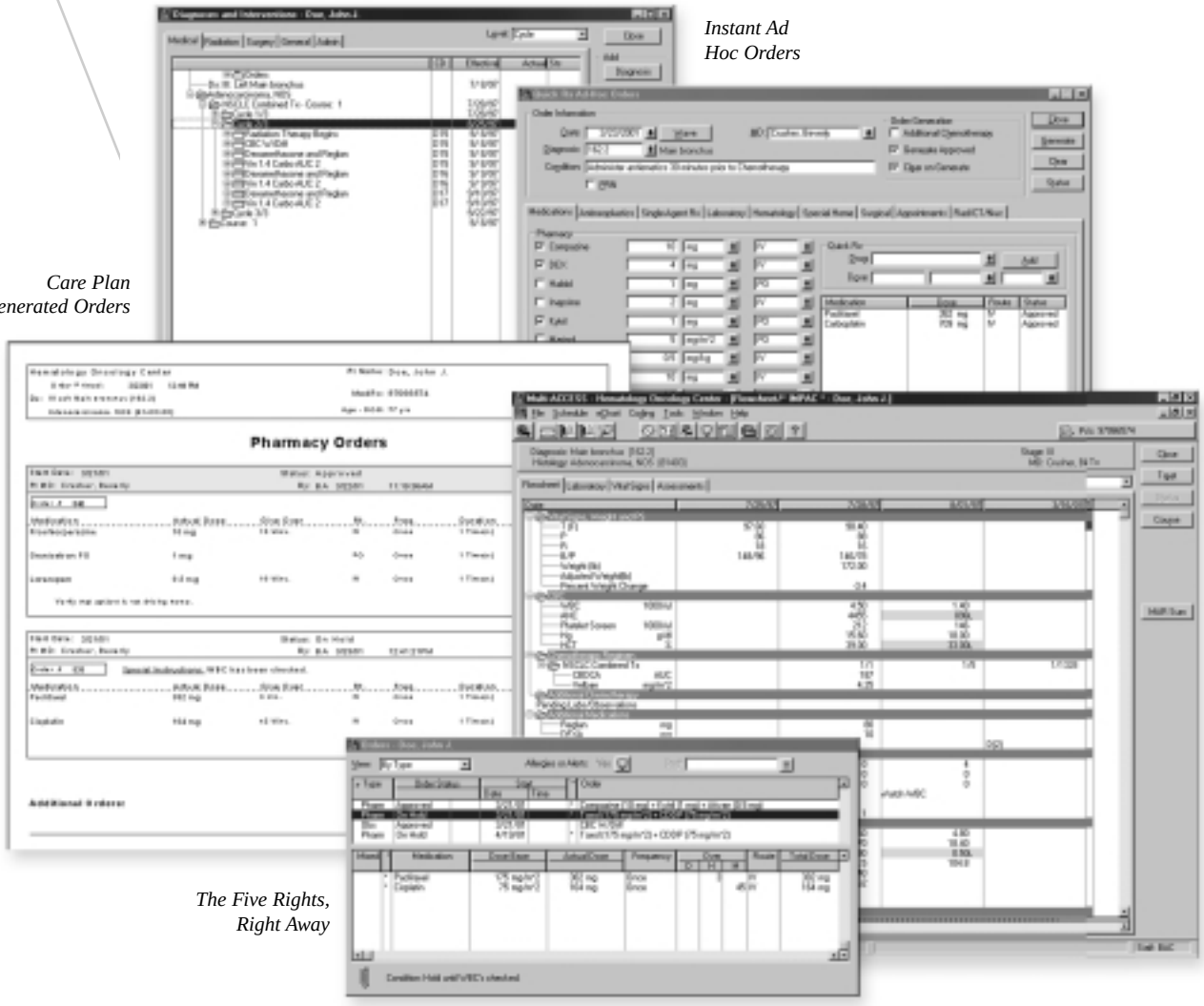

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